LONG-TERM CARE STRATEGIES IN INDUSTRIALIZED COUNTRIES: CASE STUDIES OF INSURANCE BASED AND NON-INSURANCE BASED LONG-TERM CARE SYSTEMS

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The demographic and epidemiological transitions will result in dramatic changes in the health needs of the world's populations. Everywhere there is a steep increase in the need for Long-term care (LTC). These trends reflect two interrelated processes. One is the growth in factors that increase the prevalence of long-term disability in the population. The second is the change in the capacity of the informal support system to address these needs. Both of these processes enhance the need for public policies to address the consequences of these changes.

The growing need for LTC policies is generally associated with industrialized countries. What is less widely acknowledged is that long-term care needs are increasing in the developing world at a rate that far exceeds that experienced by industrialized countries. Moreover, the developing world is experiencing increases in LTC needs at levels of income that are far lower than that which existed in the industrialized world when these needs emerged.

Therefore, the search for effective LTC policies is one of the most pressing challenges facing modern society. Recognizing that such trends greatly increase the need for well coordinated and cost-effective LTC, the World Health Organization (WHO) launched a global initiative, with the JDC-Brookdale Institute leading this effort.

The goal of the project is to prepare a practical framework for guiding the development of long-term care policies in developing countries.

This process is based on a number of major premises:
1. Previous efforts have not been successful in identifying meaningful policy guidelines that are appropriate to the unique situations of developing and middle-income countries.
2. A key resource in formulating LTC policies for developing countries is their own existing experience.
3. LTC policies in the developing world need to reflect each country's unique conditions, which have to be understood in much more depth and complexity.
4. There is much to be learned from the experience of industrialized countries in order to define the range of options and to identify successful and unsuccessful policy practices.
5. There is a need to create a deeper and more informed dialogue between the experiences of industrialized and developing countries so that there can be a mutually beneficial learning process.
Over the course of the project, a number of steps have been taken to promote the exchange of experience. In 1998, a comparative review of the implementation of long-term care laws based on legislation and entitlement principles in five industrialized countries (Austria, Germany, Israel, Japan and the Netherlands) was carried out and summarized in a widely distributed report: Long-Term Care Laws in Five Developed Countries (WHO/NMH/CCL/00.2). In implementing this study, a framework was developed for cross-national comparisons of long-term care policies that address the needs of policy makers.

In December 1999, a meeting of a group of long-term care experts from the industrialized and developing world identified specific issues in LTC provision in developing countries. Their general recommendations were submitted in a report and accepted by the 108th WHO Executive Board (WHO Technical Report Series, No. 898), and ratified by the 54th World Health Assembly in May, 2001.

One lesson from this workshop was that to go beyond previous discussions requires a more in-depth understanding of the existing situations in developing countries and the nature of the variance among countries. Thus, a plan was developed to request in-depth case studies from experts in middle-income developing countries, and in April 2001 a second workshop was organized with these experts to discuss the framework for the preparation of these case studies.

This framework was designed to emphasize additional elements that would be important in the developing country context, and also to examine the more general health and social policies and service structure along dimensions that have major implications for long-term care. Case studies of the general health system and current LTC provision in eleven developing countries were written by local health care experts (People’s Republic of China, Costa Rica, Indonesia, Lebanon, Lithuania, Mexico, Republic of Korea, South Africa, Sri Lanka, Thailand, and Ukraine).

Furthermore, to complete and broaden the picture of patterns of LTC policies in industrialized countries, case studies of countries without a legislative framework, including Australia, Canada and Norway, were commissioned.

An additional perspective was provided on the experience of the industrialized countries by commissioning a set of papers on key crosscutting issues such as:

- The role of the family and informal care, and mechanisms to support the family
Issues of coordination among various LTC services, and of LTC with the health and social service systems

Human resource strategies in delivering LTC

A series of videoconferences that opened a dialogue between WHO Headquarters and the six Regional Offices on desirable directions for long-term care was also conducted.

The next step was to convene the group of leading experts from industrialized and developing countries who had prepared the papers, together with WHO Regional Representatives and key WHO Headquarters’ staff.

Two integrative papers on the overall patterns identified and lessons learned from the case-studies of industrialized and developing countries were prepared by the Brookdale team for the meeting, which took place in November 2001 in Annecy, France.

The purpose of the meeting “Bridging the Limousine – Train – Bicycle Divide” was to assess what has been learned thus far from the experiences of both industrialized and developing countries that can contribute to the development of LTC policies for developing countries. The report from the meeting ("Lessons for Long-Term Care Policy", WHO/NMH/CCL/02.1) gives a broad overview of the nature of the background materials that were prepared and the issues that were discussed. It also presents some general conclusions that were agreed on by the participants.

In parallel, work was proceeding to estimate the current and future long-term care needs globally. R. H. Harwood and A. A. Sayer analyzed the 1990 WHO Global Burden of Disease data and prepared estimates for all WHO Member States, which are published on the web site http://www.who.int/ncd/long_term_care/index.htm and summarized in a report ("Current and Future Long Term Care Needs" WHO/NMH/CCL/02.2).

Another complimentary area of work related to family caregiving in countries with high HIV/AIDS prevalence. E. Lindsey completed several qualitative studies, focusing on Community Home-Based Care and its effects on young girls and older women. She summarized the findings from studies in Botswana, Cambodia, Haiti, Kenya, Thailand and South Africa in a guideline ("Community Home-Based Care in Resource-Limited Settings. A Framework for Action." ISBN 92 4 156213 7, WHO, Geneva, 2002).
The theoretical framework for this guideline had been developed by JDC-Brookdale for the analysis of LTC laws in 5 industrialized countries.

One additional area of work relates to ethical responsibilities in LTC and the ethical discussion countries need to initiate as input into the determination of the priority of LTC and the considerations in designing fair and just policies.

This volume is part of a series of publications designed to make the full and final materials developed through the project more widely available:

1. Major issues in the design of long term care. A review based on the experience of industrialized countries (already published).
2. Patterns of variation in LTC strategies in industrialized countries: case studies of countries with and without national LTC legislation (this volume)
3. Emerging approaches to LTC in developing countries: ten case studies (forthcoming)
4. Framework for guiding the development of long-term care policies in developing countries (forthcoming)
5. Ethical Choices in Long term Care. What does Justice Require?
INTRODUCTION

Population aging, enabled mainly by advances in standards of living, medicine and technology, is one of the most significant achievements of the 20th century. It also presents new challenges to all societies. Demographic and epidemiological changes result in dramatic shifts in the health needs of the world's populations. Everywhere there has been a steep increase in the need for management of chronic diseases and for long-term care. At the same time, there has been a worldwide decline in the capacity of the informal support system to address these growing care needs. In most countries, care has traditionally been a family task - mainly performed by women. The increasing proportion of women in the labor market and the declining ratio between those needing care and those who are potential caregivers (the “daughter generation”) are raising questions about the family’s ability to care for the elderly and disabled to the same extent.

Countries throughout the world are struggling to develop long-term care systems and policies that will meet the basic needs of the disabled elderly, ensure the most appropriate and effective care in the least restrictive environment, contain costs, and find an appropriate balance between the role of the family and that of the state.

There is considerable variation in the way countries address this challenge, and national policies have been undergoing very significant change in the last decade. This monograph examines case studies of long-term care systems in a number of industrialized countries. It has three goals:
1. To identify patterns of variation in addressing key issues in the design of long-term care systems.
2. To identify the major trends emerging in the long-term care systems in these countries.
3. To understand the considerations that underlie these patterns and trends.

One of the significant developments has been the introduction of insurance-based long-term care systems in a number of countries. Therefore, particular attention will be given to comparisons between the approaches in countries with insurance-based systems (Austria, Germany, Netherlands, Israel and Japan) and non-insurance based systems (Australia, Canada (Quebec), and Norway).

In insurance-based programs, everyone who fulfills eligibility criteria must be granted benefits, regardless of available budgets. Such programs are almost always established
through specific legislation, and allow costs to be contained only through changes in eligibility criteria, which usually requires changes in legislation.

In *non-insurance — or budget constrained — programs*, service provision is dependent on limited funds, that is, services do not have to be provided once the budget runs out, even to those who meet eligibility requirements. Applications for services within a given budget year can either be denied, or the applicant put on a waiting list. Costs can thus be contained through planned budget allocations, rather than only by adjusting eligibility criteria.

This monograph begins with a definition of long-term care and an overview of the needs for long-term care in the industrialized countries reviewed. Following are three comprehensive case studies of long-term care systems that operate on a non-insurance basis: Australia, Canada (specifically, Quebec), and Norway (chapters 3, 4, 5, respectively). The chapters are based on a framework developed collaboratively by the case study authors, the WHO and the JDC-Brookdale Institute.

Section I (of each chapter) includes a general description of the country’s social structure, and information on important economic, demographic, and epidemiological trends, using data from international sources. Section II includes an overview of the country’s general health and social care systems and the relative position of long-term care services within these systems. Section III presents information on current long-term services. Section IV assesses present and future needs for long-term care, and emerging and desired future policy directions.

We then briefly review the systems in countries that have enacted long-term care legislation (chapters 6, 7, 8, 9 and 10). The five countries that fit this category (Austria, Germany, Netherlands, Israel, and Japan) ensure access to long-term care services based on principles of social insurance. A more comprehensive description of these systems was published in a previous volume in this series (WHO, 2000. where possible, we have updated the data for this publication)¹.

The final chapter identifies some of the broad overall patterns and trends, and compares how countries that have chosen insurance-based and non-insurance based approaches have addressed major policy design issues.

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We should caution that it is often difficult to draw clear-cut conclusions from the experience of countries because there is little systematic evaluation of the implementation and outcomes of long-term care systems. Nevertheless, the case studies presented herein constitute an important resource for understanding the range of possible policies, gaining insight into the interaction between the resolution of different specific design issues, and understanding how various considerations play a role in developing these systems.
DEFINITION OF LONG-TERM CARE
AND THE NEED FOR LONG-TERM CARE

Defining LTC

Long-term care refers to the provision of services for persons of all ages who have long-term functional dependency. Dependency creates the need for a range of services, which are designed to compensate for the limited capacity to carry out activities of daily living. Dependency also results in difficulty gaining access to health care and complying with health care regimes. It affects the ability of the individual to maintain a healthy lifestyle, and to stave off deterioration in his health and functional status. Dependency also creates emotional strain and hence need, which must be addressed. Social needs also arise from limitations on maintaining regular social contacts.

Unique health problems may arise, depending on the single or multiple chronic diseases may be the source of the disability. These in themselves require complex health services and special regimes of chronic care management. Moreover, the combination of illness and functional limitation generates even greater problems, most obvious among which is limited mobility, which may require services to be brought to the home. Other problems, such as cognitive impairment, may prevent the individual from complying with complex medical regimes.

The family plays a major role in caring for the dependent elderly. The provision of this care may impinge on aspects of a family's own functioning, as well as on relationships within the family. It creates a need to manage the relationship between the disabled person and the family, as well as among family members, in relation to their roles in providing care. These circumstances require a significant effort to guide, educate, and inform the disabled person and their families.

Dependency creates a complex range of needs for services, which in turn creates a need to coordinate access to and management of these multiple services. This care management function is a need in itself.

Types of Long-term Care Services

Long-term care may be provided in either community or institutional settings. Community based care may be provided either in the home, or in the community but outside the home. Institutional care includes a range of services, from nursing homes that provide intense nursing care, to residential homes that provide a protected environment for frail older adults. Community-based care includes home care – that is, care related to daily functioning such
as personal care (e.g., bathing, dressing, eating) or homemaking (e.g. cooking, cleaning, errands), and home health care – that is, health-related care, such as skilled nursing. It also includes other services in the community such as day care and meals on wheels.

Long-term care can be provided formally by paid caregivers, or informally by persons who do not receive pay.

**Formal care** services may be provided by government organizations; by local, national, or international non-government organizations (NGOs); or by for-profit organizations. Formal care is usually provided by authorized professionals (e.g. nurses, physicians, social workers), and/or by paraprofessionals (e.g., personal care workers). Traditional healers may be an important additional source of care.

**Informal care** is provided by nuclear and extended family members, neighbors, friends, independent volunteers, and organized volunteers (e.g., through religious groups).

**The Need for Long-term Care**

Trends in industrialized countries clearly indicate a growing need for long-term care. These trends reflect two interrelated processes. One is the growth in factors that increase the prevalence of long-term disability in the population. The other is a change in the capacity of the informal support system to address this need. In this section, we briefly review demographic social trends that are leading to the increased need for long-term care using statistics from the eight countries reviewed.

As the population ages, the percentage of people with chronic diseases and related disabilities increases significantly. As seen in Table 1, a significant proportion of the population in the countries reviewed is elderly, and significant increases are projected in the coming decades. The percentage of those age 65 and over in the industrialized countries reviewed in this book ranges from 9.9% in Israel to 17.2% in Japan. By 2025, this percentage will have grown by 40% in Israel and by 60% in Japan. Even more dramatic growth is expected in the number of those over age 80, who are more likely to be frail and to need sustained care. The percentage of those age 80 and over ranges from 2.1% in Israel to 4.5% in Norway. Between 2000 and 2025, Germany, Austria, and Japan will experience an increase of between 100% and 200% in the percentage of people in the oldest age range (aged 80 and over).
### Table 1: Selected Socio-demographic and Epidemiological Indicators Relevant to the Determination of LTC Needs

<table>
<thead>
<tr>
<th></th>
<th>Israel</th>
<th>Australia</th>
<th>Canada</th>
<th>Netherlands</th>
<th>Norway</th>
<th>Austria</th>
<th>Germany</th>
<th>Japan</th>
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<td>2000</td>
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<td>14.0</td>
<td>18.6</td>
<td>20.7</td>
<td>21.9</td>
<td>21.8</td>
<td>24.3</td>
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<td>% of 80+</td>
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<td>27.7</td>
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<td>Proportion of population requiring care ***</td>
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<td>2030</td>
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<td>Female labor force participation (ages 20-64)</td>
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<td>1960</td>
<td>29.4</td>
<td>29.5</td>
<td>30.6</td>
<td>20.8</td>
<td>24.8</td>
<td>50.2</td>
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<td>2000</td>
<td>62.8</td>
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<td>78.5</td>
<td>58.0</td>
<td>64.7</td>
<td>65.9</td>
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</table>


* Elderly support ratio: the ratio of those age 65 and over per 100 persons age 20-64.
** Parent support ratio: the ratio of those age 80 and over per 100 persons age 50-64.
*** Proportion of population requiring care: projections of people in the most dependent categories of the GBD Study (6 and 7), who may need assistance with ADL (Harwood, 2002).
**** Disability dependency ratio: the ratio of dependent people per persons age 15-59 (Harwood, 2002).

Population ageing is caused primarily by a decline in fertility. It is thus associated with a decline in family size, and an attendant rise in the number of elderly, relative to younger members of the population (as reflected in the parent and elderly support ratios). This increases the pressure on children, who are a major source of support for the elderly. As can be seen in Table 1, the elderly and parent support ratios in most of the countries examined, and especially in Japan, are expected to increase significantly in the next 25 years.

While aging is the primary explanation for the increased need for long-term care, there is also a significant population of younger disabled who are functionally dependent and require long-term care. Younger people with disabilities may require more intense services, for longer periods of time. Major causes of functional dependency among younger people are chronic disease, accidents, and developmental abnormalities.
There are no universally applied standards for measuring functional dependency. Using Global Burden of Disease Study data, Harwood (2002) estimates that in 2000, the proportion of the population requiring assistance with daily care ranged from 4.1% in Australia to 5.4% in Israel. This proportion is expected to increase significantly over the next 25 years. At the same time, fewer working-age people are expected to be available to provide that assistance. The disability dependency ratio – representing the availability of people age 15-59 to care for dependent people of all ages who require daily care – will increase by around 50% between 2000 and 2030 in the countries reviewed in this monograph.

The relative resources available to address the need for long-term care may be approximated using the per capita GDP (gross domestic product, adjusted for purchasing power parity)\(^2\). The level of resources in the industrialized countries included in this monograph ranges from a per capita GDP of $18,900 in Israel to one of $27,700 in Norway. In the year 2000, health care expenditures ranged from 7.8% of GDP in Japan to 10.9% of GDP in Israel.

Concomitant with demographic and epidemiological changes are forces that affect the ability of informal support systems to provide care. Families – mainly women – who provide most long-term care, are becoming less able to meet increased care-giving responsibilities. During recent decades, more women have entered the labor force, and families have become smaller and more geographically dispersed. Labor force participation of women aged 20 to 64 in 2000 ranged from 58% in the Netherlands and in Austria to more than 75% in Canada and Norway. As shown in Table 1, most of these countries have experienced a dramatic increase in the proportion of women in the workforce over the past forty years. For example in Norway the proportion of women in the labour force in 1960 was 24.8%, representing an increase of more than 200%.

Moreover, industrialized countries have experienced a significant rise in the proportion of elderly living alone. In the 1990s, approximately half of the elderly women in Norway and Germany lived alone, and approximately one-third in Australia and Canada. The proportion of elderly living alone in Japan was much lower, and approximately 15% of women lived alone, but has been increasing (Kinsella and Velkoff, 2001).

\(^2\) PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries. All amounts are in Australian dollars unless otherwise indicated.
References


CASE STUDIES OF LONG-TERM CARE POLICIES
IN COUNTRIES WITHOUT LEGISLATION

I. Case Study of Australia -- by Anna Howe

1. General Background Data

1.1 Preamble

Australia became a federation in 1901, when the former British colonies became States and Territories under a single Commonwealth constitution. There are three levels of government. The Commonwealth, or federal government, deals with national concerns, major forms of taxation, and hence funding of most health and welfare programmes, including income support. The state and territory governments are responsible for delivery of education, health and social services. Local government is responsible for providing municipal services such as water supply, waste control, building regulations and community services. With some agencies that provide care to the elderly dating back to the colonial era, it is not surprising that responsibility for funding, administering, and providing care and other services for older people is spread across all levels of government, the private for profit and nongovernmental organization (NGO) sectors, and families. How these responsibilities should best be shared remains a continuing theme in policy debates in long term care.

Presented in detail on the following pages and briefly summarized below are background data derived from international databases. These data include demography, vital statistics and epidemiology, economic data, and health expenditure. A wide range of further information on all aspects of ageing in Australia is available in the publication Older Australians at a Glance, compiled by the Australian Institute of Health and Welfare (AIHW, 2002).

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3 For consistency reasons data used in this section are taken from international data sources:
UN, World Population Prospect, the 2000 revision (median variant);
WHO, World Health Report 2002; World Bank, World Development Indicators Data Base;
In 2000, Australia had a population of 13.1 million, 12.3% of whom were aged 65 or over. Accordingly, Australia has one of the youngest populations of the nations of the Organisation for Economic Cooperation and Development (OECD nations). The rate of growth in this age group is expected to slow over the decade from 1996 to 2006, due to the uneven size of the cohorts reaching old age, but will increase markedly from 2011, when the baby-boom cohorts begin to reach age 65. Australia will only reach the level of ageing already experienced in many European countries around 2016, when it is projected that 16% will be aged 65 years or over. It is estimated that the proportion of elderly will reach 18.6% by 2025 and 22.4% by 2050.

The more significant demographic change will be in the 'old-old' population. In 2000, those over 80 represented 2.9% of the population, but by 2025 that percentage is expected to grow by 50% (to 4.4%). Demographers and actuaries have drawn attention to the need for closer examination of the differential trends in growth of the 'young-old' and 'old-old', and especially to the need to consider more dynamic projections of mortality at very old age. Even relatively modest increases in life expectancy at advanced old age would have considerable impact on the need for care for the elderly, since demand for such services is greatest at very advanced ages.

The elderly support ratio, which measures the number of persons aged 65 and over per 100 persons aged 20–64, is presently 20.4 and is expected to reach 32.2 by 2025. The parent support ratio, which measures the number of persons aged 80 and over per 100 persons age 50–64, is currently at 18.3 and is expected to reach 23.0 by 2025. This last ratio is especially useful as an indicator of the growing pressure of caregiving responsibilities.

Life expectancy at birth is 80 years (82.6 for women and 77.4 for men), and at 60 is 22.5 (25 for women and 20 for men). Based on estimates for healthy life expectancy (HALE), Australians spend approximately 10% of their life in ill health (healthy life expectancy at birth is 71.6), and 20% of their life after age 60 in ill health (healthy life expectancy at 60 is 17.6).

Based on WHO estimates, in 2000 approximately 4.1% of the total population had a disability requiring daily care. This rate is expected to reach 4.9% by the year 2030. The disability dependency ratio, expressed as the number of dependent people per population aged 15-59, stands at 6.5, and is expected to reach 8.6 by 2030 (Harwood, 2000)

A final distinctive feature of population ageing that will become increasingly evident in coming decades is the ageing of the large numbers of migrants who came to Australia as
young adults between 1950 and 1970. This trend is foreshadowed in the increase in the proportions born in countries where English is not the main language increasing from 14% among those aged 85 and over to 23% among those aged 65 to 74. The two largest groups are those born in Italy and in Greece, and the increasing diversity in the ethnic and cultural composition of the older population poses particular challenges for the delivery of long term care.

1.2 Background Data from International Databases

Demography (year 2000)

<table>
<thead>
<tr>
<th>Population (thousands) (2001)</th>
<th>19,421</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land area (sq km)</td>
<td>7,617,330</td>
</tr>
<tr>
<td>Population density (per sq km)</td>
<td>2</td>
</tr>
<tr>
<td>Population growth rate (% 2000–2005)</td>
<td>0.99</td>
</tr>
<tr>
<td>Urban population (%)</td>
<td>91</td>
</tr>
</tbody>
</table>

**Ethnic groups (%):**

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Aged 65+</th>
<th>Total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Born in Australia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Born in English speaking countries</td>
<td>67</td>
<td>75</td>
</tr>
<tr>
<td>Born in non-English speaking countries</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Born in Greece</td>
<td>20</td>
<td>13</td>
</tr>
</tbody>
</table>

**Age structure (%):**

<table>
<thead>
<tr>
<th>Age group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–14</td>
<td>20.5</td>
</tr>
<tr>
<td>15–24</td>
<td>14.1</td>
</tr>
<tr>
<td>60+</td>
<td>16.3</td>
</tr>
<tr>
<td>65+</td>
<td>12.3</td>
</tr>
<tr>
<td>80+</td>
<td>2.9</td>
</tr>
</tbody>
</table>

**Projections 65+ (%):**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2025</td>
<td>18.6</td>
</tr>
<tr>
<td>2050</td>
<td>22.4</td>
</tr>
</tbody>
</table>

**Projections 80+ (%):**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2025</td>
<td>4.4</td>
</tr>
<tr>
<td>2050</td>
<td>7.6</td>
</tr>
</tbody>
</table>

**Sex ratio (males per female):**

<table>
<thead>
<tr>
<th>Total population</th>
<th>1.05</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-64</td>
<td>1.05</td>
</tr>
<tr>
<td>65+</td>
<td>1.02</td>
</tr>
</tbody>
</table>

**Dependency ratio:**

<table>
<thead>
<tr>
<th>Ratio in 2000*</th>
<th>20.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratio in 2025</td>
<td>32.2</td>
</tr>
<tr>
<td>Ratio in 2000**</td>
<td>18.3</td>
</tr>
</tbody>
</table>

**Parent support ratio in 2025**

| Ratio | 23.0 |

* Elderly support ratio: the ratio of those aged 65 and over per 100 persons aged 20–64.
** Parent support ratio: the ratio of those aged 80 and over per 100 persons aged 50–64.
## Vital Statistics and Epidemiology

### Crude birth rate (per 1000 population)(2000)
- 12.7

### Crude death rate (per 1000 population)(2000)
- 7.4

### Mortality under age 5 (per 1000 births)(2001)
- **Males**: 7
- **Females**: 5

### Probability of dying between 15–59 (per 1000) (2001)
- **Males**: 94
- **Females**: 54

### Maternal mortality rate (per 100 000 live births) (1995)
- 6

### Total fertility rate (children born/woman) (2001)
- 1.8

### Life expectancy at birth (years) (2001)
- **Total population**: 80
- **Male**: 77.4
- **Female**: 82.6

### Life expectancy at 60 (years) (2000)
- **Total population**: 22.5
- **Male**: 20
- **Female**: 25

### Healthy life expectancy (HALE) at birth (years) (2001)
- **Total population**: 71.6
- **Male**: 70.1
- **Female**: 73.2

### Healthy life expectancy (HALE) at 60 (years)(2001)
- **Male**: 16.4
- **Female**: 18.8

### Disability rate and Disability dependency ratio (%)**

#### Disability rate
- **2000**: 4.1
- **2030**: 4.9

#### Disability dependency ratio
- **2000**: 6.5
- **2030**: 8.6

---

*** Disability rate: Proportion of total population requiring care based on two severest Global Burden of Disease study disability categories (levels 6, 7); Disability dependency ratio: total number of dependent people/population 15–59.
Economic Data (year 2000)

GDP – composition by sector
Agriculture 3%
Industry 26%
Services 71%

Gross national income (GNI) ($PPP) **** 479 billion
GNI – per capita ($PPP) 27 970
GNI – per capita (US$) 20 240

GDP growth (annual %) (1999–2000) 1.9
Labour force participation
Male 57.6
Female 44.5

Health Expenditure (Year 2000)
% of GDP 8.3
Health expenditure per capita ($PPP) 2213
Health expenditure per capita (US$) 1698

2. General Health and Social System

2.1 Programme and Legislative Framework
The main features of Australia's long-term care system derive from the fact that it is made up of a bundle of programmes that provide a range of community care and residential care services. These programmes are integrated to varying degrees with each other and separated from health and social welfare programmes in terms of legislative and funding arrangements. Some of these programmes serve overlapping target populations, but long term care for the frail aged is largely separate from services for younger people with disabilities, and this paper focus on long term care for the aged.

Although there is still no single legislative framework for long term care, the Australian system is not characterised by the division between health services and social care services along the lines of most European countries. Indeed, the term 'social care' is not used in Australia in the sense that it is used in the OECD countries. Australia has thus avoided conflicts over which services are 'health' services, and hence to be provided by health

**** PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries
authorities and free of charge to be consistent with universal health care systems where they exist, and which are 'social care' services to be provided by social services authorities and hence to be subject to means testing.

The foundations of a separate system of long term care that encompasses health and social care services delivered in both residential (or institutional) settings and to older people living in the community lie in accidents of history rather than being the product of purposeful policy design. The last two decades have seen numerous policy and programme initiatives to develop more comprehensive and integrated services, and most services for the frail aged are now provided through one of two Acts.

1. **The Home and Community Care Act**, implemented in 1984, established a joint federal-state programme that brought together some 13 previously separate programmes that had grown up over the preceding 30 years. As those programmes covered all age groups, HACC continued to cover younger people with disabilities as well as the frail aged. HACC includes both the health and social services that commonly make up community based long term care, but even prior to that time, the historical development of community care services meant that there was not a division between health care provided by health services and social care provided by local government. Historically, local government has never had a mandated responsibility for “social care” and today only has a prominent role in community care in Victoria (and even this is not legislated). In other states, social care services are provided primarily by a number of large not-for-profit agencies. Many of these agencies were set up as voluntary community organisations 50 to 100 years ago (some have their origins prior to the federation of the Australian states in 1901), and only subsequently received government funding. Domiciliary nursing agencies have similar histories and only in two states is nursing provided through state government health services. And yet again, in two states, domiciliary nursing and allied health are provided together with social care services by single agencies which each receive around 65% of HACC funding in the state. Most HACC funding goes to a small number of these large agencies in each state, but the programme has an important community development role and so operates through a commensurately large variety of smaller agencies, such as those serving particular ethnic communities. The Commonwealth also provides funding for advocacy and representative groups under the Community Sector Support Scheme. Among the major groups are the national and state divisions of the Alzheimer’s Association and the Carers’ Association, as well as a range of disability groups. These groups play an important role in promoting community awareness of the impact of ageing and the needs of various groups.
2. The Aged Care Act passed in 1997 brought together two strands of residential care that had previously operated under separate legislation. Hostel care, now termed low level care (and similar to some forms of sheltered housing in the UK and assisted living in the US), was previously provided under the Aged and Disabled Persons’ Homes Act and nursing home care, now high level care, was provided through sections of the National Health Act. As the names of these acts imply, hostel care grew out of the housing sphere, while nursing home benefits were established in 1964 to address shortcomings in the health insurance arrangements that then applied with regard to coverage of patients requiring long term care. The question of access to free health services in long term care did not arise as, at that time, as Australia did not have a universal system of health insurance, and not all of the aged population was covered by the Pensioner Medical Scheme.

The boundaries between service programmes within LTC and with other policy spheres remain dynamic and permeable, with new initiatives in one area having an impact on other areas. Three areas of dynamism over the last two decades warrant note.

First, a number of large not-for-profit agencies that were traditionally providers of nursing home and hostel care have become involved in a variety of community care services. These agencies are recognised as “approved providers” under both the Aged Care Act and the HACC Act, and this dual approval has enabled them to develop services that serve as a bridge between care that is provided in residential care facilities and services delivered to individuals in their own homes. As well as using their residential facilities as a base for respite care and day care, they have had the organisational capacity to take on case management services, drawing on a wider range of direct care services through use of brokerage funds. The widening scope of these agencies is not only breaking down of the division between community care and residential care services provided to older people, but is bringing about a major change in the structure of the long term care sector.

The second area that has seen major change is the increasing separation of long term care for younger people with disabilities from care for the frail aged. The International Year of the Disabled Person in 1981 can be seen as the point of departure on separate pathways of development for disability and elderly care services, driven by differences in underlying philosophies and the emergence of a strong disability movement well in advance of the consumer movement among the elderly. The Commonwealth transferred provision of residential care for younger people with disabilities from the nursing home and hostel programmes to the Disability Services Programme under the 1986 Disability Services Act.
From 1991, these services became part of the accommodation component of the Commonwealth State Disability Agreement (CSDA) under the Act.

The scope of the CSDA is much wider than the long term care programme for the aged, and rather than establishing joint responsibilities, the CSDA defined clear responsibilities for each level of government. The Commonwealth has responsibility for income support and employment services for people, and the States are responsible for a range of education and training, accommodation and social care services, with an emphasis on services that promote access to generic services in the community rather than separate provision. There is only limited overlap in the kinds of social care services provided under the CSDA and those delivered through HACC, although many providers receive funding from both sources. The continued coverage of younger people with disabilities by HACC is something of an anomaly, it has not proved possible to reach agreement in principle on splitting HACC on an age basis, or in practical terms of the amount of funding that would be allocated to the younger population.

The third development is the emergence of a number of small programmes focused on particular problem areas. Many of these programmes begin on a pilot basis with short term funding provided through annual budget appropriations, outside either the HACC Act or the Aged Care Act. The main areas in which these initiatives have been taken are dementia care, carer support and post acute care, and many have served as catalysts to change in the mainstream programmes as well as adding separate services. Two of the most important initiatives, the National Care Respite Programme and Community Aged Care Packages (CACPs), are discussed below. While these additional services have added to the range and volume of community care in particular, the proliferation of separate programmes has created considerable complexity for governments, providers and services users, and has become a matter for policy attention.

2.2 Income Maintenance Programmes
Those requiring long-term care remain eligible to receive income support and health care through general social security and health care programmes. The most important interface with the retirement incomes system is in terms of means testing for the receipt of long-term care services and benefits.

Australia’s retirement income support system is part of a wider social security system that provides a guaranteed minimum income through a range of benefits to various groups. These benefits include:
• support for single parents and children on an income test basis;
• unemployment benefits;
• income support for those who cannot work due to disability; and
• support for the retired.

Eligibility for the Australian Age Pension is currently 65 years for men and 60.5 years for women, and moving progressively up to 65 by 2012. Unlike most other OECD countries, the Age Pension is funded from general revenue rather than social insurance contributions. It provides a flat rate pension subject to a means test; the recipient's home is exempt from this test. The other two pillars of the retirement income system are a compulsory retirement savings scheme, known as the Superannuation Guarantee Charge (SGC), which was introduced in 1989, and private pension plans over and above the SGC, and confined mainly to higher income groups.

The income distribution of the elderly is divided approximately as follows:
• 25% who have no income other than the Age Pension;
• another 25% who have limited private incomes and who receive a part pension close to the full Age Pension;
• a further 25% who have greater means of their own and who receive only a relatively small part Age Pension, and
• a final 25% whose wealth places them beyond the means test limits.

Retirement incomes are highest among men at an early phase of their retirement. By contrast, the majority of elderly who use long-term care services are women aged 80 and over, and so are more likely to be more reliant on the Age Pension. Fully 77% of those in residential care receive a full or part Age Pension, and another 14% receive a Veteran’s Pension. Similarly, 66% of the aged clients of the HACC Programme receive a full or part Age Pension or Veteran’s Pension, and the majority of younger HACC clients receive some another form of Government income support, mainly the Disability Support Pension. Only 6% of all HACC clients are not in receipt of any benefit. The means-testing arrangements for the Age Pension provide the basis for setting fees for both community services and residential care for the frail elderly.

Two further cash payments relate directly to long-term care.
• The Carer Payment is paid to individuals who are unable to participate in the paid workforce because of their caregiving responsibilities; the Carer Payment is paid by exception to those who do not qualify for other forms of income support, and when both
the beneficiary and the person they care for meet the requirements of a means test. The amount of the Carer Payment is the same as other income support payments.

- The Carer Allowance, a much smaller cash benefit is paid in recognition of carers’ contributions to supporting individuals in need of care; eligibility is based on assessment that the individual would otherwise be admitted to residential care. The Carer Allowance is not means tested, and amounts to a 20% supplement to the Carer Payment or Age Pension. Carers can receive both the Carer Allowance and Carer Payment.

2.3 Structure of the Health and Social Care System

Responsibilities for health, social security and long-term care services are shared by the federal, or commonwealth government, and state governments, with varying roles also taken by local government in each state. The main divisions of responsibilities are set out in Table 1.

The Commonwealth Department of Family and Community Services (FACS) administers all social security benefits through an independent agency, Centrelink. FACS is also responsible for coordinating long-term care services for younger people with disabilities (through the Commonwealth State Disability Agreements (CSDA, which will be described below).

The Commonwealth Department of Health and Aged Care is responsible for the federal roles in health and aged care; there has been a separate minister with specific responsibility for aged care since 1983.

Primary care in Australia is provided mainly by general medical practitioners. While the family doctor plays a key role in referring older patients to community care services, they cannot admit patients directly to residential care but must make a referral to an Aged Care Assessment Team. Most general practitioners work in private practice (solo or in group practices) on a fee-for-service basis. Funding of primary care under Australia’s universal health insurance scheme means that there are no financial barriers to access. General practitioners also deliver a range of health promotion and prevention services. There has been increasing attention to health promotion and ageing in recent years, and programmes that are of particular relevance to the elderly include influenza immunisation, falls prevention and self-management of diabetes. These public health programmes are also delivered through other providers, such as Community Health Services.
Table 1: Responsibilities of Different Levels of Government for Health, Social Security and Long-term Care Services

<table>
<thead>
<tr>
<th>Social Security</th>
<th>Health</th>
<th>Aged Care</th>
<th>Disability Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal or Commonwealth Government</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Family and Community Services</td>
<td>Department of Health and Aged Care</td>
<td>Department of Health and Aged Care</td>
<td>Department of Family and Community Services</td>
</tr>
<tr>
<td>Fully responsible for income support and related benefits, and employment services, administered through Centrelink</td>
<td>Fully responsible for universal health insurance scheme, Medicare, and for regulation of private health insurance</td>
<td>Fully responsible for residential aged care and jointly responsible with States for community care</td>
<td>Responsible for nationally consistent provision through Commonwealth State Disability Agreements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No direct service delivery role</td>
<td></td>
</tr>
</tbody>
</table>

State Government

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospitals and public health programs</td>
<td>Jointly responsible for community care</td>
<td>Responsible for implementation of Commonwealth State Disability Agreements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Responsible for delivery of residential care only in public sector facilities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Local Government

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Varying involvement in public health services</td>
<td>Major role in delivery of community care in some states</td>
<td>Major role in delivery of disability services in some states</td>
<td></td>
</tr>
</tbody>
</table>

The Pharmaceutical Benefits Scheme (PBS) provides low-cost access to prescription medicines, and a safety net applies to those whose expenditure reaches a defined amount in a 12-month period. Older people, particularly those in nursing homes, are major beneficiaries of the PBS.

Secondary and tertiary medical care is provided in hospitals, ranging from small community hospitals to large teaching hospitals with super-specialty services. The development of geriatric medical services in public hospitals over the last 15 years has transformed the interface between the health and long-term care sectors. In the mid 1980s, a national network of Aged Care Assessment Teams (ACATs) based mainly in public hospitals was established, and the range of hospital based geriatric medical services has expanded since that time. Notwithstanding these developments, and perhaps because of them, the interface between acute care and long-term care has been identified as an area of growing tensions over the last five years. Private hospitals – with a few significant exceptions in specialist rehabilitation – have not yet developed focused geriatric medical services. There are no
financial barriers to access to public hospital care (see below), but barriers do arise by way of waiting times for elective surgery, and geography.

Hospitals are the major source of admissions to nursing homes, with two-thirds of admissions occurring on discharge from an acute episode. Subsequent emergency and elective hospital admissions of residents of aged care facilities occur on the same basis as for the general population, but the rate of such admissions declines compared to same age residents in the community. Australian practice is to manage all care in the nursing home wherever possible, and transfers from nursing homes to acute care near the end of life are relatively infrequent.

Geography poses a considerable barrier to access to health care services in Australia for the 20% of the population that lives outside major metropolitan areas. While the health and long term care funding arrangements provide for coverage of all areas, access can be reduced in small communities in rural and remote areas due to difficulties in attracting doctors and other health care staff. Successive governments have adopted a variety of strategies to address this problem, but with only limited success. One initiative that has proved successful has been the development of Multi-Purpose Services (MPSs). MPSs have not only co-located previously separate services, but have involved pooling of funds from separate programmes to enable provision of the mix of services that can best respond to local community needs, and there is a high level of community involvement in management.

2.4 Financing of Health and Social Services

*Universal health insurance*

Australia's universal health insurance scheme, Medicare, covers the total population. Prior to the introduction of the first universal health insurance scheme, Medibank, in 1974, only eligible pensioners received free medical and public hospital care under the Pensioner Medical Service. Medibank in effect extended these provisions to the total population.

