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LONG-TERM CARE

Other Countries Tighten Budgets While Seeking Better Access

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The Honorable David H. Pryor
Chairman, Special Committee on Aging
United States Senate

The Honorable William S. Cohen
Ranking Minority Member
Special Committee on Aging
United States Senate

This report, prepared at your request, examines long-term care reforms in Canada, Germany, Sweden, and the United Kingdom. Our report specifically addresses how these countries attempt to control long-term care spending while responding to individuals' needs for services.

As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from its issue date. At that time, we will send copies of the report to interested congressional committees and other interested parties. We will also make copies available to others upon request.

This report was prepared under the direction of Mark V. Nadel, Associate Director, National and Public Health Issues. If you have any questions, Mr. Nadel may be reached on (202) 512-7119. Major contributors to this report are listed in appendix II.

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Executive Summary

Purpose

The aging of our nation's population and rising health care costs have elevated long-term care for older Americans to an issue of national importance. In the United States, the number of people age 65 and older will exceed 20 percent of the total population by the year 2030, up from 12.5 percent in 1990. Public and private spending for long-term care has risen dramatically over the past 10 years—exceeding $100 billion in fiscal year 1993—and is projected to continue this upward trend. At the same time, there is considerable consumer dissatisfaction with the cost of and access to this care.[1]

To varying degrees, other countries also face aging populations, cost pressures, and service delivery problems. As part of their long-standing health and welfare systems or through recent modifications, these countries are trying to address the difficulties of providing long-term care benefits. To examine these efforts, the Chairman and Ranking Minority Member, Senate Special Committee on Aging, asked GAO to review the provision of long-term care services in Canada, Germany, Sweden, and the United Kingdom. Specifically, GAO examined (1) the financing and cost-containment measures these countries use to control public spending for long-term care and the (2) administrative and delivery approaches the countries use to expand the range of and access to services.

Background

Long-term care is shorthand for a wide array of services for the elderly and the chronically ill or persons of any age with disabilities. The services range from the treatment of chronic illnesses to housekeeping and personal care assistance, such as bathing and grooming. They are provided in nursing homes, at home, or at community facilities.

In the United States, numerous federal, state, and local programs are available to fund and deliver long-term care services, but individuals often have trouble gaining access to services. Many people are not aware of available services; others find that services are unaffordable and that eligibility criteria for publicly provided or subsidized services vary among agencies and programs. The drain on an individual's resources to finance long-term care is also common. In the case of nursing home care, for example, the Medicaid program requires that individuals "spend down," or deplete, most of their assets before becoming eligible for Medicaid assistance.

[1]Long-Term Care: Demography, Dollars, and Dissatisfaction Drive Reform (GAO/T-HEHS-94-140, Apr. 12, 1994).

The countries reviewed have faced access barriers and service delivery problems resulting from circumstances similar to those in the United States. Responsibility for long-term care has been fragmented among many agencies and providers; some countries have had strict financial criteria to obtain public assistance for long-term care; and most public funds have been spent on expensive institutional care.

Like the United States, these countries must also handle aging populations and rising government spending on long-term care. In 1990, 18 percent of Sweden's population, almost 16 percent of the United Kingdom's population, and 12.5 percent of the U.S. population were over age 65. Between 1980 and 1990, national welfare spending on nursing home care rose two and a half times in Germany, over two times in the United States, and from virtually nothing to $2 billion in the United Kingdom as a result of 1983 legislation providing government support of residential long-term care.

In recent years, the Congress has considered numerous proposals for reforming the financing and delivery of long-term care services. As originally introduced, the Health Security Act of 1993 included a new federal-state program sponsoring home and community care. Key features of the legislation were similar to reforms undertaken in the countries reviewed.

Results in Brief

Like the United States, other countries are pursuing competing goals for long-term care: to contain public spending while enhancing access to services, particularly home and community care. To contain spending growth, the countries reviewed are applying global or capped budgets (limits on public spending) to long-term care expenditures and have strengthened other controls, such as cost sharing, fee negotiation and rate setting, and management of nursing home bed supply. Germany is in the process of developing a budget expressly for long-term care spending, while certain Canadian provinces, the United Kingdom, and Sweden have recently given local governments fixed budgets to fund nursing home care or home and community services.

Limited budgets have prompted the countries to seek ways to deliver services more efficiently. One method is to decentralize and consolidate responsibility for long-term care. Sweden, the United Kingdom, and several Canadian provinces have empowered single local government agencies to administer services, creating a "one-stop shopping" or single

point of entry approach for long-term care services. These agencies rely increasingly on case management to assess needs, coordinate the health and social services components of care, and allocate resources. Germany has invested its sickness funds—its nationally regulated insurers—with the responsibility for administering long-term care benefits.

In addition, the countries have instituted, or plan to institute, one or more of the following features:

- eligibility based on functional rather than financial need;
- emphasis on home and community care rather than the more expensive institutional care, where appropriate; and
- support for family members and other informal caregivers through financial or other benefits.

Whether the countries can broaden the pool of individuals eligible for public benefits, develop and encourage home and community services, and support informal caregivers within existing budgets remains to be seen. Of the countries reviewed, only Germany will add new funds ($7.3 billion annually) to expand long-term care coverage and benefits. Using existing funding levels, the other countries hope to expand access through some combination of a reallocation of funds among sectors and greater efficiency in service delivery. Officials in some countries are skeptical, however, about the likelihood of expanding services without also increasing expenditures. If public budgets are not adequate, officials fear that governments may raise cost-sharing requirements to a level that exceeds the means of many people, resulting in having to either deny access to services or make services dependent on means testing.

