

# Caring For The Frail Elderly: An International Review

Faced with similar problems, these industrialized countries have taken different paths toward meeting the needs of their elderly.

BY MARK MERLIS

THE AGING OF POPULATIONS throughout the industrialized world has brought increased attention to long-term care needs. Although countries vary in the current size and projected future growth of their elderly populations, every country needs to plan programs to ensure that elderly persons can live in comfort and with maximum independence. To promote sharing of experiences in the arena of long-term care, the second Commonwealth Fund International Symposium on Health Care Policy in October 1999 brought together health ministers, other public officials, and policy analysts from five major English-speaking countries to review common concerns and innovative solutions. The symposium also examined care systems in two countries that have taken very different courses: Denmark, which has emphasized publicly funded community-based care, and Germany, which has adopted universal social insurance for long-term care.

Despite surface differences, the long-term care systems in the participating countries have many common features and problems. This overview of key shared issues is based on presentations made at the symposium. Several presentations appear in this volume of *Health Affairs*, so here I provide greater detail on the countries that are not represented by papers: Canada, Denmark, and the United Kingdom.<sup>1</sup>

## Financing Long-Term Care

Although every country considered here has universal medical coverage for the elderly—usually through the same system that covers the nonelderly—long-term care is often financed separately. When the national insurance programs were designed, long-term care consisted almost entirely of institutional services for indigent elderly persons. These services were excluded from the insurance programs and left for the state, provincial, or local governments to provide. Some division of responsibility persists to this day; only New Zea-

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land, and now Germany, have fully national programs.

Where responsibility is divided, the national programs tend to cover more intensive or skilled services, while localities provide custodial or supportive care. The British National Health Service (NHS) covers care in some geriatric hospital units and nursing services in the community; all other institutional and community-based care is financed by localities. In the United States Medicare was originally responsible chiefly for skilled postacute services, and Medicaid, for less intensive long-term care. In Australia the federal program provides home care to the most dependent persons, while state programs serve the remaining population. In all of these instances the boundaries have grown less distinct over time. Separate funding and delivery systems have led to duplication and inefficiency on the one hand and to service gaps and discontinuity on the other.

Partial reliance on local financing also means that access to services can depend on local financial capacity. Each of the English-speaking countries provides some national funding assistance for local programs: matching funds for states in the United States and Australia, block grants in Canada and the United Kingdom. Still, the assistance does not fully equalize resources, and the elderly may not have a guaranteed entitlement to long-term care in the same way that they do for medical care. Instead, each locality may make its own decisions about eligibility and the nature of the care provided.

In Canada, for example, no national standards exist. While federal assistance for the provincial health insurance programs is contingent on provinces' compliance with certain fixed principles, such as universality of coverage, no such strings are attached to long-term care funding. Recent budget surpluses prompted a discussion of national home care. However, the provinces preferred across-the-board increases in the combined health and social services block grants, which had been covering a steadily diminishing share of costs.

### **Public And Individual Responsibility**

Partly because long-term care programs evolved from programs that served the indigent, most countries still use some form of means testing for eligibility or require cost sharing that is much greater than that required for medical services. Of the systems examined here, only Germany's new program uses no means testing. (In Denmark the government and municipalities recently reached a preliminary agreement to support some income and asset tests for services.)

Some countries require people to exhaust most of their savings before they can qualify for some publicly financed services, while other countries impose much more modest income-based charges. In the United Kingdom all publicly funded long-term care, except

the very limited services provided through the NHS, is means-tested. Residents of institutions whose assets exceed £16,000 must “spend down,” that is, fund their own care until their assets are reduced to this level. Even more stringent spend-down requirements apply in the United States, while in New Zealand residents with sufficient assets pay almost the entire cost of their own residential care. In Canada, on the other hand, residents pay income-based charges but are not required to use their assets. A proposal in New Brunswick to impose spend-down requirements was dropped after meeting strong opposition. Similarly, in Denmark nursing home residents make payments that may not exceed 20 percent of income but are not required to spend assets.

One consequence of asset tests is that persons expecting to need services have incentives to transfer assets to relatives; this has been a continuing concern in the United States and has also been reported elsewhere. Another way of protecting assets is to obtain private insurance. Long-term care insurance, while still rare, is growing rapidly in the United States, and there is a nascent industry in the United Kingdom; not coincidentally, these countries’ policies place elderly people’s assets most seriously at risk. Finally, financial tests may mean that higher-income persons may obtain services outside the publicly supported system. In the United Kingdom nearly a quarter of institutional care is privately purchased.