It is administered by the Commonwealth and is funded mainly from general taxation, a 1.5% levy on personal income, and through limited co-payments. The levy was introduced to cover the additional cost resulting from the extension of coverage at the inception of universal health insurance in 1974. In the first three years following the introduction of universal health insurance, the share of Gross Domestic Product spent on health care increased from 4.8% to 7.5%, but has grown only very slowly and steadily since then, and in the late 1990s stood at just over 8%.
Access and co-payments

Medicare provides free or near free access to primary and specialty medical care. The cost of care is determined by a Medical Benefits Schedule that sets a Scheduled Fee for all procedures, divided into a co-payment and a reimbursable amount. Low-income individuals issued a Health Care Card are exempt from co-payments and practitioners are reimbursed directly by the federal government through a system of “bulk billing”. The majority of general (family) practitioners charge only the Standard Fee, and the medical practitioner can either “bulk bill” the government directly for reimbursement, in which case the patient pays only the co-payment. When a physician does not "bulk bill", the patient pays the full amount and then claims the reimbursable amount from Medicare. Most (80%) of primary medical care visits are billed at the Scheduled Fee, and the great majority of these are bulk billed. Other medical services, such as pathology services, diagnostic imaging operations and specialist visits are less commonly billed at the scheduled fee.

Medical practitioners, whether general practitioners or specialists, are allowed to charge above the Standard Fee, and in these cases the patient must meet the gap between the total charge and the reimbursable amount beyond the co-payment. The amount of the gap that can be charged is however constrained by the ready access to medical practitioners who charge only the Standard Fee or close to it. Further, there is no private health insurance for ambulatory medical care, and calls to introduce “gap insurance” have been resisted because of the rise in doctors’ fees that could result

Medicare provides free care for all in public hospitals, and private health insurance provides for treatment as a private patient in both public and private hospitals; private patients in a public hospital choose their doctor and can elect to occupy a shared or a single room. As of mid 1998, there were 3 public hospital beds per 1,000 total population, and 1.2 private hospital beds, and just under one third of the population was covered by private health insurance. The main limitation in public hospital care is the waiting times for elective surgery, a problem of particular concern for older people, the major users of elective surgery for conditions such as joint replacement.

2.5 Provision of Health Services

Medicare provides free or nearly-free access to primary and specialty medical care. Payments are determined by a Medical Benefits Schedule that sets a scheduled fee for all procedures, divided into a co-payment and a reimbursable amount. Low-income individuals of all ages who have been issued a health care card are exempt from co-payments and
practitioners are reimbursed directly by the federal Government through a system of 'bulk billing'.

Medicare also provides free care in public hospitals. Private health insurance covers hospital care only (not medical services care), and patients may be treated as private patients in public hospitals or in a private hospital.

Medicare does not cover any long term care services in either the community or residential care, and there is no private insurance for long term care.

The main provision of health and long-term care services is through public agencies and the voluntary non-for-profit sector, with the private for-profit sector involved in private hospitals and private nursing homes. The other areas which are dominated by private fee for service practice without government subsidy are allied health and dentistry; there is only very limited access to publicly subsidized services of these kinds outside public hospitals, Community Health Centres and similar community agencies.

Only 30% of hospital beds are in private hospitals for which private health insurance is required, half of which are operated by not-for-profit organizations, mostly with religious and charitable affiliations, and just under half are in proprietary for-profit hospitals. The majority of private beds are in metropolitan areas.

Local government also has a substantial provider role in community care in some states. While delivering services through Local Government has the advantage of potential universal coverage, no State has mandated that Local Government provide services. Rather, discretionary participation by Local Government and the uneven spread of other community care providers results in considerable variation in the level and mix of community health and long-term community care services.

3. Long-term Care Provision
3.1 General Overview
The functional arrangements for long term care in Australia are summarised in three broad groups in Table 2. Just over one third of total government expenditure now goes to community care, including the group of “bridging services” that are funded through the residential care programme and cash payments. While residential care services still dominate, with two thirds of all expenditure, this share is a significant reduction compared to the 90% that went to residential care in the early 1980s.
Table 2: Structure of Long-term Care Services for the Frail Aged

<table>
<thead>
<tr>
<th>Community Care Programmes</th>
<th>Residential Care Programmes (under the Aged Care Act 1997)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home and Community Care (under the Home and Community Care Act, 1984)</strong></td>
<td>Services bridging residential and community care</td>
</tr>
<tr>
<td>16.4%</td>
<td>Residential care services</td>
</tr>
<tr>
<td><strong>Other community care programmes 4.1%, including:</strong></td>
<td><strong>High care (nursing home)</strong></td>
</tr>
<tr>
<td>• National Respite for Carers Programme</td>
<td>• Low care (hostel)</td>
</tr>
<tr>
<td>• Veterans’ Home Care</td>
<td>• Residential respite care</td>
</tr>
<tr>
<td>• Dementia Care Programmes</td>
<td></td>
</tr>
<tr>
<td>• Day Therapy Centres</td>
<td></td>
</tr>
<tr>
<td>• Continence Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.6%</td>
</tr>
<tr>
<td></td>
<td>65.1%</td>
</tr>
<tr>
<td><strong>Cash Payments - 9.1%</strong></td>
<td></td>
</tr>
<tr>
<td>• Carer Payment</td>
<td></td>
</tr>
<tr>
<td>• Carer Allowance</td>
<td></td>
</tr>
<tr>
<td>Assessment - 0.7%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Expenditure figures are based on Productivity Commission (2003) Submission to the Review of Pricing Arrangements for Residential Aged Care, Table 3.1.

The Commonwealth is responsible for funding residential care. Benefits are calculated on the basis of individual care need, and paid by assignment to providers. HACC is jointly funded by the Commonwealth and the States, and funds are paid to providers through grants. These arrangements are detailed further below.

Government outlays account for just under 75% of all expenditure on aged care, with the balance made up of user payments. The largest share of user payments are made by way of the a basic daily fee paid in residential care which is based on the Age Pension, and as most residents receive a full or part pension, these user payments are in fact largely transfer payments.

The financing arrangements for long term care services are separate from both health care and other social care, such as disability services. Users of long term care services are covered by Australia’s universal health insurance scheme for general practitioner and specialist medical services and public hospital care in the same way as the rest of the population.
The accounts that follow focus on the main service programmes, namely HACC and residential care, with briefer accounts of caregiver support programmes and Community Aged Care Packages. Further details of these and other aged care services are available from both published and on-line sources of the Department of Health and Ageing and the Australian Institute of Health and Welfare (see References). All data cited below are from the latest available AIHW reports unless indicated otherwise.

3.2 The Home and Community Care Programme: HACC Target Population

The target population for HACC is formally defined as

\[ \text{those with moderate levels of disability who – without support – would be at risk of inappropriate or premature admission to residential care, and their carers.} \]

The HACC target population covers all age groups, and recognition is given to special needs groups, namely;

- those from different cultural and linguistic backgrounds;
- indigenous Australians;
- those living in rural and remote areas; and
- those with dementia and related disorders.

For planning purposes, the target population is defined on the basis of data collected in surveys of Disability and Ageing conducted every five years by the Australian Bureau of Statistics, using WHO standard definitions for activity restriction and levels of disability.

Range of HACC services

HACC provides 11 types of services to individuals in their homes and in community settings. Services include:

- nursing;
- personal care;
- home help;
- meals delivered at home and in centres;
- transport;
- home maintenance and modifications;
- allied health;
- in-home respite;
- day-centre care;
- assessment; and
- training, information, and advice.
Further flexibility in the range of services provided by HACC comes from the allowance for Ministers to approve other services, and there has been considerable experimentation with new approaches to service delivery in HACC over time.

**Responsible agencies**
Responsibility for policy development, programme administration, and funding of HACC is shared between the Commonwealth Department of Health and Ageing and its counterpart departments in state governments.

The Commonwealth plays a major role in policy development, including major reviews conducted in conjunction with states. The most recent of these reviews was the Performance Audit conducted by the Australian National Audit Office in 2000.

**Benefits**
HACC services are all delivered in kind, in the client’s home and in the community.

The only cash benefits paid in the community care system are the Carer Allowance and the Carer Payment, although the Carer Payment is more properly seen as part of the income support system.

**Decision making and assessment of care needs**
Eligibility for and access to HACC services is based on a functional capacity assessment conducted by the service provider. Limited progress has been made in introducing a more standardized approach. It is recognized that different assessment approaches are needed for younger and older client groups. While assessments by Aged Care Assessment Teams (ACAT) frequently result in a referral to community care services, these assessments are not required for access to HACC services.

However, some degree of standardization does exist, as the very large home care providers that dominate in most states have standard processes within their state. In Victoria, local governments have moved towards a standard approach. Similarly, community nursing providers have a reasonably common approach to nursing assessment.

Family carers are involved in assessment processes. In some cases, the carer may be the primary client to whom support is provided.

**Limits on amount of services**
At its inception, the aim of the HACC programme was to provide a range of basic services. The stated goal of preventing admission to residential care has moderated as there has
been growing recognition of the importance of community services *per se* in maintaining functioning and independence of those who have considerable levels of disability but who, for a variety of reasons including high levels of support from family, are unlikely to be admitted to residential care. These individuals would otherwise remain at home with a lower quality of life and with considerable demands on family carers.

In 1995, Commonwealth and state authorities responsible for HACC commissioned an extensive investigation of “targeting” of services with a view to resolving the tensions between the dual goals of providing a low level of services to a larger group and of concentrating resources on those with higher levels of need.

The study included an analysis of the relationships between client dependency, service use and outcomes for some 20,000 clients assessed by ACATs. These relations were found to be complex, but three main conclusions emerged:

- The main function of HACC was confirmed as providing small amounts of service to a large number of clients. However, the smaller groups of 5–10% of clients who received the highest levels of service typically consumed up to half the resources. Only very small savings in resources could be achieved by excluding low service users, and instead facilitating early access to basic services was identified as a prime objective for HACC providers and clients.

- Levels of service use were not consistently related to client dependency. While no low-dependency clients used high levels of service, many high-dependency clients received only limited support from formal services. Given the mediating effect of family caregivers on service level, decisions to limit service to clients using only low levels could have adverse outcomes as many highly dependent clients relied greatly on those small service inputs.

- Perhaps the most telling finding was that clients already using a community service at the time of assessment were significantly less likely to be recommended by an ACAT for nursing home care than those using no services. This trend was most evident for more dependent clients with the greatest risk of admission, who therefore had the greatest potential for reducing risk, whereas low dependency clients had only a very low risk of admission in any case. Against the apparent beneficial effect of initial service support, there appeared to be diminishing returns associated with further service inputs.
Rather than seeing targeting as a simple trade-off between low and high need clients, the report of the targeting study called for recognition of a hierarchy of seven complementary targeting strategies:

- Enhancing quality of life for clients at all levels of dependency;
- Improving function and supporting independency in the community, again for clients at all levels of dependency;
- Maintaining clients with high and complex care needs in the community;
- Reducing risk of premature admission to residential care;
- Reducing use of residential care;
- Reducing unmet need for assistance, at all levels of dependency; and
- Supporting carers.

This hierarchy has since been translated into a proposed three tier framework for community care, as discussed further below.

**Providers**

The paid workforce in HACC comprises several professional and para-professional groups, including:

- nurses and social workers with high levels of formal training;
- personal care staff with basic training; and
- volunteers.

A range of training programmes for the community services workforce has developed in conjunction with the growth of HACC. Recruitment and retention of the workforce for community care is however a growing problem.

While volunteers are involved in many areas of HACC, their roles complement rather than substitute for paid staff. While nursing, personal care, and home help are conducted by paid staff with appropriate levels of training, volunteers provide important support in roles such as:

- delivery of meals to people at home;
- day care; and
- in-home respite.

Much of the management of services is undertaken by volunteer committees. HACC funding provides for training and coordination of volunteers.

HACC recognizes family carers as partners in care and provides for caregiver training, counselling, and self-help groups. However, a substantial proportion of the HACC target population do not have either a co-resident carer or any other carer. Slightly more than four
in ten HACC clients report having no informal carer, which makes them highly reliant upon formal services.

**Provider auspices**

Nearly 2,500 service providers participate in the HACC programme. In order to ensure that LTC recipients receive care which is equitably based upon need, all providers – whether in the governmental, non-profit, or for-profit sectors – are funded on the same basis by the Commonwealth and state governments. The participation of different sectors in programmes of care for the elderly is presented in Table 3.

**Table 3: Provider Auspices in Care for the Elderly**

<table>
<thead>
<tr>
<th>Sector</th>
<th>HACC 1998 (a) % of funding</th>
<th>Community Aged Care Packages 2000(b) % of places</th>
<th>Residential Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hostels 1997 (c) % of places</td>
</tr>
<tr>
<td>Not for profit</td>
<td>53</td>
<td>77</td>
<td>90.7</td>
</tr>
<tr>
<td>Private</td>
<td>&gt;1</td>
<td>6</td>
<td>3.6</td>
</tr>
<tr>
<td>Local govt.</td>
<td>17</td>
<td>16</td>
<td>5.8</td>
</tr>
<tr>
<td>State govt.</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1000</td>
<td>1000</td>
<td>1000</td>
</tr>
</tbody>
</table>

_Sources:_


The main providers of HACC services are non-government organizations (not for profit), which receive slightly more than half of all funding. Slightly less than 20% of funding is channelled through local government, and the remaining 30% goes to state government agencies.

The sectors vary considerably in their composition. The nongovernmental sector spans agencies in the 'traditional' voluntary sector associated with church and other charitable bodies, and diverse, locally based community groups. In this way, HACC combines capacity for delivery of a high volume of services with opportunities for local participation in community development to respond to particular needs.
The role of local government varies considerably from state to state. In Victoria, 40% of HACC funding is directed through the local government. In Queensland and Tasmania, the share is only 4%.

While for-profit providers are able to participate in the HACC programme, their involvement has remained limited. The entry of private providers in recent years has centred in brokerage and case management agencies operating in the Community Options programme and Community Aged Care Packages. In some cases, these agencies have been established as 'private' arms of major not-for-profit providers such as community nursing agencies. The low level of private sector involvement in community LTC – even as an offshoot of private involvement in residential care – reflects the limited scale of the total budget for community care and the very small profit margins.

**Data on service utilization and coverage**

Almost 75% of HACC clients are aged 70 and over, and two-thirds of these older clients are females.

In 1997-98, 44% of HACC clients used only one type of service, while 23% used two types of services. The remaining clients used three or more types of services. Similarly, 66% received services from only one provider, and only 15% had contact with three or more providers.

The complementary roles of HACC services and family carers is seen in data from the 1998 Disability, Ageing and Carers Survey. Among the older target population, some 43% use both formal services and informal support, another 40 rely on informal support only, and only 17% use formal services only. Formal services were most commonly used for health care, followed by home care and maintenance, and less often for personal care, mobility, and transport.

Fuller information on the use of community services will become available with the implementation of the HACC Minimum Data Set beginning in mid-2000. Considerable effort has gone into ensuring the standardization of this data set with other relevant data collections.

**Financing arrangements**

HACC funding is divided between the Commonwealth and state government and client co-payments. Under the HACC Agreements between the Commonwealth and the states, the
Commonwealth proposes an amount in each annual budget, which must be shared on the basis of 60% from the Commonwealth and 40% from the states. The Commonwealth allocates HACC funds based on each state’s share of the eligible population reported in Disability and Ageing Surveys conducted by the Australian Bureau of Statistics (ABS) every five years.

Given initial differences between the States when HACC commenced, the Commonwealth has adopted an equalization formula whereby all states will converge to the same funding per capita for the target population by 2010-11. HACC funding has grown by 6% per annum since 1990, ahead of the growth of the aged population, and the time frame for convergence will see only minor variations in the rate of growth of funding across the states.

The distribution of funds to providers within each state is agreed jointly by the Commonwealth and the states, with the goal of ensuring adequate and equitable coverage of all areas. To this end, states have developed a range of formulas to distribute funds on the basis of population need.

The Relative Resource Equity Formula used for this purpose in Victoria was recently reviewed, and additional variables are now included in the formula to take account of factors affecting the need for care. The target population is estimated first by applying the state-wide age-specific rates of moderate, severe, and profound core activity restriction to the age structure of each Local Government Area (LGA). The formula is then weighted using data on disability-free life expectancy, household income, proportion of population born in non-English speaking countries, the proportion of the population comprising indigenous people, and a measure of remoteness, the Access and Remoteness Index for Australia.

In turn, state governments make funds available to providers on the basis of negotiated contracts and service agreements. The nature of these arrangements varies from state to state, but most are moving from a basis of historic costs to standard unit costs for different types of services. Annual funding rounds call for submissions from interested providers at a regional level. However, as the programme is now well established, this process is to a large extent routine and only the growth funds are open for real redirection or new initiatives.

**Fees and co-payments**

While income is not considered in assessing need for services, it is used in determining fees. No client is refused services because he or she is unable to make a co-payment, and the great majority of HACC users pay either no fees or only nominal amounts.
The Commonwealth and states expect HACC providers to generate a fee income of 20% over and above their grant income. As a high proportion of clients are full or partial pensioners, and (as mentioned previously) many pay no fees or only nominal fees, achievement of this target is problematic for some agencies.

3.3 Caregiver Support Programmes

Development
Carers have been included in the HACC target population as clients in their own right since the inception of the programme. More recently, both the Commonwealth and some state governments have taken a number of separate initiatives to support carers. These separate initiatives have been prompted by the failure to reach agreement on expansion of HACC, which would require matching funding from all states, and increasing policy attention to recognition of the contributions of informal care-givers. Carer organizations, supported in part by HACC, have been active, and effective, in lobbying for this greater recognition.

Target population
The surveys of Disability, Ageing and Carers conducted by the Australian Bureau of Statistics provide a detailed profile of informal caregivers. The last survey in 1998 reported that some 200,000 primary caregivers were providing assistance to a frail aged on an on-going basis. Almost nine out of 10 of these carers were themselves aged over 55, and almost three out of four were women. These family members and others provide unpaid care and are distinguished from volunteers primarily on the basis of their close personal relationship with the person for whom they care.

Range of services
In addition to services for carers provided through HACC, and the cash benefits noted above, recent initiatives have focused on the expansion of a range of respite care services. Under its National Respite for Carers Programme, the Commonwealth has supported a central Carer Resource Centre in each capital city, a network of Carer Respite Centres, and additional funding for over 400 respite services. Most of the funding is channelled through the Carer Respite Centres which operate on a brokerage basis to purchase a range of forms of respite services, including in-home, day care and residential respite. The Carer Respite Centres also provide a range of information and other services to facilitate access to respite, such as running respite booking services for residential care facilities in the local area.
Carelink Centres have also been set up by the Commonwealth in all regions. These Centres serve as central points for carers and service providers seeking information on services available in any area, and operate largely through telephone and the internet.

3.4 Community Aged Care Packages

Development

Community Aged Care Packages (CACPs) were introduced as an alternative to the lowest level of residential care. From the early 1990s, the growth of hostel places fell short of the level provided for under the planning process. The total planning ratio of 100 places per 1000 population aged 70 and over was adjusted to allow for 10 CACPs, 50 hostel places (instead of 60) and 40 nursing home places.

CACPs have grown rapidly. From just 235 packages in pilot programmes in 1992, the number grew to 18 000 by 2000. As of June 2002, the programme involved over 900 service outlets providing over 26 600 packages. The rapid development of CACPs reflects not only a high degree of acceptance by clients, but also the ease of entry for providers – no large-scale capital investment is required. In 2000, there were 11 CACPs per 1000 persons aged 70 and over, as compared to a total of 84 residential care facilities providing 95 places per 1000.

The continued growth of CACPs is the result of both the continuing shortfall in hostel development and the Commonwealth's preference for directing as much funding as possible through the residential care programme rather than HACC – given the expectation that states would not match any additional funding. Around half the CACPs are held by residential care provider and half by community agencies, most of which are HACC providers and only a few are specialist CACP agencies. Regardless of the CACP agency however, much of the CACP funding flows to HACC providers directly or through the purchase of HACC services by other non-HACC CACP agencies. The actual services received by clients are exactly the same as they would have received directly through HACC.

Target population

CACPs cater for clients whose level of dependency and care needs are equivalent to client who are admitted to low care. As with admission to residential care, assessment by an ACAT is required for access to CACPs. CACPs provide an important option for clients who are on the margin of admission to residential care and who can be supported at home with additional services, often supporting a family carer as well.
Range of services

CACPs follow the case management models developed in the United Kingdom and elsewhere, with direct care services purchased through various brokerage arrangements. Funding for each CACP place approximates the lowest level of care funding in hostels (RCS 7), around $11,000 a year. On average, 30% of funding goes to case management and the balance to direct care services purchased through a variety of brokerage arrangements. CACPs draw mainly on the range of services provided under HACC, with the significant exception of nursing care. CACPs do not provide nursing on the grounds that they are equivalent to the services provided in hostels.

As with international experience, evaluations of CACPs have been ambivalent at best. Such evaluations have generally failed to show any significant or consistent differences in outcomes between those receiving case-managed packages and those receiving standard services.

A recent pilot programme of more intensive care packages, Extended Care at Home (EACH), aims to provide care at home to those requiring the equivalent of institutional nursing home care. At the end of 2002, there were 10 EACH service providers operating 290 EACH places in South Australia, New South Wales, Victoria, Western Australia, and the ACT (Australian Capital Territory). An evaluation has shown that EACH packages can support those at lower levels of nursing home care, but not those who are incontinent.

3.5 Residential Care for the Elderly

Residential care for the elderly has been a particularly dynamic area of policy development. The major reforms implemented from 1997 under the new Aged Care Act aimed to bring about the integration of the two previously separate levels of hostel and nursing home care into a single residential care system. To date, fuller integration has been achieved in some aspects of the programme than others:

- A single system of resident classification and associated funding has successfully replaced two previously separate system and enabled “ageing in place” of residents in former hostels requiring higher levels of care;

- A new Standards and Accreditation Agency has been established and implemented a unified quality assurance system that covers certification of building standards and accreditation for quality of care.

- Different capital funding arrangements remain for the two levels of care, and the capital funding for high level care continues to be problematic.
**Target population**

Planning for the target population of the residential care programme is based on the population aged 70 years and over. Admission, however, is based on assessment of dependency and care needs rather than age. Ten per cent of those in residential care are under 70 years of age; half are between ages 65 and 70, and the other half are in late middle age and have disabilities associated with age-related chronic illnesses. The majority of those admitted to residential care have a severe level of activity restriction as defined by the ABS survey, but are no longer in need of acute care. As of mid 2002, there were some 170 000 residents, in 3000 facilities.

**Types of care services**

The residential care programme provides varying levels of personal and nursing care, congregate housing, and social support. The balance between these services varies across eight levels of care that are identified through the Resident Classification Scale (RCS). The four highest levels cover skilled nursing care, and the four lower levels focus on personal care and social support. Until 1997, there was a nexus between the level of care and the type of facility in which it was provided. The introduction of the RCS as a single classification scheme applied across all residential care facilities has especially allowed for “ageing in place” of hostel residents who would otherwise have had to be transferred to a nursing home, and increasing numbers of residents in hostels have been classified at the higher levels of care.

A range of other care programmes focused on special needs have also developed within residential care facilities, using funding available through the RCS. In areas with high concentrations of ethnic communities, some facilities provide for ‘clusters’ of residents of a common cultural and linguistic background. There are also special programmes for dementia care, especially in hostels where more residents are ambulant. Most dementia care programmes operate in general residential care facilities, and may include environmental modifications. Special dementia care units cater to only a very small part of the resident population with dementia. Each facility determines the level and types of services provided, but must meet the accreditation standards that cover quality of care.

Respite care is also provided through residential care, with a respite supplement providing additional funding to the RCS to cover the extra costs of short-term admission and discharge.
Responsible agencies
The Residential Aged Care programme is administered by the Commonwealth Department of Health and Ageing, both centrally and through its offices in each state. In contrast to hospital funding, all residential care for the elderly is funded on the same basis by the Commonwealth, and regardless of ownership.

Standards are monitored by an independent Standards and Accreditation Agency established in 1997. There are also strong industry bodies representing residential care providers, with largely separate groups representing the for-profit and not-for-profit sectors.

Benefits
Benefits for residential care are divided into four components. Minor variations, reflecting historical differences, exist in funding levels between states. A convergence process is currently under way, which will bring all states to the same funding levels during the next few years.

- **A basic care fee** is provided for those receiving a full or part Age Pension, with a higher rate for non-pensioners. As of September 2001, the basic care fees were $24.00 and $30 per day, respectively.

- The level of the dependency based care benefit – over and above the basic care fee – is determined according to dependency and care needs during the month following admission, using the Resident Classification Scale (RCS). The resident is assigned to one of eight care levels, and the level of funding is set accordingly. The range between the eight levels of dependency-based funding is very wide. Residents in the lowest classification receive no funding above the basic care fee. As of mid 2001, funding ranged from $23 (category 7) to $110 (category 1) per day.

- The third component is a means-tested care fee which residents with means above the Age Pension are required to pay towards the cost of their care, which is offset against the benefits paid by the Government. As part of the 1997 reforms, income-tested fees which had previously applied only in hostels were extended to nursing homes. In addition, whereas providers previously set the fees charged to hostel residents, a single nationally consistent scheme has now been implemented.

In 2000, two-thirds of newly-admitted residents were full pensioners and paid no income tested fees, 27% were partial pensioners who paid up to $13 a day, and 6% paid up to a maximum of three times as much.
The fourth component of benefits and charges consists of accommodation charges, again based on income and asset testing. Those entering hostels (low care) may pay an accommodation bond at the time of their admission, while the accommodation charge in nursing homes (high care) is paid on a daily basis. There are provisions to protect access for low income elderly, by way of a concessional resident supplement, which means that providers are not disadvantaged by admitting residents who are unable to meet the means tested charges.

These differences in accommodation charges for the two levels of care reflect:
- historical differences in funding mechanisms and the origin of hostels as essentially a housing option;
- the different relativities of the cost of accommodation vis-a-vis care in the two kinds of facilities; and
- differences in the circumstances of admission, which mean that there is a greater margin of choice in entry to low level care.

There is a range of further payments and supplements to residential care benefits. Some are transitional arrangements to smooth the adjustment from the previously separate systems of funding for hostels and nursing homes. Others address financial viability of small homes and others cover supplies for residents needing enteral feeding and some other special treatments. These further payments are small and cover only a small proportion of all residents.

Revenue from means-tested care fees and accommodation payments in nursing homes has increased substantially since 1997. This has been a major factor limiting the growth in Government outlays.

**Limits on amount of services**
Limits on the overall level of provision of residential care places are imposed through a needs-based planning process. This process allocates new places on the basis of ratios of places per 1000 population aged 70 and over in each planning region. The consistent application of these ratios throughout the past 15 years has resulted in a considerable change in the overall balance between nursing home and hostel provision, as well as the introduction of CACPs.

The target ratios are 40 nursing home places, 50 hostel places, and 10 CACPs per 1000 persons aged 70 and over, for a total of 100 places per 1000. From 1985 to 1997, nursing home provision declined from 67 to 48 places per 1000. This decline was driven mainly by
the fact that the number of beds was held almost constant against a steadily increasing population of older persons.

The hostel ratio has been more static. Despite a substantial increase in the absolute number of beds, from slightly fewer than 35,000 in 1985 to approximately 65,000 in 1997, the ratio has increased only from 33 to 42 per 1000. The shortfall in hostel provision can be attributed to uncertainty about Government policy and funding, the increasing availability of alternative forms of supported accommodation, and the expanded availability of community care through the HACC programme and more recently through CACPs. CACPs have proved very effective in expanding community care to balance the shortfall in residential care places.

**Decision-making and assessment of care needs**

Mandatory assessment by an ACAT prior to admission to residential care was introduced in 1983. A national network includes over 100 ACATs, which are based mainly in public hospitals and in other public health services – and in a few cases in rural and remote areas. Nationally, ACATs assess approximately 185,000 people a year.

The ACATs are not required to follow a standardized assessment procedure or to use a specific assessment schedule, but they are required to report a minimum data set.

Approximately 40% of all clients assessed by ACATs are recommended for admission, and the majority are referred to community care services. The ACAT recommends only admission to low care in a hostel or high care in a nursing home, and the more detailed level of care is determined subsequently by application of the RCS after the individual has been admitted. Recommendation for admission to nursing home care is highly correlated with being in an acute hospital at the time of assessment.

**Providers**

Care is provided by a mix of registered nurses, enrolled nurses or assistants in nursing, personal care staff, domestic staff, and administrative personnel. While volunteers contribute to social programmes in many residential care facilities, they are not involved in direct delivery of care to residents.

There are no prescribed levels of staff for residential care facilities for the elderly. The 1997 Aged Care Act specifies only that providers “maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met”. The Quality of Care Principles subordinate to the Act detail the tasks that must be performed by a registered nurse in high care facilities. These include initial and ongoing assessment, planning, and
management of care; nursing services, or other services to be carried out by the appropriate professional; and administration of medication, as governed by state law.

The shortage of registered and enrolled nurses in residential care for the elderly has become a critical issue and is discussed in further detail below.

**Provider auspices**
The participation of the public, for-profit and not-for-profit sectors in residential care has been presented in Table 3, above.

Nursing home provision is the only part of the care programme for the elderly dominated by the for-profit sector, with approximately half of all beds – the majority in nursing homes. By contrast, the hostel sector is dominated by the not-for-profit sector. The private sector accounts for only 5% of hostel places. Provision by the for-profit sector is concentrated in metropolitan areas, and the not-for-profit sector and especially the public sector have much greater roles outside the main metropolitan areas.

**Data on service utilization and coverage**
Detailed Statistical overviews of residential care in Australia report on provision and use of residential care using data from the routine administrative systems for the programme. These data offer a number of different perspectives on utilisation of long term residential care:

- Compared to only some 9% of the population aged 70 and over who use residential care at any one time (or 6.8% of the population aged 65 and over), the probability of using residential care over a lifetime is 25%. This lifetime probability rises steeply with age, and more so for women than for men, to reach fully 75% for women at age 80 and almost 90% at age 90.

- Average length of stay is around 3 years, but ranges from two years for the most dependent residents to around six years for the least dependent. The average stay for the most dependent masks a skewed distribution, with some half of all separations occurring within six months.

- Half of all admissions are now for respite care, but these short admissions account for only 2% of all bed days.

The increasing availability and analysis of these kinds of data have changed the conventional view of residential care as involving long and relatively uniform stays for all residents. There is now a sound and high quality information base for policy and programme development.
4. Assessment of the Present and Future Needs for Long-term Care

Historically, policy and programme development in long term care in Australia has gone through a number of cycles, with short periods of rapid change followed by longer periods of consolidation and stabilisation. The period from the late 1980s to the mid 1990s saw steady policy and programme development within the broad framework set in the early to mid 1980s. By the mid 1990s, a number of pressures had emerged within the aged care system itself, particularly with regard to funding capital development of high care facilities, and in the wider context, particularly at the boundaries between aged care and acute care. Added to these emerging pressures, the change of federal government in 1996 brought a change in the political philosophy underpinning all areas of social policy.

Major reforms in residential aged were initiated with the passing of the Aged Care Act in 1997. The scale of these changes and the level of concern expressed about the capacity of providers to make the changes demanded of them were such that the Commonwealth implemented a two year review process to monitor progress. A number of adjustments were made as the reforms proceeded, and the Report of Two Year Review of the Structural Reforms released in early 2001 found that the reforms had largely achieved their objectives, at least within the Terms of Reference of the Review (Gray, 2001).

More widely however, a number of sources of continuing uncertainty and areas of potential future change were recognised:

- In residential care, the reform agenda itself remained incomplete, in so far as it failed to achieve full integration of nursing homes and hostels with regard to capital funding, and the experience of 'ageing in place' is proving highly variable.

- In community care, the continuing proliferation of small programmes added to the complexity of the service delivery and administration, while the rapid growth of CAPCs was shifting the balance resources away from basic community care.

- The boundary between acute care and aged care services came under increasing scrutiny with the renegotiation of the triennial Medicare Agreements through which the Commonwealth directs funding to the State-run public hospital system.

These issues have been taken up in four major Commonwealth policy exercises initiated since the release of the Report of the Two Year Review:

- Aspects of older people’s use of acute care and interactions between acute and long term care services have come under review by a Working Party on Care of Older People established by the Australian Health Ministers Advisory Council, comprises the Commonwealth Minister for Health and state counterparts.
A special Budget Paper, The Intergenerational Report, released in conjunction with the 2002-03 Federal Budget, raised issues concerning the sustainability of present arrangements for funding health and long term care in the face of the ageing of the baby boomers (Commonwealth of Australia, 2002).

A Review of Pricing Arrangements in Residential Aged Care was announced in January 2003, with terms of reference to address all aspects of financing of residential care, and giving particular attention to alternative financing options, including the mix of government and user funding, regulatory constraints and capital markets.

The Commonwealth released a Consultation Paper proposing a new strategy for community care in March 2003 (Department of Health and Ageing, 2003). A framework of three tiers of community care – access and information, basic care services and care packages – was put forward as a basis for integrating the various Commonwealth and State programmes, and advancing a renewed joint approach to community care.

In addition, the industry body representing the not for profit sector, Aged and Community Services Australia (2001) has produced a discussion paper on the future of community care, and a leading philanthropic body, the Myer Foundation, has undertaken a research and consultation project to develop a vision for aged care in Australia with a 20 year time horizon (Myer Foundation, 2003). There has also been some debate as to whether or not policy directions in Australia are converging with trends in the UK (Gibson & Means, 2000; Healy, 2002)

The high level of engagement in these exercises on the part of provider agencies, older people’s representative groups, policy analysts, public interest groups and state governments reflects the breadth of issues being canvassed, and has brought forward a wide range of options for consideration. With the Commonwealth Pricing Review and community care exercise to report by the end of 2003, the policy environment of long term care in Australia is poised to enter a new and potentially very dynamic phase of development.
Bibliography

Notes:


II. Canada - - by Howard Bergman, François Béland, Lysette Trahan, Patricia Caris, and Anne Perrault

1. General Background Data

1.1 Preamble

Canada is a federal state consisting of ten provinces and three territories, and has a parliamentary system of government. At both the federal and provincial levels, the people elect a legislature. The party with the majority of elected members forms the Government. Elected members of the legislature from the majority party are appointed by the leader of the Government to comprise the Cabinet. The Cabinet determines Government policies.

Social reforms in the 1960s and 1970s created a universally accessible and publicly managed health care system. Provincial governments are responsible for the organization, management, and delivery of health and social services. The federal government, through its taxation powers and transfer payments, established the basic principles of the Canadian health care system – in particular for the delivery of care by physicians and acute care hospitals.

Funding and organization of long-term care (LTC) do not provide the same comprehensive coverage as do other health care services, and there is a great deal of variation among provinces. The LTC system in Canada, often referred to as the continuing care sector, is a complex array of community and institutional services built upon the principles of universality and selectivity (i.e. payments for certain aspects of care are made by the consumer on the basis of income). It provides a range of health, social, and support services to help people with functional deficits to live as independently as possible.

The Canadian LTC sector has evolved from a care sector providing primarily palliative support services to a system striving to meet the complex health and social service needs of the functionally disabled and of frail older persons. The LTC sector is involved in prevention, assessment, treatment, rehabilitation, and support of care.

Although the methods of hospitalization and health insurance are governed by common principles, health care system organization varies widely among provinces. For this reason, this case study will first describe the general characteristics of the Canadian health and social service system. It will then provide a more detailed description of the long-term care system in Quebec, the second most populous province in Canada.
Presented in detail on the following pages and briefly summarized below are background data derived from international databases.\(^4\) These data include demography, vital statistics and epidemiology, economic data, and health expenditure.

As of 2000, Canada had a population of 30.7 million, 12.6% of whom were aged 65 and over and 3% aged 80 or over. Canada is still relatively young in international terms. Among the 29 countries in the database of the Organisation for Economic Co-operation and Development (OECD), Canada’s proportion of elderly ranked 25\(^{th}\) in 1980 and 21\(^{st}\) in 1997. However, a significant growth in the proportion of elderly people in the population is expected. These percentages of persons aged 65 and over will reach 20.7% by 2025, and 24.3% by 2050.

The most significant demographic change will be in the ‘old-old’ population. In 2000, persons over 80 represented 3% of the population. By 2050, that percentage is expected to double, to 8.9%.

These demographic trends are reflected in the elderly support ratio, in relation to the working-age population (i.e. the number of persons aged 65 and over per 100 persons aged 20–64). This ratio is expected to grow significantly, from 20.5 in 2000 to 35.6 in 2025. The parent support ratio (the number of persons aged 80 and over per 100 persons aged 50–64) currently stands at 18.7 and is expected to reach 23.4 by 2025.

Life expectancy at birth is 79.3 years (81.9 for women and 76.6 for men), and at age 60 is 22 years (24 for women and 20 for men). Based on estimates for healthy life expectancy (HALE), Canadians spend approximately 13% of their lives from birth in ill health (healthy life expectancy at birth is 69 years). They spend 25% of their lives after age 60 in ill health (healthy life expectancy at 60 is 16.6 years).

In 2000, based on WHO estimates, approximately 4.2% of the total population were disabled (defined as persons of all ages that required daily care). This percentage will reach 5.1 by the year 2030. The disability dependency ratio provides an indication of the pressure of caregiving responsibilities. The number of dependent persons per 100 persons aged 15–59 is currently 6.6, and is expected to reach 9.3 by 2030.