For Sweden and certain Canadian provinces, where universal health care coverage has traditionally included certain long-term care benefits and reforms include reallocation of funding, there is potential to cover a greater array of services while controlling cost growth. Expansion of services also appears feasible in Germany, where additional taxes will be used to pay for long-term care. In the United Kingdom, however, concern exists that recent efforts to reorganize the financing and delivery of long-term care without explicitly increasing resources may not improve access to services.

Principal Findings

Countries Put Long-Term Care on a Budget

Until recently, Germany and the United Kingdom provided benefits largely through welfare programs with uncapped entitlements. The United Kingdom has just put long-term care benefits on a fixed budget, and Germany plans to do so in 1995. Germany intends to cap spending by tying spending growth for long-term care to growth in the payroll taxes used to finance care. The United Kingdom, basing its long-term care budget on existing funding levels, has temporarily restricted the amount of money local authorities can raise through imposing taxes.

In Canada, many provinces are increasing support for long-term care by reallocating funds from acute care. However, to control costs of long-term care, provinces are also beginning to fix spending for certain services. For example, British Columbia has set a global budget for nursing home care, and Ontario has capped the budgets for locally administered home and community care. When Sweden recently consolidated the responsibility for financing long-term care within its municipal governments, it temporarily restricted municipalities' authority to raise taxes for all public services. This restriction implies that long-term care spending can only increase at the expense of other services.

Critics of the new budget reforms are concerned that spending limits could create shortages of services or discourage delivery innovations. They also cite the need to conduct periodic assessments of the population's long-term care needs to develop appropriate funding levels.

Countries Stress Cost Sharing, Other Controls to Stretch Limited Public Funding

Except for Germany, the countries reviewed are generally unwilling to commit new funds to expand access and coverage for long-term care, as suggested by the spending limits recently imposed. Countries are therefore asking individuals to pay out of pocket—or share costs—usually in the form of copayments based on ability to pay.

Germany, Sweden, and some Canadian provinces separate the costs of institutional care into a lodging component and a care component. Public funds generally pay for care, while the individual generally pays for lodging. Under recent reforms to be implemented in 1995, Germany has not established guidance on what constitutes care as distinct from lodging, giving payers and possibly providers the incentive to shift as much of the

care costs as possible to the individual. If the individual's cost-sharing requirements make services unaffordable, more people then become eligible for public assistance, with welfare remaining a major source of funds for nursing home care. In the United Kingdom, cost sharing for nursing homes is set centrally while requirements for other services are established locally. Under tax-raising restrictions, local authorities anticipate growing cost-sharing requirements that could result in pricing long-term care services beyond the reach of individuals of modest means. In Sweden, despite traditionally heavy government subsidies of long-term care, recent limits on municipalities' authority to raise taxes lead officials to expect additional cost-sharing requirements.

The countries' new budget limits underscore the importance of other cost controls. Governments will continue to set prices for services either independently or through negotiations with providers. Officials report that budget concerns will likely result in greater efforts to limit prices, raising fears that low prices may require providers to compromise on quality. Governments will also continue to control the supply of beds in nursing homes and other institutions to limit use.

Countries Seek to Enhance Access Through Decentralization and Consolidation

In the United Kingdom, Sweden, and certain Canadian provinces, responsibility for long-term care, which was previously divided among many agencies and governmental levels, has been decentralized and consolidated at the most local levels of government. Now individuals can seek access to services through single local agencies. In the United Kingdom, for example, local authorities are newly responsible for determining the community's long-term care needs. The intent is for case managers—generally a team of health and social service professionals—to assess individuals' needs and obtain the appropriate mix of services that are available from various public and private organizations providing care. Similar arrangements exist in Sweden and the provinces of British Columbia and Ontario.

Germany's fragmentation of home and community long-term care among various private organizations has created uneven access to services across geographic areas. When reforms are implemented in 1995, Germany will mandate that its 1,200 sickness funds, which currently reimburse providers for acute health care services, provide a standard package of long-term care benefits.

Countries Broaden Eligibility by Making Functional Need Top Criterion

Under countries' new arrangements for administering long-term care, an individual's eligibility for services is not intended to be based on ability to pay. By contrast, in the United States, Medicaid provides financial assistance for long-term care only to individuals with few financial assets. The program tests people's financial means to determine eligibility for benefits. Although this is true for Germany now, coverage for long-term care benefits—both nursing home and home and community care—will be provided through insurance in 1995, making financial need a consideration only for services not covered by the standard package of benefits.

Sweden and certain Canadian provinces have traditionally provided long-term care services on the basis of functional need—that is, a person's ability to perform self-care functions such as bathing, grooming, and housekeeping. In the United Kingdom, functional need is expected to be the local authority's first consideration in providing benefits, but officials are concerned that fixed budgets may require the agency to apply some form of means testing once it makes an initial functional need assessment.

Countries Seek to Cultivate Home and Community Care Services

For the countries reviewed, most public spending on long-term care has supported institutional—largely nursing home—care. In cases where care needs are modest or family caregiving is available, care provided at home or a community facility is generally more economical than nursing home care.