Cost sharing tends to be less stringent for community-based services. In Canada services defined as “medical” are free, while sliding fees may apply for “support” services. Services are free for modest-income seniors in New Zealand, while in Australia clients contribute only about 10 percent of costs. In the United States home health services are exempt from the cost sharing required for most Medicare services. For Medicaid community-based services, on the other hand, eligibility rules are almost as stringent as for nursing home care; personal and supportive care may be available only to persons who impoverish themselves.

One reason that most countries require higher cost sharing for institutional services is that these services include housing, food, and other personal costs that persons living in the community must pay from their own resources. The United Kingdom is considering a proposal that would equalize treatment of the two populations. People in both settings would pay for their own food, accommodation costs, and “comfort” items, but personal and health care would be supported equally in both. Denmark already makes such distinctions. Australia also distinguishes between care and accommodation costs; the balance of public and individual shares in the two types of costs has been hotly debated in recent years.

## Balance Of Institutional And Community Care

As Stephane Jacobzone shows, rates of institutionalization have dropped in nearly every country.<sup>2</sup> At the same time, provision of home care has expanded to the point at which most people receiving formal long-term care services are now living in the community.<sup>3</sup> However, the connection between the two trends is not always clear. While New Zealand's spending for community-based care grew fourfold in the 1990s, overall provision of residential care has been stable. Greater home-care provision appears to have played a role in the slight drop in nursing home use in the United States in recent years, although further study is needed to fully explain the trends. The United Kingdom actually saw an explosion in use of institutional care in the 1980s, because of an initiative that allowed Social Security funding for private residential care; the effects of the recent abandonment of this policy are not yet fully evident.

In Denmark community-based services have more clearly replaced institutional care. A freeze on nursing home construction and an expansion of community-based services led to significant drops in institutionalization in the 1980s and early 1990s. Whereas 20 percent of persons age eighty and older were in nursing homes in 1982, only 12 percent were by 1996; among all persons age sixty-seven and older the rate dropped from 6.6 percent to 4.6 percent. The savings have been sufficient to allow provision of community-based services to nearly a quarter of all elderly persons, while long-term care spending dropped from 2.6 percent of gross domestic product (GDP) in 1982 to 2.3 percent in 1994.<sup>4</sup>

Even when utilization rates for institutional services have declined, spending for these services may not have dropped proportionately. Canada has reduced nursing home beds, both in absolute numbers and in proportion to the population. However, the population remaining in institutions is more severely disabled and requires more care. At the same time, strict standards for nursing home admission have left a highly disabled population in the community. Further pressure on the system is created by sharp reductions in inpatient hospital stays; priority in home care is shifting toward postacute services and away from long-term care. The result may be that community-based services for highly dependent persons crowd out services for persons with fewer disabilities. A study conducted in Moncton, New Brunswick, and in Montreal found that 56 percent of elderly persons requiring assistance with a high level of instrumental activities of daily living (IADLs) were not getting all of the help they needed.<sup>5</sup>

Similar concerns about targeting community-based care have

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arisen elsewhere. Programs with limited budgets can focus on the most dependent persons, providing extensive services to prevent institutionalization —perhaps even if institutionalization would actually be less costly. Or they can seek to meet the needs of a larger number of elderly persons, at the risk of underserving the most disabled. Most countries seem to have focused on those needing the most intensive services. In the United Kingdom it was once alleged that localities tried to provide a little service to every voter; now services are focused on more dependent persons. The result is tight access, waiting lists, and a turn to the private sector by higher-income persons. Budget limits in New Zealand also have meant that the most dependent receive priority. Even Germany’s new system, although it insures everyone, actually provides benefits only to those meeting fairly strict functional status tests.