### 1.2 Background Data from International Databases

**Demography (year 2000)**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (thousands)</td>
<td>30 757</td>
</tr>
<tr>
<td>Land area (sq km)</td>
<td>9 220 970</td>
</tr>
<tr>
<td>Population density (per sq km)</td>
<td>3</td>
</tr>
<tr>
<td>Population growth rate (% 2000–2005)</td>
<td>1</td>
</tr>
<tr>
<td>Urban population (%)</td>
<td>79</td>
</tr>
</tbody>
</table>

**Ethnic groups**

- British Isles origin 28%
- French origin 23%
- Other European 15%
- Amerindian 2%
- Other, mostly Asian, African, Arab 6%
- Mixed background 26%

**Religions**

- Roman Catholic 42%
- Protestant 40%
- Other 18%

**Age structure (%):**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–14</td>
<td>19.1</td>
</tr>
<tr>
<td>15–24</td>
<td>13.3</td>
</tr>
<tr>
<td>60+</td>
<td>16.7</td>
</tr>
<tr>
<td>65+</td>
<td>12.6</td>
</tr>
<tr>
<td>80+</td>
<td>3.0</td>
</tr>
</tbody>
</table>

**Projections 65+ (%)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2025</td>
<td>20.7</td>
</tr>
<tr>
<td>2050</td>
<td>24.3</td>
</tr>
</tbody>
</table>

**Projections 80+ (%)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2025</td>
<td>4.7</td>
</tr>
<tr>
<td>2050</td>
<td>8.9</td>
</tr>
</tbody>
</table>

**Sex ratio (males per female):**

<table>
<thead>
<tr>
<th>Group</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>0.98</td>
</tr>
<tr>
<td>15-64</td>
<td>1.01</td>
</tr>
<tr>
<td>65+</td>
<td>0.74</td>
</tr>
</tbody>
</table>

**Dependency ratio:**

- Elderly support ratio in 2000*: 20.5
- Elderly support ratio in 2025: 35.6
- Parent support ratio in 2000**: 18.7
- Parent support ratio in 2025: 23.4

---

* Elderly support ratio: the ratio of those aged 65 and over per 100 persons aged 20–64.
** Parent support ratio: the ratio of those aged 80 and over per 100 persons aged 50–64.
<table>
<thead>
<tr>
<th>Vital Statistics and Epidemiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude birth rate (per 1000 population) (2000)</td>
</tr>
<tr>
<td>Crude death rate (per 1000 population) (2000)</td>
</tr>
<tr>
<td><strong>Mortality under age 5</strong> (per 1000 births) (2001)</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td><strong>Probability of dying between 15–59</strong> (per 1000) (2001)</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td><strong>Maternal mortality rate</strong> (per 100 000 live births) (1995)</td>
</tr>
<tr>
<td><strong>Total fertility rate</strong> (children born/woman) (2001)</td>
</tr>
<tr>
<td><strong>Life expectancy at birth</strong> (years) (2001)</td>
</tr>
<tr>
<td>Total population</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td><strong>Life expectancy at 60</strong> (years) (2000)</td>
</tr>
<tr>
<td>Total population</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Healthy life expectancy (HALE) at birth (years) (2001)</td>
</tr>
<tr>
<td>Total population</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td><strong>Healthy life expectancy</strong> (HALE) at 60 (years) (2001)</td>
</tr>
<tr>
<td>Total population</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td><strong>Disability rate and Disability dependency ratio (%)</strong>*</td>
</tr>
<tr>
<td><strong>Disability rate</strong></td>
</tr>
<tr>
<td>2000</td>
</tr>
<tr>
<td>2030</td>
</tr>
<tr>
<td><strong>Disability dependency ratio</strong></td>
</tr>
<tr>
<td>2000</td>
</tr>
<tr>
<td>2030</td>
</tr>
</tbody>
</table>
Economic Data (year 2000)

GDP – composition by sector
Agriculture 3%
Industry 31%
Services 66%

Gross National Income ($PPP) **** 836 billion

GNI – per capita ($PPP) 27 170
GNI – per capita (US$) 20 240

GDP growth (annual %) (1999–2000) 4.5

Labour force participation
Male 58.8
Female 48.8

Health Expenditure (year 2000)
% of GDP 9.1
Health expenditure per capita ($PPP) 2534
Health expenditure per capita (US$) 2058

2. General Health and Social System
2.1 Basic Income Maintenance Programmes

There are three types of income support for older persons in Canada.

- Government pension programmes

These programmes are funded through tax revenue. Programmes include Old Age Security (OAS), the Guaranteed Income Supplement (GIS), the Spouse’s Allowance (SPA), and the Widowed Spouse’s Allowance (WSPA).

Nearly all Canadians aged 65 and over, rich or poor, are eligible for the same OAS pension. The Government reclaims a portion of OAS funds in the form of taxes. Policies that diminish

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**** PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries

***** Disability rate: Proportion of total population requiring care based on two severest Global Burden of Disease study disability categories (levels 6, 7); Disability dependency ratio: total number of dependent people/population 15–59
the universality of the OAS include the requirement for wealthier seniors to pay back a percentage of OAS benefits (known as clawback), and the introduction of a residency requirement which will preclude many immigrants from getting full OAS. The GIS goes to the poorest seniors and is not taxed. The SPA and WSPA go to spouses and widow(er)s of low-income pensioners aged 60–64, respectively.

- **Canada/Quebec Pension Plan (CPP/QPP)**
  Created in the early 1970s, this income-dependent plan was intended as an income maintenance programme rather than as an income security programme. All wage earners pay a portion of their income into the plan. In 1997, payments represented 20.4% of the average senior's income, with the benefits paid to 80% of the senior population. In reality, CPP/QPP payments are low and do not replace a significant percentage of the average person's income.

- **Private retirement savings in the form of Registered Retirement Savings Plan (RRSP).**
  These programmes are privately purchased and encouraged by the Government through tax rebates. Although currently only 3.8% of the average senior's income, this percentage will steadily grow as more funds mature and the responsibility for income security is transferred from Government to the individual. In practice, people in higher income brackets pay more into the plan and in greater numbers than people in lower brackets.

- **Housing**
  Another form of income support for seniors and people with disabilities is provided by both the federal and provincial governments through housing programmes in the form of grants, loans, tax, and rent rebate programmes. These initiatives do not possess the same cultural and symbolic stature associated with the Canadian Pension Plan and Medicare programmes, nor are they as systematically (universally) available. Seniors use a disproportionately large percentage of these housing programmes.

**2.2 Organizational Structure of Decision-making**
The Canadian health care system emerged in the second half of the 20th century, together with other significant developments in social policy. Between 1966 and 1972, all provinces and the territories joined the federal government’s cost-sharing comprehensive medical insurance programme. The *Canada Health Act* is based on five guiding national principles:

- **public administration**
- **comprehensiveness**, i.e. the plan must insure all medical care
- **universality**, which makes all residents in each province eligible for this insurance
- **accessibility**, i.e. no extra billing beyond the reimbursement of public insurance
- **portability**, which allows residents of one province access to the same benefits when they move to another province.

The Canadian health care system is largely a publicly managed and funded system guaranteeing universal free access to primary care and inpatient hospital services. Certain types of health and social services are considered complementary, and the principles of universality and free-of-charge services that govern the Canadian health system do not encompass them. Such complementary services include:
- home care;
- medication;
- technical aids;
- optometric service; and
- dental care.

Therefore, depending on the provincial plans, these supplementary health services, can be covered, partially covered, or covered only for specific subgroups. With some variation among provinces, professional (medical) long-term care services, both community-based and institutional, are included, with co-payment for support and 'hotel' services.

Provincial governments have primary jurisdiction over health care, and therefore play a central role in the provision and financing of health services, including long-term care. The federal government, however, retains a role with respect to health promotion, prevention, research, and service delivery to specific groups (e.g. veterans and native people living in reservations). It also helps fund health services through transfer payments and taxation. In fact, the federal government’s role in transferring funds helps it enforce standards for health care. The division of powers between the two levels of government means that there are really ten different, though related, health care systems in Canada.

### 2.3 Financing of Health Services

The health system is financed through a combination of taxation and consumer contributions. In 1998, the majority of spending (69%) was derived from the public sector in the form of provincial and federal tax funds, while 31% came from private contributions (ranging between 68% and 93%, depending on the province or territory in question) (see Table 1). By contrast, in the mid 1970s, 75% of the overall health care and social services costs were publicly funded.
Table 1: Breakdown of Total Health Expenditures by Sector of Finance, Canada, 1998

<table>
<thead>
<tr>
<th>Sector of finance</th>
<th>% Total health expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial (^1)</td>
<td>45.4%</td>
</tr>
<tr>
<td>Federal cash transfers (^1)</td>
<td>18.0%</td>
</tr>
<tr>
<td>Federal direct services (^1)</td>
<td>3.7%</td>
</tr>
<tr>
<td>Other (^)</td>
<td>1.6</td>
</tr>
<tr>
<td>Private (^2)</td>
<td>31.3%</td>
</tr>
</tbody>
</table>

\(^1\) Through taxation  
\(^2\) Generally concentrated in areas such as drugs, dental services, vision care, and home care, for the most part not covered under the *Canada Health Act*.  
Source: *Canada's health care system*, 1999

As in many health care jurisdictions in industrialized countries, the Canadian health care system witnessed an important increase in spending during the 1970s and 1980s. This can be explained by the increased cost of technology and intensity of care. In the 1990s, the federal government reduced transfer payments to the provinces and the provinces cut their own budgets – which had the overall result of a significant decrease in health care spending. Absolute health care spending actually decreased, and the percentage of the GDP for health declined.

When the health insurance plan was established, the federal government reimbursed the provinces for up to 50% of costs related to hospitalization and health insurance. In reality, the federal government's share of public health care expenses was less than this percentage. It decreased substantially during the 1990s to approximately 30% (with all form of transfer payments combined), while provincial expenditures continued to increase.

Federal government funds are made in the form of cash transfers to provinces. In 1977, the federal government enacted the *Established Program Financing* (EPF) Act, which linked cash grants to population size and GNP. Provinces could use federal transfers according to their own health priorities. While the Act increased the Provinces' power in directing funds and health care, the amount of federal funding to the provinces was reduced.

The federal funds directly affecting long term care come through the *Extended Health Care Services* (EHCS) Act, which provides federal dollars for long-term care. These grants led to the development of provincial nursing homes and home care programmes.
Dissociating funds from specific health expenditures restrained the rate of growth of federal costs. It also gave more control over health expenditures to the provinces, because transfers were no longer dependent on the use of specified services (i.e. acute care hospitals and physician services).

The year 1999 signaled the end of the trend towards reducing federal contributions to health care. The deficit had been paid off, and provincial governments indicated they could no longer maintain the same services with continued cutbacks. Moreover, Canadians who perceived a decrease in access and quality were supportive of the federal government’s renewed involvement in health care matters.

2.4 Services Delivery System

Health care institutions in Canada range from teaching hospitals to rehabilitation centres, chronic care facilities, nursing homes, and outpost nursing stations. There are 800 hospitals across the country with 132,000 approved beds, cribs, and bassinets. The majority of these hospitals provide acute care as well as short-term diagnostic and treatment services.

Mirroring health care reforms in other jurisdictions, almost all of the Canadian provinces have implemented significant reforms with the objective of increasing ambulatory care, decreasing hospital beds, and length of stays and promoting integration of health care services. Between 1984 and 1996, the number of approved beds decreased by 25%, with a 150% increase in outpatient day care (e.g. same-day surgery).

In 1998, there were 56,203 physicians (28,542 family practitioners and 27,661 specialists) and 227,651 registered nurses employed in nursing – a national average of 18 physicians and 75 nurses per 10,000 inhabitants. Physicians are paid on a fee-for-service basis, although some provinces reimburse some physicians according to salary, sessional, or mixed payment methods. The supply of registered nurses relative to the number of inhabitants declined between 1994 and 2000 from 80.3 to 75.4 per 10,000.

2.5 Long-term Care

Long-term care services are considered extended health services, and are not governed by the same principles as hospital and medical care insurance. Provinces are free to choose whether or not to insure these services. This being said, long-term care services have developed and are delivered within the context of provincial health and social care policies.
and within the common framework of a publicly planned and organized health and social care system.

Because funding for long-term care comes from different sources with differing requirements, each province has developed its own terms and conditions for service provision. Consequently, the range of services included in publicly-funded home-care programmes varies from province to province and each home care programme is unique within its provincial and territorial jurisdiction.

At the same time as provinces were moving away from expensive inpatient care in order to reduce costs, provinces were also investing more in community-based services such as home care, with the objective of decreasing both hospital use and LTC institutional placement.

A 1999 report commissioned by the federal government, entitled A synthesis of home care programs provided a national perspective on similarities and differences across the Canadian provinces. The report found that current home care programmes are targeted to those in need and that provinces have implemented single-entry, case-managed programmes with efficient administrative structures. On the other hand, the provincial programmes are characterized by varying eligibility criteria requirements, coverage limits, covered services, and public investment.

A report published by Health Canada’s Home Care and Pharmaceuticals Division reported that at least 663 agencies provide home care services in Canada, with 93% receiving some Government funding and over 50% receiving all funding from Government sources. The home care workforce is largely unregulated and comprised of women, most of whom work part time. These women may hold multiple part-time jobs to make an adequate income, receive few fringe benefits, and have few career options within the field.

2.6 Information System
Since 1994, the Canadian Institute for Health Information (CIHI) has played a critical role in the development of Canada’s health information system. CIHI is a federally chartered but independent, not-for-profit organization. One of its mandates is to collect, process, and maintain data for comprehensive health databases covering health human resources, health services, and health expenditures (the website is at www.cihi.ca). CIHI develops the tools to
advance Canada’s health policies and to strengthen the health sector. It can potentially lay
the groundwork for a national database on long-term care.

Canada does not yet have a national information system to provide regular and reliable
countrywide data on long-term care. Besides policy differences, almost every province has
its own nomenclature for services provided and its own information system, making it
virtually impossible to make interprovincial comparisons.

Furthermore, there are no quality standards. While each province has its own mechanism
for measuring quality of care, there is no standardized reporting mechanism. Consequently,
there is little literature on the quality of home care in Canada. Furthermore, since Canada
has no uniform national information system, estimates of the number of persons receiving
homemaking, personal, and nursing home care vary widely. In 1996/97, for example,
estimates for all age groups ranged from a high of 950,000 persons based on provincial
sources, to slightly less than 850,000 according to Health Canada, and to as low as 500,000
according to the Statistics Canada National Population Health Survey.

2.7 Conclusion of General Overview of Health and Social Service System in Canada
During the last decade, there was a significant reduction in the number of hospital beds and
a corresponding increase in the number of hospital closures, with a relative reduction in the
number of institutional LTC beds. There was also a reduction in the number of physicians as
a result of capping, reducing medical school enrolment, and restricting licensing (Table 2).

Table 2: Trends by Category of Health Expenditures for 1960, 1979, and 1999 (%)

<table>
<thead>
<tr>
<th>Category</th>
<th>1960</th>
<th>1979</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>38</td>
<td>42.5</td>
<td>31.6</td>
</tr>
<tr>
<td>Other institutions</td>
<td>6</td>
<td>11.3</td>
<td>9.7</td>
</tr>
<tr>
<td>Physicians</td>
<td>17</td>
<td>14.9</td>
<td>13.9</td>
</tr>
<tr>
<td>Other professionals</td>
<td>8</td>
<td>10.2</td>
<td>12.8</td>
</tr>
<tr>
<td>Drugs</td>
<td>13</td>
<td>8.6</td>
<td>15.2</td>
</tr>
<tr>
<td>Capital *</td>
<td>9</td>
<td>3.8</td>
<td>2.6</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>8.8</td>
<td>14.1</td>
</tr>
</tbody>
</table>

* Capital expenditures by the private sector

Source: National Health Expenditure Database, Canadian Institute for Health Information (CIHI)

This health care reform was conducted within a context of deficit reduction. Therefore
reduction in the health care budget was compromised by the fact that sufficient resources
were not available to be transferred to the community sector. This health care reform was
perceived as budget slashing. Moreover, the late 1990s and early 2000 witnessed an increase in spending, with medication being the fastest rising cost.

*Responsiveness of the system*

In 1997, the federal government set up the Health Transition Fund to support innovations leading to more integrated care. The Fund distributed $150 million\(^5\) over a three-year period to help provinces identify approaches for continued reform and improvement of the health care system. Of the full amount, $120 million funded provincially sponsored projects, and $30 million funded federal initiatives. Two priority areas for research identified by the Fund were home care services and integrated service delivery.

A sense of dissatisfaction with the health system developed after decades of budget cuts, reflecting in particular the perception that access to acute care and specialized services as well as to home care and long-term care services had been significantly curtailed. This led to the creation of independent commissions of enquiry into the health and social service system in Quebec (Clair Commission) and in Saskatchewan (Fyke Commission), as well as a special Senate Committee on the State of the Health Care System in Canada. More recently, the federal government established a Royal Commission on the Future of Health Care.

3. The Province of Quebec

As mentioned previously, there is great provincial variation in the provision of long-term care services. This section describes the actual organization and provision of services, taking the province of Quebec as an example.

3.1 General Background

Quebec is the second most populous province in Canada. In 2000, its population was 7.37 million, representing 24% of the Canadian population. The proportion of people aged 65 and older is similar to the country as a whole: 12.8% of the population are aged 65 and over, and 7.5% are aged 75 and over. The proportion of elderly is expected to double by 2026, when it is estimated that the population aged 65 and over will represent 24% of the population. By 2041, it is expected to reach 29%.

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\(^5\) Unless otherwise indicated, “$” refers to Canadian dollars.
The growth in the proportion of persons aged 85 or over will be even more striking. From 93,000 in 2001, this group is expected to increase fivefold to reach 435,000 in the next 40 years. If these projections are borne out, Quebec will be second only to Japan in the speed at which its population is ageing.

In 1998, life expectancy at birth was 75.2 years for men and 81.5 years for women, and life expectancy at age 65 was 15.6 years for men and 20 years for women. In 1996, the dependency ratio was 19, i.e. there were 19 seniors for every 100 persons aged 20–64. It is expected that the ratio will reach 42 by 2025 and 54 by 2041.

When all 'dependants' are taken into account (that is, persons under 20 and over 65) in relation to those aged 20–64, the dependency ratio was 101 in 1961, when the vast majority of dependants were young people. It fell to 61 in 1996 and to 58 in 2001, where it is expected to remain until 2011.

By 2041, seniors will dominate the dependent population. This change in the composition of dependants will lead to changes in the type of services required by the population, thus necessitating a redistribution of resources. The problem facing the Government will then be to choose among priorities. The parent support ratio (the number of persons aged 80 or over per 100 persons aged 50–64) was 17 in 1998, and is projected to reach 29 in 2025 and 57 in 2041.

Over half (58%) of those aged 65 and older live in urban centres, where provision of services is more varied. Nevertheless, 26% live in agglomerations of 30,000 or fewer, 16% of whom live in rural regions.

An important fact to take into consideration in planning long-term care is the growth in the population with disabilities. It is estimated that among Quebec’s population living in private households in 1998, approximately 169,600 persons aged 65 or over had a moderate or serious disability. Among the total population of persons aged 65 or over, the rate of moderate disability was 12% and the rate of serious disability was 9%. These rates remained virtually unchanged between 1986 and 1998.

In 1996, the proportion of single persons ranged from 34% among those aged 65–69 to 72% among those aged 80 or over. This situation was more striking for women: 50% of women aged 65 or over had no spouse, as compared with 14% of men in this age group. However, this does not necessarily mean that these people have been abandoned by their families.
For every 100 persons who need help for a long-term health problem, there are 121 family members and friends (in three-quarters of the cases these are family members). More than 18% of these caregivers provide at least ten hours of help per week and 10% provide between five and nine hours. Women comprise 70–83% of family caregivers.

Trends in hospital use in Quebec suggest that current long-term care services may not be adequate to meet current needs. Nearly 15% of persons aged 65 and over are hospitalized at least once in any given year, close to double the proportion of those aged 25–64. The frail elderly utilize acute hospital care even more frequently. Indeed, according to results of the SIPA evaluation study, up to 30% of older persons with moderate to severe disability in instrumental and personal activities of daily living are hospitalized in one year, and up to 40% have at least one emergency room visit. Among community-dwelling older persons, hospitalizations represent 42% of health care costs, which is the greatest contribution to health and social services for this age group. Several studies suggest that a sizeable proportion of hospitalizations are inappropriate and are linked to the lack of resources for outpatient and community services. The fact that older persons become users of acute care beds while at the same time presenting needs for long-term care is an acknowledged problem. However, this problem has been difficult to document.

3.2 Structure and Financing of the Health Care System

Health and social services have been administratively integrated since 1970. The Ministère de la Santé et des Services Sociaux (MSSS) is responsible for regulating the system and the network, providing a general direction for policies, evaluating the results obtained, and distributing resources among the regions in an equitable manner.

The 18 regional authorities (16 regional boards, one Regional Centre and one Aboriginal Regional Board) are responsible for organizing and coordinating services, as well as allocating budgets to the institutions in their territories. Health services and social services are provided by the local community service centres (CLSCs), hospital centres, residential and long-term care centres (CHSLDs), rehabilitation centres, and child and youth protection centres. Services are also provided through community organizations, physicians’ offices, local pharmacies, and private organizations.

As in the rest of Canada, the Quebec health system is public. Universal and free access to hospital services in Quebec dates back to 1961 – to 1971 for medical care, nursing care, rehabilitative services, and psychosocial services. It is financed by the state from the Consolidated Fund, which is derived primarily from provincial taxes and federal transfer
payments. In 2001, 34% ($49.2 billion) of the budget was spent on health and social services.

In 1997, Quebec instituted a universal insurance programme for complementary health services such as drugs, dental care, optometric services, technical aids, and long-term care. This programme is based on collaboration between the public and private sectors. It provides insurance to the entire population, regardless of their age, income, or health status, but requires a financial contribution from individuals. Services such as optometric or dental are included for certain population groups, while others, such as technical aids and home support services, are covered under certain conditions.

3.3 Long-term Care Provision

There is no legislative framework governing long-term care. LTC is managed through policies or orientations which specify, among other things, the vision of MSSS as to how the services should evolve, the role that it intends to play, and the types of organization of services to which it intends to give priority.

Traditionally, taking care of the disabled has been the responsibility of the family. The fact that an increasing number of people with functional limitations are living at home for longer and longer periods and that people are hospitalized for shorter and shorter periods has resulted in new responsibilities for family and friends.

It is also known that women are the principal providers of this informal care. Although the contribution of family and friends, particularly of women, is being increasingly recognized, this is not yet fully reflected in the organization of services and the means of support and respite care implemented.

However, this assistance can represent a significant burden, one which has consequences for the health and social life of informal caregivers, particularly women. Moreover, the number of persons aged 80 or over per 100 women aged 50–64 is 32 and will remain under 40 until 2015. It will reach 57 in 2025 and 113 in 2041.

Thus, there will be fewer and fewer women available to care for the growing number of elderly. And, of course, this does not take into account the effective availability of women in a context of sustained growth in women’s participation in the labour market. This raises the issue of how the state and families should share responsibilities.

The majority of services for the disabled and for seniors with decreasing autonomy were implemented following the restructuring of the health system in the early 1970s. The
Canadian laws have thus partly determined its organization. Old age was considered pathology and the services provided were mainly institutional in nature. The hospital, because of its round-the-clock, seven-day-a-week accessibility and the availability of physicians, was still the ultimate setting where medical and social problems were solved. Placement in a residential centre was also an answer to the problems, undoubtedly because the needs of seniors were mostly understood from the medical–hospital logic that prevailed in the Canadian health system.

In 1985, the MSSS introduced a new report recognizing the necessity of adjusting certain services provided. Many subsequent studies conducted by both the MSSS and external research groups underlined the growing difficulty for the health and social services network to meet the numerous needs of seniors. The health system would have to make considerable readjustments in order to better respond to the needs of an ageing population.

**Home care**
Since the early 1980s, the Quebec government has been committed to supporting people living in their own environment. This commitment was the foundation of the government policy *On equal terms* (1984), promoting the social integration of handicapped persons. The same commitment was reiterated in the *Health and Welfare Policy* in 1992, and was specified in Section 1 of the Act with reference to health and social services. In 1995, the MSSS adopted a plan of action to accelerate the provision of ambulatory care and services. Supporting people in their community is one of the foundations of the organization of services, and institutional placement should be an exceptional measure.

**Target population**
An eligible person is one who, regardless of age, has temporary or permanent disabilities due to physical, social or psychological causes, and must receive in his or her home part or all of the services required as well as support from family and friends.

**Range of services**
Home care provided by the public network, in collaboration with its partners includes:
- personal care and homemaking services to compensate for functional limitations (mobility in the home, dressing, eating, care of clothing, etc.);
- specialized home health care and services (medical care, nursing care, general rehabilitative services, and psychosocial services); and
- civic-support services, accompaniment for outings, and friendly visits.
Personal care services and home health nursing care are the two most used home care services.

**Responsible agencies and providers**

The management of home care by the State was consolidated only towards the end of the 1970s, with the adoption in 1979 of an official policy in this area by the Ministère des Affaires sociales. Prior to the implementation of this policy, home care was viewed as an extension of hospital treatment. Numerous organizations (hospitals, social services agencies, etc.) delivered nursing care, domestic help, and psychosocial assistance, but there was no coordination between services or consistency in eligibility criteria.

The new policy specified that services be provided by the public sector in local community services centres (CLSCs). The 150 CLSCs throughout Quebec are responsible for providing and/or coordinating the majority of home care services. Home care represents close to 50% of their budgets.

CLSCs are usually the direct providers of professional care services (medical, nursing, rehabilitative, and psychosocial) and personal care services (personal hygiene, mobility assistance, etc.) The level of care delivered in the home has become specialized: 70% of CLSCs provide intravenous antibiotherapy, and 80% provide oxygen therapy at home.

CLSCs commonly subcontract homemaking services (preparing meals, housekeeping, shopping), civic support, and respite relief to social economy businesses, community organizations and private agencies, most of which are found in large urban centres.

In addition to home care, CLSCs provide a variety of other social services, including social care for youth, and maternal and infant health. They may also provide general primary medical care, although this role is complementary to services provided by other sources such as family physicians. It can be said that they have full responsibility for community-based social services and for community health preventive services.

The role of CLSCs in primary care may become more central if the provisions for family medicine promoted by the recent Clair Commission in Quebec are implemented. In
particular, the SIPA\textsuperscript{6} model of care recommended by the Clair Commission will give CLSCs a huge responsibility in the financing, coordination, and delivery of social and health care to the frail elderly.

\textit{Benefits}

The majority of community-based long-term care services are provided in kind. Several programmes provide cash, vouchers, or tax rebates to low-income seniors and younger people with disabilities, which can be used to access personal/domestic care services.

Over the past few years, funding for home care services has been diversified via the \textit{Financial Program for Domestic Help Services} (PEFSAD), a blueprint for the social economy in domestic help services. Diversification of funding has also been advanced by the \textit{Tax Credit respecting home-support services for seniors}.

The social economy proposed in Quebec is based on the possibility of promoting the creation of non-profit businesses capable of providing services and creating real jobs. The goals of the programme, which is financed by the MSSS, are to:
\begin{itemize}
  \item create jobs in the social economy;
  \item offer the population domestic help services;
  \item support the development of domestic help services organizations; and
  \item stimulate people to obtain services from these social economy organizations.
\end{itemize}

Financial assistance is provided directly to the organization. Accordingly, the client pays only the difference between the amount requested by and provided to the organization.

The social economy enables society to respond to certain social needs that remain unmet because neither the public nor the private sector has focused on these areas. Home support services constitute one of the sectors chosen to help establish the social economy. PEFSAD grants financial assistance to the elderly and younger people with disabilities designated by a CLSC, based on household income and size. In all cases, at least a minimal contribution is requested from the persons receiving the services.

\footnote{\textsuperscript{6}“SIPA” is a community-based primary care system responsible for assuring the provision of comprehensive and integrated care. Covered services include primary and specialty medical care, hospitalization, medications, rehabilitations, prevention, social services, technical aids, and long-term care. The programme is clinically and financially responsible for all care of frail elderly in a defined catchment area.}
The Tax Credit respecting home-support services for seniors entitles persons aged 70 or over, whether or not they are eligible for the home support services programme of a CLSC, to a refundable tax credit for expenses incurred for certain home support services. They can select the services of an organization or a self-employed worker of their choice. The credit is equal to a 23% reduction in the total costs, up to a predetermined annual threshold. The introduction of these programmes has in some cases resulted in considerable variations among territories, particularly in access to free domestic services.

Quebec also offers the option of direct cash allowances or vouchers for personal/domestic home care. This programme was intended to meet the growing demands for support services and to respond to budgetary restraints. It offers recipients an opportunity for a greater degree of control and independence over home care services. In 1990, 65% of the 159 CLSC home care teams were using this form of payment to provide home support services. Within this programme, clients can negotiate directly with the potential service provider. They can also be assisted by a CLSC case manager. Payments can be made directly to the care receiver, or indirectly through a voucher that the care provider presents at a Government office.

The programme is being questioned because workers are paid very small wages without contributions to unemployment insurance or benefits, often ‘under the table’. Consequently, this kind of work can potentially be exploitive of women. Corrective measures are being taken in this connection, and the social economy domain encourages and stimulates the creation of non-profit cooperatives of independent home care workers with whom contracts are set up to regulate service provision and assure the necessary administration.

**Limits on amount of services**

Although there is no formal cost sharing associated with home care, CLSCs with insufficient resources are forced to apply priority criteria such as the level of support from family and friends and the level of income. CLSCs can also choose to limit the range or intensity of services in order to serve a greater number of persons.

For example, Quebec covers a maximum of 35–40 hours of home support per week. The freedom to use these priority criteria makes it difficult for people to understand the system. It is also difficult to understand the system because services that are available in the community differ from one CLSC territory to the next and are not always available throughout the same year. Seniors and their families may suddenly be faced with lower levels of services or without a particular service.
**Contribution of community organizations**

Community organizations offer a variety of home support services that supplement those provided by CLSCs. They provide:
- inexpensive hot meals which are delivered to homes by volunteers;
- escorts for outings and transportation for health care;
- support for civic activities; and
- respite and relief.

Some organizations provide support to caregivers through:
- help lines;
- meetings; and
- newsletters

In order to provide:
- information;
- moral support;
- encouragement of the pooling of experiences through discussion and mutual aid; and
- defence of rights and interests.

Social economy businesses which have been developed – especially those focusing on domestic help – play a significant role in the provision of services in Quebec. Private domestic services agencies share a smaller segment of the market and are concentrated in large urban centres.

**Decision-making and assessment of care needs**

One of the strengths of long-term care in Quebec lies in the system established to determine eligibility for this care. All requests for care, whether community or residential, are subject to an individual clinical assessment of the person’s bio-psychosocial needs, regardless of his or her income or degree of disability. The response to the needs thus assessed is then adjusted on the basis of available resources.

The CLSCs are responsible for assessing eligibility. While standard assessment tools exist, they are not used by all CLSCs. A unique standardized grid for assessing the needs of persons with decreasing autonomy is currently being developed and may be adapted in eligibility assessments.
Quebec uses the tool "outil d’évaluation clientèle." It uses the general formula where need for home care intervention equals (=) Functional Need minus (–) adequacy of Clients Informal Support.

**Data on service utilization and coverage**

Home care services are used mainly by seniors and those with physical disabilities. Half of those who use these services are over 65 years of age, although approximately 20% of seniors receive home care. The use of home care is increasing in all age groups, as reflected in Table 3.

**Table 3: Number of Different Users Receiving Home Care from 1994 to 1996**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons aged 64 or under</td>
<td>60,614</td>
<td>66,045</td>
<td>81,545</td>
<td>34.5</td>
</tr>
<tr>
<td>Number per 1000</td>
<td>9.4</td>
<td>10.2</td>
<td>12.5</td>
<td></td>
</tr>
<tr>
<td>Persons aged 65 or over</td>
<td>135,383</td>
<td>146,876</td>
<td>175,211</td>
<td>29.4</td>
</tr>
<tr>
<td>Number per 1000</td>
<td>159.3</td>
<td>168.1</td>
<td>195.4</td>
<td></td>
</tr>
</tbody>
</table>

Note: Data on programme users are provincial estimates

Source: Boucher and Côté, 2000

**Financing arrangements**

The increase in the amounts devoted to home support services over the last ten years attests to a will to invest more in this sector. In the last five years alone, the home care budget has increased by 53%. In 1999, half of the expenditures for home support services were allocated to frail older persons, but this budget represented only 3.5% of public expenditures on health in 1999, as compared to 2.6% five years previously.

**Table 4: Expenditures for Home Care in Quebec**

<table>
<thead>
<tr>
<th></th>
<th>Seniors with decreasing autonomy</th>
<th>All clienteles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995–1996</td>
<td>$168.5M</td>
<td>$331.9M</td>
</tr>
<tr>
<td>1999–2000</td>
<td>$258.1M</td>
<td>$508.7M</td>
</tr>
<tr>
<td>% increase</td>
<td>53.2</td>
<td>53.3</td>
</tr>
<tr>
<td>Relative share of costs attributed to seniors 1999–2000 (%)</td>
<td>50.7</td>
<td></td>
</tr>
</tbody>
</table>

Note: Expenditures include those of community organizations and support activities.

Source: MSSS, DGPSÉ

The Quebec per capita home care expenditure was $69 compared to the national average of $82. Amounts per capita vary from one to two and a half times from region to region, and
with differences between CLSCs within the same region. These differences also contribute to the variation in criteria of access between CLSCs, in the range of services provided, and in the methods of delivery. These differences are seen mainly in domestic help services (homemaking), civic-support services, and supervision services.

**Integration of home care services**
CLSCs receive funding for both home health and personal care. Various centres have adopted different models for linking both programmes within their organization. In some cases, programmes are organized by clientele. Both homemaking and nursing-home care are available, depending on needs and availability. These programmes involve the elderly, post-op situations, the needs of family and children, etc. In others, homemaking and nursing-home care are fused or separated.

**Other long-term care services in the community**
All CLSC territories have day centres, which offer daytime activities on an outpatient basis to people of all ages who have decreasing physical and psychological capacities. They offer promotional, preventive, therapeutic, educational, and socialization activities. Clients are required to contribute to the cost of meals and transportation. The volume of clients has remained steady over the last few years. It is surprising that there has not been more growth, given the increasing shift of care to the community in Quebec in recent years.

Quebec has approximately 40 day hospitals, concentrated in four regions. Day hospitals offer – on an intensive, outpatient basis – diagnostic assessment and therapeutic activities. These activities are appropriate when the client’s condition requires that he or she be present continuously for a period of observation of from four to six hours per day, but when his or her status does not require hospitalization. Clients may be asked to make a minimal contribution for transportation.

The shift towards ambulatory care during 1994–1995 put intense pressure on the CLSC system. From 1994 to 1997, persons needing post-hospitalization care increased from 45% to 63% of users. The service with the greatest increase (34%) in users was home care nursing.

The main users of day centres and day hospitals are persons over the age of 65 (see Table 5). Persons aged 65 or over comprise 85% of day hospital users and 91% of day centre users.
A minority of people cannot be maintained in their own environment. Due to the intensity of their needs and the nature of their disabilities, it is more appropriate to provide them with services in an alternative environment.

Table 5: Day Activity Use, 1999–2000

<table>
<thead>
<tr>
<th></th>
<th>Day hospital</th>
<th>Day centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of institutions</td>
<td>41</td>
<td>135</td>
</tr>
<tr>
<td>Number of users</td>
<td>8293</td>
<td>24,124</td>
</tr>
<tr>
<td>Expenditures</td>
<td>$32.1M</td>
<td></td>
</tr>
</tbody>
</table>

Source: Association des CLSC et des CHSLD du Québec and Direction de la gestion de l'information, MSSS

Institutional long-term care

A minority of people cannot be maintained in their own environment. Due to the intensity of their needs and the nature of their disabilities, it is more appropriate to provide them with services in an alternative environment.

Despite trends towards the provision of more support in the community, and the decreasing rate of institutionalization, nursing-home services represent a significant proportion of long-term care expenditures. They comprise nearly 78% of all public expenditures for long-term care and services – community and institutional – to seniors with decreasing autonomy.

Target population

To be considered for institutionalized care, individuals must require at least 1.5 hours of care per day. However, the majority of those admitted require at least 2.5 hours of care per day.

Types of services

Residential care centres provide:
- assistance, support, and supervision services;
- rehabilitation, psychosocial, and nursing care; and
- pharmaceutical and medical services.

Various residential centres offer different levels of care to meet the specific needs of people needing institutional care. Those providing intermediate and low levels of care are generally attached to a public institution – which ensures access for residents and is responsible for accrediting them.
A temporary housing programme offers low-cost respite, relief, and convalescence services. This programme offers similar services to those provided by the day hospitals and day centres described above.

**Specialized geriatric services**
Many hospitals and some of the larger residential centres provide specialized geriatric services in short-term geriatric care units (UCDGs). They offer case-by-case assessment, adaptation, and rehabilitation services targeted at preventing deterioration in the health status and autonomy of fragile seniors.

Ambulatory services which are intended for persons with decreasing autonomy are offered by outpatient clinics attached to hospital centres. Several hospitals, CLSCs, and day hospitals have ambulatory psychogeriatric teams which provide assessment and treatment services, support for caregivers, and information and training to seniors affected by mental health problems.

**Benefits**
The majority of the costs are covered by the Government. However, individuals are expected to contribute up to $1,300 per month, based on a sliding income scale. This contribution contributes to board and lodging. Private residential centres provide approximately 3,000 places to clientele with decreasing autonomy, with financing fully covered through residents' contributions.

**Decision-making and assessment of care needs**
Eligibility for institutional care is assessed on several levels. The first step is a full professional assessment, based on a unique and standardized grid. Multidisciplinary teams then determine the services required. Next, the regional, subregional, or local committees decide where to direct the persons involved, based on their needs, wishes, and available resources.

The methods used to transpose a person's health problems and disabilities into the level of care they require do not reflect all the needs for care and services, in particular those related to cognitive disorders. A more appropriate methodology for classifying needs and determining the most suitable programme to which a person should be directed is currently being tested.

**Limits on amount of services**
Technically, there is no limit on institutional care. Nevertheless, space may not be available even when someone qualifies for a residential care bed. In the year 2000, there was an
average waiting time of two months for a place in a public residential centre. The average waiting time for a given date, however, was approximately six months.

People who can no longer stay in their natural environment are often reduced to looking for a place in a community home (residence or other type of lodging). Choices are more limited for people with reduced financial means, and thus institutional accommodation seems to be the only recourse.

It is a generally acknowledged fact that older persons occupy acute care beds when they really require long-term care, but this problem has been difficult to document.

**Provider auspices**

Residential care centres may be publicly owned, under agreement, or private institutions.

**Data on service utilization and coverage**

There are approximately 42,000 places/beds in centres that are publicly owned or operate under agreement. There are an additional 6,000 places/beds that provide intermediate levels of care for people who are more independent.