The German reforms to be implemented in 1995 explicitly endorse the use of home and community care. The legislation states that, to the extent possible, individuals requiring long-term care should be able to live at home. Similarly, a stated goal of U.K. reforms is to improve access to services, including home and community care. Local officials are doubtful, however, that public support for these services will expand significantly with the use of only existing funds. British Columbia has begun reallocating funds from its global budgets for physician and hospital services to spending for home and community services. Ontario's goal is to increase public spending on home and community care by 1997 from 20 to 30 percent of all long-term care spending. Sweden, which already spends 35 percent of its long-term care resources on home and community care, has recently expanded services in this area, providing a wider variety of home nursing, personal care, adult day care, supportive housing, meal, and transportation services.

Some Countries Encourage Informal Caregiving

To stretch public resources and compensate families for the burden of providing long-term care at home, countries provide various financial benefits to family caregivers. Germany's reforms will enable individuals to receive cash benefits to pay family members and others for providing long-term care services. In addition, unpaid informal caregivers will be entitled to certain employment benefits, such as public pension credits. Sweden requires employers to grant up to 30 days of paid leave for providing home care. Sweden also pays salaries to family members who give full-time or part-time care. Under 1992 reform legislation, the national government expected to provide municipalities additional funds to support informal caregiving.

Implications for Long-Term Care Reform in the United States

Observations made on other countries' efforts to expand access to a broader range of long-term care services while keeping public costs manageable may help inform policy decisions in the United States. It is too soon to judge the outcome of countries' recent reforms, but it may be useful to recognize certain common themes in their approaches to controlling costs and administering services:

- Fixed budgets or spending caps, coupled with other controls, may control costs but could also threaten access.
- Consolidating the administration of long-term care should make service delivery more responsive to the individual.
- Increased public support for home and community care should improve individual satisfaction with services while avoiding costly institutional care.

Mindful of the foreign experience, the United States will want to deliberate on the division of responsibility between the public and private sectors and the appropriate role of these sectors in both the financing and the delivery of care.

Recommendations

GAO is making no recommendations.

Agency Comments

GAO obtained comments on this report from long-term care experts and from selected officials in each country studied. Their suggested revisions were incorporated, as appropriate, into this report.

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Related GAO Products

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Abbreviations

CAP	Canada Assistance Plan
DM	deutsche mark
GDP	gross domestic product
HHS	U.S. Department of Health and Human Services

Chapter 1

Introduction

The aging of the population and the escalating cost of providing services has made long-term care—nursing home services and home and community-based care—a critical public policy issue in the United States. Demographic trends point to a significant rise in the number of frail elderly in need of long-term care.[2] At the same time, the supply of family and friends who currently provide most of the long-term care informally, or on an unpaid basis, is expected to decline.

Numerous federal, state, and local programs fund and administer various long-term care services and serve a large portion of the population in need of care. Not all those who need care, however, have access to appropriate or preferred services or an adequate means to pay for them. Individuals and their families must either make substantial contributions to pay for their care, deplete income and assets to qualify for public assistance, or simply do without needed services.

Other countries are also experiencing aging populations, rising public costs for long-term care, and service access problems. In response to these concerns, some countries are modifying their existing systems or overhauling their systems of financing and administration. Accordingly, the Chairman and Ranking Minority Member of the Senate Special Committee on Aging asked us to examine recent reforms as well as traditional mechanisms for financing and delivering long-term care in Canada, Germany, Sweden, and the United Kingdom. This review examines the countries' controls for containing public spending and strategies for enhancing access to services.

Long-Term Care Reforms Being Considered in the United States

Long-term care encompasses a variety of services ranging from therapeutic interventions for the treatment and management of chronic illness to assistance with basic activities of daily living, such as bathing, dressing, and other personal care needs. These services are needed by individuals who have lost some capacity for self-care due to chronic illness or physical or mental conditions that result in both functional impairment and physical dependence on others for an extended period. Major subgroups of individuals needing such care include the frail elderly, those with physical or developmental disabilities, and those with cognitive impairments. Health and social service professionals are the formal providers of care; family and friends are the informal caregivers. Services

[2]Persons in need of long-term care include not only the frail elderly but also younger persons with chronic disabilities.

are delivered in institutions (primarily nursing homes), the community, or the home.

In the United States, public spending for long-term care primarily supports institutional—largely nursing home—care and is increasing rapidly. Multiple agencies and various levels of government and the private sector share responsibility for funding and providing care. At the federal level, Medicaid is the largest program providing support for long-term care services.[3] Other federal programs include Medicare, the Social Services Block Grant, the Older Americans Act, and the Rehabilitation Act. In addition, a number of state and local programs fund long-term care services.

Despite high levels of public and private spending, which exceeded $100 billion in 1993, considerable dissatisfaction exists with the current financing and delivery of long-term care. Many people find services costly, difficult to access, and not matched well with individual needs and preferences.[4]

Over the years, the Congress has considered numerous proposals for reforming the financing and delivery of long-term care. Proposals have ranged from social insurance programs that would provide universal coverage to other programs that would limit federal support to tax incentives for the purchase of private long-term care insurance.

Most recently, the Health Security Act of 1993 proposed several long-term care reform provisions, including a new federal-state program sponsoring home and community care. Federal funding for the new home and community-based services program would be phased in, reaching a level of $38 billion in fiscal year 2003. Three features of this program are as follows:

- Capped federal funding: The legislation would set annual limits on the federal share of public spending. Regardless of the size of the pool of eligible individuals, access to this program's services would be limited by the funds available. By contrast, there are no limits on federal outlays for

[3]Medicaid, the health care program for the poor, is jointly funded by federal and state governments. It is a means-tested welfare program, requiring individuals to meet strict income and asset limits set by the state before becoming eligible for benefits.

