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Editorial

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Examining Some International Trends in Long-Term Care Services Policy for the Elderly

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Globally, national policies regarding long-term care are a mixture of “embedded” policies and trans-national trends. Health and related long-term care policies are “embedded” in situations that are unique to specific countries. The specific contexts of such policies include many aspects such as demographic characteristics, socio-cultural factors, governmental organization and political circumstances. These factors create existential limits to choices to some extent that are termed “path dependency” or “sunken costs.” Such path dependency shapes the trajectory of emerging health and related long-term care policies.

Nevertheless, in many respects, long-term care policies in industrial/post industrial countries face similar problems arising from the aging of populations, biomedical and medical technological advances, as well as relatively limited “options” in seeking to deal with specific issues. Thus, globally nations seek similar goals such as social equity and access, quality of care and cost/benefit efficiency. Regarding the need for cost/benefit efficiency, a Swiss federal official in 2008 noted that long-term care is increasingly a significant factor regarding health care costs. He observed that: “Financing of long term care ... [forms] a growing pressure on public finances and tends to overload the financial burden of health insurance… some projections indicate a growth of 77 % of the long term care costs between 2000 and 2040 [will be due to] … population aging” [1]. In the process of seeking the goals we have noted globally policy learning and the transfer of ideas occurs between countries.

Nations provide “a mix” of home-based, community-based and institutional care services. The organization and provision of such care is shaped by the type of health care system within which such care is embedded. This often involves a mix of public and private services. In this context, funding and organizational issues are important factors. Also, significant is the degree to which support is provided for the substitution of institutionally-based care services by formal and informal home care and community-based supports for home care. Another dimension that is important regarding long-term care services is the interface between formal and informal care.

An important element in the development of social policies is the extent to which it ameliorates the “social exclusion” which may be experienced by the elderly in relationship to the rest of society. Tim Blackman has noted that: “Older people - vulnerable to age discrimination and dependency on others, often regarded as ‘non-productive’, and often isolated by immobility and a decline in social networks [2] - are clearly at risk of the multi-dimensional impact of social exclusion” - and Jongmin Shon and Howard Palley have noted that this may have contributed to the sharp rise of suicides among the elderly in the Republic of Korea [3].

This phenomenon is found in both European as well as Asian societies. Increasingly, particularly in industrial/post-industrial societies, this is a universal problem the response to which is often “embedded” in particular national approaches. Indeed, a study of elderly residents in Jerusalem, Israel found that perceived social support was a more important predictor of health than were measures of network structure.

In two Scandinavian nations where long-term care for the elderly has been addressed, Norway and Denmark, a study indicated that between one fifth and one fourth of persons aged 65 and over were receiving organized social care services funded entirely by taxation and allocated according to assessed need. Norway had a greater tendency to utilize nursing and residential homes in comparison to Denmark which has had a greater emphasis on in-home and community-based care services. However, Norway too has increasingly emphasized home and community-based services. On the other hand, in Greece, Ireland and especially the south of Italy (the Mezzogiorno), there are extremely low levels of publicly-funded institutional and domiciliary care and family members have the main responsibility for meeting the needs of older relatives

While publicly funded social care services are available in principle to all in the United Kingdom’s predominant population unit, England, in practice such services are concentrated among those with low incomes. Other needy elderly often do not apply due to high personal charges - either not utilizing services or utilizing often less expensive and mostly unregulated private services. While the U.K.: England obligates local authorities to assess elderly persons in need of social care services regardless of income (in the same way that local authorities are so obligated in Norway and Denmark), in England, there is less funding available for such services and a greater amount of means test related charging for such services.

Nevertheless, in England, Norway and Denmark, there is a “single access point” for decision-making about eligibility for publicly-funded services. Also, “care management” or “case management” is part of the implementation process in these three countries with a single professional taking responsibility for organizing the delivery of services to older persons. In Greece, Italy and Ireland, the role of the state in these areas is minimal and discretionary. In these countries, virtually all social care is provided within the family and women are increasingly pressured by employment roles and family obligations which are resulting in declines in fertility levels which will increasingly lead to shortages of family caregivers.

Denmark is often viewed as an exemplar of social care services for the elderly. In Denmark, a policy of allowing the elderly to remain in their own homes as far as possible has been nationally established. Denmark has engaged in an extensive building program of sheltered housing and house modification for older people plus a policy of closing “surplus” nursing homes. Care services have been focused increasingly on supportive personal care/home help services rather than “upkeep” services involving home maintenance.

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In Denmark, there is some "disjunction" between the counties which are responsible for medical and hospital services and municipalities which have the statutory duty to offer home help for both domestic and personal care, sheltered home dwellings, adapted dwellings, nursing homes and day care services. However, social and health service organizations seek to achieve coordinated care by forming integrative staffing units in substantial portion of its communities. Community-based social care is free of charge; day centers offer recreation and rehabilitative services without charge following professional assessment; the loan of equipment and the provision of meals involve modest charges. Not-for-profit organizations, as well as some for-profit organizations have contractual agreements with the municipalities for delivery of some social care services.