As shown in Table 6, between 1991 and 2000 there was a decrease in the absolute number of places and people in residential centres in Quebec.

**Table 6: Number of Places and Number of Attendance Days in Residential Centres in Quebec, 1991–2000**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of places</th>
<th>Number of attendance days</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>46 410</td>
<td>16 140 232</td>
</tr>
<tr>
<td>1992</td>
<td>46 719</td>
<td>16 243 566</td>
</tr>
<tr>
<td>1993</td>
<td>46 604</td>
<td>16 130 564</td>
</tr>
<tr>
<td>1994</td>
<td>46 663</td>
<td>15 996 727</td>
</tr>
<tr>
<td>1995</td>
<td>46 300</td>
<td>16 089 507</td>
</tr>
<tr>
<td>1996</td>
<td>45 807</td>
<td>15 873 453</td>
</tr>
<tr>
<td>1997</td>
<td>44 325</td>
<td>15 326 504</td>
</tr>
<tr>
<td>1998</td>
<td>42 336</td>
<td>14 850 562</td>
</tr>
<tr>
<td>1999</td>
<td>42 207</td>
<td>14 714 987</td>
</tr>
<tr>
<td>2000</td>
<td>42 512</td>
<td>14 774 137</td>
</tr>
</tbody>
</table>

*Source: STATÉVO database, Direction de la gestion de l'information, MSSS, February 2001.*
The rate of institutionalization among persons aged 65 or over fell from 5% in 1994 to around 4% in 2000. Nearly 90% of those living in institutions are aged 65 or older, and 70% are aged 75 or over. The institutionalization rate is low among persons aged 65 to 69 (under 1%), but it rises to 15% among those aged 85 to 89, and to 32% for persons who are aged 90 or older. Institutionalized persons have shown higher levels of disability than they have in the past, as reflected in the level of care required in institutions (Table 7).

Table 7: Distribution of Institutionalized Persons in Quebec, according to Level of Care/hours Required (%)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low intensity care</td>
<td>21</td>
<td>7</td>
<td>–66.7</td>
</tr>
<tr>
<td>Medium intensity care</td>
<td>30</td>
<td>36</td>
<td>20.0</td>
</tr>
<tr>
<td>High intensity care</td>
<td>49</td>
<td>63</td>
<td>28.6</td>
</tr>
</tbody>
</table>

Source: Boucher and Côté, 2000; and Annual Statistical Report of CHs and CHSLDs

Link between institutional and home care

Residential centres are institutions separate from the CLSC. However, there is now a single entry point system for admission to both types of LTC institutions. The intention is to merge this system with the single entry point for home care.

Both public and private institutions are publicly supported. In some case, CLSC and CHSLD have been merged. However, at least in Montréal and perhaps in other regions as well, a CLSC-CHSLD home care client cannot be directly admitted to a bed. The admissions must go to a regional admission board, and there is no guarantee that the individual will be admitted to the referring CLSC-CHSLD.

4. Future Development of Long-term Care

In 2001, the MSSS adopted a new policy to address the major problems involving access to services and the fragmentation of responses to needs of seniors with decreasing autonomy. The policy is intended to enable the health care system to meet the specific needs of frail older persons more appropriately, while creating alternatives to the short-term solutions offered by the health system that are inappropriate for older persons.

This policy was developed as part of a major search for innovative solutions by individuals working within the health and social services system. Specifically, the policy proposes the creation of three component integrated service systems, responsible for organization, clinical aspects, and management of the health care system. The integrated service systems will assume full responsibility for the older population within a territory, including the entire range
of health care and social services, and responsibility for the territorial budget that may be fully used upon the establishment of a specifically allocated budget to services for the frail elderly.

The policy must alter the entire organizational perspective, which – in the case of the frail elderly – previously focused on compensating for disabilities. It must now increasingly prioritize methods for early intervention, treatment, and rehabilitation. The policy proposes a range of more complete services that are more closely adapted to developments in practice and intervention, and which standardize accessibility to services from one territory to another.

The policy also prioritizes constant readjustments in the organization of services for older persons, which must evolve with knowledge regarding intervention and prevention methods. The evolution of practice must also be based on a clearer understanding of needs and – above all – on a transfer of knowledge to professionals in the health care and social service areas. The policy includes the creation of a system to monitor ageing and demographic changes, together with ongoing training and research, and is equipped with an evaluation framework.

As this policy is implemented, frontline services must be restructured. This restructuring is of major importance within a context in which access to general medical services remains difficult, especially for frail older persons.

The organizational component of such networks relies first on the existence of a single entry point and a single mechanism for directing and admitting persons who make requests for home care and accommodation in a region, thus facilitating access to services. A system for assessing needs is especially important in the implementation of a network of integrated services. Such a system must include an assessment tool that provides a core of standardized data and ensures that information is not collected more than once by clinicians.

Interactive communication systems are another essential element in the implementation of networks of integrated services. They link the various professionals involved, thus fostering a multidisciplinary approach. Through such systems, clinicians have access to the patient’s medical history and assessment, and to the protocols for detecting a problem, providing early intervention, and linking with the functional and psychosocial status of the senior.
Clinical case management is the responsibility of a case manager, who ensures that services and care are provided on a continuous basis. This process in turn ensures continuity of all interventions intended for a senior and his or her family and friends. Needs assessment, service delivery, and follow up of the senior's status, are carried out by the CLSC’s local home support services team and CHSLD professionals. The team collaborates with the Regional Department of General Medicine (DRMG), physicians' offices, and community organizations within the territory. The establishment of family medicine groups as recommended by the Clair Commission (Commission d’étude sur les services de santé et les services sociaux) should make it easier for seniors to access necessary medical care.

Concerning geriatric services, regional geriatric teams must be established to serve either as consultants for local professionals or to intervene directly with seniors who have decreasing autonomy. As a general rule, this team must act on all cases referred by the local team, attending physician, or emergency services of the territory.

The administrative component will be organized around cooperative mechanisms based on the collaboration between professionals and managers of institutions with representatives of community organizations, in the planning and management of resources and services. They must also take into account the clinical and administrative aspects of managing networks of integrated services.

Consistent with this new vision, the Clair Commission proposed the creation of community-based integrated service networks for frail elderly, with clinical and financial responsibility based on a per capita budget for the full range of community, hospital, and long-term care institutional care.

Budgetary management methods that facilitate the integration of services should be developed to support the establishment and operation of these networks. The gradual implementation of a budget devoted to seniors who have decreasing autonomy is essential to help professionals choose the best resource to meet their needs.

This budget could eventually include funds reserved for drugs to promote the better use of drug therapy, including that for seniors who live at home. The 'seniors with decreasing autonomy' budget would eventually include amounts to compensate physicians for their participation in integrated services network activities. This budget will be associated with population-based responsibility, and will provide a true opportunity to orient service utilization and make it more effective.
The organizational perspective that was previously oriented primarily towards compensation for disabilities is increasingly being reoriented towards early intervention, treatment, and rehabilitation. In the context of an integrated service network, this range of services is increasingly defined according to the type of interventions and the intensity of services needed by the senior.

The organization of services must also better respond to the clear desire of seniors to live at home. From this perspective, home must be the primary location of service delivery. The policy proposes a range of services to reflect the change in practices and interventions, while standardizing accessibility to services among territories.

The policy recognized that it is extremely important to ensure that the organization of services for seniors continuously adapts to changes in knowledge about modes of intervention and prevention. The evolution of practices must also rely upon a better understanding of needs, and especially upon a transfer of knowledge that is adapted to the needs of health and social services professionals.

In addition to the measures which are needed in the area of further training and research, the policy creates an 'ageing watch' network to monitor demographic changes within an evaluative framework.
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III. Norway -- by Tor Inge Romoren

1. General Background Data

1.1 Preamble

The purpose of this case-study of Norway is, in part, to represent the Scandinavian welfare model. The Scandinavian countries share similar social welfare systems, which are built on the principle of equal access to services to all its citizens - independent of location and income.

The National Insurance System (NIS), which is primarily funded by general tax revenues, also provides pensions, income replacement, education, and other welfare services. In Norway, health and social services account for approximately half of public sector spending. Long-term care in Norway is provided through the public sector welfare system, and is accessible to all inhabitants regardless of income.

Norway has three levels of government. The National Government is largely responsible for setting policies and budgets. The 19 counties and 435 municipalities share responsibilities for providing services.

As the ageing of the population started early in Scandinavia, Norway began developing its long-term care system ahead of other industrialized countries. Influence from pressure groups in the 1950s led to the establishment of standards for LTC institutions and incentives to expand the institutional LTC sector and community-based services. Institutional care was emphasized throughout the 1980s, with the central Government covering up to 75% of the costs.

The focus of services shifted in the 1980s, when the health and social systems were reorganized according to the principles of decentralization and of primary care in the community as a base for all other services. The reorganization of LTC was completed in 1988, when responsibility for the operation of nursing homes was transferred to the municipalities. These changes were intended to channel the diminishing growth of resources towards community care.
Presented in detail on the following pages and briefly summarized below are background data derived from international data bases. These data include demography, vital statistics and epidemiology, economic data, and health expenditure.

In 2000, 4.47 million people were living in Norway. The proportion of elderly in Norway is expected to grow more slowly than other European countries, though the proportion of very old (older than 80), will increase much more sharply. Persons 65 or over will increase from 15.4% in 2000 of the population to 26.2% by 2050. Those 80 or over will increase from 4.5% (30% of the 65+ population) to 10.3% over the same period (40% of the 65+ population).

These demographic trends are reflected in the elderly support ratio in relation to the working-age population (the number of persons 65 and over per 100 persons aged 20–64). This ratio is expected to grow from 26.0 in 2000 to 38.0 in 2025. However, the parent support ratio (the number of persons aged 80 and over per 100 persons age 50–64) will fall slightly, from 27.1 in 2000 to 26.4 in 2025.

Life expectancy at birth is 78.8 years at birth (81.4 for women and 76.1 for men), and at 22 years at 60 (24 for women and 20 for men). Based on estimates for healthy life expectancy (HALE), Norwegians spend approximately 10% of their lives in ill health (healthy life expectancy at birth: 70.8), and 25% of their life after aged 60 (healthy life expectancy at 60: 16.6).

Based on WHO estimates for the year 2000, approximately 4.4% of the total population were disabled (defined as persons of all ages requiring daily care). This rate will reach 5.2 by the year 2030. The disability dependency ratio provides an indication of the pressure of caregiving responsibilities. The number of dependent persons per 100 population aged 15-59 is currently 7.2, and is expected to reach 9.8 by 2030.

---

### 1.2 Background Data from International Data Bases

#### Demography (year 2000)

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (thousands)</td>
<td>4469</td>
</tr>
<tr>
<td>Land area (sq km)</td>
<td>307,860</td>
</tr>
<tr>
<td>Population density (per sq km)</td>
<td>14</td>
</tr>
<tr>
<td>Population growth rate (% 2000-2005)</td>
<td>0</td>
</tr>
<tr>
<td>Urban population (%)</td>
<td>75</td>
</tr>
<tr>
<td>Ethnic groups</td>
<td>Norwegian (Nordic, Alpine, Baltic) &amp; Lapps (Sami) 20,000</td>
</tr>
<tr>
<td>Religions</td>
<td>Evangelical Lutheran (state church) 86%, Other Protestant &amp; Roman Catholic 3%</td>
</tr>
</tbody>
</table>

#### Age structure (%):

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0−14</td>
<td>19.8</td>
</tr>
<tr>
<td>15−24</td>
<td>12.0</td>
</tr>
<tr>
<td>60+</td>
<td>19.6</td>
</tr>
<tr>
<td>65+</td>
<td>15.4</td>
</tr>
<tr>
<td>80+</td>
<td>4.5</td>
</tr>
</tbody>
</table>

#### Projections 65+ (%)

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2025</td>
<td>21.8</td>
</tr>
<tr>
<td>2050</td>
<td>26.2</td>
</tr>
</tbody>
</table>

#### Projections 80+ (%)

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2025</td>
<td>5.5</td>
</tr>
<tr>
<td>2050</td>
<td>10.3</td>
</tr>
</tbody>
</table>

#### Sex ratio (males per female):

<table>
<thead>
<tr>
<th>Category</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>0.98</td>
</tr>
<tr>
<td>15-64</td>
<td>1.03</td>
</tr>
<tr>
<td>65+</td>
<td>0.71</td>
</tr>
</tbody>
</table>

#### Dependency ratio:

- **Elderly support ratio in 2000**: 26.0
- **Elderly support ratio in 2025**: 38.0
- **Parent support ratio in 2000**: 27.1
- **Parent support ratio in 2025**: 26.4

---

* Elderly support ratio: the ratio of those aged 65 and over per 100 persons aged 20–64.
** Parent support ratio: the ratio of those aged 80 and over per 100 persons aged 50–64.
**Vital Statistics and Epidemiology**

| **Crude birth rate** (per 1000 population) | 11.4 |
| **Crude death rate** (per 1000 population) | 10.0 |

**Mortality under age 5** (per 1000 births)

<table>
<thead>
<tr>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

Probability of dying between 15-59 (per 1000)

<table>
<thead>
<tr>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>101</td>
<td>60</td>
</tr>
</tbody>
</table>

Maternal mortality rate (per 100 000 live births) (1995)

| 9     |

**Total fertility rate** (children born/woman) (2001)

| 1.7   |

**Life expectancy at birth** (years) (2001)

<table>
<thead>
<tr>
<th>Total Population</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>78.8</td>
<td>76.1</td>
<td>81.4</td>
</tr>
</tbody>
</table>

**Life expectancy at 60** (years) (2000)

<table>
<thead>
<tr>
<th>Total Population</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>20</td>
<td>24</td>
</tr>
</tbody>
</table>

**Healthy life expectancy (HALE) at birth** (years) (2001)

<table>
<thead>
<tr>
<th>Total Population</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>70.8</td>
<td>69.3</td>
<td>72.2</td>
</tr>
</tbody>
</table>

**Healthy life expectancy (HALE) at 60** (years)

<table>
<thead>
<tr>
<th>Total Population</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.8</td>
<td>15.6</td>
<td>17.9</td>
</tr>
</tbody>
</table>

**Disability rate and disability dependency ratio (%)***

<table>
<thead>
<tr>
<th><strong>Disability rate</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
</tr>
<tr>
<td>2030</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Disability dependency ratio</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
</tr>
<tr>
<td>2030</td>
</tr>
</tbody>
</table>
Economic Data (year 2000)

GDP – composition by sector

<table>
<thead>
<tr>
<th>Sector</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>2%</td>
</tr>
<tr>
<td>Industry</td>
<td>25%</td>
</tr>
<tr>
<td>Services</td>
<td>73%</td>
</tr>
</tbody>
</table>

GNI ($PPP) **** 133 billion

GNI – per capita ($PPP) 29630

GNI – per capita (US$) 34530

GDP growth (annual %) (1999−2000) 2.3

Labour Force Participation

<table>
<thead>
<tr>
<th>Category</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>56.1</td>
</tr>
<tr>
<td>Female</td>
<td>38.0</td>
</tr>
</tbody>
</table>

Health Expenditure (Year 2000)

<table>
<thead>
<tr>
<th>Category</th>
<th>% of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health expenditure per capita ($PPP)</td>
<td>8.3</td>
</tr>
<tr>
<td>Health expenditure per capita (US$)</td>
<td>2373</td>
</tr>
</tbody>
</table>

2. General Health and Social System

2.1 Basic Income Maintenance and Poverty Reduction Programmes

Norway has a national pension system that is part of the NIS and financed through equal contributions from wage earners and employers. The national Government also subsidizes these funds. In 1999, the state contributed 3.5% of GDP to cover pension costs. Unlike other OECD countries, the pension system is fully integrated into the central Government budget and is not a separate social insurance scheme with contribution rates linked to outlays.

All Norwegian residents are entitled to an old age pension at age 67, although since 1989 early retirement incentives in certain sectors allow for individuals to receive old age pensions as early as 62. Although Norway has the highest employment ratio for older workers (aged 55 to 64) in the OECD, employment rates fall sharply with age. Only one third of people aged 64 are employed, even though the official retirement age is 67. This reflects the

*** Disability rate: Proportion of total population requiring care based on two severest Global Burden of Disease study disability categories (levels 6, 7); Disability dependency ratio: total number of dependent people/population 15−59.

**** PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries
introduction of the early retirement scheme in 1989 and the gradual lowering of pensionable age in this scheme during the 1990s.

In the absence of reforms, the ageing of the population combined with a still-maturing pension system could result in one of the steepest increases in pension expenditures in the OECD in the next 50 years. Pension outlays of the NIS are expected to more than double from the current 7.3% to 17% in 2050.

The minimum pension is about one-third of the average full-time wage. In addition to government pensions, approximately 50% of the workforce is covered by an occupational pension scheme. People with low or no supplementary pension rights receive a special supplement, which together with the basic pension adds up to a minimum pension. Income can be further augmented through rent subsidies, based on needs testing. The NIS also provides pensions to those who have less than 50% of working capacity after having received appropriate medical treatment and rehabilitation lasting up to two years.

2.2 Structure of the Health and Social Service System

The health care system covers the entire population of Norway. The system guarantees universal access to a benefit package including most preventive and curative services.

The Norwegian health and social service system is highly decentralized, at three main levels:
- the central state,
- 19 counties, and
- 435 municipalities.

At a national level, three national bodies oversee the health care system: the Ministry of Health and Social Affairs, the National Institute of Public Health, and the National Board of Health. The Ministry of Health and Social Affairs is responsible for overall planning, budgeting and oversight for health and social services.

There have been attempts to promote a meaningful regional level in the health care sector. This level consists of health regions - administrative entities managed by counties. The five health regions (comprising 19 counties) are responsible for financing, planning, and provision of acute care in hospitals and specialty services. Previously, these services were provided by counties.
This 'centralization' of administration and financing of hospital and specialist services was introduced in order to improve control over budgets and to avoid duplication of services. Since 1974, regional health committees have been established in each region. To date, the impact of these committees has been limited. To revitalize these committees, during the year 2000 each region was required to submit strategic plans to the Ministry.

The 435 municipalities (with a mean population of 10,000 inhabitants), are responsible for financing and providing primary care, social services, and long term care services. Local authorities are allocated block grants, based on population characteristics, for service provision. These grants can be budgeted as each municipality considers appropriate. In addition, grants and subsidies are earmarked for major reforms and investment projects.

The Ministry of Local Government and Local Authorities is responsible for distributing these block grants to municipalities. Funding from the national level provides approximately half of the local budgets, with the remainder coming from other tax bases and out-of-pocket payments.

Beyond primary care, municipalities are also responsible for the provision of social services, including care for the elderly and the disabled, continuous care residences (nursing homes, rehabilitation centres, etc.), social support and leisure activities, day-care centres, and social security benefits.

Generally, each municipality has three separate administrative departments, for provision of:
- medical care;
- nursing and home care; and
- social services.

In 1986, municipalities were given the authority to prioritize services, on the assumption that autonomy in financing and service provision would better serve local needs.

The municipal board approves a health plan according to local needs and demands. Local politicians can determine the amount of funds to spend on health, but the Local Authority Health Care Act defines a number of services which are mandatory at local level.
2.3 Financing of Health and Social Services

The most prominent feature of the system is the predominance of tax-financed public provision of services and limited out-of-pocket payments (the role of private insurance is very limited). Typical for the Scandinavian welfare model, most health and social services are both publicly-financed and publicly-provided. All in all, taxes finance about 90% of the services, the rest from out-of-pocket payments.

Co-payments are made for visits to medical doctors, essential drugs, home help physiotherapy, and institutional LTC. Users are responsible for the full cost of provision of non-essential drugs and dental services, neither of which is included in the basket of health services. There is no user contribution for home nursing and respite care or hospital stays.

While all users must contribute to the cost of services, the amount is graded by income level. There is also a legal maximum for user contribution, so even those with high incomes receive subsidized services. For example, no more than 85% of an individual's annual income can go towards institutional care.

2.4 Provision of Services

The care delivery system is mostly owned and operated by the Government.

Both primary health care and social services are provided on the municipality level, promoting service integration. Again, and as indicated above, municipalities are responsible for:

- primary care;
- the provision of social services, including care for the elderly and the disabled;
- continuous care residences (nursing homes, rehabilitation centers, etc.); and
- social support and leisure activities, day-care centres, and social security benefits.

In general, limits on the amounts of service provision are determined by local authorities’ economic resources, in competition with resources needed in such other sectors as primary education, roads, etc.

General practitioners (GPs) occupy a central role in the primary care system. The most common organization of GPs is into groups of between two and six. Although not required of them, most GPs specialize in general/family medicine. Patients can choose their GP. Other health providers, such as specialists and physiotherapists, receive reimbursement only when patients have been referred by their GP.
Physicians are either salaried by municipalities (in 1998, approximately one-fifth of the total were so employed), or work on a contract basis (since 1997, their income has been based on a combination of capitation and fee-for-service approaches).

Hospitals and specialist medical services (somatic and psychiatric) are provided by national Government agencies. Hospitals are publicly owned and operated.

NGOs and a few for-profit organizations provide between 5–10% of health and social services, and are integrated in public plans. NGOs receive extensive public financial support.

Since 1969, counties have assumed responsibility for the financing, planning, and provision of specialized health care. Since 1974, however, hospitals and specialist medical care have been administered through five geographical regional offices. While the system remains decentralized, coordination among levels of government has been strengthened in order to minimize duplication and fragmentation of services.

Geographical and social equity is a central political issue. A main problem is the supply of general practitioners and specialists in rural areas, especially in the northern part of the country.

Recent reforms have been made to improve accessibility to the system. The range of services has been expanded to meet better the needs of the elderly and disabled. In order to balance the distribution of health care providers across the country, and especially to improve access in rural areas, efforts have been made to increase the number of health care providers working on a contract basis and to monitor reimbursement to those providers working without a contract.

2.5 Data Collection
Except for hospitals, the statistical information systems in the health and social care sector is generally poor. Since 1970, the Central Bureau of Statistics has gathered simple administrative data on a national basis. The Norwegian Institute of Gerontology has refined these data and combined them with other national statistics, and published them in tabulated, time series form. Since 1989 the Central Bureau of Statistics has improved its routine data collection on long-term institutional care. An information system on LTC services, based on separate user episodes, is under way.
3. Description of Long-term Care Provision

3.1 Overview

All citizens in need are allowed long term care services. In theory, services can be denied in the case of an acute fiscal crisis in the economy of the municipality or other local authority; in practice, this never happens. There is strong budgetary control, and all long term care services are provided as part of the total local public budget - always with some degree of 'slack'.

The volume of services must be adjusted from year to year, based on the authorities' economic resources. However, if this volume falls below a legally defined level, national authorities intervene and instruct local authorities as to how to allocate resources above the legal minimum for LTC. In such cases, other obligations which are considered to be at a lower priority - such road maintenance - will be reduced instead.

LTC services for the elderly in Norway are comprised of two parts:
- community care (sheltered housing, home help, and home nursing), and
- institutions (nursing homes and residential homes).

As mentioned above, municipalities are responsible for the majority of long-term care services. Responsibility for institutional care was transferred from the national government to the municipalities only in the 1980s, in conjunction with a policy to encourage more community care.

Hospitals, which are funded through the national Government, still pay for a good portion of the care for the elderly. However, this portion has decreased as hospitals have reduced lengths of stay and have shifted responsibility of rehabilitation to nursing homes.

The proportion of those aged 65 years and older in institutional care declined during the 1980s and 1990s. Accompanied by an increase in home services, this decline has contributed to reduce the operating costs of the system. Notwithstanding this trend, Norway still has more resources concentrated on institutional care - especially nursing homes - as compared with other Scandinavian countries.

Because institutional LTC was developed before sufficient community services were available, admission cohorts will gradually shift over time, in their characteristics and lengths of stay. The relatively young-old permanent stayers from the first phase of institutional development will be replaced by the relatively old and shorter stayers of today.
increased use of nursing home resources for rehabilitation and respite purposes is resulting in an increasing turnover rate and an expanding proportion of live discharges.

### 3.2 Community Care

**Target population**

All citizens with functional limitations have access to community long-term care. Because the majority of the older and disabled populations live in the community, the potential population for community-based care of one form or another is much larger than that for institutional care.

**Range of services**

Access to community care has increased substantially in Norway. These changes indicate a policy shift from institutional to more community-based care. Services in the community include:

- home-based care;
- day-care centres;
- recreation clubs;
- meals;
- alarm systems;
- social support; and
- special housing programmes.

**Home-based care**

The two major forms of home-based community care are home help and home nursing services.

**Home help** provides assistance with meals, housekeeping, home maintenance, shopping, and other household needs. The home helper also has a social, supportive function. Home help is normally provided for 1–3 hours a week on a regular or more occasional basis, but may reach 50–60 hours a week or more – particularly for young severely handicapped persons.

**Home nursing** refers to home health and personal care services provided in the home by registered or semi-trained nurses. Home nursing is mostly provided during visits, often of short duration, to perform medical services or supervision. Community services (mainly home nursing) are increasingly becoming available around-the-clock and on week-ends. Approximately 95% of Norwegian municipalities currently provide 24-hour-services.
**Other services in the community**

Most municipalities also provide other community services, such as meals-on-wheels, counseling, handy man service (utbedringslan og-tilskudd), alarm service (omsorgsalarmer), and respite services. However, these services may be differently organized. They are frequently provided through service centres, which are open to all retirees in the particular municipality or township. These centres function partly as places for social meetings and activities, and partly as service institutions. Approximately 300 service centers in Norway are concentrated primarily in urban areas. An estimated 20% of retirees visit these centres on a regular or occasional basis, and many also work as volunteers. Nearly half of the service centres are public, while the other half is run by publicly-funded voluntary organizations.

Community care is often provided in 'special housing', originally planned in the 1940s and 1950s onwards as ordinary retirement flats in response to housing shortage among older and disabled people. There are ordinary retirement flats for 32 000 persons (80% of whom are elderly). Retirement flats may be either public or private, or a mixture of public and private. Residents pay rent, and in some cases also deposits. They then treat the flats as their own, as in the case of ordinary housing. Rents and deposits are normally subsidized by the municipality, and residents may also receive a housing allowance from the state.

**Benefits**

Most services are provided in kind. In 1988, however, the Municipal Health Services Act (of 1986) formally introduced a payment arrangement for informal care as a new service. This arrangement provides opportunities for paying a so-called 'care salary' to relatives with substantial informal care responsibilities (Omsorgslön). The trend towards payment for informal care has developed most extensively in Scandinavian countries, due to the high level of female participation in the labour market. In addition, family members (beyond spouses) have no formal obligation for care and econonic support.

Nevertheless, relatively few professional and unpaid carers have taken advantage of this payment. During the year 2000, approximately 6000 persons received cash payments. Approximately a third of these payments were provided for care of disabled children, another third for care of disabled adults and the remaining third for the care of disabled elderly. The mean number of hours per week paid per carer is 10. Because the carers are predominantly female, there is some opposition to such payment because it may have the result of forcing women into this role.
Decision-making and assessment of care needs
Applications for institutional or home-based LTC are evaluated by a local nurse. The methods employed in this process vary among communities. A committee reviews both the applications and the nurse's recommendations in consultation with local professionals, and decides upon the nature and scope of services to be provided. Applicants have the right of appeal to a state representative in the region.

Most requests for home nursing come from primary physicians, hospitals, or nursing homes.

Limits on amount of services
As mentioned, home help (assistance with homemaking) is normally provided for 1–3 hours a week on a regular or more occasional basis, but may reach 50–60 hours a week or more - particularly for young severely handicapped persons. Home nursing is provided most frequently during short visits by professional health carers, which are generally available around-the-clock. Nevertheless, those in need of more than 6 or 7 hours of help in their homes each day will be encouraged to apply for institutional care. By law, however, the local administration is obliged to provide any service which is needed around-the-clock in the event that the applicant refuses to move into an institution. This situation, however, is rare.

The profile of institutional and community care has changed, towards more selective and targeted allocations for the most needy. A rationalization in the hospital sector that old patients are discharged earlier increases pressure on municipal services. This poses major challenges to the welfare state to become more selective and to prioritize the needs to be first served. Moreover, the fact that the system is so decentralized encourages municipalities and counties to shift part of the burden onto each other by restricting supply. There have been complaints about shortages, problems in quality of services provided, and regional inequalities.

Time has been an increasingly scarce resource in the provision of community services. In response, home nurses have increased the number of their visits and reduced the time for each visit.

Practical homemaker services are also given less priority relative to personal care. Practical services are increasingly seen as a personal or family responsibility, with the public service concentrating on personal care and attendance.
Providers
Historically, home helpers were traditionally employed on an hourly basis, and the great majority were housewives serving only one or two clients as a source of extra income. In recent years, the home help service has become professionalized. The number of home helpers has declined, with each home helper serving more clients and employed on a full or half-time basis. Home nursing is provided by registered or semi-trained nurses.

The professionalization of community services has been a necessary and positive move. However, unintended consequences have included an increase in 'indirect time use' (administration, traveling, paid absence, etc.) relative to the time devoted to the provision of direct care. This 'indirect time' use may also be a consequence of geography. Norwegian home nurses spend about a third of their time in their automobiles between clients — more than half in municipalities where distances are longer. These developments — together with shorter working hours and medical developments — have increased the costs per care unit. Because these factors are not accommodated in equally high investments, allocations have become tighter.

Financing arrangements
Recipients pay for home help in accordance with a sliding scale stipulated by the council of the municipality. Users cover approximately 3% of the cost of home care through their contributions. There is no co-payment for home nursing.

Data on service utilization and coverage
Almost 94% of those aged 65 and over live in private accommodations. Approximately one-fifth of this group receives regular home services. More than 136 000 have access to home help and/or home nursing (of whom 80-85% are elderly). Home-help was used by 169 per 1000, and home nursing was used by 131 per 1000.

Unfortunately, separate figures are not available for residents in sheltered housing and people living at home with formal care. Neither is it known how many home nursing clients used home help and vice versa. Altogether, a maximum of 300 per 1000 used formal community care during 1995.

An estimated 60% of those aged 80 and over receive at least one community-based service — 19% of this group are in sheltered accommodation, and another 40% receive home services in the community. Among this 80+ age group, home help was used by 456 per 1000 and home nursing used by 351 per 1000. More than nine-tenths of the 90+ age group
receive services, which are equally split between community care and sheltered accommodation. It seems reasonable to conclude that most of the elderly in need of help do have access to some formal (mainly public) service. They may, however, not have the type and volume of help they need.

The volume of sheltered and supported housing has been particularly low relative to needs. This shortage of such facilities and of community services leads to increased pressure upon nursing homes, and of course upon the family. In response to this scarcity, ordinary retirement flats are increasingly modified towards the sheltered accommodation concept (service housing), but such information is not well-documented to date.

In recent years, the development of various types of sheltered housing (care housing) has been financially encouraged and stimulated, with a resultant increase in numbers. This development is part of a more general de-institutionalization policy, which also includes the mentally handicapped. The aim of this approach is to promote independent living while providing services from the community according to need.

### Table 1: Availability of Selected Community-based LTC Services in Norway, 1999

<table>
<thead>
<tr>
<th>Service</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sheltered housing</td>
<td>4.6 places per 100 persons aged 65+</td>
</tr>
<tr>
<td>Social centers for the elderly</td>
<td>15–20 persons served per 100 persons aged 65+</td>
</tr>
<tr>
<td>District nursing</td>
<td>4.3 personnel per 100 persons aged 65+</td>
</tr>
<tr>
<td>Home help</td>
<td>16.9 persons per 100 persons</td>
</tr>
<tr>
<td>Home nursing</td>
<td>13.1 persons served per 100 persons</td>
</tr>
</tbody>
</table>

*Source: Social Protection for Dependency in Old Age in 15 EU Member States and Norway, European Commission, 1999*

### 3.3 Institutional Care

**Target population**

While there is no strict age or disability limitation on access to institutional care, the policy over the past several decades has been to limit access to the most frail and disabled. Residents are more disabled and have a shorter life in institutions than previously; accordingly, more persons are accommodated per bed than has been the case in the past.

**Range of Services**

Long-term care institutions for the disabled and the aged include residential homes for the aged and nursing homes, described as follows:
Residential homes, which are regarded as 'social' institutions, offer a common household with 24 hour staffing for people who are not able to live on their own but are not in need of continuous medical or nursing services. Serviced housing, a semi-institutional form of care, is becoming more popular as a compromise between retirement flats and nursing homes.

Many municipalities have organized 'combined institutions' which include both residential and nursing home units.

Although nursing homes are used mainly for long-term stay, pressures have led some hospitals to provide short-term institutional care as well. Most nursing homes also provide short term institutional care for cases of acute illness or respite services. Nursing homes may also function as day-care centres for people receiving care in the community.

In recent years, various types of serviced housing have developed as intermediate solutions between institutions and ordinary retirement flats, offering independent living combined with certain care services available onsite. Their number is sharply increasing.

They offer not only independent living but also services and care, and in some cases approach modern, non-custodial institutions. This category of sheltered accommodation is now substituting for traditional residential homes, and to some extent nursing homes, although residential and nursing homes have still remained the predominant service. They offer services on a 24-hour basis through the community.

Some municipalities have to some extent replaced institutional care with the service housing concept, and in that process has increasingly separated their responsibility for housing from that of services. In this approach, housing is regarded as a personal responsibility, while the municipality concentrates on provision of services.

**Responsible agencies**

Institutional care is the responsibility of the municipalities. Nursing homes, which provide not only a sheltered home but also medical attention, have traditionally been classified both functionally and legally as medical institutions. They are subject to regulation under different laws than are homes for the aged, which provide only shelter and social care. As mentioned previously, in many communities the two institutions are combined in one building.
**Financing and benefits**

The cost of institutional care in Norway is high compared to that in other European Union member states, and the Government pays the majority of the costs.

**Table 2: Average Cost for Institutional and Hospital Care in Norway, 1999**

<table>
<thead>
<tr>
<th>Average cost per month</th>
<th>Cost (ECUs)</th>
<th>Percent covered by State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Old age home</td>
<td>2288</td>
<td>80%</td>
</tr>
<tr>
<td>Nursing home</td>
<td>3346</td>
<td>80%</td>
</tr>
<tr>
<td>General hospitals</td>
<td>12,810*</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Source: Social Protection for Dependency in Old Age in 15 EU Member States and Norway, European Commission, 1999

* highest of all EU member states

While all users must contribute to the cost of services, the amount is graded by income level. There is also a legal maximum for user contribution, so even those with high incomes receive subsidized services. Users pay approximately 16% of total expenses (pensioners pay 75% of the basic amount above the threshold of 12% of the basic amount, and 85% of the supplementary pension for institutional care).

Accommodingly, no more than 85% of an individual's annual income can be paid for institutional care. It is worth noting that pensions are paid directly to the institution when a person is admitted to residential or nursing homes. The older person then receives pocket money from the institution. This system does not contribute to independence.

**Decision making and assessment of care needs**

Decisions for admission are made by an admission team, usually consisting of:

- a representative from the home nursing services;
- the physician (usually a general practitioner associated with the nursing home);
- the director of the nursing home; and
- other representatives from the local health and social services.

Decisions are made on an *ad hoc* basis, using no formal pre-admission assessments. The team tries to find the best overall solution in each case, considering all resources available in the local service system. The home nursing team member has the strongest influence on the final decisions, as this person has the best information concerning the overall situation of
the patient and of the informal care resources. Decisions not accepted by the elderly or their families can be appealed to the central government health authority representative in the area.

More and more nursing homes are connected to the services offered in community care. In 1990, 72% of admissions made directly from the community. The rest were mainly from acute hospitals.

**Limits on amount of services**
Estimated user rates over time indicate how access to institutional care has declined in recent years. However, reduced access to institutional care has primarily affected the younger (and probably less disabled) age groups, while the oldest have been somehow been more protected from this decline in access. Institutionalization rates among those over aged 90 increased until 1990, before leveling off.

In an effort to limit institutional care to the old-old (80+), allocation of beds since 1970 has been much more selective. This can be illustrated by the steadily increasing proportion of residents aged 80 and older, from 52% in 1960 to 73% currently. Survey data also substantiate the facts that residents in institutions are in general more frail today than a decade or two ago, and that a growing proportion of them suffer from dementia.

While access to services in general has declined and become more selective, standards for staffing and material standards have improved. The cost for each service unit has increased substantially, helping to explain the need for selectivity in allocations.

**Providers and standard of services**
Institutions are small, ranging from 7 to 20 beds, with an average of 42 beds per unit. Nursing homes in Norway are fairly well staffed, with an average of 71.6 full-time therapists and other care staff per 100 beds (of this total, 18.3 of these staff are registered nurses, 38.6 are nursing assistants, 8.4 are non-professional nursing personnel, .6 are physicians and 5.7 are other professional staff). In homes for the aged, staffing averages 51.2 per 100 beds.

Core personnel in LTC are nurses and nurses aides (approximately 60-70% of the total), who are assisted by other staff with less formal education.
The resident–staff ratio in institutions has increased from 1:0.47 in 1970 to 1:0.9 in 1999. These figures include all – not only nursing – staff, and are not corrected for changes in working hours during this period.

Housing standards in institutions are being improved, through the construction of new and more modern facilities. An increasing number of residents have rooms of their own, which in some cases also include a bath/toilet and in more unusual cases a kitchenette.

Standards have also improved by increased educational standards for staff, and probably through better medical care quality. Special small units have been developed for demented persons, which are normally better staffed than are ordinary units. Approximately 15% of nursing home beds are now organized in such units.

**Data on service utilization and coverage**

There are presently nearly 43 000 institutional beds (45 000 including serviced housing). Of these, 70% are in nursing homes, with a staffing ratio of 6.1 (6.4 respectively) per 100 persons aged 65+.

In 1995, approximately 6% of persons aged 65+ and 25% of those 80+ were receiving long-term institutional care. Those in service housing represented a very small proportion — less than 0.05% — of those over 65.