[4]Long-Term Care: Demography, Dollars, and Dissatisfaction Drive Reform (GAO/T-HEHS-94-140, Apr. 12, 1994).

Medicare and Medicaid, which fund acute health care and certain long-term care services.

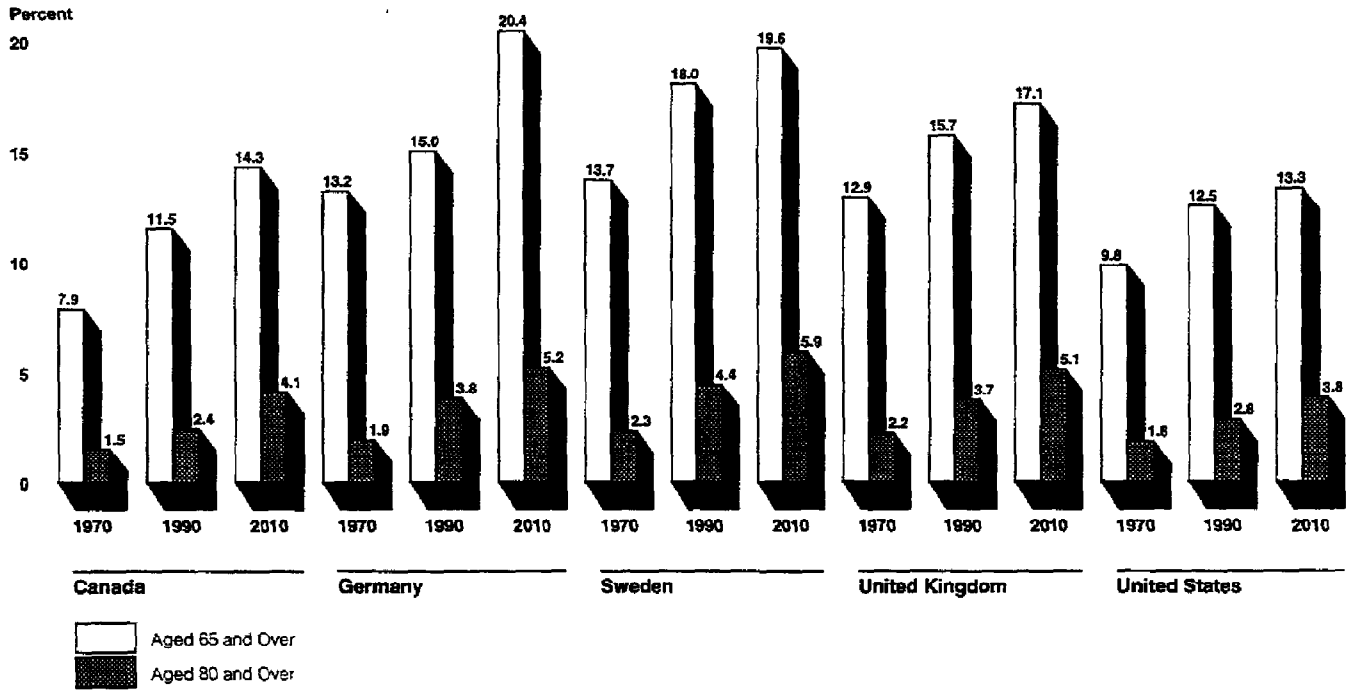
- Cost sharing by individuals, proportionate to income: Individuals would pay, out of pocket, up to 25 percent of the costs for services. Payments typically would be made as copayments, with the rate based on the individual's income.
- Eligibility based on need rather than means: Regardless of income, individuals' eligibility would be determined by an assessment of their functional need for assistance.[5] By contrast, to become eligible for Medicaid, individuals must have extremely limited income and assets.

Demographic Changes Are Expected to Increase Demand for Long-Term Care

In the countries reviewed, the most dramatic growth in the elderly population is expected for those over age 80, who are most likely to be frail and in need of sustained care. As shown in figure 1.1, except for Canada, the populations of the countries reviewed have proportionately more elderly than the U.S. population. Sweden has the most elderly, with 18 percent of its population over age 65 and approximately 4 percent over age 80. These countries have experienced an earlier and more rapid shift in the age structure of their populations.

[5]Functional need is a measure of a person's ability to perform self-care functions such as bathing, grooming, and housekeeping.

Figure 1.1: Elderly as Share of Population in the United States and Other Countries, 1970-2010



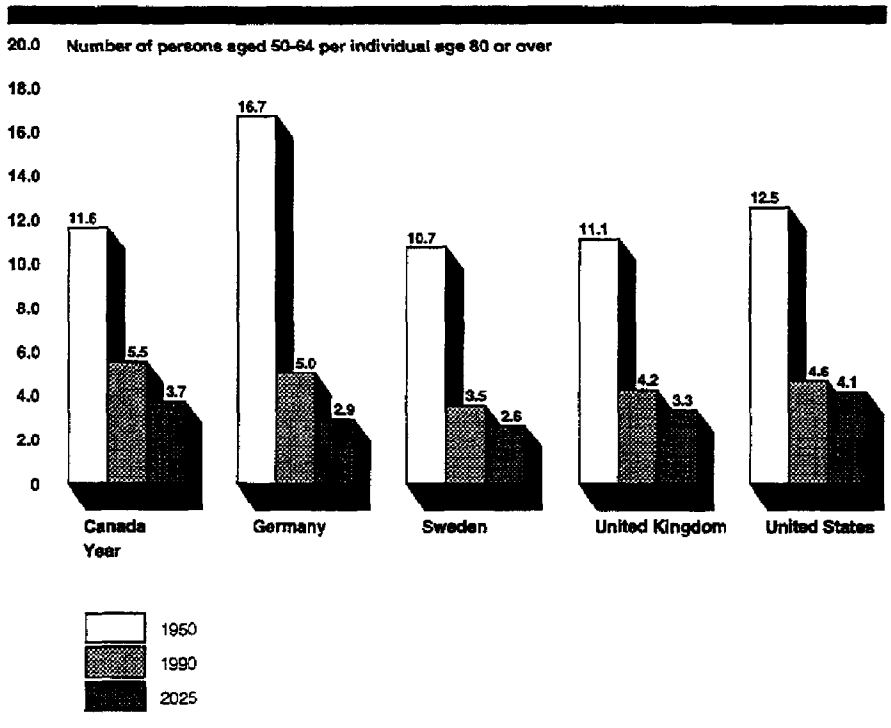
Source: U.S. Bureau of the Census, Center for International Research, International Data Base on Aging.