Targeting in the United States is somewhat paradoxical. Medicare home health care is available at no cost to the beneficiary, and recent reimbursement changes may encourage agencies to serve the least disabled. Strictly means-tested Medicaid services, on the other hand, are often available only to a few severely disabled persons. One consequence is that one in five community-dwelling adults with long-term care needs in 1994 reported some unmet need.<sup>6</sup>

## **Assessment, Care Management, And Quality Assurance**

A corollary of efforts to target services is the development of systems to assess clients’ needs and coordinate services. Every country has adopted some form of screening before admission to institutional care, usually with the aim of diverting applicants to community-based care; assessment for community care is less general. Australia and New Zealand have taken limited steps toward uniform assessment systems and the use of multidisciplinary teams for service planning. In the United Kingdom assessment tools, criteria for assistance, and available services vary by locality, as is true for Medicaid.

Of the countries examined here, Denmark has the most comprehensive system of assessment and management. Everyone age seventy-five and older is entitled to at least two preventive visits a year from a municipal worker, to evaluate needs and assist with planning for functional independence. Those in need of formal care are assessed by a home care manager; the manager develops a care plan,

which amounts to a quasi-contractual specification of needed services. These contracts in effect replace municipal discretion in service delivery with an entitlement. There have been concerns that some municipalities use automatic criteria, rather than individual evaluations, to plan services. However, service allocations can be appealed.

An alternative to case management is to allow clients to oversee and arrange their own care within a fixed budget. In Germany's new program 76 percent of community participants use the cash payout option, under which they choose their own services and providers. Community beneficiaries in Nova Scotia may opt to receive the cash equivalent of the expected costs of the services they are expected to need after assessment. Demonstration projects in the United States are testing a similar approach.

For quality assurance, there have been some shifts from external review of institutional services toward contractual or cooperative regulator/provider efforts. In New Zealand quality expectations in such areas as client satisfaction and outcomes are written into service contracts with institutional providers; while enforcement has varied, many providers have developed internal quality assurance programs. In Australia compliance with outcome standards for residential care is assessed by regulator/provider teams.

Assuring quality of home-care services has proved to be more difficult: There are no facilities to inspect, nor can clients easily be examined, and there is a wide range of types of services and providers. There are concerns about untrained, casual providers and possible neglect or abuse. Australia and New Zealand report some progress in developing national standards and assessment systems.

## **Integration**

The boundaries between acute and long-term care, or between different levels of community-based care, often are fuzzy. Because responsibility for funding different types of care is often divided between national and local governments, and budget concerns apply at both levels, incentives exist for one program to shift potentially costly clients to the other. Some Medicaid programs seek to maximize clients' use of Medicare home health benefits. In Australia the federal/state general home-care programs may shift some clients to special federal programs for the more dependent. Differential cost sharing for different services also may lead to boundary disputes; in the United Kingdom, where hospital care is free under the NHS, geriatric patients and localities may resist transfer to residential or community settings, where patients and local governments must bear the cost. Denmark has adopted an interesting solution to cost

shifting between municipalities, which cover long-term care, and counties, which cover hospital care. A municipality must pay the county if patients must remain in the hospital because needed long-term care is unavailable.

There also are concerns about inadequate coordination of services. Although many countries have programs to coordinate the full spectrum of social services, less progress has been made in integrating acute and long-term care. The United States has perhaps been most active in this area, experimenting with health maintenance organization (HMO)-like programs that merge Medicare and Medicaid funds and services. In Canada, Alberta has also experimented with a capitated HMO-like model, while Quebec has developed programs under which community primary care centers assume the responsibility for managing the full spectrum of health and social care. These programs are not yet capitated, but the plan is that they will mature into systems assuming full financial and care responsibilities for all the frail elderly persons in a given neighborhood. The United Kingdom has considered proposals under which primary care groups (PCGs) would manage both NHS and long-term care services for their enrolled populations.

More globally New Zealand has shifted funds for disability support services from the social welfare to the health budget, while Germany's new program is administered by the same private sickness funds that administer medical benefits. In both cases, however, budgets for medical and long-term care remain distinct, even as managerial responsibility has been merged. Thus, opportunities are missed for achieving efficiencies across sectors. For example, greater provision of rehabilitation services can reduce later need for long-term care. But in both countries this would mean spending from the medical budget to achieve savings in the long-term care budget.

Finally, there have been a number of experiments with vertical integration of services within the long-term care sector, to promote "aging in place" and sharing of professional services. In the United States continuing care communities provide apartments, assisted living, and nursing home care in a single location; residents move among settings as their needs change. In Denmark integrated programs combine nursing home and adult day-care services with sheltered housing; nursing home staff serve residents in all of the settings. Similar systems are emerging in New Zealand.