**Table 3: Availability of Selected Institutional LTC Services in Norway in 1999**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing homes</td>
<td>4.7 beds per 100 persons aged 65+</td>
</tr>
<tr>
<td>Special housing for the elderly –“trygedeboliger” (includes sheltered housing/service flats)</td>
<td>4.6 places per 100 persons aged 65+</td>
</tr>
<tr>
<td>Psychiatric nursing homes</td>
<td>0.4 beds per 100 persons aged 65+</td>
</tr>
<tr>
<td>Housing for the disabled</td>
<td>0.3 places per 100 persons aged 65+</td>
</tr>
</tbody>
</table>

*Source: Social Protection for Dependency in Old Age in 15 EU Member States and Norway, European Commission, 1999*

The development in the institutional care sector should also be judged according to the development of service housing and community care services, as these are intended to reduce and/or postpone the need for institutionalization.
The 'purpose of stay' recorded at admission for the total nursing home population in the middle of January 1990 was

- 8% for rehabilitation;
- 14% for respite care; and
- 77% for permanent care.

Of the residents discharged alive from nursing homes in 1990, 82% returned to the community. Between 1972 and 1998, the total number of discharges doubled and the proportion of live discharges increased from 53% to 71%. These figures are indicators of a developmental dynamic throughout the LTC system and a more conscious shift in the use of the nursing home segment toward more rehabilitation and respite care. The implication of these changes is that more persons are accommodated per bed than previously.

The declining volume of institutional care may to some extent be explained by better health among the elderly, by improved housing standards, and the expansion of community services. On the other hand, changing family and household patterns — primarily the growing number of single households among the very old — are adding to the need for sheltered accommodations.

Developments in the (municipal) services for the aged should also be seen in the context of the changes in the (county) hospital sector. The number of hospital beds has been radically reduced during this period, while the number of treated patients has increased. The average current stay (6.8 days) is less than half compared to that of 20-30 years ago. Patients are discharged earlier, and responsibility for rehabilitation of old patients is transferred to the municipalities.

### 3.4 Integration of Services

In recent years, local authorities have attempted to reduce segmentation and to rationalize and streamline services by bringing them under the same administrative service within the municipality. All long term care — both community-based and institutional—is part of one service organization operated by local authorities. These services are fully integrated, administratively and economically, in the local (common) health and social service administration.

Primary health care for the general population is also provided through this same system. Most general physicians work in private practice, but have extensive arrangements with local
authorities about their duties and rights in the service system. This unique organizational model allows for continuity of care.

4. Issues and Policy Developments Concerning Long-term Care

In 1997, Parliament adopted a four-year action plan for 1998-2001. The principal aims were to ensure that the capacity of the local social and health care services would increase with the increasing number of elderly people and to improve the quality of care. That quality of care – as measured by housing and institutional standards and the number of qualified personnel – was not considered satisfactory.

Goals of this plan include:

- promotion of the independence of individuals for as long as possible;
- encouragement of user participation in assessing needs; and
- establishing uniform standards.

Minimizing costs of long-term care by enhancing co-operation between hospitals, primary health care, and care services for the elderly has not been a focal point in the action plan. However, this is considered an important aim by the Ministry of Health and Social Affairs.

A 1998 evaluation of the action plan found that most municipalities had used special grants to:

- increase nursing positions;
- offer training to care personnel; and
- strengthen operating functions within the elderly care sector.

As of mid-2002, the Government had allocated a total of 28 billion Norwegian Kroner in special grants towards municipal investment to create places in nursing homes and sheltered accommodations. These grants extend over an eight-year period through 2005, when it is expected that 38 400 new units for the elderly will have been created.

Major issues emerging from the existing establishment for LTC services involve:

- **Geographical and social equity** - limitations and variations as a result of differences in financial resources among local authorities, and complaints about shortages and poor quality of care;
• Need for more resources devoted to home-based LTC, with the goal of reducing demand for institutions, as well as for ideological reasons;

• Experiments with contracting of LTC (especially by institutions) to NGOs or private for-profit organizations. Some private proposals are emerging as alternatives to the public system

• A general shortage of manpower; and

• Information systems to determine LTC needs and service utilization to support policy decisions.

Given current usage patterns and the low cost of services to the user, the financial burden of the care system could rise rapidly. The extensive use of some high-cost services requires a better assessment of the most efficient solutions for individual cases. The low level of charges is likely to have increased the demand for public services.

Options for improving care for the elderly

• Preventive measures, that would permit the elderly to live independently as long as possible, may need to be strengthened further.

• Better assessment methods for individuals within the context of the current extensive use of some high-cost services. Some countries have set up geriatric assessment units (bringing together the elderly, their families, the family doctor, and social workers) to better assess the needs of the elderly and the mix of services needed to keep them independent for as long as possible. Such measures are even more necessary where the elderly pay only a small share of the overall costs.

• Better consolidation of supply across municipalities. There are distinct advantages to having responsibility for some welfare services at different Government levels, as this permits local circumstances to be taken into account. However, where it encourages municipalities and counties to shift part of the burden onto each other by restricting supply, a better integration would reduce costs. At the same time, there may be economies of scale and scope, which can be obtained if nearby municipalities combine services for the elderly.
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Ebbe, 1980


Ivar Brevik, Action *Plan for Care of the Elderly*, Oversight by the regional offices of general government of special grant spending in the municipal government, NIBR R.
A REVIEW OF LONG-TERM CARE IN FIVE COUNTRIES

Introduction

While all developed countries provide long-term care services, only a few of them have implemented long-term care systems based on legislation and entitlement principles – a very recent development. Traditionally, long-term care has been provided on the basis of budget-limited programmes and not as part of an insurance scheme.

In this chapter, we describe and compare the long-term care laws of five countries: Austria, Germany, Israel, Japan, and the Netherlands.8

These countries have placed long-term care at the forefront of their national political agendas. At the same time, in designing and implementing long-term care laws, each of the countries sought a balance between meeting needs and containing costs and had to choose Thus they have addressed design issues such as the target population and eligibility criteria, the type of benefit (cash allowances, services in kind, or both) and services offered (community care, institutional care, or both), as well as the range of services and level of benefits, and the organizational structure and responsible insuring agency (i.e. whether long-term and acute care are organizationally and financially linked or discrete). We describe and compare the programs, based on a conceptual framework (presented in a summary table) that helped us identify the major structural features of each law, the similarities and differences among the laws, and the issues of concern to policy makers in each country – such as cash benefits versus in-kind services, the integration of acute and long-term care, and the balance between the role of the family and the state.

Description of the Long-term Care Laws

1. Austria

Background

Until January 1994, statutory sickness insurance provided benefits only in the event of acute illness; long-term care was not covered. This led people needing long-term care to use acute hospital care. It is estimated that they accounted for 5%-10% of acute hospital bed-days. One reason for changing the Austrian system of care and expanding social services was to curtail this use of acute hospital services (Rubisch et al., 1998).

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8 A more comprehensive description and analysis of these systems was published in a previous volume in this series: Brodsky J, Habib J, Mizrahi I (2000), Long Term Care Laws in Five Developed Countries – A Review, World Health Organization, Geneva
In addition, long-term care services were provided by social welfare agencies at the discretion of the federal provinces and they were limited in scope. The level of services provided and the criteria for receiving them differed among the provinces due to their uneven tax bases and independent sovereignty, and the provincial governments could not be equalized without federal assistance.

Advocacy organizations for the disabled lobbied to improve long-term care services and standardize eligibility criteria across Austria. At the same time, public criticism arose in provinces that had difficulty meeting the costs of long-term care, especially among the elderly and their families, who found it difficult to pay for care (Evers et al., 1994). These factors led the federal government to an attempt to find ways to standardize and fund the equitable provision of long-term care (Keigher, 1997; Rubisch et al., 1998).

The Long-term Care Allowance Act
Austria has enacted two laws: The Federal Long-term Care Law, which covers people who are entitled to social security pensions (90% of the population), and the Provincial Long-Term Care Law, which covers the remaining 10% of the population. In January 1993, the Austrian parliament ratified the Long-term Care Allowance Act. An agreement between the federal and provincial authorities was signed in May 1993, and the Federal and Provincial Act went into effect on January 1, 1994. Thus the uniformity of long-term care allowances is guaranteed throughout Austria.

The Long-term Care Allowance Act introduced a cash allowance to which there is statutory entitlement. Under the Act, those eligible for long-term care are given a cash benefit, which may be used to purchase formal services or pay informal caregivers, or used for any other purpose, at the client’s discretion. The goals of the law are to help people remain at home for as long as possible by enabling them to receive appropriate services, and to help them make the transition to an institutional framework when necessary. The benefit is designed to increase the recipient’s sense of autonomy and self-determination, and relieve the financial and emotional burden of informal caregivers, most of whom are women. In addition, the cash benefit was intended to create demand that would spur the development of local services and improve the standard of services (Evers & Leichsenring, 1994; Keigher, 1997).

Insurer: The Federal Ministry of Labour, Health and Social Affairs grants the long-term care allowances.

The provincial authorities make arrangements for decentralized development and expansion of community and institutional services so as to extend full geographic coverage while maintaining minimum standards. To ensure that enough staff are available for home care
services, the federal and provincial authorities have agreed to improve staff training and working conditions.

**Eligibility:** Eligibility is based on disability, independent of the reason for the disability – whether mental, physical or sensory; eligibility is not based on financial status or the availability of family assistance.

Eligibility is granted to people who have a need for personal care for at least six months and need more than 50 hours of care per month. Eligibility is granted to those age three or older; however, in cases of extreme hardship, the benefit may be granted at a younger age.

The law distinguishes seven levels of disability based on the assistance required with activities of daily living (ADLs) and instrumental activities of daily living (IADLs – e.g. housekeeping and shopping), translated into the extent of need for care per month (see Table 1). People with Level I disability need between 50 and 74 hours of assistance, while people with Level IV disability need more than 180 hours of assistance per month.

In addition, certain types of disability automatically classify an individual at particular level. For example, people who need a wheelchair are classified as having at least Level III disability, people who are blind are automatically classified as having Level IV disability, and people who are both blind and deaf are automatically classified as having Level V disability.

**Table 1: Disability Levels**

<table>
<thead>
<tr>
<th>Level of disability</th>
<th>Hours of care needed per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>50-74</td>
</tr>
<tr>
<td>II</td>
<td>75-119</td>
</tr>
<tr>
<td>III</td>
<td>120-179, including persons with severe sight impairment</td>
</tr>
<tr>
<td>IV</td>
<td>180 or more, including blind persons</td>
</tr>
<tr>
<td>V</td>
<td>180 or more, needing an unusually high level of care, including deaf and blind persons</td>
</tr>
<tr>
<td>VI</td>
<td>180 or more, needing permanent supervision or comparable level of</td>
</tr>
<tr>
<td>VII</td>
<td>180 or more, practical immobility or comparable condition</td>
</tr>
</tbody>
</table>

**Eligibility assessment:** At present, eligibility is assessed and level of disability determined by private physicians; in the future, nurses and other professionals will be involved in this process. Screening of applicants is carried out by the same authorities that dealt with granting helpless persons’ allowances and related benefits before implementation of the new long-term care programme.
**Benefits:** As noted earlier, people needing long-term care are given an unrestricted cash allowance. The benefits, by level, range from about $160 to $1,686 (see Table 2). Benefit payments are made 12 times a year and are tax exempt.

**Table 2: Disability Levels and Benefits Awarded**

<table>
<thead>
<tr>
<th>Level of Disability</th>
<th>Payment per Month (in US$)*</th>
<th>Payment per Month (in ATS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>160</td>
<td>2,000</td>
</tr>
<tr>
<td>II</td>
<td>295</td>
<td>3,688</td>
</tr>
<tr>
<td>III</td>
<td>455</td>
<td>5,690</td>
</tr>
<tr>
<td>IV</td>
<td>683</td>
<td>8,535</td>
</tr>
<tr>
<td>V</td>
<td>927</td>
<td>11,591</td>
</tr>
<tr>
<td>VI</td>
<td>1,264</td>
<td>15,806</td>
</tr>
<tr>
<td>VII</td>
<td>1,686</td>
<td>21,074</td>
</tr>
</tbody>
</table>

* Calculated by the authors (according to 1988 exchange rates, ATS 12.5=$1.00)

Recipients continue to receive the benefit even after entering a nursing home. Recipients in the home can keep some pocket money from their public pension, as well as 20% of the long-term care benefit. The long-term care benefit is terminated, however, if the recipient is hospitalized in an acute hospital for 4 weeks or more.

The cash allowance is intended to enhance consumer independence. It may be spent in any way the beneficiary believes will meet his or her health and/or personal needs. Generally the money is used to pay an informal caregiver, or to purchase formal personal care assistance or housekeeping and escort services (Badelt, 1998).

A beneficiary deemed “not capable of running his/her affairs” may have a legal representative appointed to manage the money on his/her behalf (Evers et al., 1994).

About 7% of beneficiaries are in an institution, and their benefits are transferred directly to the provider, as noted above. An evaluation of beneficiaries residing in the community revealed that 56% of those surveyed use one or several social or nursing services (47% received services in their own home and 22% receive services outside their home). Among those who receive services at home, about 10% receive home nursing services, 17% receive home help services, and 14% receive meals-on-wheels. Service utilization varies by region, ranging from 34% in Carinthia to 84% in Vorarlberg. These differences may be explained in part by gaps in the availability of services among regions (Badelt et al., 1997).

It is important to note that benefits are not meant to cover all needs but, rather, are designed to cover part of the actual cost of care. For example, it is estimated that benefits cover about
four hours of nursing care or eight hours of home help for those with a Level I disability (who
need a minimum of 50 hours of care per month). In other words, the benefit covers at most
16% of the needs of people in this category. For people at Level VII (who need more than
180 hours of care per month), the benefit covers about 40 hours of nursing care or 80 hours
of home help – 44% of need, at most. The Austrian benefit covers about 50% of the cost of
institutional care.

**Providers:** Services are provided by NGOs, non-organized workers, and family members.
NGOs provide about 90% of community services. As noted above, the provincial authorities
are responsible for service development and supply. Based on an agreement between the
federal government and the provinces, the latter have agreed to provide community and
institutional services that meet a minimum standard. To ensure implementation, the
provinces have also agreed to perform needs assessments and draw up a plan for reducing
the gaps between need and supply by the year 2010.

The Federal Ministry of Labour, Health and Social Affairs oversees the programme.
Beneficiaries are required to file reports on the care they purchase with the allowance
(Keigher, 1997). Local authorities have the power to reduce or terminate a recipient's
funding, or to provide care directly if an individual is reported to be badly neglected.
However, according to Furstl-Grasser et al, (1999), such cases are very rare.

**Finance:** A unique feature of the long-term care programme in Austria is that it is financed
from general tax revenues, rather than from a special contribution, as are other social
insurance programmes. Despite the use of general taxation, there is a personal entitlement
and the programme has no budget restrictions. It is important to note that employee and
employer sickness insurance contributions were increased in 1993, to offset the extra costs
incurred by the introduction of long-term care allowances.

**Coverage:** As of 1998, 324,000 people were receiving long-term care benefits under the
law: 86% under the Federal Long-term Care Allowance Act, and 14% under the Provincial
Long-term Care Allowance Act (Enge, 1999). They represented about 3.9% of the total
population and some 17% of those aged 61 and over.

As can be seen in Table 3, of those eligible for the benefit in September 1997, most (80%)
were classified as having one of the three lowest levels of disability: 12.4% were classified
as having Level I disability, 47.3% were classified as having Level II disability, and 21% were
classified as having Level III disability; only 2.6% were classified as having the highest two
levels of disability (Rubisch et al., 1998).
Table 3: Recipients of the Federal Long-term Care Benefit, by Level of Disability, September 1997

<table>
<thead>
<tr>
<th>Level of Disability</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>12.4</td>
</tr>
<tr>
<td>II</td>
<td>47.3</td>
</tr>
<tr>
<td>III</td>
<td>21.0</td>
</tr>
<tr>
<td>IV</td>
<td>9.4</td>
</tr>
<tr>
<td>V</td>
<td>7.3</td>
</tr>
<tr>
<td>VI</td>
<td>1.6</td>
</tr>
<tr>
<td>VII</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Rubisch et al., 1998

According to the Austrian Ministry of Labour, Health and Social Affairs (1999), the income structure of beneficiaries shows that there would be no point in introducing a means test for the long-term care benefit, since very low income ceilings would have to be imposed to achieve any worthwhile budgetary savings. This in turn would make a large portion of those affected more heavily dependent on social assistance.

The great majority (83%) of recipients are 61 years or over (36% age 61-80, and 47% age 81 or over); 9% of the recipients are age 41-60; 5% are age 21-40; and 3% are age 0-20 (Enge, 1999).

**Cost:** The cost of the Federal Long-term Care Allowance Act is approximately ATS 18 billion (about $1.4 billion) annually (Rubisch et al., 1998). The cost of the Provincial Long-term Care Allowance Act is approximately ATS 3 billion annually. Thus the total cost of long-term care programmes is ATS 21 billion ($1.7 billion) (Enge, 1999). Austria devotes about 0.9% of the GNP to these programmes.

**Issues in the Implementation of the Long-Term Care Allowance Act**

A major concern voiced at the outset of the programme (Evers 1994) was whether the supply of services would increase enough to allow for genuine choice and real opportunities to reduce the burden on family caregivers. According to Keigher (1997), Badelt (1997), and Furstl-Grasser et al. (1999), a key objective of reforming the provision of long-term care was to give more support to family caregivers by developing and expanding community services. However, this objective has been achieved only partially, with considerable differences among regions. As noted above, under the long-term care agreement between the federal government and the provinces, the latter have undertaken to guarantee nationwide provision of social services by 2010. They will accomplish this in three stages, and they have
submitted their respective plans for closing existing gaps by that time (Federal Ministry of Labour, Health and Social Affairs, 1999).

Another issue of importance is the assessment of eligibility. At present, since this assessment is made by physicians, the success of an application may depend on the applicant's relationship with the physician. For example, critics have claimed that blue collar workers may be less likely to have their applications approved.

Little systematic evaluation of the programme has been carried out. According to a major study conducted by Badelt et al. (1997), the programme appears to have enabled more people to use formal services, thereby reducing the burden on family caregivers. Above, 56% of the beneficiaries have reported purchasing at least one formal service since implementation of the law. Furthermore, one-third of disabled respondents have reported receiving more formal services since implementation of the law. However, one-quarter of them also reported needing more help.

Those favouring the cash benefit in Austria claim that it allows for greater freedom of choice and flexibility in the provision of care. A frequent argument is that cash benefits have stimulated the development of service suppliers, and the law’s creation of a demand for services has increased the supply of services.

It has also been claimed that most dependent people will still be unable to afford sufficient help at market prices and may therefore prefer to purchase care from unorganized individuals in the “grey market” – that is, illegal foreign workers, workers who evade income tax, or workers who earn wages below legal limits (Evers & Leichsenring, 1994; Keigher, 1997).

In addition, concern has been raised about the employment rights of family members who provide personal care (Keigher, 1997). Given the lack of options for purchasing services, relatives often provide care out of necessity, rather than choice. Studies indicate that about one-quarter of the caregivers under retirement age find that their employment is impeded or limited by caring for a relative. This is regarded as a social problem, since people who are not employed do not receive social insurance. Some argue that even family caregivers who are paid should be covered by social insurance, although this will raise the cost. About 30% of the caregivers interviewed indicated that they do not themselves have a pension, but are insured through their spouse's pension (Badelt, 1998).

In order to improve the situation of family caregivers, since 1 January 1998, people who care for a close relative who has been classified with a Level V, VI, or VII disability and who have
had to forfeit employment in order to care for their disabled relative, have been given the option of continuing to pay into their pension insurance at a lower rate. Under this scheme, the federal government pays the insurance contribution that would have been paid by the caregiver’s employer.

The Austrian programme is unique in adopting a full cash strategy and not assuming direct responsibility for in-kind service provision. Therefore, it is important to evaluate in depth the implications of the law for meeting needs and for costs.
References


2. Germany

Background
In Germany, health care is provided under a national health insurance law that covers people whose income is below a set ceiling; they are allowed to choose their provider (sick fund). People whose income is above this ceiling may voluntarily join a health insurance plan. In 1999, the monthly gross wage cut-off for voluntary membership in a sick fund was as follows: DM 6,375 in the former West, and DM 5,400 in the former East. The health insurance scheme covers acute medical care.

In contrast to acute care, care for the frail and disabled non-working population was for many years the responsibility of the local Länder, which received no direct federal contribution; care was provided through means-tested welfare programmes. Thus, long-term care was a growing financial burden on local governments (Cuellar & Wiener, 2000; Schneider, 1999). People needing formal care had to pay out of pocket; if they could not meet constantly rising costs, they had to turn to welfare assistance. People needing institutional care, whose costs easily exceeded even above-average pension allotments, almost always had to call upon the welfare system. Yet in order to be eligible for welfare benefits, one had to have depleted his personal assets and exhausted the possibility of family support and direct care. The need for long-term care thus also placed financial strain on the dependent’s closest relatives.

According to Schneider (1999), it was not until two issues came to the fore that long-term care was placed on the public agenda. First, the high prevalence of poverty among the elderly was straining municipal budgets since 80% of those needing institutional care were dependent upon welfare benefits. Second, the quantity and variety of formal care were insufficient. Private for-profit providers were all but barred from the market by the preferential treatment toward and subsidization of NGOs. Studies conducted in the 1970s, 1980s, and early 1990s revealed both quantitative and qualitative under-provision of care to the elderly. The provision of formal care by NGOs could not keep pace with the increasing extent and variety of demand (Schneider, 1999; Alber, 1990).

This situation created a need for the development of national policy that would improve the accessibility and availability of long-term care services and ease the fiscal crisis of local authorities.

The Social Dependency Insurance Act (SDI)
After many years of discussion about the most effective way to improve the system, the Social Dependency Insurance (SDI) Act was enacted in 1994, introducing universal long-
term care insurance. The new act adopted some basic features of existing German social insurance schemes, but also introduced components that represented a new approach to financing and cost-containment.

The Social Dependency Insurance Act was implemented in two stages: in April 1995, it was implemented for home care, and in July 1996, institutional care was added.

**Insurer:** Special “care funds” were established under the auspices of existing sickness funds. All residents of Germany are legally obligated to participate in the statutory long-term care insurance scheme. However, persons with higher incomes, who are not subject to statutory health insurance, may be released from this obligation if they can prove they own a private long-term care insurance policy that offers benefits comparable to those provided by the statutory long-term care insurance scheme (Scheil-Adlung, 1995).

Long-term care insurance could have been established under the auspices of Germany’s social insurance system in any of three ways: by making it a new responsibility of the sick funds, by making it an additional responsibility of the pension funds, or by making it an independent appendage to the existing system. While the government initially sought to combine acute health and long-term care, Social Dependency Insurance (SDI) was ultimately organized as a separate responsibility of the so-called “care funds.” Although the special care funds are legally independent corporate bodies, they are closely linked to the sick funds and take advantage of their structure: sick fund staff handle both health insurance and SDI claimant records. Care funds screen applicants with the help of sick fund medical staff and reimburse the sick funds for this service.

**Eligibility** is granted regardless of age or financial status, or reason for dependency, and includes dependency resulting from physical or mental disability. Eligibility is granted to people who need assistance in two or more activities of daily living (ADLs) for at least 6 months. The need for assistance in instrumental activities of daily living (IADLs) is considered only if a person has met the ADL requirements. The law distinguishes three levels of disability – substantial, severe, and very severe – based on the frequency with which assistance is needed in personal care and housekeeping (see Table 1). People with substantial disability need assistance at least once a day for about 1.5 hours; people with severe disability need assistance three times a day for 3 hours; and people with very severe disability need assistance day and night, for at least 5 hours.
Table 1: Levels of Disability Defined by Social Dependency Insurance

<table>
<thead>
<tr>
<th>Level of Disability</th>
<th>Disabilities in ADLs and IADLs</th>
<th>Frequency of Assistance in ADLs/IADLs</th>
<th>Amount of Assistance Needed in ADLs/IADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantial</td>
<td>Two or more ADLs; need for assistance with IADLs</td>
<td>ADLs at least once a day; IADLs several times a week</td>
<td>Min. 90 minutes for ADLs and IADLs, with at least 45 minutes for ADLs</td>
</tr>
<tr>
<td>Severe</td>
<td>Two or more ADLs; need for assistance with IADLs</td>
<td>ADLs at least three times a day; IADLs several times a week</td>
<td>Min. 3 hours for ADLs and IADLs, with at least 2 hours for ADLs</td>
</tr>
<tr>
<td>Very severe</td>
<td>Two or more ADLs; need for assistance with IADLs</td>
<td>ADLs day and night; IADLs several times a week</td>
<td>Min. 5 hours for ADLs and IADLs, with at least 4 hours for ADLs</td>
</tr>
</tbody>
</table>

Source: Schneider, 1999.

Eligibility criteria do not include income or the availability of family assistance. Germany chose a universal programme in which disability, rather than a subjective evaluation of potential informal support or unmet needs, is the basis for eligibility.

Expanding eligibility for the cognitively impaired has recently been debated. Critics contend that existing criteria do not adequately address the needs of persons with cognitive impairment (e.g. Alzheimer’s disease) because they need time-consuming general supervision, which is not factored into eligibility assessments. Concern has been expressed, however, that counting supervision hours in the assessment process would place all cognitively impaired persons in the most costly category. Although changes may be expected in this area, it is likely that proposals to accommodate more persons with dementia will involve tightening eligibility for others, to ensure budget neutrality (Cuellar & Wiener, 2000).

**Eligibility assessment:** Screening for social dependency insurance is performed by medical staff of the sick funds (primarily physicians, who are reimbursed by the care funds). Care funds then issue authorizations to service providers.

**Benefits:** The level of benefits is determined by the level of disability. Benefits may be provided as in-kind services, cash allowances or a combination of the two. Recipients of a cash allowance are not obligated to use it to purchase services, but may incorporate it into their household budget. The amount of the cash allowance is 45%-53% lower than the monetary value of in-kind services. Beneficiaries may receive the benefits for which they are eligible in the community or in an institution.
Coverage of community care includes personal care, housekeeping, assistive devices, home adaptations, day care, night care, and respite care.

Coverage of institutional care involves the provision of in-kind services only, which are graduated according to the level of disability. The costs of board and lodging are not reimbursed by the care funds, and clients are required to share at least 25% of the total cost. This is meant to be an incentive to choose community care, which is perceived as preferable to institutionalization (Schneider, 1999).

Table 2 details the benefits provided per month. At the end of 1997, benefits for the substantially disabled living at home ranged from DM 400 for cash benefits to DM 750 for services in-kind, and about DM 2,000 for those in institutions. For the most severely disabled living at home, benefits ranged from DM 1,300 for cash benefits to DM 2,800 for services in kind; for those in institutions it was about DM 2,800 (DM 3,300 in exceptional cases).

Table 2: Monthly Benefits Provided under the Social Dependency Insurance Act, in Deutsche Marks (DM) and United States Dollars ($)*

<table>
<thead>
<tr>
<th>Level of Disability</th>
<th>Care at Home</th>
<th>Care at a Day Care Centre</th>
<th>Care in an Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantial</td>
<td>DM 400-750</td>
<td>DM 750</td>
<td>DM 2,000</td>
</tr>
<tr>
<td></td>
<td>$200 - $375</td>
<td>$375</td>
<td>$1,000</td>
</tr>
<tr>
<td>Severe</td>
<td>DM 800-1,800</td>
<td>DM 1,500</td>
<td>DM 2,500</td>
</tr>
<tr>
<td></td>
<td>$400 - $1,400</td>
<td>$750</td>
<td>$1,250</td>
</tr>
<tr>
<td>Very severe</td>
<td>DM 1,300-2,800</td>
<td>DM 2,800</td>
<td>DM 2,800</td>
</tr>
<tr>
<td></td>
<td>$650 - $1,400</td>
<td>$1,050</td>
<td>$1,400</td>
</tr>
<tr>
<td>Exceptional hardship</td>
<td>Up to DM 3,750</td>
<td>___</td>
<td>DM 3,300</td>
</tr>
<tr>
<td></td>
<td>$1,875</td>
<td></td>
<td>$1,650</td>
</tr>
</tbody>
</table>

Source: Schneider, 1999.
*Sums in DM are accurate for the end of 1997, and sums in US$ were calculated by the authors at exchange rates DM2= $1.

It is important to note that benefits are not meant to cover all needs but are designed to cover only part of the actual cost of care. It is estimated that in 1995 a beneficiary at the substantial care dependency level would have needed a minimum of DM 2030 to cover full needs (that is, a minimum of 90 minutes of assistance per day), while SDI home care benefits for this category were MD 750. Thus the benefit covered about 37% of needs. For the severe care dependency level, a beneficiary in 1995 would have needed a minimum of DM 4,100 to cover full needs (a minimum of 3 hours of assistance per day), while the SDI was DM 1800, that is, about 44% of needs. For the very severe level, a beneficiary would have needed a minimum of MD 6,667 (a minimum of 5 hours of assistance per day), while
SDI was DM 2800, that is, about 42% of needs. For institutional care, the benefits in Germany covered between 44% and 64% of the charges in 1995, depending on the location of the facility and the degree of dependency (Schneider, 1999).

People who have additional needs are eligible for additional benefits from the welfare system, on an income-tested basis (Alber, 1996; Scheil-Adlung, 1995; Schneider, 1999; Schulte, 1996).

The law attempts to provide special support for family caregivers by including day or night care, day care centres, training courses organized by care funds, and various forms of respite care, such as an alternate provider for up to 4 weeks a year and short-term residence in an institution. In addition, contributions to old-age pension and accident insurance are made for informal caregivers who provide care for more than 14 hours a week and who are not gainfully employed for more than 30 hours a week. At present, about half a million family caregivers – 90% of whom are women – receive such pension coverage (Deutscher Bundestag, 1997).

**Providers and Quality Assurance:** Services may be provided either by NGOs or the for-profit private sector. As noted earlier, prior to implementation of the law, the quantity and variety of formal care were insufficient, there was a lack of facilities for the elderly, the care in old age homes was below standard, and there was a shortage of personnel (Brautigam & Schmid, 1996; Evers & Olk, 1991; Backer, 1991).

As a possible solution to these problems, legislators laid a foundation for the development of the for-profit sector by eliminating barriers to the entry of private providers into the long-term care system (Klie, 1996, in Schneider, 1999). In addition, any provider offering guarantees of adequate care at reasonable prices is approved, regardless of actual demand. These measures are intended to promote competition and keep prices down (Scheil-Adlung, 1995). Under the law, the private market has indeed developed: The number of agencies providing long-term care has nearly tripled – from 4,000 in 1992 to 11,700 in 1997 (Deutscher Bundestag, 1997). Nevertheless, the increase has not kept pace with need, and there is still a lack of providers and professional services (Schneider, 1999).

Various measures to address quality assurance have been introduced. Agencies are required to employ at least one registered nurse with at least 2 years’ practical experience, obtained within the past 5 years, to be eligible as a service provider.
According to the 1994 legislation, providers in Germany are obliged to undergo external regulation of quality by the care funds and sickness funds. In addition, providers must establish an internal system of quality assurance, which includes establishing quality circles, enabling institutional residents to provide feedback on the quality of their care (through specially designed questionnaires), and setting standards. They are also encouraged to take voluntary measures, such as holding quality assurance conferences or implementing voluntary certification programmes. In May 1996, care funds, central municipal associations, public authorities providing welfare benefits and services providers jointly issued the first binding statement of quality principles and guidelines. These take into account the quality of the structure, process and outcomes of care.

Applicants who choose the cash allowance for personal care are obligated by law to undergo three inspection visits, the costs of which are partially paid by the client. The purpose of these visits is to ensure the quality of informal care, to update the client’s knowledge of available services, and to advise informal caregivers. The visits are made by formal service providers, but this has raised the question of conflict of interest, since providers see inspection visits as an opportunity to advertise their services. Further, compensation for these visits is not high and hence does not encourage extended consultation. Moreover, since the visits are not fully financed, they are not well accepted by clients. Dissatisfaction has been expressed mainly by the young disabled, who were used to managing their own care needs before the new legislation (Deutscher Bundestag, 1997; Neumann, 1996; Schneider, 1999).

The law obligates care funds to offer free training classes to informal caregivers. There also seems to be a need for training of the nurses responsible for inspection (Gro, 1998, in Bscher, 1999). Jansen and Kardorff (1996) have proposed more conceptual development of inspection based on case management principles (Bscher, 1999).

For recipients of in-kind benefits, care funds negotiate agreements that specify services and fees with authorized providers. The reimbursement system is complicated. Providers of services at home must specify the elements of service, each of which is worth a certain number of points; care funds set standard payments for each point, but these may differ by region or federal state.

The law assigns the task of quality assurance and monitoring to care funds and to third-party agents. A clause of the law stipulates that care funds, federal states, local authorities and service providers (both NGOs and for-profit organizations) must agree upon uniform
principles of quality assurance for care provided both at home and in institutions. Providers must cooperate with quality assurance inspections performed by the care and sick funds.

**Finance:** A payroll tax (premium) of 1.7% of gross wages is levied to finance the system. The contribution is shared equally by employees and employers, although, as mentioned above, employers are compensated for their premium payments through designation of a holiday as a working day. Retirees share premium payments equally with their pension fund. Coverage is extended to spouses and children of members of the SDI scheme, without the need for an additional premium payment.

The payroll tax is levied on gross wages, with a ceiling of DM 6,375 in former West Germany and DM 5,400 in former East Germany. This limit is adjusted annually, and equals 75% of the contribution assessment ceiling for old-age insurance.

In addition, there is a co-payment for institutional services; beneficiaries entering a long-term care institution are required to pay at least 25% of the cost of institutional care.

**Coverage:** In 1998, the number of people receiving benefits was about 1.8 million. This approximated the number of people estimated to be eligible, based on a household survey in 1992 (Schneider, 1999). More detailed data is available for 1997. As of July 1997, about 1.6 million people were receiving benefits under the SDI Act, and another 100,000 clients were covered by payments from private insurers. Of the recipients of care, 41.8% were substantially disabled, 42% were severely disabled, and 16.2% were very severely disabled. Approximately 1.2 million people (74% of beneficiaries) were receiving benefits for care at home, and approximately 430,000 people were receiving benefits for care in an institution. About two-thirds of beneficiaries were age 74 or over.

In 1996, among the community-based population, most (79%) of those eligible for benefits chose cash allowances, while about 11% chose a combination of cash allowances and in-kind services and 9% chose services only (see Table 3). As would be expected, the proportion choosing cash allowances declined with the level of disability. A higher percentage of those with substantial disability than those with severe, or very severe disability chose cash benefits (84%, 77% and 67%, respectively) (Deutscher Bundestag, 1997; Schneider, 1999). In 1998, there was something of a decline in the choice of cash benefits: About 74% of the community-based population chose cash benefits, 11% chose in-kind services and 14% chose a combination of the two. Sixty percent of the most disabled group in the community chose cash only, compared with 80% of the least disabled (Cuellar & Wiener, 2000).
Table 3: Preferred Benefit for Care at Home, by Level of Disability, 1996 (in %) as of July-December

<table>
<thead>
<tr>
<th>Preferred Benefit</th>
<th>Substantial</th>
<th>Severe</th>
<th>Very Severe</th>
<th>Exceptional Hardship</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-kind services</td>
<td>8.8</td>
<td>8.7</td>
<td>8.7</td>
<td>99.9</td>
<td>8.8</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>83.7</td>
<td>77.1</td>
<td>67</td>
<td>0</td>
<td>78.6</td>
</tr>
<tr>
<td>Combination</td>
<td>6.6</td>
<td>12.6</td>
<td>22</td>
<td>0.1</td>
<td>11.3</td>
</tr>
</tbody>
</table>

Source: Schneider, 1999, based on the Federal Ministry of Labour and Social Affairs, (Deutscher Bundestag, 1997)

When the law was passed, policy makers believed that cash benefits would empower consumers of long-term care, increase their autonomy and freedom of choice of services and service providers, and generate competition among service providers, thereby improving services. Furthermore, cash allowances were viewed as giving families a stronger incentive to continue caring for an elderly or disabled relative and offering disabled people an opportunity to express their appreciation for the efforts of helpers.

A major finding of studies of the law in Germany is that cash allowances are used primarily to supplement the family budget, rather than to purchase services of a formal caregiver (Evers, 1997). For example, a study conducted at the University of Hamburg⁹ (Runde et al., 1996) found that the majority of cash recipients (85%) cited the advantage of being able to use the funds without restriction.

Problems with the availability of services have been cited as one factor affecting the decision to choose cash benefits (Cuellar & Wiener, 2000). According to Evers (1995), the preference for cash benefits may be also a response to problems in the way services are provided (e.g. inflexible hours).

Some have criticized how cash allowances are provided in Germany. They claim that the disabled and their families are not able, and in many instances do not know how, to negotiate directly with service providers (Schneider, 1999; Evers, 1997). Moreover, a large proportion of beneficiaries have cognitive impairments and yet receive cash benefits. In response to these concerns, beneficiaries electing cash are subject to periodic visits every 4-6 months, depending on their disability level, to ensure that adequate care is being provided.

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⁹ The study was conducted in the spring of 1996, before the introduction of the benefits for institutional care. Respondents (n=3,359) were age 30 or over. Runde, et al. 1996: “Germany’s Social Long-Term Care Insurance: Design, Implementation and Evaluation”. International Social Security Review 52:31-74
Moreover, as mentioned above, the need to develop more counseling and care management services has been noted.

**Cost:** The annual expenditure for SDI in 1999 was estimated to be DM 31 billion (about $15.5 billion). As mentioned above, about a quarter of clients receive benefits for institutional care; however, because institutional care is more expensive, it accounts for a higher share of expenditures. Institutional care takes about 42% of expenditures, home care cash allowances 29%, home care services 12%, pension contributions for carers 8%, and other benefits such as short-term care the remaining 9% (Report by The Royal Commission on Long-Term Care, 1999). Germany devotes about 0.9% of the GNP to the programme.

It emerges that after considerable revenue surplus in the early years of SDI, the surplus was then reduced up to the year 1999 where for the first time there was a small negative balance of revenues and expenditures. This raised questions as to whether SDI was running out of money so soon after its start and whether the politically desired objective of having a stable contribution rate can be maintained in the long run. Predictions as to the future need for long-term care were perhaps too restrained from the start. There has been a small but visible increase in the choosing of benefits in-kind over cash benefits and the cost of development of institutional care has also added to the expenditures. The topic of a raise in the contribution rate (now in discussion, 2.4% up to 2.8%) has already been met with strong opposition by employers and has strong reservations from the political arena (von Kondratowitz et al., 2002).