At the same time, family and friends, who currently provide most long-term care, are becoming less able to meet increased caregiving responsibilities. Wives, daughters, or daughters-in-law provide most long-term care services on an informal, unpaid basis. During the last decade, however, more women have entered the labor force, and families have become smaller and more geographically dispersed. In addition, the number of informal caregivers is not expected to keep pace with the growing number of people who will need long-term care.

One measure of the availability of informal care is the parent support ratio. This is an approximation of the number of children (aged 50 to

64) available to care for an aging parent (aged 80 or older). As shown in figure 1.2, the number of children potentially available to care for aging parents has declined significantly over the past 40 years. This decline is expected to continue over the coming decades, though not as dramatically as in the past.

Figure 1.2: Parent Support Ratios in the United States and Other Countries, 1950-2025



Note: We have defined the Parent Support Ratio as the number of persons in the population age 50-64 for each person age 80 or older.

Source: U.S. Bureau of the Census, Center for International Research, International Data Base on Aging.

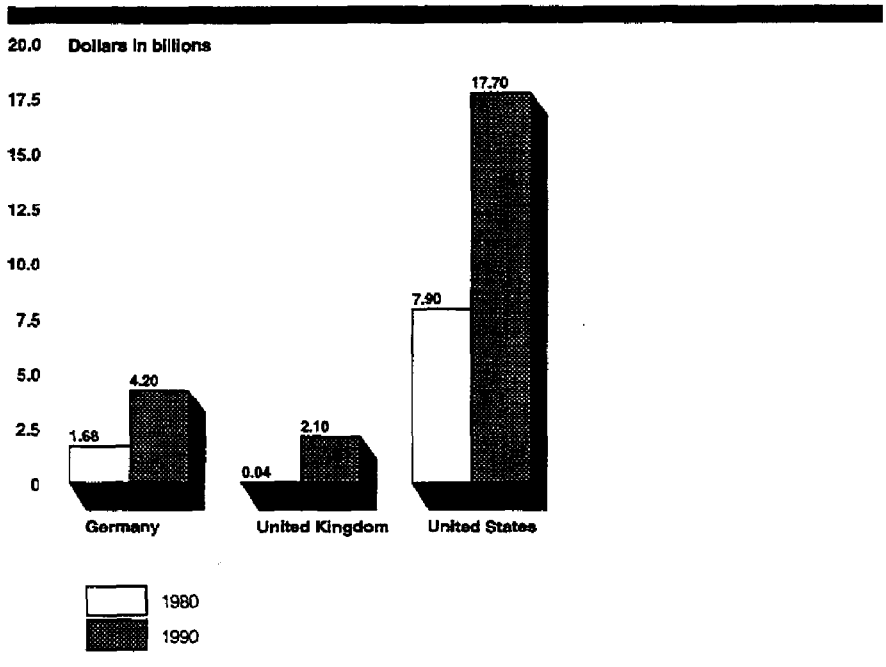
Countries Face Rapid Growth in Public Spending for Long-Term Care

In Germany and the United Kingdom, means-tested welfare programs—programs that base eligibility on financial need—have been the source for most public funding for long-term care.[6] In such programs, individuals are typically required to have limited resources or to deplete assets before becoming eligible for public assistance to pay for long-term care. Because long-term care services are expensive, these welfare systems have served not only as a safety net for poor, but also as the primary source of public financing for formal long-term care.[7] As shown in figure 1.3, welfare-based spending for nursing homes increased dramatically in Germany, the United Kingdom, and the United States during the past decade.

[6]In the United States, Medicaid supported an estimated 63 percent of all public long-term care spending in 1993, according to projections by the Department of Health and Human Services (HHS).

[7]Because nursing home costs range from $24,761 to $37,000 per year in the countries that still maintain welfare-based systems (Germany, the United Kingdom, and the United States), the nonpoor "middle-class" often quickly exhaust their resources and become dependent upon welfare assistance.

Figure 1.3: Total Welfare Spending for Nursing Home Care: Germany, the United Kingdom, and the United States, 1980-1990



Notes: The purchasing power parity exchange rate for gross domestic product (GDP) was 2.50 deutsche marks (DM) per U.S. dollar in 1980 and 2.09 in 1990.

The purchasing power parity exchange rate for GDP was 0.520 British pounds per U.S. dollar in 1980 and 0.602 in 1990.