Since implementation of social care policies occurs at the municipal level, there exists variability of service delivery at this level. For instance, a 2005 report indicated that in the 25 percent of municipalities with the lowest number of nursing home placements, 9 percent of the older population received assistance in the evening and 4.7 percent during the late night. However, in the 25 percent of municipalities with the highest availability of nursing home units, 5.7 percent of the elderly received evening care and 2.1 percent received late night care. A few municipalities had closed all of their nursing homes and were providing services to the elderly only in community-based independent dwellings. In another area, increasingly home help services were being "contracted out" at the municipal level to private firms which may be either not-for profits or for-profits. Similar trends in services delivery occurred in Norway. The United Kingdom: England, Austria, Denmark and some regions of Italy provide a variety of mechanisms and initiatives that encourage family and informal caregivers to organize the care of older people at home.

In Denmark and Norway, services are usually provided for any elderly person needing assistance. In the United Kingdom, services beyond a very basic level are delivered only in times of crises and they have been criticized by the Report of the Royal Commission on Long Term Care for being inadequate and means tested. However, since that Report, National Health Service circulars to some extent addressed this problem by recommending an emphasis on care in the community that combines social and medical services. These circulars recommend that for elderly persons recovering from an acute medical incident, care be coordinated by an "intermediate care coordinator who would be responsible for delivering nationally required intermediate integrated care". Such care would be provided by interdisciplinary working teams that would include a physician, a speech and language specialist, a social worker, a psychologist, an orthodontist, a nurse, an occupational therapist, a physiotherapist, a dietician and other relevant health care professionals as needed. Also more recent studies of European countries have emphasized the centrality of case management as a mechanism for coordinating long-term care needs of the elderly and the disabled. projects,

Some underlying themes having a somewhat different emphasis in these varied national long-term care policies are a concern with safety and quality of care, a continuing concern with adequate nursing home care and residential care facilities plus an increasing emphasis on home and community-based care. In some countries (the Netherlands and the U.S.) a "two class" system has developed in terms of utilization of publicly subsidized long-term care services. While in Scandinavia, benefits to long-term services emphasize collective entitlement, the Japanese system partially emphasizes this entitlement while leaving substantial costs to be met by clients and substantial care burdens by informal caregivers. These cost burdens and care burdens are somewhat greater within the German system.

Some International Comparisons and International Issues:

Austria and the Netherlands are countries that have been very successful in moving funding in order to emphasize in-home and community-based care, However, in most countries public expenditures still weigh heavily toward institutional care.

Some national policy approaches for improving the achievement of a continuum of care have included the establishment of joint assessment teams of geriatricians and social care staff in Australia, Japan and the Netherlands; improvements in care management approaches (Japan and the U.K.) and the integration of responsibility for long-term care at a single governmental level or in a single agency (New Zealand, Sweden and the U.K.). Some consumer directed initiatives that characterize international long-term care policy include personal care budgets for spending on care assistants (the Netherlands, some U.S. states, and the U.K.); payments to persons needing care to spend as they wish (Austria and Germany); and payments to informal caregivers to replace employment income (Australia, Ireland and the U.K.). Also, different financial patterns are followed for institutional long-term care and home-based care. For instance in Switzerland, financing for institutional care for the elderly is divided in the following manner: about a fifth of revenue expenditures come from health insurance, 5 percent from old age and survivors insurance, about 16 percent from the supplementary allowance for old-age insurance, and about 9 percent from cantons and municipalities. A substantial amount of revenues comes from private households and a small amount from other sources. Public sources of revenue cover home care more thoroughly. Internationally there was a trend towards the development of outcome measures and the institution of comprehensive structural "quality frameworks".

Some general global concerns of long-term care policy in industrial/postindustrial nations are: Seeking measurements and standards of quality of care; as well as providing an increasing degree of in-home and community-based care rather than institutional care and an increasing emphasis on case management of services. Another major trend in a number of national programs is increasing the extent of patient "self-management" of services. Still another area of concern is achieving a high degree of coordination of health and long-term care services. In addition, there exists an internationally recognized need for the systematic collection of relevant data in order to further rational public policy development with respect to the long-term care needs of the elderly. As Jeffrey Sachs has noted: "Communications technology makes possible seamless linkages that were [until recently] unimaginable …"[4].

Long-term care program initiatives are "refracted" in a variety of national social policy contexts. They have been developed on a federal/state/local basis in Australia, the United States and Germany. They have been dealt with structurally on a national/local basis in New Zealand, Denmark, Norway and Sweden. Sweden has increased the targeting of services to the more sick and disabled. It has also required greater use of private resources - either through buying of private services or the increased use of family services for those with lesser disabilities. Long-term care policy for the elderly in Germany, Japan and the Netherlands occurs within the framework of these nations' social insurance systems. In the United States and the United Kingdom, these services are generally means tested and

largely contracted-out to the private sector - to both proprietary and voluntary agencies. In the United Kingdom, since 2001, reforms have reduced the impact of means testing for institutional care - without ending such care and national guidelines were issued to encourage greater consistency between local governments in charging for home care. In the Nordic countries, such services are mainly delivered through the public sector. Nevertheless, every nation utilizes a mixture of public and private resources in the delivery of long-term care services. Universality in provision of services characterizes the delivery of services in the Nordic countries, Germany and Japan. Also, while services are theoretically available on a universal basis in the Netherlands, in reality, in some areas, they are utilized primarily by the poor elderly.

Funding, methods of assessment, and organizational developments tend to follow unique national patterns - which are affected by "embedded" historical and political contexts. In a "global context" where communication at international conferences and seminars and e-mail communication have become "natural phenomena", trends such as an increased emphasis on home and community-based care and an increased concern with quality assessment have become international.

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