**Issues in the Implementation of the Social Dependency Insurance Programme**

**The benefit ceiling and eligibility criteria**

The law has been criticized for not covering needs more fully. As noted earlier, benefits are not intended to cover the full cost of long-term care. Both in-kind and cash benefits (the entitlements for cash allowances are even less generous than those for in-kind services), and entitlements for institutional long-term care are designed to be lower than estimated costs. One way of providing more intensive services without increasing costs would be to change eligibility criteria, for example by taking into consideration income. Some have criticized the fact that the benefit level is not linked to income and benefits are equally provided to people with low, moderate and high incomes (Schneider, 1999).

To fully cover the need for formal home care services, beneficiaries may need to seek supplementary coverage, or pay out-of-pocket. If the beneficiary does not have supplementary private insurance, he will probably need to apply for social assistance
benefits (Scheil-Adlung, 1995). It is estimated that 40% of the people receiving long-term care will apply for social assistance benefits, mainly for institutional care. This is viewed by some as inconsistent with the SDI’s goal of significantly reducing the need to apply for social assistance benefits (Schneider, 1999). Nevertheless, as a result of SDI, the municipal budgets for social assistance for long-term care have declined (Cuellar & Wiener, 2000).

There has also been discussion of the minimum disability level required for eligibility. As noted above, one must need at least 1.5 hours of assistance daily to receive benefits. In 1995, it was estimated that 450,000 people who needed less personal care were not receiving benefits under the law (Schneider, 1999), and another two million people who needed assistance with housekeeping only were not receiving benefits under the law (Evers, 1998). The decision to link eligibility with the need for frequent assistance has drawn much criticism as being short sighted. It is argued that providing assistance to people who need it less might help them maintain their functional status and defer premature institutionalization (Schneider, 1999).

Advocates of present entitlement levels predict that more generous provision of benefits would lead to the replacement of informal care by formal care, and hence an escalation of costs (Goerke, 1996; Greiner & Schulenburg, 1996). However, this question needs further study (Schneider, 1999).

Establishing a separate programme
The separate social dependency insurance scheme has been criticized for perpetuating fragmentation between acute and long-term care, which impedes continuity of care and is considered unsound from a health care perspective (Schneider, 1999). One of the goals of the long-term care legislation was to enhance rehabilitation services; however, the law does not provide adequate financial support in this area. At the same time, sick funds are reluctant to invest in rehabilitation given that the potential payoff for such treatment would be appropriated by the care funds (Schneider, 1999; Cuellar & Wiener, 2000).

Quality assurance
Schneider (1999) argues that adequate mechanisms for quality assurance and public accountability have not been institutionalized; that legislator missed the opportunity to set federal standards for professional training and licensing; that the training provided to home care workers is not uniform; and that the profession remains unattractive.
Schneider (1999) and Cuerall and Wiener (2000) also argue that there is a need to develop more counseling and care management services, given the complexity of the process of choosing appropriate services, and negotiating and contracting with a service provider. At present, there are no broad-scale counseling services. For the most part, beneficiaries and their families make decisions on their own, or with the assistance of a provider. Discussions are underway about how to assist consumers more effectively.
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United States General Accounting Office (1994) Long-Term Care: Other Countries Tighten Budgets while Seeking Better Access. Report to the United States Senate Special Committee on Aging, Washington D.C.

3. The Netherlands

Background

Health care in the Netherlands is largely funded through a system of public and private insurance schemes. The insurance system is divided into three categories in accordance with the current method of classifying health care. The first category is insurance for acute medical care, covered by public or private insurance schemes, the most important of which is governed by the Health Insurance Act (implemented in 1966). Persons whose annual salary is below a statutory ceiling, and all recipients of social security benefits are insured by this act, covering about 64% of the Dutch population. Another 5% are covered by the health insurance scheme for public servants, and about 31% are privately insured. The second category includes the exceptional medical expenses associated with long-term care or high cost treatment, where the risk is perceived as such that it cannot be born by individuals or adequately covered by private insurance. This care is covered by the Exceptional Medical Expenses Act. The third category includes supplementary components of care, perceived as being less necessary and covered by private health insurance schemes. The insurers themselves determine the content and scope of the benefit and the conditions.

The Dutch parliament first entertained the possibility of providing the country’s citizens with insurance for long-term care and medical risk in 1962; in 1967, the parliament passed a law to this effect (Exceptional Medical Expenses Act [AWBZ]), and implementation began on 1 January 1968. Though the benefits covered by the law initially served mainly as a means of funding long-term or high-cost care in various types of institutions, these benefits have been changed or extended over the years to cover more elements of health care, many of which are not long-term care in nature (Ministry of Health, Welfare and Sport, 1998). For example, in the 1980s psychiatric care, aids and appliances once covered by public or private health insurance were transferred to AWBZ. At the beginning of the 1990s, the benefits under AWBZ were extended to include genetic testing, rehabilitation, audiology treatments and medications (these were transferred back to health insurance programmes in 1996). This process was motivated by the government’s desire to create a more comprehensive health insurance system by integrating the different insurance programmes. However, to date the government has not succeeded in fully implementing this plan.

In the 1980s, as a result of an increase in expenditures for long-term care, the Dutch government reexamined its policy, which had favoured the institutionalization of elderly and disabled people. In fact, in 1980, the rate of institutionalization was over 10% – quite high compared to other European countries. In 1980 home nursing services were introduced into the AWBZ, and in 1989 the programme was expanded to include home help services.
These developments reflected a policy of cost containment based on a new philosophical approach – “the caring society” – which encouraged people to take greater responsibility for themselves, rather than relying on institutional frameworks. This approach later evolved into the “substitution policy.”

The “substitution” policy was designed to promote the replacement of institutional services by less expensive community services. This policy reflected a belief that many elderly were receiving more care than they required: For example, some elderly people opted to remain in the hospital even after their treatment was finished, while others preferred to enter an institution despite being able to live independently (Pijl, 1991; Evers & Leichsenring, 1994; Pijl et al., 1994).

**The Exceptional Medical Expenses Act (AWBZ)**

As mentioned above, the Exceptional Medical Expenses Act was implemented in January 1968. The law initially included coverage for high-cost long-term institutional care but it has been expanded over the years to include other services. The most significant changes were the introduction of home nursing in 1980, home help in 1989, and residential care in 1997 (Ministry of Health, Welfare and Sport, 1998; Huijbers & Martin, 1998).

**Insurer:** The insurer is the Ministry of Health, Welfare and Sport, which designates health insurance companies to implement the AWBZ (health insurance funds, private health insurance companies approved by the government, and the insurance schemes for public servants). These insurance companies are regulated by the Ministry’s Health Insurance Council.

**Eligibility criteria:** Eligibility is granted to all residents of the Netherlands without regard to nationality, and to foreign workers. Entitlement is universal and includes all ages. The Netherlands has adopted a holistic approach to assessment of an individual’s need for long-term care. Its assessment process reviews the applicant’s general health, physical disability resulting from illness, psychological and social functioning, home and environment, as well as the formal and informal care available to him and the possibility of continuing this care. The Dutch government allows for considerable professional discretion in assessment of the type and level of assistance needed, and includes the availability of informal care as a criterion. An individual’s income level is not a criterion for receiving benefits, reflecting the universal approach of the law.
**Eligibility assessment:** Since 1998, assessments have been made on a regional basis, through Regional Assessment Organizations (Regionaal Indicatie Orgaan, or RIO). Each RIO comprises representatives of policyholders, consumer organizations, service providers, physicians, insurers, and the local authority or municipality. These representatives appoint professional assessment teams – whose members vary with the type of application for benefits and may include nurses, social workers, psycho-geriatricians and social geriatricians. A further review by a team of experts is necessary for admission to an institution. At present, there is no national, uniform set of assessment tools, although one is being developed (Huijbers & Martin, 1998).

Assessments are valid for a finite period, except for applications for long-term institutional care. In the case of disability caused by an unusual but not permanently damaging event, the assessment is valid for 1 month. Based on the team’s assessment, the RIO will determine whether institutional or community care is required, as well as the urgency of its provision. In the Netherlands, long-term care insurance does not set a clear limit on the total benefits per beneficiary, although it limits the amount of specific services (such as home nursing).

The assessment team reports its decision to the applicant, who then initiates self-referral to service providers. The applicant himself chooses the provider from which he will receive care; however, his freedom of choice is limited by the limited nature of the service provision market (private providers are active in large cities only; elsewhere, one large organization usually offers services), the waiting lists for admission to old age homes, and the concentration of long-term care institutions in large cities. The urgency of a case affects how soon care is received.

Once an individual has approached a service provider and received its agreement to provide services, a programme of care is designed in accordance with the guidelines of the assessment. To a large extent, the individual is responsible for obtaining services. However, regional AWBZ offices have been taking increasing responsibility for ensuring that the programme of care is carried out.

**Benefits and service providers:** Services are provided in kind to people who are eligible for benefits in the home or in an institution. The package of services offered includes a variety of community services, such as home nursing, personal care, homemaking, day care, respite care, assistive devices, and night care. Under an experimental programme of “personal budgets,” restricted cash benefits are provided for people who are eligible for care
in the home; they must use the cash benefits to purchase services from formal and informal providers. In this way, the family may be compensated for providing informal assistance. The services provided and the frameworks in which they are provided are briefly described below.

**Home care**
The two types of home care – home nursing and home help – are provided mainly by non-profit organizations, which operate in defined areas; there is no competition among them. A few for-profit agencies also provide home care, primarily in the large cities. Providers of home care must meet three criteria: They must provide a range of services, including nursing care, personal care (assistance with ADLs), homemaking, and the loan of assistive devices; they must comply with a set of uniform standards of quality (measured primarily by personnel qualifications); and they must uphold collective labour agreements with professional home help aides and nurses (Boot & Knapen, 1996).

**Home nursing**
Home nursing includes nursing care and the loan of assistive devices (e.g. wheelchairs, walkers, etc.). The services are provided by qualified nurses with a background in public health. The services may be provided for a long or a short period of time. There is no specification of the minimum length of time the service is to be provided. This is adapted to the needs of the elderly person; however, there is a limit on services of 3 hours a day (in exceptional cases, such as the terminally ill, this service may be extended to a maximum of 8 hours per day).

**Home help**
Home help is defined as assistance with housekeeping and personal care, and emotional support. The hours of care provided are determined by the individual's needs. Home help staff are divided by the type of population served (e.g. those who care for the elderly, those who care for disabled young people), and they receive special training. Sometimes the same worker provides both personal care and housekeeping services.

An additional programme called “Alpha Care” provides home help dispensed by housewives who are paid directly by clients, rather than through a professional service agency. This service is less expensive, and it is limited to 16 hours per week.
Institutional Care

Nursing homes
Nursing homes provide diagnosis and assessment, nursing care, rehabilitation and terminal care in a positive social environment.

Residential homes for the elderly
Admission to residential homes for the elderly is limited to those 65 or over. These homes provide an appropriate environment for people who cannot live alone and provide assistance with ADLs, activity therapy, and medications. Sometimes they provide services to the community such as hot meals, alarm systems and emergency assistance, help with bathing and showering, recreational day care programmes and respite care (Monk & Cox, 1991). Adjacent to many residential homes for the elderly are sheltered housing projects for people who are capable of living independently if they have a supportive and adapted environment. AWBZ covers most services in these accommodations.

The distinction between nursing homes and residential homes for the elderly has become blurred over the years. Both types of facilities are now expected to help organize programmes for the community. Most of them have "day hospital" or day care programmes that serve elderly people residing in the community who need supervision for part of the day. AWBZ covers expenditures for both day hospitals and day care, including transportation, consultation, and personal programmes of care.

Other services
The package of services offered by AWBZ is very broad and covers assistive devices, rehabilitation (under special conditions), in- and out-patient psychiatric care, psychotherapy, care of the blind and the deaf (tests, treatment, counseling and institutions), tests for metabolic disorders, vaccinations for children, care for the mentally disabled (e.g. special day care, hostels, institutions), tests for Hepatitis B during pregnancy, and nutritional counseling. Acute hospitals are covered under special circumstances: AWBZ will cover the cost of care, including treatments and room and board, after 1 year; the first year of hospitalization is paid for by an individual’s regular public or private health insurance. If an individual is discharged but re-admitted to the hospital within 26 weeks, AWBZ will cover all his hospital expenses. If the re-admission occurs after 26 weeks have passed, the expenses are covered by regular health insurance. Under certain conditions transplantation of organs may also be covered (Ministry of Health, Welfare and Sport, 1988).
**Personal budget**

As noted above, the “personal budget” is granted on an experimental basis to people eligible for home care. It enables them to choose and directly pay service providers (whether non-profit or for profit), or pay informal caregivers. In 1995, the Health Insurance Fund Council decided to set guidelines for receiving a personal budget, in order to prevent money from being spent on personal consumption items or employment of aides from the (illegal) “grey” market who are not meant to be covered by AWBZ. These guidelines were voted into law in 1996.

To receive a personal budget, an individual must need care for more than 3 months and must continue to live in his home. Eligibility for a personal budget is determined based on an assessment of need, including whether immediate family members can provide support. The personal budget is calculated by multiplying the number of hours of care that the older person is estimated to need by the authorized cost per hour of the indicated type of care. Need is reassessed every 6 months.

Apart from a small, fixed sum of NFL 2,400 per year, which may be spent on care entirely at the older person’s discretion, an older person does not directly control his personal budget. The Association of Personal Budget-Holders is the intermediary between budget-holders and providers. This arrangement was negotiated by the Ministries of Social Affairs and Finance to assuage anxiety about the possible purchase of services on the grey market and the consequent evasion of social security and income tax payments. While the budget-holder may choose service providers, he delegates financial administration of his personal budget to the Association, which pays the providers.

**Service providers and quality assurance:** Services may be provided by governmental agencies, NGOs and for-profit agencies. There have been efforts to increase the role of the for-profit sector, but the majority of the services are provided by NGOs.

Quality assurance is the responsibility of the national government, and a number of systems of quality assurance are used. There is periodic formal inspection of service providers by a representative of the health care system. Providers are also expected to have internal quality control mechanisms that assess services. It is in their interest to present themselves as providing a high level of services, given the competition among providers. Finally, the law mandates that every agency supplying care have a consumer council. Efforts are now underway to strengthen quality assurance. Structured instruments for inspection and regulation are being developed (Huijbers, 1999), and the federal government is planning to increase regulation by setting price and quality standards (Coolen & Weekers, 1998).
**Finance:** AWBZ is funded through a compulsory premium, a co-payment, and general taxation.

The compulsory premium is integrated into the income tax structure. In 1997, the premium was 8.85% of income; it rose to 9.6% in 1998 for people earning between NFL 8,600 and NFL 47,000 a month. The employer pays the lion’s share of the premium. Those who earn above NFL 47,000 pay a flat payment. Children (under the age of 15) and persons over 15 with no taxable income are not required to pay a premium (Ministry of Health Welfare and Sport, 1998).

Co-payments are determined by the type of care and the recipient’s level of income. For home nursing, there is a payment of NFL 55 annually to register with a home nursing agency, which then makes the co-payment on its members’ behalf. If an individual needing home nursing does not belong to such an agency, the required membership fee for the first year is NFL 137. The co-payment for home help and for Alpha Care is NFL 10 per hour. Those with lower incomes pay NFL 5 per week, regardless of the number of hours of care they receive. The maximum co-payment for all forms of home care is NFL 250 per week. Co-payments for home care (and Alpha Care) are transferred to the Central Administration Office (CAK) of AWBZ, which pays the service providers. Even those receiving the “personal budget” may be charged a user’s fee similar to that charged for services in kind, depending on their income.

The co-payment for institutional care is determined according to an individual’s income (but not assets – as was the case prior to 1997). The co-payment is set yearly by the Ministry of Health. In 1998, the monthly co-payment was NFL 2,200. However, individuals earning less than NFL 4,734 per month (and couples earning less than NFL 7,893) are exempted from the co-payment. The co-payment for long-term care institutions is determined in the same way as that for old age homes. People under age 65 have a co-payment of NFL 1,350 per month (Huijbers & Martin, 1998).

**Coverage:** No data were available on total number of beneficiaries of the AWBZ law. From data on utilization rates by type of service, it may be estimated that a minimum of 20% of the elderly received institutional or community care.

As seen in Table 1, in 1990, 9.5% of the elderly were in an institution, less than 1% were admitted for short-term stays in an institutional setting, 20% received home nursing on an occasional basis, 4.5% received home nursing on a regular basis, and 9% received home help (Coolen, 1995).
Table 1: Percentage of the Elderly Population (Age 65 and Over) Using Services (1990)

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage of Elderly Using Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing homes</td>
<td>2.5</td>
</tr>
<tr>
<td>Residential homes for the elderly</td>
<td>7.0</td>
</tr>
<tr>
<td>Short-term admission in residential homes</td>
<td>0.7</td>
</tr>
<tr>
<td>Day care in nursing homes</td>
<td>0.3</td>
</tr>
<tr>
<td>Day care in residential homes</td>
<td>0.8</td>
</tr>
<tr>
<td>Home nursing on regular basis</td>
<td>4.5</td>
</tr>
<tr>
<td>Home nursing – occasional</td>
<td>20.0</td>
</tr>
<tr>
<td>Home help</td>
<td>9.0</td>
</tr>
</tbody>
</table>

Source: Coolen, 1995

The data suggest that compared to other countries, there is a high level of utilization of institutional care, and a high level of utilization of occasional home nursing that in other countries is often financed through health insurance. Moreover, the pattern of service utilization reflects the absence of a minimum disability level.

No data were found in the literature on the number of applications for AWBZ services that were rejected. Data began to be collected on the number of applicants and rejections in 1998, when RIO activities began.

**Cost:** By 1997, the expenditures for the services covered under AWBZ amounted to NFL 26,267 million (about $13 billion). The proportion of expenditures on services for the elderly was about 52%: 21% for long-term care institutions, 20% for old age homes, 7% for home help and 4% for home nursing. Forty-eight percent of the budget was spent on other services.

The breakdown of financing in 1997 (provided by Huijbers & Martin, 1998), was as follows:

1. **Premiums** - NFL 23,844 million (87%).
2. **Co-payments** - NFL 3,421 million (12.5%). Co-payments for residential homes were 32% of expenditures, co-payments for nursing homes were 12% of expenditures, co-payments for home nursing were 16% of expenditures, and co-payments for home help were 12% of expenditures.
3. **General revenues through the Ministry of Health** - NFL 107 million (0.4%).

Expenditures increased from NFL 24,841 million in 1993 to NFL 28,265 in 1998. However, the increase was the result of the transfer of some services to the AWBZ basket of services,
Issues in the Implementation of the Exceptional Medical Expenses Act

There has been no systematic evaluation of the long-term care insurance law in the Netherlands. In fact, constant changes in the law have made it difficult to evaluate the law’s implications for addressing needs and costs. For example, one goal of the law was to preclude institutionalization. Indeed, institutionalization rates have dropped over time – from 10% in the 1970s, to less than 7% in 1995. However, because there has been no systematic evaluation of the law, we do not know what part it played in the reduction of institutionalization rates. We do know that the reduction was due in part to the creation of national standards for the supply of long-term care beds (de Klerk, Huijsman, & Rutten, 1995). At the same time, the Netherlands has been active in the implementation and evaluation of experimental programmes aimed at resolving problems that have persisted in the system such as lack of coordination and continuing efforts have been made to reduce the rate of institutionalization and enhance flexibility in meeting individual needs (Peterson & White, 1989; Alter & Hage, 1993; Baldock & Evers, 1991).

There is a particular need for systematic evaluation of the personal budget programme. As noted above, this is intended for people who are eligible for home care, and it provides a sum of money that may be used to purchase services or pay informal caregivers, at the recipient’s discretion. Since most of the expenditures for long-term care for the elderly take the form of in-kind services, only 3%-5% of total expenditures are allocated for the personal budget programme. In 1997, about 5,500 beneficiaries received a personal budget. Service utilization patterns and satisfaction among the beneficiaries in this programme have been monitored (Miltenburg & Ramakers, 1996; Ramakers & Miltenburg, 1997 in Coolen & Weekers, 1998). It was found that most of them (54%) use the personal budget for housekeeping services, 10% for personal care, 4% for home nursing, and 32% for a combination of various types of care. The studies reported that recipients of personal budgets were satisfied with the control of care these gave them. Of those who used their personal budget to purchase housekeeping services only, one-third (37%) hired informal caregivers or unorganized workers, while two-thirds (63%) contracted with a professional agency. Some beneficiaries think of the personal budget primarily as a way of rewarding informal caregivers. An indirect positive consequence of personal budgeting has been increased pressure on established providers to become more competitive in quality and price. According to Weekers and Pijl (1998), the most striking findings from evaluation studies are the reported improvement in the quality of services and increases in elderly

and hence a reduction in expenditures elsewhere in the health system (Huijbers & Martin, 1998). It is estimated that the Netherlands devoted about 3.6% of the GNP to the AWZB law.
budget-holders’ feelings of autonomy. Beneficiaries have reported that service providers related to them better, and they experienced fewer turnovers of workers than before.

Despite their satisfaction, personal budget recipients have complained that the process of receiving a personal budget is lengthy, and information about eligibility is insufficient. Professionals have criticized the lack of sufficient alternative suppliers of services to enable real choices of services, the lack of flexibility in service provision, and problems of coordinating service provision (services may be provided by a number of personnel working in the same organization). At present, the choice of service providers is limited, since most service providers operate as monopolies (Coolen & Weekers, 1998).

Associations of disabled and elderly people have pushed for greater access to personal budgets, emphasizing that this would increase their freedom to choose the type and amount of services they receive. However, opposition has arisen among service providers, which fear for their market shares, and among labour unions, which want to protect their members’ rights. Policy makers also cite problems of cost containment.

The Dutch system has unique features that clearly distinguish it from the other long-term care systems. Most striking are the broad commitment to meeting needs, the flexibility of the system, and the efforts to tailor services to individual and family needs. The end result is a holistic approach to assessment of needs and eligibility, which includes family care.
References


4. Israel

Background

In response to the aging of Israel's population over the past two decades, the system of services for the elderly has undergone rapid development and change. Social services in general have grown dramatically in Israel, and services for the elderly have increased in tandem.

In January 1995, a new National Health Insurance Law went into effect. This law mandates universal health coverage and defines a basic basket of services to which all citizens are entitled. Within the framework of this law, all of Israel's residents are insured by one of four service providers, or health plans (similar to American health maintenance organizations). In addition to assuring universal coverage and the right of mobility among sick funds, this law introduced a capitation formula for allocating health insurance premiums, collected by the National Insurance Institute (Israel’s social security administration). The capitation formula is weighted according to age, thus providing an incentive for sick funds to develop and improve services for the elderly. However, there is ongoing debate about the adequacy of this incentive. As in all countries, the elderly use health services more than any other segment of society. Visits to physicians by the elderly are double those of the general population, and the elderly’s rate of hospitalization is three times higher than that of the general population, accounting for approximately 40% of hospitalization days (Mashav, 1999).

Health services covered by the law include primary care (ambulatory care), acute hospitalization, medications, laboratory tests, medical rehabilitation, and professional home care (provided by doctors and nurses). Institutional long-term care services for the severely disabled were intended to be included; however, this component of the law has not been implemented, and it is not clear if and when it will be implemented.

The System of Care for the Disabled Elderly

Responsibility for financing services for the aged is shared by a number of agencies; they include the National Insurance Institute, the Ministry of Labour and Social Affairs, the Ministry of Health, and the four sick funds. These agencies operate within a clearly defined but complex system in which responsibility is determined by type of service and by level of disability, classified along a continuum from dependency in instrumental activities of daily living (IADLs) (the semi-independent), to moderate dependency in ADLs (the frail), to severe dependency or cognitive impairment (the severely disabled and mentally frail and those requiring complex or medically skilled nursing care). The National Insurance Institute, or social security administration, provides community services for chronically disabled and mentally frail elderly under the Community Long-term Care Insurance Law, which is
described below. The Ministry of Labour and Social Affairs is responsible for financing institutionalization and community care (personal care, housekeeping services) for the semi-independent and frail elderly, and for operating day care and sheltered housing frameworks. It does so through a network of local social bureaus, which provide these services on a discretionary basis and within budgetary constraints. Eligibility criteria for public assistance are based on an assessment of the family situation and a means test. The Ministry of Health is responsible for institutional care for the severely disabled.

Thus, the two major sources of funding of institutional long-term care are the elderly and their families, and the government – that is, the Ministry of Health and the Ministry of Labour and Social Affairs. Government assistance is based on an income test. Interestingly enough, according to the Alimonies Law, which provides for filial responsibility, children in Israel are required to contribute to the cost of institutional care, depending on their economic situation and that of their elderly parent.

**The Community Long-Term Care Insurance Law**

As noted above, the National Insurance Institute provides community services to the chronically disabled and mentally frail elderly under the Community Long-term Care Insurance (CLTCI) Law. This law is responsible for major changes that have occurred in the provision of community care for the elderly in recent years. In the 1980s, forecasts of a significant growth in the number of disabled elderly raised fears that the cost of institutionalization would skyrocket if alternatives were not found. At the same time, uneven distribution of funding for community and institutional services led to the desire for a more appropriate funding balance. Policymakers realized that they had not sufficiently considered community resources as an alternative way to meet the needs of the elderly. Moreover, there was consensus regarding the desirability of enabling the elderly to remain in the community for as long as possible and making institutionalization a last resort. All of these factors led to a range of efforts to develop community services (Habib & Factor, 1993).

Despite the consensus about the need to expand home-care services, a major debate arose as to the best way to develop these services. This debate focused on whether the right to home-care services should be an entitlement under social security or subject to budgetary constraints. Israel chose to adopt the social insurance approach. In 1980, a 0.2% employee contribution to national insurance was levied to create a reserve fund for implementing the law. In 1986, the Israeli Parliament completed the enactment of the Community Long-term Care Insurance (CLTCI) Law, and full implementation began in April 1988.
**Insurer:** The National Insurance Institute is responsible for implementation of the CLTCI Law; it has become the major source of funding for personal care services for the disabled elderly.

**Eligibility criteria:** Eligibility is extended to men over age 65 and women over age 60 who are functionally disabled in activities of daily living (ADLs), or who require constant supervision as a result of cognitive disabilities (this need is defined as the risk that an individual, if left unsupervised, will harm either himself or others).

Elderly people residing in nursing homes are not eligible for benefits under the law.

It should be noted that, since 1979, social security has provided benefits to disabled people under the Attendance Allowance Law and the Disabled Child Law. The attendance allowance is provided to disabled people who, in addition to having lost their earning capacity (which entitles them to a disability pension), are limited in their daily functioning and require the assistance of others. An unrestricted cash benefit is provided to persons who are dependent on the help of others to perform everyday functions as a result of a physical or mental impairment. Earlier questions were raised about the need for similar legislation for the elderly, who were not eligible for an attendance allowance if they applied after reaching retirement age. With implementation of the CLTCI Law, an impaired person receiving an attendance allowance benefit who has reached the age of 60 (for women) or 65 (for men) can choose to continue receiving a cash benefit under the Attendance Allowance Law, or to transfer his entitlement and receive benefits under the CLTCI Law.

As noted above, difficulty in performing activities of daily living (ADLs) and the need for constant supervision are the primary criteria for eligibility under the CLTCI law. Eligibility for benefits is based on the level of need for assistance, as indicated by the number of hours of assistance required per day; benefits are granted to elderly people who need at least 2.5 hours of personal care per day. Eligibility for benefits is not affected by the informal assistance an elderly person receives or may receive from family members. Thus, Israel has chosen a universal programme in which disability, rather than a subjective evaluation of potential informal support and unmet need, is the basis for eligibility. However, an applicant’s living situation (whether he lives alone or with others) is factored into the assessment of eligibility: an elderly person living alone receives extra points in the assessment of eligibility; this is described below. The less disabled elderly, who are not eligible for services under the CLTCI Law, may receive home care services from the social welfare system under a budget-restricted, income-tested programme, which provides fewer hours of care.
There is a means test for receiving benefits under the CLTCI law, but it is set at a high level relative to the income status of the elderly. To be eligible for full benefits, a single person must have an income that is not higher than the average wage, and a couple must have an income that is not higher than 1.5 times the average wage. An additional amount equivalent to half the average wage is added for each child. Half of the benefit is provided when income exceeds the means test but is not higher than 1.5 times the average wage for a single person, or 2.25 times the average wage for a couple; in these cases, an additional sum of 0.75% of the average wage is added for each child. Those with higher incomes are not eligible for benefits.

**Eligibility assessment:** The assessment of disability is performed by public health nurses from the Ministry of Health, under contract with the National Insurance Institute. This assessment has legal standing as the basis for eligibility determination and is subject to judicial review on appeal. It is carried out at the home of the applicant, using a structured protocol (Zipkin & Marginistin, 1998).

ADL scores may range from 0 to a maximum of 8 points; in addition, the need for constant supervision gives 6.5 points, and living alone gives 2 points (therefore, the maximum a person may receive is 16.5 points). Israel has set two levels of eligibility: for the lower benefit level, a minimum of 2.5 points (or 2.0 for those living alone) is required, while for the higher benefit level, a minimum score of 6.5 points is required.

The greater the number of levels into which eligibility is divided, the greater the extent to which resources may be allocated according to functional level. Therefore, in Israel, after 11 years of experience, the levels of care have been re-examined, and a change in the law has been proposed to include three levels of disability instead of two.

Eligibility may be reassessed on the initiative of the National Insurance Institute, or on the initiative of an applicant who wants to increase his or her eligibility level. A high percentage of reassessments are performed on the applicant’s initiative.

**Benefits:** Basic eligibility is for in-kind services. Cash benefits are provided only to eligible people for whom services are unavailable, and only then if the beneficiary does not live alone (because it is assumed that a disabled elderly person living alone would not be able to use the cash benefit effectively. A negligible number of elderly have received cash benefits due to the unavailability of a service provider.
The “basket of services” provided under the law includes a defined list of community services: personal care, housekeeping, day care, laundry services, undergarments for the incontinent, and emergency alarm systems in the home.

Services are provided at two benefit levels, as noted above: at the lowest benefit level, services are paid for at 25% of the average wage, while the highest benefit level pays for services at 37.5% of the average wage (in 1999, payments at the basic benefit level were equivalent to about $360, which can purchase about 10 hours of personal care per week, and at the higher benefit level they were equivalent to $540 or 15 hours of personal care per week).

An elderly person may choose to use the benefits for a combination of services: for example, two visits a week to a day care centre and the remainder in personal care services. In the rare cases when services are unavailable, the cash benefit is provided at a rate of 80% of the relevant benefit level; the difference is attributable to administrative costs for providing benefits in-kind.

**Providers and quality assurance:** Home care (personal care and housekeeping services) is provided by semi-professional staff working in certified, licensed agencies. These agencies may be NGOs or for-profit agencies. The choice of service provider is made by a local committee responsible for care planning, in consultation with the client and his family. During initial implementation of the law, there was a great deal of concern about the adequacy of the supply of services. Therefore a decision was made to encourage service development, expand the network of community services and allow the entrance of for-profit agencies. The concern about supply proved to be unjustified since there was a tremendous growth in community services following implementation of the law and enhanced competition among providers. The proliferation of service providers has created a dilemma. On the one hand, competition, in principle, improves the quality of care and enhances choice. On the other hand, when there are a large number of service providers in the market, inspection of quality becomes complicated. Furthermore, uncontrolled competition can lead to bankruptcy, particularly of smaller for-profit providers; and this is detrimental to the continuity of care for the elderly. To prevent such a scenario, the National Insurance Institute has intervened in order to limit the number of providers (for example, by setting a minimum number of clients per provider) (Katan & Loewenstein, 1999). This was challenged in the courts by the agencies, but the agencies lost the case, enabling the National Insurance Institute to set criteria by which providers may be selected by tenders. This plan is currently in operation.
In an additional effort to encourage service supply, the CLTCI Law established a fund (set at 10% of annual contributions) for the development of both community and institutional services. Although the fund was initially temporary and was meant simply to ease the transition to the new law, it has been continuously extended. A significant proportion of this allocation has been used to develop day care centres and train home-care workers. Allocations to long-term care institutions have been used to expand the supply of beds and upgrade services.

Israel employs several mechanisms of quality assurance: licensing of service providers, structured training of home care workers, the development of standards of quality, and the creation of quality assurance mechanisms.

Israel's law stipulates that care can be provided only by agencies licensed by the Ministry of Labour and Social Affairs. These agencies are required to submit to inspection of their personal care workers, by social workers, nurses, or senior personal care workers.

The National Insurance Institute has invested considerable effort in the development of structured training courses for personal care workers in the home. Personal care workers may also attend supplementary courses that increase their skills and train them to care for specific populations, such as the severely disabled elderly or the mentally frail (Korazim & Kahan-Strawczynski, 1997). It should be noted that participation in these courses is not mandatory.

The agencies also provide in-service training to every new personal care worker. There are still no uniform standards for the extent of training, and there is a great deal of variation in the training provided by different agencies, but nevertheless, training is very widespread. Moreover, standards of quality have been developed for personal care workers, and these have been disseminated in three languages (Hebrew, Arabic and Russian) (Korazim & Kahan-Strawczynski, 1999). The agencies providing personal care use these standards as a training tool.

The National Insurance Institute monitors long-term care in two ways: 1) through sample interviews with the elderly in their homes to examine whether the beneficiary is receiving the appropriate quantity and type of services, and determine how satisfied the beneficiary is with the services; and 2) through an organizational review of agencies, which includes the appropriateness of payments to personal care workers, to ensure that all the social benefits covered by wage agreements are paid. These reviews are conducted annually on about
one-third of the service providers, such that each provider is reviewed at least once every 3 years. Those providers who are found deficient are again reviewed the following year.

Interestingly, the volunteer unit of Israel’s social security administration has implemented a programme in which volunteers monitor beneficiaries under the law. These volunteers call the beneficiaries and ask them whether they are satisfied with services and whether there are any problems with service providers; if there are, they are reported to the social security administration. The programme has been quite successful in identifying problems.

Day care centres providing services under Israel’s Community Long-term Care Insurance Law must also be licensed. The Ministry of Labour and Social Affairs is responsible for licensing, as well as inspections based on new standards of quality developed in recent years (Korazim & Kahan-Strawczynski, 1997).

**Finance:** There are two sources of financing of the CLTCI Law: a special payment to the National Insurance Institute, and general taxation. Contributions began to be collected in 1980 and were set at 0.2% of employee wages. They were divided equally between employers and employees (0.1% each). As a result of subsequent government policy, the rate for employers has been reduced to 0.06%; the government pays the 0.04% difference. In addition, government support covers elderly immigrants who would have been ineligible under earlier residency requirements (12 months’ residence), and housewives who are uninsured under the social security law. This coverage has constituted an increasingly large share of total benefits (now about 20%) (Zipkin & Morginstin, 1998).

**Coverage:** In 2001, about 110,00 elderly were entitled to benefits under the CLTCI Law, representing about 14.5% of the elderly population (men age 65 and over and women age 60 and over). More than half are age 80 and over. About 76% are eligible for the lower benefit, while 24% for the higher benefit.

The overwhelming majority of beneficiaries received personal care services in their homes. Emergency alarm systems have become increasingly popular, and in 1997, 13% of beneficiaries received them. Also, a significant proportion of beneficiaries attended day care centres and received disposable undergarments (about 7% each) (Table 1).
Table 1: Beneficiaries by Type of Service, 1997

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal care at home</td>
<td>88.8</td>
</tr>
<tr>
<td>Day care</td>
<td>7.1</td>
</tr>
<tr>
<td>Disposable undergarments</td>
<td>6.9</td>
</tr>
<tr>
<td>Emergency alarm systems</td>
<td>12.6</td>
</tr>
<tr>
<td>Laundry and other</td>
<td>0.8</td>
</tr>
</tbody>
</table>

*A person may receive more than one service at a time.
Source: National Insurance Institute 1999

The annual percentage of applications has remained stable for the past several years (about 8% of the elderly population), as has the rate of approval (about 50% of the applications). However, the rate of re-applications has shown a steady rise, and these accounted for an estimated 45% of all applications in 1997 (Zipkin & Morginstin, 1998).

**Cost:** In 2000, total expenditures for the CLTCI programme were almost NIS 1.7 billion (about $370 million). These expenditures included direct benefits to eligible elderly, 15% of annual contributions transferred to the Ministry of Health and the Ministry of Labour and Social Affairs to cover the cost of financing institutional beds, and 10% of annual contributions for the development of services. Israel devotes about 0.36% of the GNP to the Community Long-Term Care Programme.

Annual operating expenditures have outstripped contributions, and the deficit is now more than half the expenditures; this deficit has been financed with surpluses from other branches of the National Insurance Institute. The unexpectedly high cost of the CLTCI programme is due to the fact that demand for services has exceeded forecasts.

Efforts are being made to identify the reasons for the deficit and to address this problem. Various approaches are being tried. One approach has been to re-examine the reliability and validity of the assessment of eligibility for benefits. Another is to strengthen the periodic reassessment of functional status, so as to ensure that only those who are eligible for benefits continue to receive them.

**Issues in the Implementation of the Community Long-term Care Insurance Law**
When the law was passed, its overall objectives were to reduce unmet needs, lessen the burden on family caregivers, and preclude unnecessary institutionalization of the elderly. Several studies have examined the law’s effects in these areas.
Coverage of community long-term care services
The first effect of the law was to tremendously increase the resources earmarked for community care. This resulted in a more balanced allocation of public resources between institutional and community care. Prior to the law’s implementation, expenditures for community services were limited, representing only 17% of public funds for long-term care (Naon & Strosberg, 1995). Since 1994 (four years after the law’s implementation) public funds for community care have constituted about half of public funds for long-term care.

The law has had a dramatic effect on the coverage of disabled elderly people. The proportion of elderly receiving home care increased from 2% prior to implementation of the law to nearly 15% of the total elderly population. The increase in the number of those receiving care reflects, in the main, the very dramatic increase in the number of moderately disabled elderly people who have begun receiving services. In the past, this group had “fallen between the cracks” due to budgetary constraints and the division of service provision between the health and the social services (Brodsky et al., 1993).