The dramatic increase in spending for nursing homes in the United Kingdom between 1980 and 1990 was due primarily to the introduction of national social security (welfare) support for residential long-term care in 1983.

As in the United States, private insurance contributes little to the financing of long-term care in the countries reviewed. In Canada and Sweden, little or no private insurance exists. In Germany, the private insurance industry began offering long-term care policies in 1986. To date about 133,000 private policies, representing less than 1 percent of the total population, have been sold. In the United Kingdom, the first policies were sold in 1991 and as of 1992 seven insurers reported offering some long-term care coverage.

Countries Support Mostly Institutional Care

In Canada, Germany, Sweden, and the United Kingdom, home and community care services are often less developed and less well funded than institutional care. As in the United States, the more generous or readily available public funding for institutional care has created incentives in these countries to favor the use of nursing home care over home or community care.[8] In these countries, the majority of public resources for long-term care supports institutional services.

In many cases, the absence of sufficient or affordable home and community-based alternatives has made institutional care the only option for elderly individuals living at home and unable to manage with the assistance of family and friends. Consequently, individuals needing care may receive institutional services when a less intensive and potentially lower cost mix of services would be more desirable. While some elderly manage to remain at home, the burden of caregiving on their families and friends can be considerable.

Countries Challenged by Fragmented Administration and Delivery Systems

The fragmentation of administrative and financial responsibility for long-term care among levels of government and between public and private entities is a common concern expressed by officials in all countries. National governments set broad guidelines for the delivery of services; with some exceptions, they finance medically related services and nursing home and other institutional care. State, regional, and local governments generally provide social services, including personal care in the home, congregate and home-delivered meals, adult day care, specialized housing arrangements, and respite care services. Private and voluntary organizations, such as charities, churches, and foundations, also provide a variety of care services.

The multiplicity of players involved in long-term care has produced complex and overlapping sets of health and social programs with varied objectives. As a result, individuals experience great differences in service levels, eligibility criteria, and service availability within the countries reviewed.

[8]In the United States, approximately two-thirds of total public spending for long-term care, estimated by HHS to be $45.5 billion in 1993, supports institutional long-term care services.

Countries Respond to Long-Term Care Concerns

Demographic, financing, and service delivery concerns have prompted the four countries reviewed to modify or reform the way in which they organize, provide, and pay for long-term care. Table 1.1 highlights the key measure undertaken in each country.

Table 1.1: Key Long-Term Care Reform, by Country

Country	Reform
Canada	1978 to present: Most provinces, using incremental reforms, have developed long-term care as a universal benefit program.
Germany	1995-96: Reforms will make long-term care services standard benefits to be provided through national health insurance.
Sweden	1992 Adel Reform: The legislation shifts resources and taxing authority to municipalities, making them fully responsible for administering long-term care services.
United Kingdom	1990 Community Care Act: Implemented in 1993, the act grants local authorities strict global budgets for long-term care services.

Changes have occurred at different times and entail a variety of financing and administrative arrangements tailored to each country's unique social and economic environment. In general, however, the countries made the modifications or developed the reforms to achieve the following common goals:

- control the escalating public costs for long-term care;
- improve the efficiency of service delivery through decentralization and consolidation; and
- enhance access to services by attempting to (1) broaden the pool of eligible individuals, (2) develop a broader range of services, namely, home and community care services, and (3) acknowledge the value of family and friends providing care informally.

Objectives, Scope, and Methodology

At the request of the Chairman and Ranking Minority Member of the Senate Special Committee on Aging, we examined the experiences of Canada, Germany, Sweden, and the United Kingdom in providing for the long-term care needs of their populations. Specifically, we sought to determine what (1) financing and cost-containment mechanisms the countries use to control public spending for long-term care and (2) new

approaches to the administration and delivery of care the countries are taking to expand access to services.

Our review includes data and information obtained from Canada, (particularly the provinces of British Columbia and Ontario), Germany, Sweden, and the United Kingdom. We interviewed officials and experts in each country, including government officials, providers of long-term care, consumer advocates, and embassy officials. In addition, we participated in several meetings of domestic and international health and long-term care experts and obtained information from representatives of the Organization for Economic Cooperation and Development in the United States and Europe.

Most data on the four countries contained in this report were provided by officials of the respective countries or by international research organizations. As such, we did not verify the data obtained and made no judgments about the reliability of the systems which produced the data.

We conducted our review from July 1992 through July 1994 in accordance with generally accepted government auditing standards.

Countries Emphasize Controlled Public Spending for Long-Term Care

Like the United States, Canada and the European countries reviewed all currently face mounting long-term care costs that have focused the governments' attention on spending controls. Government funds for long-term care are straining under demographic trends: greater numbers and proportions of the total population are aged (see figs. 1.1 and 1.2) and unpaid caregivers—family and friends—are less able to provide needed care.