## **Family Caregiving**

Most elderly people in the community are cared for informally by family members, friends, or neighbors, with or without supplementary formal care.<sup>7</sup> While it is difficult to place a value on these

services, it is clear that public spending would be much greater if informal help were not available. As a result, most countries have taken measures to promote or support informal caregiving.

In Germany community-care beneficiaries who choose the cash option may use the money to pay for services from professionals and others, including family members. Some countries pay family caregivers directly, partly in recognition of the fact that they may be forgoing employment earnings. In Australia, however, the payments are set too low to replace salaries. Denmark actually bases allowances on caregivers' previous earnings, but the program is limited to persons caring for the terminally ill and has been little used.

A more common form of support is respite services, which allow family members a break from caregiving. In Germany up to four weeks are allowed, while in Australia short-term admissions for respite care are estimated to account for as many as 40 percent of all residential care admissions. Other services for caregivers may include information and education efforts; Australia's caregiver package has recently been emulated in the United Kingdom.

One issue faced by some community-based programs is whether the availability of family caregiving should be considered in allocating services. Germany decided not to include this factor in its assessments, on the grounds that it should be irrelevant in distributing an insurance benefit. In Denmark needs assessment considers the presence of a spouse but not the availability of help from children.

## Challenges For The Future

Although long-term care costs for the elderly will rise considerably with population aging, the burden is not unsustainable. Even with no further decline in the prevalence of disability, public long-term care spending in most countries will remain around 1 percent of GDP.<sup>8</sup> At least in the next two decades the major challenge for policymakers will not be finding the money to pay for long-term care, but using available resources more equitably and effectively.

Long-term care systems everywhere are evolving in the direction of greater emphasis on community-based services and more involvement by participants and their families in planning and choosing services. Despite progress, more needs to be done, and innovative solutions are urgently required in several areas.

■ **Equity.** As recent, highly contentious debates in several countries suggest, striking the right balance between public support and individual responsibility can be politically difficult. This issue may become more pressing if income-security programs are allowed to erode and the elderly are less able to contribute to their own care.

■ **Quality.** Although advances have been made in monitoring and

improving institutional care, assuring quality of community services remains a concern. In addition, there is a need for practical measures that can assess the performance of the entire system in maintaining independence and functional status.

■ **Integration.** Experiments in merging medical and long-term care delivery are still in their infancy and have focused chiefly on elderly persons who are already very frail. Models are needed that can serve a broader population and coordinate early medical and social interventions to promote maximum functioning.

■ **Supporting informal caregiving.** Policymakers must find ways to relieve and support overburdened caregivers while avoiding incentives to shift care unnecessarily to the formal sector.

PERHAPS A GREATER CHALLENGE than restructuring the way in which care is financed and delivered is finding ways to reduce the need for care, by promoting healthy aging and giving greater priority to prevention. Many chronic illnesses are not preventable, at least so far, but their debilitating effects can be reduced through secondary prevention and rehabilitation. Once again, closer integration of health and social services is essential to achieving this goal.

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## NOTES

1. Presentations for these countries were François Béland and Evelyn Shapiro, "Community and Long-Term Facility Care in Canada"; Jørn Henrik Petersen and Tine Rostgaard, "Delivery of Long-Term Care to the Elderly in Denmark"; and Howard Glennerster, "Long-Term Care Financing and Delivery: United Kingdom."
2. S. Jacobzone, "Coping with Aging: International Challenges," *Health Affairs* (May/June 2000): 213-225.
3. G.F. Anderson and P.S. Hussey, "Population Aging: A Comparison among Industrialized Countries," *Health Affairs* (May/June 2000): 191-203.
4. Petersen and Rostgaard, "Delivery of Long-Term Care."
5. Béland and Shapiro, "Community and Long-Term Facility Care," citing François Béland, "Soins de Longue Durée: Création d'un Système Intégré" (Presentation at the annual meeting of l'Association Canadienne de Gerontology, 1998).
6. J. Feder et al., "Long-Term Care in the United States: An Overview," *Health Affairs* (May/June 2000): 40-56.
7. Anderson and Hussey, "Population Aging."
8. Jacobzone, "Coping with Aging."