Informal care
As expected, research has shown that the addition of services has had a positive effect on the well-being of the elderly and has reduced their unmet needs. In Israel, no evidence has been found of a decrease in the amount of informal services because of the provision of formal services. It appears that community services have supplemented rather than replaced informal care. Yet caregivers’ sense of burden has been significantly reduced (Morginstin & Baich-Moray, 1992; Brodsky & Naon, 1993) because the availability of formal services allows family members more choices about what type of care they will provide. In addition, the knowledge that formal care is guaranteed by statute and therefore reliably available gives families a sense of security that encourages them to continue caring (Brodsky & Naon, 1993).

Despite the improvements brought about by the expansion of formal services, the elderly in Israel still have many unmet needs, and caregivers still feel burdened (Morginstin & Baich Moray, 1992; Brodsky & Naon, 1993). A recent legislative initiative has proposed expanding the number of benefit levels from two to three, which would improve the matching of needs to resources. Those recipients at the highest and middle benefit levels would receive more service hours, while recipients at the minimal threshold for benefits would face a cut in service hours (Zipkin & Morginstin, 1998).
After more than a decade of experience with a programme that ensures a basic level of home care for the elderly, many professionals believe it is time to increase the programme’s flexibility. Services purport to meet the needs of families, but in fact they are limited in scope and type. At present, formal caregivers are not able to use their discretion in service provision, and the elderly and their families have limited choice among alternative services (Brodsky & Morginstin, 1999).

Before the final enactment of the CLTCI Law, a public commission was appointed by the Minister of Labour and Social Affairs to formulate guidelines for the operation of the law. A major issue considered by the commission centred on the type of benefits to be included: cash or in-kind (Mann, 1988; Morginstin & Shamai, 1988). After considerable debate, the commission decided to maintain the focus on in-kind services, providing cash benefits only if no services are available in the community, and only if the beneficiary does not live alone. The logic behind this was that a disabled elderly person living alone would not be able to use the cash benefit effectively. In reality, very few people receive cash benefits. However, debate has again arisen over cash allowances, and some have proposed providing cash rather than in-kind benefits.

**Substitution of community for institutional care**

In order to examine whether the CLTCI Law has indeed enabled dependent disabled elderly people to remain at home and delayed or prevented their institutionalization, two studies have been conducted of rates and patterns of institutionalization before and after implementation of the law. The first was conducted one year after implementation of the law, and the second four years after implementation of the law. The studies monitored national data on institutionalization patterns, and did an in-depth investigation of applicants and entrants for institutional placement.

It is interesting to note that unexpectedly, there was a sharp increase in applications for institutional placement during the first year following implementation of the CLTCI Law. It appears that in determining eligibility for community services, the law “discovered” a sizable population of disabled elderly people who had not previously been in contact with the service system and who had not been referred to institutional services. The sharp increase in demand, and the fact that those who applied to institutions after implementation of the law were more disabled than those who applied before implementation of the law, led to the conclusion that, prior to implementation, the needs of a large number of people for community and institutional services were not being met. Thus, as awareness of existing services – particularly institutions – grew, the decline in the need for institutional placement
resulting from the law was offset by the increased demand for assistance resulting from the discovery of new cases among the very disabled. This implies that the law helped identify and refer severely disabled elderly clients – who had hitherto gone unrecognized by caregiving authorities – to institutional care (Naon, Factor, & Primak, 1993; Naon & Strosberg, 1995).

The second study, carried out four years after implementation of the law, revealed a significant change in the patterns of institutionalization of frail (moderately disabled) elderly. The use of services under the law enabled the less severely disabled to remain in their homes and avoid institutionalization (Naon & Strosberg, 1995). As noted above, after implementation of the law, the percentage of those receiving community care increased, particularly among the moderately disabled. Applications for institutionalization by elderly people with moderate disability have continued to decline. The lack of impact on the severely disabled has been attributed to the relatively low level of the benefit.

The Community Long-Term Care Insurance Law increased the resources earmarked for community care and created an infrastructure of community services. This resulted in a more balanced allocation of public resources to institutional and community care. After more than a decade of experience, revisions are being suggested to improve the programme, create adequate mechanisms to ensure coordination and continuity of care between acute and long-term care, enhance flexibility in meeting individual needs, and contain costs.
References


5. Japan

Background

Of all the OECD countries, Japan is experiencing the most rapid demographic aging. The dramatic increase in the elderly population and women’s changing roles in the family and in the labour force have raised public and governmental concern over care of the elderly in Japan. Although the three-generation patriarchal family in which a daughter-in-law looks after elderly parents is still prevalent in Japan, the proportion of elderly people living alone or with their spouse has more than tripled since 1960, especially in the cities (OECD, 1994).

Health and social services for the elderly have developed as an outgrowth of the enactment of several laws, some of which concern the total population, and others of which are directed specifically at the elderly (see Appendix for a chronological overview of the development of the system of care).

In 1922, Japan’s Health Insurance Law – the first social insurance programme in Asia – was enacted, although universal coverage was not achieved until 1961, when this law was entirely revamped. The 1963 Welfare Law for the Aged aimed to provide home help, respite care (short-term stay) and institutional care for the elderly with low incomes who had no one to care for them. However, as the demand for long-term care increased, coverage expanded. Before the implementation of the new long-term care insurance law (described below), elderly persons needing long-term care received it under this law (Ihara, 2000), and those who are not eligible for services under the new law can continue to receive services under it. Fees for long-term care are based on the recipient’s income level, and range from nothing to nearly full cost. Municipal governments decide who is eligible for such care, according to their income and the availability of a family caregiver.

Since 1973, medical care, including hospital care, has been free for those aged 70 or over (and those who are bedridden and age 65 or over); in other words, they are exempt from co-payments (Ikegami, 1997). It should be noted, however, that small co-payments were reinstituted. In 1983, when the Health Medical Service Act for the Elderly was enacted to provide comprehensive health and medical services for people age 70 and over, and to balance the burden of medical expenditures for the elderly among the various insurance schemes (Shoji & Hironari, 1999). Under this law, the national government contributes 20% of the cost of medical care for the elderly, the prefectures and primary local governments contribute 5% each, and health insurance associations cover the remaining 70%. Until the implementation of the new law, social services, including nursing homes and home care, remained means-tested and targeted at those without family support (under the 1963 Welfare Law for the Aged).
The Ministry of Health and Welfare has primary responsibility for health administration, although decentralization underlies national policy. Japan is divided into 47 prefectures; local administration is conducted by these prefectures, and by municipal (city, town, village) governments. All prefectures are required by law to establish and run a national health insurance programme (administered by “local national health insurance associations”).

Hospitals are the main providers of care in Japan, however, traditionally, the Japanese concept of hospitalization has differed from the Western one. Japan has no exclusively “acute” hospitals: Patients with chronic illnesses who in the West would find themselves in long-term care institutions have been treated as in-patients in Japanese hospitals (Nakahara, 1997). As a result of the lack of financial barriers for hospital-based long-term care, together with the absence of a negative stereotype associated with extended hospital care and the lack of general practitioner gatekeepers, hospitals have been extensively used for long-term care (Ikegami & Campbell, 1995; Ihara, 2000).

As a consequence, the average length of stay in a Japanese hospital is long. For example, in 1983, the average length of stay in a hospital in Japan was 39 days – much longer than that in other OECD countries. Lengths of stay are even longer for elderly patients, half of whom remain in the hospital for more than 3 months, and between one-quarter and one-third of whom remain in the hospital for more than a year.

The lack of a system of assessment or triage of elderly patients and the uniform fee system (which does not take into account the severity of a patient’s illness or disability) have resulted in the placement in hospitals and nursing homes of many patients who are only slightly disabled and need minimal care (Ikegami, Morris, & Fries, 1997). Those nursing homes that exist are part of the special welfare system for the elderly. Their expansion has been curtailed by general expenditure constraints, such that their numbers have not increased concurrent with the increase in the number of hospital beds.

As in some other OECD countries, the rate of institutionalization of the elderly in Japan is about 6%. The problem is that a relatively high proportion of this 6% are in acute hospitals rather than in skilled nursing homes (which are less costly) (Ihara, 2000). In fact, this was one of the main factors contributing to the enactment of the long-term care law described below.

The proportion of elderly people receiving home help has remained small and, as noted above, this benefit has typically been targeted at people with low incomes or who lack family
support. The development of community-based services was very limited until the introduction of The Gold Plan in 1989.

In response to the growing concerns of the Japanese public and government about care for the elderly, in 1989 the Ministry of Health and Welfare issued a Ten-Year Strategy for Promoting Health and Welfare Services for the Elderly (the so-called “Gold Plan”), which promoted home care for the frail elderly and assistance to family caregivers. Prior to enactment of this plan, nearly 90% of the Ministry’s budget for care of the elderly went to institutional care (Sodei, 1996). The Gold Plan defined specific goals to be achieved over a ten-year period. These included numerical targets for increases in facilities and staff (home caregivers, short-term beds, day care centres and nursing homes). Nevertheless, the increase in services was expected to meet only half of the needs of the elderly population (Sakamoto, 1996).

In 1994, a New Gold Plan was introduced, to expand the variety of services for the home-bound elderly so as to improve the care of elderly suffering from dementia and reinforce home-based care for the frail elderly.

The perception that the system of care was not functioning efficiently, and that long-term care needs were therefore not being adequately addressed prompted the reform of Japan’s system of long-term care.

The Public Insurance Scheme for Long-term Care (Kaigo Hoken)
The most recent effort to improve long-term care is the Public Insurance Scheme for Long-term Care passed by the Diet (parliament) in 1997. Implementation began in April 2000. Under the law, long-term care is an entitlement, based on the insurance principle of personal eligibility.

Insurers: Under the new law, Japan’s 3,200 municipalities – which are already responsible for health insurance programmes for the self-employed and for retirees, and which provide social services –share the responsibility of providing coverage with the national government and the prefectures. A national pooling mechanism (the Social Insurance Medical Fee Payment Fund) was established to distribute funds to the municipalities. This is intended to address demographic imbalance among municipalities and ensure equitable allocation of resources.
**Eligibility criteria:** Eligibility levels are determined through assessment of an individual’s functional and cognitive abilities. Neither the availability of informal care nor income will be considered for this purpose – a radical departure from traditional Japanese attitudes toward the family’s responsibility for providing care. All residents age 40 and over are eligible for care, although eligibility differs depending on age: Disabled people age 65 and over are automatically be eligible for long-term care, but disabled people between the ages of 40 to 64 have to prove that they suffer from an “age-related” condition (such as dementia, cerebrovascular diseases, amyotrophic lateral sclerosis, Parkinson’s disease, spinocerebellar degeneration, chronic obstructive lung disease, rheumatoid arthritis, or osteoporosis with bone fracture) (Okamoto, 1999).

**Eligibility assessment:** Assessment of eligibility may be made in the community or in an institution. Applicants are expected to require care for at least 6 months. Once care has begun, the recipient should be re-assessed every 3-6 months.

To ensure fair and equitable assessment, a national uniform standard of eligibility has been developed. Assessment is made using a structured form that measures performance in activities of daily living (ADLs) and cognitive, sensory (visual and verbal), and functional abilities. Once eligibility has been established, an individual is classified as being at one of six levels that determine the level of benefits. The points fixed for each level, which represent hours of care in an institutional setting (ranging from 25 minutes to 110 minutes), were derived from a care time study. The amount of care required to be eligible for the highest level seems low relative to the level of benefits granted at this level (Ikegami, 2000).

Care managers – a new role established as an adjunct to the law – are responsible for the initial eligibility assessment. These care managers may be employees of an organization that provides services. It has been argued that because of the overlap between their roles as care managers and providers, there may be a conflict of interest and the process of eligibility determination may have a built-in bias towards severity, to favour providers. However, final decisions about eligibility is made by an expert committee (Campbell & Ikegami, 2000).

Responsibility for planning care may reside with the individual and his family, or with a care manager, who advises patients on planning their care (care plans must be approved by the patient or his family), coordinate service provision, and monitor services and claims.
Benefits: The law will provide services in-kind, either in the community or in an institution:

Home care and community services comprise visiting nurses, personal care and housekeeping services, including the possibility of multiple, brief (10- to 30-minute) visits around the clock; rehabilitation services at home or at a day care centre; medical management; respite care (in a geriatric hospital or geriatric ward of a general hospital); day care; group home services for people with dementia; assistive care devices; and minor home remodeling (e.g. widening doorways to admit a wheelchair).

Institutional services comprise nursing homes and health service facilities for the elderly; and geriatric care hospitals (long-term care wards).

Benefit levels range from ¥ 61,500 (about $560) per month for the minimum level of assistance (e.g. up to two housekeeping visits per week, one nursing visit per week, up to two visits to adult day care per week, and up to two 1-week respite stays per year), to ¥ 358,300 (about $3,260) per month for the maximum level of assistance (e.g. seven housekeeping/personal care visits per week, two nursing visits per week, three visits to adult day care per week, and a 1-week respite stay every month) (Okamoto, 2000; Crume, 1997). Within this range, the recipient can freely combine different types of home care and institutional services.

One of the issues debated most while planning the law was whether or not to provide cash allowances for family care. Despite public support, the decision was made not to allow cash benefits (Okamoto, 2000). Professionals claimed that rapid expansion of formal services should be the top priority, and this would necessitate a large demand for services in kind. Feminists argued that cash allowances would merely become part of the household budget while family caregivers continued to provide the bulk of care. Concern was also raised that if cash allowances were offered, there would be a rush on applications for benefits – yet the government is counting on a relatively low level of applications initially, since it wishes to phase in the programme gradually (Campbell & Ikegami, 2000).

10 Maximum monetary limits for home care (monthly, by level of disability) (US$1=¥109.8):

- needs support (level 1)---------------------¥61,500 ($560)
- level 2-------------------------------------¥165,800 ($1,510)
- level 3-------------------------------------¥194,800 ($1,774)
- level 4-------------------------------------¥267,500 ($2,436)
- level 5------------------------------------¥306,600 ($2,792)
- level 6------------------------------------¥358,300 ($3,263)

Although the long-term care law does not allow cash benefits for family caregivers, in the last months prior to initiation of the programme, the government decided that a ¥100,000 grant will be awarded to beneficiaries who have applied for benefits under the law and have been classified as having a Level IV or a Level V disability; have little or no income (that is, are near the poverty line); and have not received services under the law for 1 year. It should be noted that this grant is not an insurance benefit under the long-term care law but, rather, will be financed out of general revenues (Okamoto, 2000; Campbell & Ikegami, 2000). This decision was a political decision and it is perceived as a compromise between those in favour and those against the provision of cash allowances (Okamoto, 2000).

Providers and quality assurance: Along with the implementation of the law, Japan is hoping to expand service supply, particularly through the participation of the for-profit sector in service provision; indeed, this is viewed as one of the prerequisites for successful implementation of the law. The municipalities have tended to prefer service providers that they operate or fund, rather than for-profit providers. The long-term care system will offer the same competitive conditions for public and private sector service providers. This is expected to enable the elderly and their families to have more choice among service providers (Ihara, 2000; Crume, 1997). However, it is not clear whether the development of services will actually meet demand, since there is a great deal of variation across regions and in types of service (Campbell & Ikegami, 2000).

Concomitantly, there is concern about assuring the quality of long-term care services, especially with the entry of for-profit providers. It is expected that the new role developed – care manager – will include attention to quality assurance. According to the practice standards, care managers are to monitor the provision of services to clients on an on-going basis (Okamoto, 1999).

Finance: The law is funded by premiums to be paid by everyone age 40 and over (estimated to be 65 million people by 2000). These is collected through a combination of mandatory social insurance contributions (a payroll deduction and matching employer contribution for those who are employed, health insurance premiums for the self-employed, and deductions from pensions for retirees), which are amount to half of the total cost after the co-payment, and contributions from the national government, prefectures, and municipalities (on a 2:1:1 ratio).

In addition, there is a 10% co-payment at the point of service provision.
**Coverage:** When the law was passed, it was estimated that 2.7 million elderly people, who comprise 12.4% of the elderly population, would be eligible for benefits in 2000. The implementation of the law begun in April 2000. By October 2000, 1.9 million were receiving benefits, that is about 78% of the estimated eligible population. The proportion of the elderly receiving benefits was 9.1%

The government has not altered its spending forecasts, since it believes that not all of the benefits will be accessed because of the 10% co-payment demanded of beneficiaries (Ikegami, 2000). Thus, the estimated cost of the law during the first year of its implementation (2000) is ¥4.3 trillion (about $39 billion). Accordingly Japan will devote about 0.8% of the GNP to the long-term care law.

**Issues in the Implementation of the Long-Term Care Insurance Programme**

The implementation of the Public Insurance Scheme for Long-Term Care Law has just begun, and it is difficult to assess its impact. However, the passage of the law is evidence of a change in the Japanese people’s perception of long-term care – from a problem that can and should be resolved largely within the family, to one that demands the society’s attention and effort (Ihara, 2000).

According to Ihara (2000), the authors of the Public Insurance Scheme for Long-term Care expect it to significantly improve the system of long-term care, and to accomplish the following:

1. Ensure a stable source of revenue for long-term care, which, given the rapid aging of the population, would be difficult to achieve with existing programmes.

2. Stem the deterioration of the fiscal state of health insurance caused by the long-term hospitalization of elderly patients.

3. Enhance service supply by creating equal, standard conditions for government providers, NGOs, and for-profit providers, thereby increasing competition and consumer choice. Though shortages in some areas are expected immediately following implementation, it is hoped they will disappear with the entry of for-profit providers into the long-term care market.

4. Integrate the welfare, health, and long-term care insurance systems for the elderly, and balance service distribution across geographic regions.

5. Introduce the concept of “care management” into the long-term care system so as to help consumers plan appropriate programmes of care and choose qualified providers.
The following issues have been raised concerning implementation of the new scheme:

- **Cost control:** It is expected by many that expenditures might outstrip revenue by the time the LTCI is scheduled for a full review after five years (Campbell & Ikegami, 2002). Part of the reason is that there are several weaknesses in the government’s financial assumptions. They may have successfully predicted the increase in ratio of the 65+ who would be eligible (from 12.4% to 12.9% by 2006) but the number does not take into account the ageing of the elderly population, with a much higher proportion of people aged 80+ (Campbell & Ikegami, 2002). The problem is that it is not clear where new money might come from. The standard premium for paid by elders 65+ is decided by each municipality and mayors claim that it is difficult to raise these premiums so there is a de facto constraint on programme growth. One logical suggestion is to make both the premiums and the coverage universal, defined by functional disability alone, rather than age as well. Some groups representing younger disabled people have already called for such an expansion which would produce a large net gain for the system (Campbell & Ikegami, 2002).

- **Use of benefits:** One of the goals that was implicit in LTCI was to encourage community-based care rather than institutional care. But the start of LTCI saw a flood of new applications to institutions where waiting lists are getting longer. This is partly because before the introduction of LTCI, access to institutional care was strictly means tested by income and available family assistance. Now all beneficiaries have suddenly become eligible so waiting lists are long and expenses are high (Campbell & Ikegami, 2002; Matsuda, 2002). There is a need to encourage use of community-based services. Although it has since risen, at the start, most beneficiaries who lived at home used only about half of the services to which they were entitled, possibly due to the co-payment, or perhaps due to a lack of enthusiasm for too many visits to adult day-care centers, or by outsiders coming into their houses (Campbell & Ikegami, 2002).

- **The new legislation will be beneficial to middle-class elderly and their families, but its benefits for elderly people with low incomes are mixed.** Previously, low-income recipients of services paid little or nothing for these services. According to the new system, premiums will be deducted from their pensions (on a sliding scale), and they will be required to make a 10% co-payment, which may be a hardship for them (Gross, 1997; Crume, 1997). Moreover, some recipients of long-term care services are not frail enough to qualify for the new programme, yet they will still be required to make this co-payment. Various steps have been taken to ease this situation, including allowing residents classified as non-eligible to remain in nursing homes for 5 years,
and reducing the co-payment to 3% for those who have previously received services in the community (Campbell & Ikegami 2000).

- Since the early 1990s when the first Gold Plan was enacted, the long-term care needs of the elderly have been a priority in Japan. Public feeling that the system of long-term care was inadequate led to major support for the new law: According to a 1995 government survey, 82% of Japan’s population favoured its introduction (Ikegami, 1997). Japan’s Medical Association also supported the law.

The situation in Japan is somewhat unique in that prior to the new law there was already a relatively high level of expenditure on care but the system was not considered efficient. Thus, the Japanese are offering a high level of potential benefits, but the government does not expect that major increases in financing will be needed.
References


Takeo O. Adult Care Services in Depopulated Rural Areas, Trial Programs by the Agricultural Cooperative Associations. Unpublished report by the National Institute of Populations and Social Security Research. www.ipss.go.jp/English/R_S_P/No4_P65.html
<table>
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<th>I. Framework</th>
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<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
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<tr>
<td>1. Long-term care services provided by statutory programme based on personal entitlement</td>
<td>Yes; two programmes(^1)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes; three programmes(^2)</td>
<td>Yes</td>
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<tr>
<td>2. Programme name</td>
<td>Bundespflege-Geldgesetz (The Federal Long-Term Care Allowance Act; The Provincial Long-Term Care Act)</td>
<td>Pflegeversicherung (Long-Term Care Insurance Law, or Social Dependency Insurance Programme)</td>
<td>Algemene Wet Bijzondere Ziektekosten (AWBZ) (The Exceptional Medical Expenses Act)</td>
<td>Chok Bituach Siyud (Community Long-Term Care Insurance (CLTCI) Law)</td>
<td>Kaigo Hoken (Long-Term Care Insurance Programme, or the Care Insurance Law for the Elderly)</td>
</tr>
</tbody>
</table>

1 Austria has enacted two laws: The Federal Long-term Care Law, which covers people who are entitled to social security pensions (90% of the population), and the Provincial Long-Term Care Law, which covers 10% of the population.

2 Description refers to the Community Long-Term Care Insurance Law, which covers the elderly; others needing long-term care are covered by the Attendance Allowance Law (age 18-64) and the Disabled Child Law (age 0-17).

3 Having initially served mainly as a means of funding long-term or high-cost care in various types of institutions (e.g. nursing homes), its provision has been extended over the years to cover more elements of health care, many of which are neither prolonged nor expensive (Health Insurance in the Netherlands, 1998). In 1989, home care services were included and in 1997 residential homes were included.
## Summary Table: continuation

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<tr>
<td><strong>II. The Nature of the Programme and the Insuring Agency</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>1. Special/part of health or social insurance</td>
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<td>Special programme</td>
<td>Special programme</td>
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<td>2. The insuring agency</td>
<td>Ministry of Labour, Health and Social Affairs</td>
<td>Care funds linked to sickness funds</td>
<td>Ministry of Health, Welfare and Sport(^4)</td>
<td>National Insurance Institute (Social Security)</td>
<td>Municipal Government</td>
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<tr>
<td><strong>III. Eligibility Criteria</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Age</td>
<td>Three and over</td>
<td>All ages</td>
<td>All ages</td>
<td>Women 60+, men 65+</td>
<td>40+</td>
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<td>2. Health, functional status</td>
<td>Disability in ADL, IADL (forecast need for care for at least six months); need for at least 50 hours assistance per month (the blind/severely visually impaired, deaf, wheelchair-bound are automatically entitled)</td>
<td>Disability in two or more ADL (forecast need for care for at least six months); need for at least 1½ hours assistance per day</td>
<td>Health problems, functional disability</td>
<td>Disability in ADL and/or need for constant supervision</td>
<td>40-64: age-related disease (e.g. CVA, senile dementia) 65+: difficulty in ADL, cognitive ability, sensory ability (forecast need for care for at least six months) Minimum level includes almost independent people(^5)</td>
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<tr>
<td>3. Availability and extent of family assistance</td>
<td>Not considered</td>
<td>Not considered</td>
<td>Considered</td>
<td>Not considered</td>
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</tr>
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4 The AWBZ is managed through health insurers: the health insurance funds, or private health insurance companies approved by the government. The government is responsible since insurance organizations cannot take financial risk to cover AWBZ.

5 The minimum level of disability includes people who are able to sustain an independent daily life. Services are aimed at improving the current situation and preventing the deterioration of underlying conditions. Services include periodic home visits to provide guidance to family caregivers and health counseling (Okamoto, 2000).
### Summary Table: continuation

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<tr>
<td>4. Means test</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Yes; for full benefit-income not higher than average wage for single person, and 1.5 for couple(^6)</td>
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<tr>
<td>5. Other criteria</td>
<td>None</td>
<td>None</td>
<td>Psycho-social; condition of the home and environs; type and level of formal care provided</td>
<td>Living alone (adds points toward eligibility)(^7)</td>
<td>None</td>
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#### IV. Eligibility Assessment

<table>
<thead>
<tr>
<th>1. Assessment tools</th>
<th>Structured; uniform nationwide</th>
<th>Structured; variation among provinces</th>
<th>Discretionary; uniform protocol being prepared</th>
<th>Structured; uniform nationwide</th>
<th>Structured; uniform nationwide</th>
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<tr>
<td>2. Levels of eligibility</td>
<td>Seven levels, by hours of care per month (50-180 hours)</td>
<td>Three levels, by hours of care per day (1 ½-5 hours)</td>
<td>Tailor-made care</td>
<td>Two levels, by hours of care per day (2½-6½ hours)</td>
<td>Six levels, by hours of care per day (25 minutes to 110 minutes)(^8)</td>
</tr>
</tbody>
</table>

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\(^6\) For a person with children – an additional income amount equivalent to half the average wage is added for each child. Half of the benefit is provided when income is above the average wage, but not higher than 1.5 the average wage for a single person and 2.25 times the average wage for a couple. Those with higher incomes are not eligible.

\(^7\) Living alone adds points only if the applicant needs assistance in ADL for at least two hours.

\(^8\) The minutes are derived from a care time study in institutional settings (Ikegami, 2000).

\(^9\) Care funds conduct the assessment for eligibility through the sickness funds, medical service, and reimburse the sickness funds for the use of the service.

\(^10\) The National Insurance Institute pays independent public health nurses per assessment.

\(^11\) The municipality pays independent care managers for eligibility assessment.
Summary Table: continuation

<table>
<thead>
<tr>
<th></th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Professionals</td>
<td>Physicians</td>
<td>Physicians or nurses</td>
<td>Multi-disciplinary team (social workers, nurses, physicians)</td>
<td>Nurses</td>
<td>Care manager (from various professions)</td>
</tr>
<tr>
<td>making assessment</td>
<td></td>
<td></td>
<td></td>
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</table>

V. Benefits

1. Cash allowance (unrestricted/ restricted\(^{13}\)), in-kind services, or combination of both

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<tr>
<th></th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash allowance</td>
<td>Cash allowance (unrestricted)</td>
<td>Both (in-kind services and unrestricted cash allowance): value of cash allowance is lower than that of in-kind services (45%-53% of benefit depending on disability level)</td>
<td>In-kind services (restricted cash allowance being used experimentally)</td>
<td>In-kind services (cash – 80% of the benefit – offered only in the absence of services)</td>
<td>In-kind services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
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2. Main services covered:
* Institutional care
* Home care\(^{17}\)
* Day care
* Other

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<tr>
<th></th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary’s Choice, in all categories</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

| Respite care, night centres, assistive devices | Yes | Yes | Yes | Yes | Yes |
| Respite care, Visiting nurse, Assistive devices, Home nursing, Rehabilitation, Undergarments, Laundry services, Emergency Alarm system | Yes | Yes | Yes | Yes | Yes |

---

12 RIO employs professional staff for the assessment. Expertise is not explicitly stated in the regulations; therefore, several professions may perform the assessment. To assist in specialized assessment, expert consultation may be required (e.g. in case of suspected dementia).

13 Unrestricted cash allowances enable beneficiaries to use the funds as they see fit, while restricted cash allowances may be used only to purchase services.
<table>
<thead>
<tr>
<th>Summary Table: continuation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3. Level of benefits per month (estimated in US$)</strong></td>
</tr>
<tr>
<td><strong>Austria</strong></td>
</tr>
</tbody>
</table>
| Between $160 and $1,686 (cash allowance) (as of 1998)<sup>14</sup> | *Community care*: In-kind services between $375 and $1,400 (or $1,875 in hardship cases); cash allowance: between $200 and $650 (as of 1999)  
*Institutional care*: (in-kind services): Between $1,000 and $1,400 (or $1,650 in hardship cases) (as of 1999)<sup>15</sup> | Not specified – no formal limit on total benefit, maximum limit in specific services (such as 3 hours per day for home nursing) | Between $360 and $540 (for in-kind services) (as of 1999)<sup>16</sup> | Between $560 and $3,260 (for in-kind services) (as of 2000)<sup>17</sup> |

<table>
<thead>
<tr>
<th><strong>VI. Programme Operation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Auspices of service providers</strong>&lt;sup&gt;18&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>2. Responsibility for care planning</strong></td>
</tr>
</tbody>
</table>

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<sup>14</sup> Calculated by the authors according to exchange rates: ATS 12.5=$1.00.
<sup>15</sup> Calculated by the authors according to exchange rates: DM 2=$1.
<sup>16</sup> Calculated by the authors according to exchange rates: NIS 4.1=$1.
<sup>17</sup> Calculated by the authors according to exchange rates: ¥ 109.8=$1.
<sup>18</sup> Government includes national or municipal.
<sup>19</sup> However, the actual care planning is made by a senior care-worker of the provider agency.
### Summary Table: continuation

<table>
<thead>
<tr>
<th>VII. Finance</th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sources of Finance:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Special payment/ premium</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>· General taxation</td>
<td>Yes (100%)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>· Co-payment</td>
<td>Yes (for institutional care)</td>
<td>Yes (for all services)</td>
<td>Yes (for all services)</td>
<td>Yes (20%)</td>
<td>Yes (50%)</td>
</tr>
<tr>
<td>2. Premium cost(^{20})</td>
<td>Not relevant</td>
<td>1.7% of gross wages, upper limit contribution – DM 6375 (former West Germany) DM5400 (former East Germany) – equal contribution of employer and employee(^{21}); retirees share cost with pension fund</td>
<td>9.6% of taxable income between NFL 8,600 and NFL 47,000; above this wage, annum flat payment; majority paid by employer, remainder paid by employee</td>
<td>0.16% payroll tax shared by employee (0.1%) employer (0.06%); pensioners do not pay</td>
<td>0.9% of average monthly earnings for employees aged 40-64, shared equally with employers; $26 (average) per month; for persons aged 65+, deducted from pensions</td>
</tr>
</tbody>
</table>

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\(^{20}\) Premium contributions for the self-employed may be different, and the premium for those who are not employed may be covered by other funds.

\(^{21}\) The contributions of the employers are recompensed by the designation of a paid holiday as a working day.
### VIII. Coverage

<table>
<thead>
<tr>
<th></th>
<th>Austria</th>
<th>Germany</th>
<th>Netherlands</th>
<th>Israel</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of recipients</td>
<td>324,000 recipients (1998)</td>
<td>1.8 million recipients (1999)</td>
<td></td>
<td>recipients 110,000 (2001)</td>
<td>1.9 million recipients (Oct. 2000) 77.7% of eligible population. 9.1% of the 65+ population.</td>
</tr>
<tr>
<td>2. Percentage of benefit recipients</td>
<td>3.9% of total population (about 17% of those aged 61+)²²</td>
<td>2.19% of total population (9.6% of those aged 65+)</td>
<td>A minimum estimate of 20% of the elderly (1990)²³</td>
<td>14.5% among women age 60+, men age 65+</td>
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</tr>
</tbody>
</table>

### IX. Cost

<table>
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</thead>
<tbody>
<tr>
<td>1. Cost in local currency</td>
<td>$1.7 billion</td>
<td>$15.5 billion</td>
<td>$13 billion</td>
<td>$370 million</td>
<td>$39 billion</td>
</tr>
<tr>
<td>2. Estimated cost in US$</td>
<td>0.9%</td>
<td>0.9%</td>
<td>3.6%</td>
<td>0.36%</td>
<td>0.9% (0.8% of GDP)</td>
</tr>
</tbody>
</table>

²² Estimated by utilization rates by age group, based on Enge, 1999.
²³ Estimated by utilization rates of the elderly by type of services, based on Coolen, 1995.
²⁴ Expenditures for the Federal LTC Allowance Act are about ATS 18 billion, and for the Provincial LTC Allowance Act about ATS 3 billion on average.
²⁵ Expenditures are for the broad package of services available to the entire population.
²⁶ Expenditures are only for community services for the elderly.
COMPARING AMONG SYSTEMS: SUMMARY AND EMERGING ISSUES

Background
The case studies in this monograph has demonstrated the significant variation in approaches to providing LTC, and the significant efforts that have been made in all the countries to better address these needs over the last decade.

This chapter compares these approaches and the directions of change. In particular, it examines the differences between insurance-based and non-insurance based approaches in addressing the other major policy design issues.

Insurance versus Non-insurance Approach in LTC
As we have seen, long-term care systems in industrialized countries may be distinguished by whether or not they adopt an insurance approach. Traditionally, long-term care has been provided on the basis of budget-limited programs funded by general revenue. In response to the growing need for long-term care, several industrialized countries have opted to legislate social insurance based-systems that provide individuals with a personal entitlement to long-term care services.

In insurance-based programs, everyone who fulfills the eligibility criteria must be granted benefits, regardless of available budgets. Such programs are established through specific legislation, and allow costs to be contained only through changes in eligibility criteria, which usually requires changes in legislation. We illustrated this approach in the case studies of five countries with insurance-based entitlement programs: Austria, Germany, The Netherlands, Israel, and Japan.

In non-entitlement—or budget constrained—programs, service provision is dependent on budget constraints, that is, services do not have to be provided once the budget runs out, even to those who meet eligibility requirements. Applications for services within a given budget year can either be denied, or the applicants put on a waiting list. Costs can thus be contained through planned budget allocations, rather than only by adjusting eligibility criteria.
In this book, we illustrate this approach in the case studies of three countries: Australia, Canada (Quebec)\textsuperscript{11}, and Norway.

The choice a country makes between an insurance-based and a non-insurance-based system may reflect in part its philosophy regarding social service provision. That is, whether it believes that long-term care services should be defined as a right, which is protected from general budgetary and political processes, or whether it believes that such services should be subject to controls based on budget allocations, which can be flexibly adjusted to fit the overall budgetary situation. In insurance-based systems, as noted, changes in the benefits package or eligibility criteria require changes in legislation, rather than administrative decisions. Consequently, they are subject to public debate, and are more difficult to effect, if the government encounters a recalcitrant legislature or significant opposition. By definition, this process is more protracted.

It may be too soon to tell whether the long-term care services provided in insurance-based systems are protected more than the services provided in non-insurance-based systems. Among the five countries with legislated insurance-based systems, only Israel has reduced its long-term care benefits package. This was only done in 2003 in the context of major budget cutbacks throughout the social welfare system. The Netherlands has even expanded the LTC benefits covered under their insurance-based system since its enactment.

However, there is no evidence from the countries studied in this volume with non-insurance-based systems that long-term care necessarily suffers. In all three countries, efforts have been made in recent years to improve the capacity and quality of long-term care services. In Quebec, for example, the budget for community-based care increased by 53% between 1995 and 2000. In 1999, 3.5% of Quebec's public expenditures on health were spent for long-term care, compared to 2.6% in 1994. Similarly, in the mid-1990s, Norway instituted a national plan to expand existing long-term care services.

In Australia, community-based services are provided through the Home and Community Care Act (HACC) program, which is funded jointly by federal and state governments. Many states have opposed budget increases to expand these services. Consequently, the federal government has added community-based services to its institutional-care financing

\textsuperscript{11} Since each province in Canada has its own independent LTC system, this analysis is based on the system in Quebec, the second largest province in the country. And despite the variation among provinces, it does provide a general picture of trends in Canada as was described in the case study.
framework, which does not involve state funding, to better meet the need for community-based services.

We now proceed to review the variation in the systems across the countries reviewed in this monograph against the background of differences between insurance-based and non-insurance based systems.

**Universality versus Selectivity**

Another important distinction between long-term care systems is the population they choose to cover: either the entire population – both those who are poor and those who are not – or only people in lower-income groups.

There are several rationales for supporting the broader population:

- The catastrophic potential nature of LTC costs that implies that broad segments of the population may find it difficult to pay for them, and when their resources are depleted, they will become a burden on public programs.

- Concern with the broader social costs of care provision and an interest in easing the burden on families and particularly on female caregivers who provide much of the care.

- An interest in reducing the utilization of more costly acute care services (particularly hospitalization) by substituting LTC.

Insurance-based systems that are entitlement-based are designed to be universal, and usually do not require applicants to undergo an income test. While non-insurance-based systems have less of an obligation to provide services to all, the long-term care systems presented in this book are also based on the principle of universality. There are a number of other industrialized countries with non-insurance-based systems which do target the poor. In the United States, for example, Medicaid provides long-term care services—in both the community and in institutions – for people with low income only. People with higher income must either pay for long-term care services out of pocket, or purchase private long-term care insurance.

However, the only insurance-based system that has made receipt of services dependent on an income test is Israel; however, this only affects 1% of the applicants, as most of the elderly, and the dependent elderly in particular, have income levels below the threshold of 1.5 times the average wage. The three non-insurance based case studies included in this book represent non-insurance based countries that have not implemented means testing.
Another way of introducing income testing is to have a separate system of care that supplements the more universal system. As the systems reviewed only aim to cover a portion of long-term care needs, people with lower income will not be able to afford the cost of care that is not covered by the system. As will be discussed later, some countries such as Germany, Israel and Japan, have supplementary programs for low-income beneficiaries to supplement the care provided through their insurance-based programs.

There are various ways of linking income and the level of service. Beyond imposing an income test that excludes people with higher incomes, it is also possible to impose co-payments that vary by level of income. In systems that implement sliding scales for co-payments, beneficiaries who have higher income pay a larger proportion of the cost of the services, and beneficiaries who have lower income pay little or nothing.

All of the countries included in this monograph impose significant co-payments for institutional care, usually on a sliding scale. In some cases, co-payments are earmarked to cover non-medical aspects of care within the institution, though in other cases no distinction is made among aspects of care.

There is no general rule governing co-payments for community care. Two of the insurance-based systems impose co-payments for community-based care – the Netherlands has sliding co-payments based on income, and Japan charges 10% of the cost of services to the beneficiary, regardless of their income. Of the non-insurance based systems, Norway and Quebec charge co-payments on a sliding income scale for personal care, but not for home health care. In Australia, co-payments on a sliding income scale are required for all community-based care.