Each country has in place or is planning to use certain controls to moderate public spending for long-term care services. The controls countries use to varying degrees—as part of their current financing systems or under planned reforms—array themselves generally into the following categories:

- "Global" budgets: Limits on the amount the government spends for a particular group of services. Officials in each country reviewed believe that the discipline of a global budget is necessary to control the rising costs of long-term care. Recently, in Germany global budgets have trimmed the annual rate of growth for acute care spending from 9.2 percent in 1992 to –1.6 percent in 1993.[9] However, some critics are concerned that global budgets may adversely affect access and quality by creating shortages of services or discouraging the development of innovative services.
- Cost sharing: An individual's out-of-pocket spending for costs not paid by insurance or other sources. Typical forms of cost sharing include deductibles and copayments. Cost sharing may produce savings for the payer because a portion of the cost of services is passed on to the consumer and because the individual's financial obligation may discourage unnecessary utilization.
- Fee negotiation and rate setting: The process of negotiating with nursing homes and other providers to get their best price for long-term care services and residential care rates. The ability of governments to influence the prices of services has become an increasingly important cost-containment tool. Providers are concerned that arbitrary rate setting may threaten their ability to remain in business. Consumer advocates also fear that quality of care may be compromised or costs shifted to consumers if rates are not adequate.
- Managing supply: The practice of limiting the construction of facilities to control the use of nursing home beds. The countries reviewed are increasingly placing limits on the number of beds in nursing homes and

[9]While the declines in the growth rate for some sectors such as hospital care were modest, falling from an annual rate of 8.3 to 5.2 percent, other sectors such as pharmaceuticals showed a more dramatic decline from 9.1 to –19.6 percent over the period.

other institutions that provide long-term care. These limits include requiring prior certification to construct new facilities and limiting nursing home licenses on the basis of bed-to-population ratios. Some government officials and consumer advocates in the countries reviewed are concerned that localities facing budget constraints will not expand supply when needed. Inadequate supply of nursing home beds could result in individuals waiting, at public expense, in more costly hospital beds or in people going without needed services.

Germany Will Use Existing Social Insurance System to Finance Long-Term Care

Of the countries reviewed, Germany is the only one that plans to add new funds—approximately $7.3 billion annually—for the financing of long-term care services. Between 1995 and 1996, Germany plans to convert its financing of long-term care from welfare funds to a tax-based system of social insurance. It will add long-term care benefits to the standard package of acute health care benefits provided through its national health insurance system.

Most Germans obtain their health insurance from one of approximately 1,200 government regulated payers called sickness funds. These funds provide a comprehensive benefits package covering most health costs with little or no copayment. Under reform, the new long-term care funds (part of the sickness fund structure) will also cover certain nursing home and home and community care services. A government-mandated payroll tax shared equally by workers and their employers will continue to finance this system, with an increase in the tax rate to fund the new benefits.

Until Germany's reform is fully implemented in 1996, means-tested welfare will remain the primary mechanism of public financing for long-term care. Local welfare offices grant public benefits only after strict financial requirements are met.[10] An estimated 70 percent of individuals in nursing homes in the former West Germany and 100 percent in the former East Germany have exhausted their resources and depend on welfare assistance to pay for a portion of their care.

[10]To qualify for welfare in Germany, not only must individuals exhaust personal income and assets, but family members such as adult children are legally obligated to contribute as well.

Budget Control

To finance the new long-term care benefits, a new payroll tax will contribute an estimated $11.7 billion annually.[11] Reforms call for limiting long-term care spending growth to the amount of increase in wages. The government through locally administered social assistance schemes will continue to use general tax revenues to pay the cost-sharing obligation (uncovered costs) of those recipients who cannot afford to do so themselves.[12]

Under the new financing arrangement, the government's spending on long-term care from general revenues is expected to drop to $1.9 billion from current spending of $4.6 billion. Benefits financed by the new payroll tax will substitute for hospital and home care services for long-term care patients. As a result, sickness funds are expected to save an estimated $3 billion, which they currently pay in hospital costs and home care services.

The reform proposal has caused a heated political debate in Germany, with employers demanding to be compensated for the increased tax burden added to their already high labor costs. Some opponents of reform are concerned that plans to finance long-term care through an additional mandatory payroll contribution will hurt their international competitiveness. Furthermore, German industry is concerned that once a mandatory contribution is in place, it will inevitably be raised as the country faces pressure from the growing aging population, increasing care costs, and rising expectations of coverage and quality.

Since Germany's long-term care budget—financed by payroll contributions—will be based on only an initial needs assessment, German officials warn that the changing long-term care needs of the population should be continually measured to ensure that the budget is adequate. Provider organizations, insurers, and trade union representatives are already concerned that the budget may be inadequate by the time the reforms are implemented in 1995 and that payroll contribution rates will have to increase to meet the shortfall.

[11]The payroll tax will equal 1.0 percent of wages in 1995 and increase to 1.7 percent in 1996, borne equally by employers and employees. The payroll tax is based on a nationwide needs assessment which determined that 1.65 million citizens were in need of long-term care.

[12]For those individuals claiming public welfare and unemployment benefits, the respective provider of the benefits is liable to pay the contributions. In the case of pensioners, half of the contribution is paid by the pensioner and half by the pension insurance fund.

Cost Sharing

Financing reforms will require individuals to pay out of pocket a portion of their long-term care insurance. Nursing home residents will be required to pay room and board costs, while the sickness fund will pay for care-related costs. Specific guidance on what constitutes a "care" cost versus a "lodging" cost has not been established, however, and providers and payers may have incentives to overstate lodging costs to shift them to individuals. Because the public welfare program will contribute to the lodging component of care for those unable to afford the full cost, welfare could remain a major source of funds for nursing home care in Germany.

Fee Negotiation and Rate Setting

Proposed reforms call for the sickness funds to negotiate rates and fees annually with local providers of long-term care services, using explicit national guidelines governing the content and conduct of these negotiations. If the rate setting and fee negotiation process is comparable to that used for acute health care, it will incorporate the views of major stakeholders: the central government, state and local governments, sickness funds, and providers of long-term care services.