An important consideration regarding co-payments is their impact on service utilization. On one hand, they may limit unnecessary utilization. On the other hand, they may deter the use of needed services.

**Designated Contributions versus General Revenue Finance**

Long-term care services are funded from three main sources: a designated contribution or premium; general taxation; and co-payments.

Countries that adopt insurance-based systems generally finance long-term care through contributory payments, whereas countries with non-insurance-based systems always finance long-term care through general taxation. A pre-paid premium is viewed as granting a right to service, while general taxation does not necessarily give the individual the same claim to a
right. Concern for the ability to finance long-term care may create a preference for contributory programs. It may be easier to generate public support for a program that serves the general population, if it is founded on principles of compulsory social insurance and financed by designated contributions. This in turn leads to the adoption of an entitlement approach.

In four of the five countries with insurance-based systems, long-term care services are primarily financed by contributory social insurance payments. The exception is Austria, which finances its system through general revenue, though health insurance contributions were increased when the system was instituted in order to offset the extra costs incurred.

The non-insurance-based systems reviewed in this monograph use general revenues collected at both the national and the local levels to fund LTC.

**Mixed Models**

Several countries have developed a mixed model of insurance and non-insurance based long-term care provision. These are either for people who are not eligible for the main insurance-based system, or to supplement services for those who are eligible. As mentioned earlier, in Germany, low-income beneficiaries of the long-term care social insurance law are allowed to supplement their long-term care benefits with services from social welfare programs (this is primarily used to cover the co-payment for institutional services). In both Israel and Japan, those who do not meet the eligibility criteria under the law can receive similar services through the social welfare system based on income testing.

Another variant is that certain services may be fully provided by a separate, non-insurance-based program. In Israel, for example, only community-based care is included in the insurance-based program, while institutional care is available through a separate, budget-limited program.

Two of the non-insurance based systems have small supplementary programs that provide cash grants focused to family carers to compensate them for the loss of income.

**Centralization versus Decentralization**

There are four areas of system management that can be the responsibility of central or local governments: Financing, setting policies regarding eligibility criteria and benefits, administration (assessing eligibility, disbursement of funds/benefits), and service provision (development, organization, provision, follow-up).
In insurance-based systems, financing and setting policy regarding eligibility criteria and benefits are usually centralized.

Japan is somewhat an exception in the sense that the responsibility for financing is shared by the central and local authorities, and the federal government finances 50% of the long-term care program, and 50% is funded by the local authorities. In Israel and Germany, financing for the insurance-based long-term care system is provided only by the central government, although the supplementary system of services for those not eligible under the law is funded in part by the central government (75%) and in part by local government (25%). Austria's system is fully financed by the national government.

In non-insurance based systems, financing is shared, but setting policy regarding eligibility criteria and benefit packages are decentralized. Interestingly, each of the systems reviewed gives responsibility to a different local level. In Australia, this takes place on a state level, in Norway on a municipal level, and in Quebec on the provider level. It is significant to note that in Quebec, this highly decentralized model has led to wide variations, both between and within regions, in per-capita spending, eligibility criteria, the range of services provided, and the modes of delivery. Australia's system is more centralized than are the other non-insurance-based systems reviewed. Institutional care has been financed and administered nationally since the Aged Care Act was enacted in 1997. Community-based care is funded jointly by the federal and state governments, and the states are responsible for ensuring adequate service delivery by contracting with local service providers.

Beyond centralization of finance, there are other dimensions of LTC systems that can be implemented on a centralized or de-centralized basis. In countries with decentralized financing, administration will also follow the same pattern. Thus, non-insurance based systems, in which financing is shared between the national and local level, have decentralized administration. In insurance-based systems, there is a tendency for centralization of administration taking into account the particular infrastructure of each system. Germany and the Netherlands both use the national health insurance companies to administer the long-term care system, taking advantage of the infrastructure, which was already in place, to administer acute health care. Israel also takes advantage of the existing social and health services infrastructure. Austria, which requires minimal administration since the benefit is in the form of cash, contracts out these responsibilities to the health system, which is centrally administrated.

Even highly centralized systems leave the arrangement of service provision to the local government, which will be more sensitive to the particular needs of the population in each
region. The only exception is Israel, which has centralized responsibility for service provision. Providers are hired by the national insurance system itself rather than the local government.

Benefits and Eligibility

Benefits Package

Long-term care may be either home-based or institutional. Home-based care may be provided either in the home, or in the community but outside the home. Institutional care includes a range of services, from nursing homes that provide intense nursing care, to residential homes that provide a protected environment for frail older adults. Community-based care includes home care – that is, care related to daily functioning such as personal care (e.g., bathing, dressing, eating) or homemaking (e.g. cooking, cleaning, errands), and home health care – that is, health-related care, such as skilled nursing. It also includes other services in the community such as day care and meals on wheels.

All of the systems provide the full range of long-term services in one framework or another. Historically, long-term care systems in industrialized countries have had a particular focus on institutional care. However, in recent years, there is a growing trend towards the development of community-based care. “Aging in place” is perceived as being preferred by the elderly and, in the majority of cases, as a less expensive alternative to institutional care. Planners hoped that if community-based long-term care became more broadly available, the use of acute care hospitals would decrease, as would the demand for residential facilities and nursing homes, and this would, in turn, reduce costs. The extent to which the long-term care programs have influenced the patterns of referral to institutions has depended in part on the extent and type of community-based care available. When that is limited, it is less likely to offer an alternative to institutionalization or hospitalization, particularly for the more severely disabled elderly.

In Japan and Quebec, for example, one of the problems with the system of care for the elderly has been the overutilization of hospitals by people needing long-term care, which is reflected by the relatively high average lengths of stay and the number of older persons occupying acute hospital beds while awaiting placement in a nursing home. This was an impetus for the reform of Japan’s system of long-term care, and for the reforms being introduced in Quebec (Brodsky, et. al, 2000; Bergman, 2001). Quebec began promoting community-based care in 1979, giving local community service centres (CLSCs) responsibility for providing services and has continued to develop this sector. The Netherlands, which had a particularly high rate of institutionalization (10% of all elderly in
revised its law in 1980 and 1989 in an effort to promote the replacement of institutional services with less expensive community services (e.g., personal budgets, sheltered housing, intensive personal care, short-term institutionalization) (Brodsky, et. al, 2000). Israel's legislation only covers community-based care, reflecting a policy decision to reinforce care in the community. All the systems have maintained or instituted high co-payments for institutional care.

In Norway, community-based services were promoted by the decentralization of the health system in 1986, during which municipalities assumed responsibility for primary and long-term care. Australia instituted its HACC program for community-based care in 1985, and has expanded it over time.

**In-kind Services versus Cash Benefits**

Community-based long-term care benefits can be provided in the form of direct services – that is, services "in kind" – or as restricted or non-restricted cash benefits. Restricted cash benefits, such as "vouchers", require beneficiaries to use them for long-term care services. Unrestricted cash grants entitle beneficiaries to use them at their discretion. Traditionally, benefits have been provided in kind. In recent years, there has been more interest in cash grants that are not restricted to the purchase of services. The actual value of these benefits is usually lower than the cost of receiving direct services or restricted cash benefits. This is based on the assumption that clients will use unrestricted cash benefits to purchase services from non-organized providers or family members, and therefore obtain services at a lower cost.

Since their impact on how well the needs of the elderly are addressed is uncertain, unrestricted cash benefits remain controversial. Proponents of these benefits claim that they empower recipients by increasing their autonomy and freedom of choice among services and service providers; facilitate flexible care planning; and enable recipients to schedule personal assistance as they please and to choose and directly contract with service providers (including non-organized caregivers). Furthermore, cash benefits may give families a greater incentive to continue caring for an elderly or disabled relative, by offering some level of income replacement for informal caregivers. It is also assumed that the provision of cash allowances will generate competition among service providers, thereby improving services.

Critics of unrestricted cash benefits argue that the quality of care may be compromised. Beneficiaries may have difficulty choosing providers on their own, and families may abuse the funds or neglect the elderly person’s needs. In addition it is claimed that cash
allowances will not necessarily spur the development of community services and provide consumers with options. Finally, it is argued that considerable choice and flexibility can be built into a system that provides in-kind services by offering more choice and participation by the clients in the decision making process. Vouchers also offer a great deal of flexibility.

Unrestricted cash grants are more commonly found in insurance-based programs, in which benefit levels are formally defined. Austria is the most extreme example of this approach, as it provides cash benefits only. Germany offers beneficiaries a choice between in-kind services and a cash allowance. More people than expected have chosen cash over in-kind services, even though its value is much lower. In the Netherlands, a restricted cash benefit was recently introduced, which allows 10% to be used on an unrestricted basis.

The other two countries with insurance-based systems, Japan and Israel, only offer cash grants when no other services are available; this is decided on a case-by-case basis. Israel is considering offering a restricted cash benefit for families that wish to employ a caregiver around the clock. Debate over this issue has been renewed by the increasing number of elderly people who employ a 24-hour caregiver (usually a foreign worker), at a cost well above the value of the in-kind services provided under the law. At present, such caregivers are hired through agencies that receive payment from Israel's social security administration. The agency pays the caregiver half of what it receives from social security, and the family makes up the differences in the caregiver's salary. If families were to receive a cash allowance directly from social security, they could purchase this service from non-organized providers at a lower cost.

In non-insurance-based systems that have no legal obligation to provide a specific level of services, unrestricted cash benefits are not a common alternative to in-kind service. The systems reviewed in this analysis each provide some kind of opportunity for cash benefits. In Quebec there is a limited opportunity to receive a cash benefit in lieu of some in-kind services. As noted above, Australia and Norway both offer limited cash carer allowances: income replacement for family members who care for a disabled relative. In Australia, these allowances are limited to people not eligible for other income support.

**Eligibility Criteria**

Beyond income testing, which was mentioned earlier, there are a number of design issues that arise in defining eligibility criteria: age limits, disability threshold, and the consideration of family support.
All Ages versus Age Limited

When determining age criteria for eligibility, there are three possibilities: a) include people of all ages in the same program; b) define specific long-term care laws for different age groups (this may involve establishing separate eligibility criteria and/or benefits); c) limit long-term care benefits to one specific age group.

In Japan, only the elderly and some who are younger with age-related diseases are included in the long-term care social insurance program. The system is limited to people in two defined age groups: individuals age 40 and over who have an age-related disease (e.g., CVA, senile dementia); and individuals age 65 and over who have difficulty functioning in ADL, or cognitive or sensory disability. The first group includes people with serious conditions that require intensive care, and the second group includes those who need intensive care, and those who live independently, but need some functional and health-related assistance. Israel has two separate social insurance systems—one for the elderly, on which we have focused in this monograph, and a second system for those under age 60 for women and age 65 for men. When these individuals reach age 60, they can choose to continue receiving this allowance, or can transfer their entitlement to the long-term care law.

The other systems reviewed include people of varying ages who need long-term care, though the majority of beneficiaries are age 65 or over. Austria’s program excludes children from birth to age three, as it is assumed that all children require full-time care at these ages, regardless of their physical or mental situation; exceptions are made to this exclusion in cases of financial need. Australia has two separate programs of long-term care. The HACC program is oriented towards the elderly, although it covers all ages; a separate program targets only younger people, and places greater emphasis on employment support.

Disability Level

Within a given cost framework, there is a trade-off between limiting benefits to the severely disabled so as to provide more benefits to fewer people, and offering benefits to broader levels of disability, so as to provide a lower level of benefits to a larger group. Advocates of targeting benefits on persons with more severe disabilities argue that in these cases the family carers are subject to particular strain and are in need of this support in order to be able to continue in their roles. On the other hand, it is argued that giving even minimum help to people with lower disability levels helps to prevent deterioration. We will further relate to disability levels as a means of targeting services later on in this section.

Against this background, it is interesting to compare the different disability thresholds in the different systems. In the insurance-based systems, this is generally defined in terms of
minimum hours of care needed per day. Austria and Germany have similar disability thresholds - 1.7 and 1.5 hours of care needed per day respectively. In Israel, the minimum disability threshold is about 50% higher at 2.5 hours per day. However, the disability threshold for those living alone is lower, at 2 hours per day. Japan's disability threshold is much lower, and is set at 0.5 hours a day. The Netherlands is an exception and does not have a defined threshold because its concept for eligibility is similar to that of the non-insurance based systems.

Germany and Israel have supplementary programs for those who don't meet the disability threshold, and separate programs providing home health with different criteria.

Family Support
A concern in establishing eligibility for long-term care services is the role of the family and informal carers. On one hand, the systems reviewed aim to reduce the burden of care on families; on the other hand, they do not wish to eliminate the role of informal caregivers. Providing families with extra assistance may strengthen their capacities to give care for more extended periods and to diminish the impact of the burden of care on the informal caregivers, and want to reinforce the continued support of the family. Countries must thus determine the extent to which the availability of informal carers should be taken into account when defining eligibility for services.

Considering available family support makes it possible to target those most in need of assistance. However, it is difficult to include such criteria in insurance-based systems, as they require the person making the assessment to exercise discretion, and because of the argument that family support should not keep you from receiving benefits for which you have "paid." Consequently, insurance-based systems do not usually consider the availability of informal care. The exceptions are Israel (partially) and the Netherlands. In Israel, an applicant's living arrangement (whether he lives alone or with others) is factored into the assessment of eligibility: An elderly person who lives alone receives extra points toward eligibility. In the Netherlands, family support is included as a factor in determining the overall level of benefits. In the non-insurance-based systems reviewed in this monograph, the availability of family assistance is not a criterion for eligibility for care; however is it taken into consideration in determining the level of assistance to be provided.

Set Levels of Eligibility versus Flexible Service Allocation
Benefit levels and eligibility criteria in insurance-based systems tend to be rigorously defined by precise measures and cut-off points that do not allow for the exercise of discretion. Generally, several discrete levels – rather than a continuum – are defined. The greater the
number of levels into which eligibility is divided in insurance based systems, the greater the extent to which resources may be allocated according to need. Israel has set two levels of eligibility, Germany has set three levels, Japan has set 6 levels, and Austria has set 7.

By contrast, in non-insurance based systems there is more flexibility in allocating resources in relation to needs. This distinction follows from the legal framework of the systems. Once a benefit is defined as a personal entitlement, the parameters of that benefit must also be clearly defined.

Despite the fact that the Netherlands is also an insurance-based program, it employs a flexible service allocations process that allows for considerable discretion. Local professionals devise "tailor made" service plans based on individual needs, and reassess plans at different points in time (six months) to ensure that appropriate service levels are maintained.

All countries with insurance-based systems, with the exception of the Netherlands, set both minimum and maximum levels for benefits based on disability level. The insurance-based systems do differ in the breadth of benefits they offer. In Austria, the highest benefit is ten times that of the lowest benefit; in Japan it is about six times that of the lowest benefit; in Germany it is four times that of the lowest benefit; and in Israel, the highest benefit for community services is one and a half times that of the lowest benefit. Although there is no formal benefit limit in the Netherlands, there are limits on some specific services, such as home nursing (which is limited to three hours per day, or eight hours per day for terminally ill patients).

Another dimension of flexibility is with regard to the services included in the benefits package. In the insurance-based systems, this package of benefits is very clearly defined. As noted, non-insurance-based systems have flexible benefits packages. In Norway and Quebec, providers have the prerogative to offer as many or as few kinds of services as they see fit, based on needs and the amount of funding available. This means that they can exclude a service altogether, or stop offering it when funds run out.

An advantage of set eligibility criteria is the standard it sets for uniform distribution of services among individuals. On the other hand, more discretionaty systems are more able to finely tailor the services to individual needs.

Assessing Eligibility and Responsibility for Assessments

In addition to establishing criteria, it is necessary to establish a procedure for evaluating or assessing eligibility. Given that eligibility criteria are more well defined in insurance-based
than in non-insurance-based systems, most of the insurance-based systems have structured eligibility processes, use standardized assessment tools, and provide extensive training—all of which aim to diminish discretion and promote objectivity. The Netherlands is an exception as it does not currently have a structured assessment tool, although is in the process of developing one.

While non-insurance-based systems have less of an imperative to use standardized eligibility assessments, they do recognize the value of assessment tools to appropriate resource allocation. Consequently, the development of assessment tools, especially for institutional care, is becoming more common. Various regions in Quebec have developed their own assessment tools to define how much service a particular patient might need. Australia has introduced a standardized tool—the Aged Care Assessment Team (ACAT)—for institutional care.

In insurance-based systems there is a tendency to assign actual eligibility assessment to external or semi-independent bodies so as to ensure objectivity.

Integration

Integration is one of the most complex and important issues facing LTC systems, and therefore we shall discuss them in more detail than other issues covered in this chapter. The interest in integration arises out of a number of concerns for the quality and efficiency of care. These include the ability to provide coordinated care packages; to combine services and consider alternative services in the most appropriate and optimal way; and to ease access to services by offering one-stop easily identified sources of provision.

In this section we distinguish between two dimensions of integration.

1. **Integration among the various types of long-term care services**—In LTC systems, it is common to find various forms of fragmentation. Home health is often provided separately from personal care and homemaking services; home care is separated from institutional care; and even the personal care and homemaking services are sometimes separated. One of the defining characteristics of the challenge of integration is that LTC includes a broad range of services, and we find various forms of fragmentation between community based care and institutional care, and even between the various forms of community based care (home health, personal care and homemaking services.
2. Integration between long-term care services and the general health and social service systems – Long-term care services may be independent of these general systems, or may be integrated either as a package or individually in the general health or social services.

The general conclusion is that it is not easy to achieve full integration along all these dimensions and there may be a need to make choices. Thus, there is a need to decide which elements of integration are more important.

There are three broad patterns of integration with regard to health and social services

**Fully Integrated system** – Only when the basic health and social systems are themselves unified is it possible to have a long-term care system that is integrated with both. At least partial integration may be achieved through a special budget pooling arrangement between the health and social systems. Another variant is that all long-term care services are integrated into one of these two systems, so as to integrate the various components of long-term care.

**Independent long-term care system** – An independent long-term care system can provide an opportunity for integration among the components of long-term care.

**Fragmented long term care services, components of which are integrated into different systems** – Because there are strong health and social systems in industrialized countries, this is the most common pattern. In particular, home health is generally integrated with the health system, homemaking with the social system, and personal care with either. Institutional services are divided between the health and social services based on the level of care required.

1. Integration among the various types of long-term care services

In Table I below, we summarize the patterns of integration among LTC services in the countries reviewed. As the table reveals, there is no single pattern of integration among long-term care services.

All three non-insurance based systems integrate home health and home care. Norway integrates institutional care as well. In Quebec, institutional care may also be accessed through the same system that provides home health and home care. However the financing of institutional care is through a separate budget.
Table 1: Integration Among Long-term Care Services*

<table>
<thead>
<tr>
<th></th>
<th>Insurance-based systems</th>
<th>Non-insurance based systems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Austria</td>
<td>Germany</td>
</tr>
<tr>
<td>Home Health</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Home Care</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Institutional Care</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

* This refers to both financial and administrative integration.
** In Israel, all components are independent.
*** Austria provides a cash benefit that beneficiaries can use at their discretion. Thus, it could be argued that home health is also integrated. However, it is available through the health system.

Austria, the Netherlands and Japan integrate all the components of long-term care. While Germany integrates home care and institutional care, home health is provided independently through the health system. Israel's long-term care system is the most fragmented, with the various services divided among different systems. The insurance-based system provides home care; the health system provides home health; and a separate non-insurance based system covers institutional long-term care. Israel is in the initial stages of a pilot program for co-location of services, which will create a single-entry point into the system for all components of LTC.

2. Integration between long-term care services and the general health and social service systems

Integration with the health system can create a continuity of care with general health and with home health. It makes it possible to take advantage of health providers that will be going into the home for home health reasons. It creates an incentive to provide adequate home health care, or to provide rehabilitation if the health care providers can capture the benefits of reduced home and institutional long-term care.

At the same time, a number of concerns have been raised about full integration between the long-term care and other service systems, particularly the health system. In particular, there is concern that long-term care needs would be neglected if they were integrated into the general health systems since acute health care needs would receive greater priority. Health systems tend to be biased towards addressing acute care needs or more medically oriented needs, as opposed to those that are more function related. The system may not perceive the potential savings of providing more long-term care, or be able to overcome the conflicting interests. An additional concern is that long-term care services will become "overmedicalized", and as a result more costly. For example, skilled nurses may be used to
provide basic personal care; or long-term care services that could be provided in an institution might be channeled to more expensive hospital settings.

The question of how to assure the most appropriate levels of long-term care financing is an important consideration in discussing their integration. The nature of the general political processes in the country by which social budgets get determined will influence the extent to which more funds will be allocated to long-term care when financed through separate budgets. Will the integration with the health or social service system enable it to command greater resources even if there are biases in the allocation of resources within these systems? Will more resources be allocated to long-term care when it is integrated with health and social care, or will there be a greater tendency to finance and support an independent long-term care program?

Another factor that influences integration of long-term care services is the distinction between services that are more social in nature, and those that are more health related. This is part of an unresolved ongoing territorial conflict between health and social systems that is not restricted to long-term care. The question is not only where to draw the line, but whether these lines should be drawn at all.

There has been a trend promoted by WHO to view health in broad terms, and to consider the social aspects of health. WHO defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". This definition involves a mandate to include social as well as medical aspects of health. Similarly, various health professions (such as nursing) have expanded their view of their roles to address the social dimension of care and include emotional support and guidance to caregiving networks. This debate also involves conflict between professions.

The implication of full integration of long-term care with health systems is of course that health providers would have to attend to the full range of long-term care services including those that tend to be viewed as a direct extension of the general health services as well as, those sometimes viewed as more social in nature. Personal care is often seen as part of health care. By contrast, homemaking services, various forms of day-care, arranging informal care, and various forms of residential day care that cater to the less dependent and have a social emphasis, are usually seen as part of social service. Emotional support to families is often seen as part of both health and social services.

When long-term care is integrated into a health or social system, a link is created between the principles of entitlement, eligibility, and finance for long-term care, and the broader
systems. This influences the decision as to whether long-term care should be integrated with the health and social systems.

A further difficulty in integration of long-term care in health systems based on entitlement principles without defined budgetary constraints is the difficulty in predicting the cost of long-term care. This becomes a major issue when the health providers are nongovernmental and financed on a capitation basis.

A further major dimension in discussing integration is that there are a number of programmatic components that can be integrated: finance, administrative responsibility, and organization of care (including gatekeeping, assessment and direct provision). Integration can imply the unification of one or all of these components. For example, unified administrative responsibility need not imply pooled finance.

Table 2 summarizes the aspects of integration existing in the countries reviewed between the long-term care system and the general health and social systems.

### Table 2: Integration between LTC Services and the General Health and Social Systems

<table>
<thead>
<tr>
<th>Financial</th>
<th>Administrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>yes*</td>
</tr>
<tr>
<td>Germany</td>
<td>yes*</td>
</tr>
<tr>
<td>Israel</td>
<td>partly</td>
</tr>
<tr>
<td>Japan</td>
<td>no</td>
</tr>
<tr>
<td>Netherlands</td>
<td>no</td>
</tr>
<tr>
<td>Australia</td>
<td>partly***</td>
</tr>
<tr>
<td>Quebec</td>
<td>partly**</td>
</tr>
<tr>
<td>Norway</td>
<td>yes**</td>
</tr>
</tbody>
</table>

* with the health system only
** only community-based care with the health and social systems that are integrated at the local level
*** only institutional care with the health system

### Financial Integration

The insurance-based long-term care systems reviewed in the monograph are not financially integrated with the health or social systems. The non-insurance-based systems have more elements of integration. In Norway, long-term care and primary health care and social services are financed on the municipal level from a common budget. In Quebec, community based LTC care is integrated with the general health and social system in the CLSC framework, which receive a global budget to provide the full range of community based LTC and other services. However, institutional care is financed by a separate budget. In Australia, institutional long-term care is financially integrated with the secondary health care system.
Administrative Integration

Whether or not the countries have financially integrated LTC with the general health and social systems, they have instituted some form of administrative integration. Japan is the one exception as its system is completely independent. Norway is an example of a system that has integrated finance and administration of LTC and the general system, all administered at the local level. Austria, Germany, Quebec, and the Netherlands use the existing infrastructure of professionals from the health or social system to determine eligibility levels for long-term care benefits and to administer the services.

In Israel, eligibility for long-term care services is conducted by professionals from the insurance-based system (National Insurance Institute), but care planning and service arrangement is the responsibility of inter-organizational teams composed of professionals from the general health and social systems.

In sum, we see that the countries reviewed in this monograph, like many other industrialized countries, have integrated or linked aspects of their long-term care system with other service systems, but have avoided full integration, with the exception of Norway. While insurance-based systems separate financing for long-term care from other systems, they do integrate many administrative and service delivery functions. In countries with non-insurance-based systems, the financing and administration of long-term care is sometimes integrated with other systems at the local or regional level.

The lack of full integration has created the need for coordinating mechanisms. It is worth noting that many of these countries have been experimenting with coordination mechanisms that aim to maintain an efficient continuum of care at the individual level, which were described in the case studies.

Coverage and Costs

Percentage of Needs Covered

The extent of coverage of long-term care systems is influenced by two main factors: The disability thresholds for eligibility and the level of benefits provided in relation to need. Moreover, both are influenced by the extent of co-payments. We use two sources to examine differences in coverage. One is information on the percentage of the elderly receiving long-term care services as shown in Table 3. This reflects primarily the nature of the cutoff points for eligibility, particularly for home care, as well as the extent to which co-payments deter applicants from applying. The second is the amounts of service provided per recipient. This is reflected in the structure of the benefit as related to disability levels.
None of the systems attempt to meet full need for long-term care, but rather aim to fill a portion of those needs. Estimates of the percentage of the elderly receiving services do not reveal significant differences between the insurance-based and non-insurance-based systems. Norway is exceptional with very high coverage as a result of the extensive provision of community-based services. This can also reflect the fact that in the non-insurance based systems the disability threshold for eligibility is more liberal. Germany and Japan are particularly low, and the reasons are unclear, and these differences deserve further investigation. Both of these countries have a supplementary system that is not fully reflected in the data.

There is a general pattern of maintaining relatively low utilization of institutional care, while increasing access to community services. In the case studies (as well as in most industrialized countries), the portion of the population age 65 and over residing in institutions ranges between 4% and 7%. This percentage does not appear to have grown dramatically in recent years, despite the continued aging of the population. In some countries, such as Quebec, the percentage has even declined. The rise in assisted living, sheltered housing, and other special housing arrangements are examples of new forms of care that are emerging as alternatives to traditional nursing home care. There is a great deal of variation in the services offered by these alternative residential frameworks: Some concentrate more on social needs, while others more on medical needs (Pacolet, 1999; OECD, 1999; Royal Commission on Long Term Care, 1999).

**Table 3: Estimated Percentage of Elderly Receiving Long-term Care Services**

<table>
<thead>
<tr>
<th>Insurance-based systems</th>
<th>Non-insurance based systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>Australia</td>
</tr>
<tr>
<td>17% of those 61+</td>
<td>19.5% of those 65+</td>
</tr>
<tr>
<td>(1998/9)</td>
<td>(2001/2)</td>
</tr>
<tr>
<td>Germany</td>
<td>Quebec</td>
</tr>
<tr>
<td>9.6% of those 65+</td>
<td>25% of those 65+</td>
</tr>
<tr>
<td>Israel*</td>
<td>Norway</td>
</tr>
<tr>
<td>19% of women 60+</td>
<td>36% of those 65+</td>
</tr>
<tr>
<td>Japan</td>
<td></td>
</tr>
<tr>
<td>9.0 of those 65+</td>
<td></td>
</tr>
<tr>
<td>(1990)</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td></td>
</tr>
<tr>
<td>20 of those 65+</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| * Includes 5% institutional care provided through the non-insurance programs provided by the health and social system.

Another perspective on the coverage of needs is the level of benefits per recipient in relation to disability levels. In systems with very explicit benefit levels associated with levels of disability and that do not take family support into account in defining need, it is easier to identify the planned rate of coverage of needs. Thus for the insurance-based system, this type of data is available. In Germany, for example, it is estimated that in 1995, non-
institutionalized beneficiaries received between 37% and 44% of the care they were assessed as needing. The benefits covered between 44% and 64% of the fees for institutional care, depending on the location of the facility and the degree of dependency (Schneider, 1999). Austria covers between 16% and 44% of the cost of community-based long-term care, and 50% of the cost of institutional care (Austrian Federal Ministry of Labour, Health and Social affairs, 1999). In Israel, the first level of benefits covers between 35% of the need (for the most severely disabled) and 57% of need (for the less severely disabled) (Morginstin, et. al., 1993). The level of benefits offered in Japan is higher, and is assumed to provide for a higher percentage of needs: For example, it covers almost the entire cost of institutional placement (Campbell and Ikegami, 2000).

As noted above, cash allowances are lower than the monetary value of in-kind services. For example, in Germany, the cash allowance is about half the value of in-kind services, depending on the beneficiary’s level of functioning. In Israel, the cash allowance provided when no other service is available represents 80% of the value of in-kind services.

In countries with non-insurance-based systems that have broad discretion in determining the level of benefits per recipient, it is not easy to identify an a-priori goal in regards to the percentage of needs to be covered. Therefore, we do not have comparative information for these systems. Moreover, since the level of benefits also takes into account the availability of family support, the concept of need is different.

Costs

It is difficult to obtain fully comparable data on the cost of long-term care because of the multiple systems involved in the various components of long-term care, and the lack of adequate data. Still, it is possible to obtain a general sense of the dimensions of the cost of long-term care, and of the differences among the countries.

The cost of the various systems as a percentage of Gross National Product (GNP) is compared in Table 4. Canada\textsuperscript{12} and Australia devote about 0.75% of GNP on long-term care, and are at the lower end of the scale among the countries reviewed in this monograph. Japan, Germany, Austria, and Israel are somewhat higher, and have supplementary programs that are not reflected in the cost data. The costs are much higher in Norway (2.8%) and the Netherlands (3.6%). The Netherlands data includes, however, selected medical expenses that are also financed within the long-term care program. In general,

\textsuperscript{12} No specific data for Quebec was available, therefore we use the percentage of GNP on LTC in Canada.
there is no systematic difference between insurance based and non-insurance based systems, and it depends more on the particular specifications of the eligibility and benefits within the program.

Table 4: Estimated Public Spending in LTC as a percentage of the Gross National Product (GNP)

<table>
<thead>
<tr>
<th></th>
<th>Austria (a)</th>
<th>Australia (b)</th>
<th>Canada (b)</th>
<th>Germany (a)</th>
<th>Israel (a)</th>
<th>Japan (a)</th>
<th>Netherlands (a)</th>
<th>Norway (b)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.9 (1998)</td>
<td>0.73 (1992/95)</td>
<td>0.76 (1992/95)</td>
<td>0.9* (1999)</td>
<td>1.0** (2000)</td>
<td>0.8* (2002)</td>
<td>3.6*** (1997)</td>
<td>2.80 (1992/95)</td>
</tr>
</tbody>
</table>

(a) Five Country Report.
(b) Jacobzone, 1999

Home health is included in the costs in Australia, Canada, Japan, Netherlands and Norway.

* Not including complementary long-term care assistance through the welfare systems.

** Includes long-term care assistance covered by the Community Long-term Care Insurance Law (0.36%), as well as institutional and home care services provided on an income tested basis by the health and social systems.

*** Includes other selected medical expenses that are also financed within the long-term care program.

In most countries that have implemented insurance-based systems, these systems have in part replaced existing sources of support. For example, in Germany, municipal budgets for long-term care have declined since the implementation of the SDI Law (Schneider, 1999; Cuellar and Wiener, 2000). In Japan, the infrastructure established by the insurance-based system has changed the locus of care of the elderly, who were previously treated in acute care hospitals financed by health insurance. Similarly, the long-term care system in Israel replaced the support provided by health plans and the Ministry of Health, which had been responsible for home care for the disabled elderly.

Another issue is what has been the trend in costs over time. This is interesting in countries that have implemented insurance-based systems against the background of the concern that the implementation of insurance based systems might lead to an ongoing dynamic of increased cost. Germany’s Social Dependency Insurance (SDI) Law did not incur a deficit in its first years of implementation. In fact, it produced surpluses, in part because more beneficiaries than expected chose cash payments, which are lower than the monetary value of in-kind services. In 2002, however, the program incurred a deficit and policy makers are still considering how to respond to this situation.

In the Netherlands, expenditures have continuously increased under the Exceptional Medical Expenditures Act (AWBZ). It has been suggested that this is a result of the transfer of numerous services to the AWBZ budget, and the concomitant decline in expenditures elsewhere in the health care system (Huijbers and Martin, 1998).
In Israel, contributions have proven insufficient to cover the cost of the long-term care program because of the rapid increase in the numbers of beneficiaries well beyond the projections. The resulting deficit is financed with surpluses from other branches of social security. Efforts are being made to identify the reasons for the rapid growth and address them. As noted, in 2003, the law was amended to decrease the number of hours of service permitted to a beneficiary.

Conclusions

1. The aging of the population and rising health care costs have elevated long-term care to an issue of national importance in most of the industrialized world. All industrialized countries provide some level of public funding for long-term care, and nearly all offer a broad package of services. To address increasing needs, all systems have undergone significant expansion, with a particular emphasis on the expansion of community care.

2. During the past decade, a number of countries have introduced LTC systems based on social insurance principles, proving an entitlement. This has served to expand the range of ways of providing LTC that are actually being implemented, and from which we can learn.

3. One consideration in choosing between an insurance-based and a non-insurance-based program is the philosophy regarding social service provision: that is, a preference for rights-based versus budget-constrained service provision. Countries that desire to protect access to social services in the political process will choose an insurance-based system, while countries that believe that such services should be flexibly adjusted to fit the overall budgetary situation will choose a budget-limited non-insurance based system. Moreover, as is true with health services in many countries, there may be a special interest in protecting long-term care from the exigencies of the budgetary process.

These considerations may be more important in periods, such as today, of the scaling back of spending on social protection, in general. This leads to pressure to contain public spending on long-term care services, as well. As these societies continue to age, the need for long-term care will only increase and the creation of a contributory tax for long-term care might be a politically feasible method of increasing the financing for long-term care services. However, countries with a tradition of maintaining generous social welfare benefits through general revenues may not feel the need to protect services from budget cuts. It may very well depend on the conditions specific to each country as to which type of system is conducive to maintaining LTC.
On the other hand, concern over the ability to control costs may lead a country to prefer a non-insurance based system. The only way to limit spending on an entitlement is to cut the level of benefits. In insurance-based systems, changes in the benefits package or eligibility criteria require changes in legislation, rather than administrative decisions. Consequently, they are subject to public debate, and are more difficult to effect, if the government encounters a recalcitrant legislature or significant opposition. By definition, this process is more protracted.

4. The comparison of the case study reveals that there are systematic differences in the characteristics of insurance-based and non-insurance based systems. Five main differences emerged.

- **Standardization** - Insurance-based systems place a great deal of emphasis on standardized eligibility criteria and benefits packages, both among applicants, and among geographic regions. Non-insurance based systems have less rigidly defined eligibility criteria, and allow a great deal of flexibility in the amounts and mix of services provided. Budget restrictions also create additional variation. Finally, the preponderance of mixed national and local finance and determination of eligibility and benefits leads to significant geographic variation.

- **Cash Benefits** – Insurance-based systems have been more open to introducing cash benefits in addition to, or in place of, in-kind services. In non-insurance based systems, the cash option is either not offered or is assigned a very marginal role.

- **Co-payments** – While all systems require significant co-payments for institutional care, non-insurance based systems more often include co-payments for community-based services. The co-payment itself is often on a sliding scale basis with income level.

- **Distribution of funds** – While no significant differences were found in the levels of expenditure between insurance-based and non-insurance based systems, there remain differences in the way the funds are distributed. In general, the non-insurance based programs tend to have a broader range of hours of care and less rigid restrictions on the level of disability required for eligibility.

- **Integration**: The non-insurance based systems reviewed have more integration between LTC and the general health system than the insurance based systems. Accordingly, there is also more integration between home health and home care in
these systems. In insurance-based systems, there is more integration between community and institutional LTC.

5. There are very significant cost differences between the systems. However, these systems are not necessarily correlated with the adoption of an insurance or non-insurance approach.

6. Countries use a range of methods to limit costs. Non-insurance-based systems have capped budgets as a primary mechanism for containing costs. In addition, they may seriously restrict eligibility through income tests. However, none of the examples in this monograph of non-insurance based systems restrict eligibility restrict services on the basis of income. They do employ other cost containment mechanisms. They tend to more liberally utilize co-payments (to share costs and limit utilization), and also utilize management of supply to control costs (e.g., limiting the number of beds in nursing homes). Insurance-based systems set minimum disability levels for eligibility and maximum benefit levels, and use co-payments for more costly services, such as institutional care. One of the concerns has been with the potential cost effects of providing institutional care on an entitlement basis. However, the insurance-based systems reviewed in this monograph have not necessarily led to higher costs even when institutionalization is included in the same program. This is accomplished through imposing high co-payments on the use of institutional care and offering more community care as an alternative.

7. The motivation for expanding LTC in many of the countries includes an interest in saving on the costs of other components of the service system. Thus, one of the expectation is that expanding LTC services will reduce acute hospital care. Similarly, expanding community care services is viewed as reducing the use of institutional LTC.

8. Fragmentation among LTC services and between LTC and the general health and social systems remains an issue in all the systems, with the possible exception of Norway. The trend has not been towards full financial integration into the health system, although there are various forms of administrative and service level integration. Integration among the various form of LTC provision is also very partial. Four of the eight countries have integrated institutional and community-based long-term care. There has been more of a trend towards more integration of home health and home care (six of the eight countries). The countries reviewed have employed various coordinating mechanisms and strategies to minimize the negative consequences of fragmentation.
9. There is a growing trend in both insurance-based and non-insurance based systems towards more inclusive systems that include all age groups and types of disability (cognitive, mental, physical).

As we have seen in this volume, this has been a period of major system reform, as well as ongoing efforts to modify the systems. In reviewing the experiences of these countries, there were very few formal evaluation studies that could be used to assess the impacts of the important changes that were made. More systematic evaluation of systems in general, and of specific programs, will help these countries to better develop their own systems, and make these experiences more accessible to countries that are just now beginning to develop long-term care systems.
Bibliography