Managing Supply

A legislative provision that requires the German states and the sickness funds to agree on decisions to construct new facilities is intended to control Germany's supply of nursing homes. The rationale for this approach is that the sickness funds, through their reimbursements to providers, will pay the operating costs of these new facilities.

United Kingdom Sets Local Budgets to Control Long-Term Care Spending

In the United Kingdom, public expenditures for nursing homes rose dramatically over the past decade, straining the national welfare budget. Approximately 57 percent of nursing home residents met the financial criterion of less than $12,698 in assets and were dependent on welfare. As of May 1992, the welfare budget equaled $3.9 billion, which supported 270,000 people in nursing homes.

Public financing for most nonmedical long-term care is separate from National Health Service funding for acute health care. It is financed from national welfare funds, which are transferred to local authorities as part of the reforms implemented in 1993.

Global Budgets

In 1993, the United Kingdom created a global budget—a spending limit—for national government spending on long-term care. The national

government allocates this budget incrementally over 3 years (again $3.9 billion for 1993) to local authorities to cover not only residential and nursing home care but also home and community-based care. Allocations in the form of block grants are based primarily on past expenditures.[13] For the first 3 years of the new system, national government funds are earmarked for long-term care, with local authorities required to spend the full amount of transferred funds solely on long-term care needs. Of this amount, 85 percent must be spent in the private sector. After the first 3 years, however, the funds will no longer be earmarked for long-term care, and the local authorities can spend it according to their priorities.

The 3-year restriction on the use of block grants was intended to ensure that localities would develop and fund long-term care services and would encourage the policy of privatization of these services. Once the restriction is lifted, critics warn that localities' funding flexibility may result in diminished spending on long-term care in favor of other local spending priorities, such as child care and substance abuse treatment. In addition, the reform's requirement that 85 percent of the funds be spent in the private sector raises concerns about availability and cost of services. For example, as local authorities divert funds to home care, they are finding that private home and community care services have been only minimally developed.

The most serious concerns about the United Kingdom's long-term care financing reforms relate to the adequacy of funding levels contained in the national government's global budget and to limitations on local authorities' ability to raise additional taxes in support of long-term care. The national government based localities' long-term care block grants on past expenditures rather than on an assessment of population need. Past expenditures, however, covered care after recipients had spent down their income and assets and rarely covered the full cost of nursing home care, which relatives and charities would frequently supplement. In addition, the national government imposed a 3-year restriction, also beginning in 1993, on the amount of money that can be raised through local taxes. Local authorities are therefore concerned that their long-term care block grants may not be sufficient to provide the range of services needed and that they will be unable to supplement funds through increased local taxation.

[13]The block grants, using past expenditures as a baseline, are then distributed according to a demographically based formula referred to as the standard spending assessment. The formula considers population, age structure, housing conditions, and other factors.

Cost Sharing

In the absence of specific national guidance regarding cost sharing for services other than nursing home care, requirements for out-of-pocket long-term care spending may vary widely at the discretion of local authorities. Given localities' current fixed budgets and tax-raising restrictions, officials anticipate that individuals' cost-sharing requirements could increase significantly, thereby raising the family burden for long-term care financing or barring an individual's access to services altogether. Although, in such cases, most authorities are likely to include a means-tested allowance.

Fee Negotiation and Rate Setting

Under the 1993 reforms, local authorities are responsible for negotiating rates for nursing homes and other institutions and fees for other long-term care services. By requiring 85 percent of the long-term care budget to be spent on private sector services, the government hopes to increase consumer choice and competition among providers. Officials believe that increased competition will create incentives not only for efficient provision of services but for improved quality as well.

Canadian Provinces Redirect and Integrate Funding Streams as Part of Reform

Canadian provinces finance long-term care from a variety of sources, mostly supported by general tax revenues. These sources primarily include federal block grants for health services under the Canada Health Act, matching payments for nonmedical services provided under the Canada Assistance Plan (CAP),[14] and provincial general revenues. Both federal and provincial governments have been under considerable pressure in recent years to control rapidly increasing health costs while responding to growing demand for long-term care. Because of recessionary pressures nationwide, the federal government has frozen its block grant payments to all provinces for the past several years, and matching payments under the CAP have been capped for the provinces of British Columbia, Alberta, and Ontario.

In response to these and other pressures, provinces are seeking greater efficiency and cost-effectiveness in the delivery of health and long-term care services. As part of an overall cost containment strategy, many provinces are seeking to redirect funds from costly acute health care and into home and community-based services. In addition, some provinces are attempting to expand support for long-term care through integration of fragmented health and social service funding streams. Many officials

[14]Under the CAP, provinces collect matching payments from the federal government for services provided to low-income persons.

believe this fragmentation creates a bias toward high-cost institutional services when low-cost community supports may be more appropriate. Within the long-term care sector, provinces are attempting to manage or control costs through increased use of global budgets, increased consumer cost sharing, and tighter limits on the supply of expensive institutional beds.

Global Budgets

Some Canadian provinces are beginning to impose global budgets or other spending caps to control long-term care costs. For example, British Columbia funds nursing homes through an annual global budget. The province also allocates annual capped budgets to some of its 21 regional health authorities to fund home and community care services. Similarly, under the proposed reforms in Ontario, the province will allocate fixed home and community care budgets to newly created "multiservice" agencies.

Cost Sharing

Unlike acute care in Canadian provinces, long-term care services are not required to be "free at the point of service." Most provinces require copayments for both institutional and community care. Typically, nursing home residents pay a fixed daily fee for the room and board component of care. In some provinces, this copayment is set according to old age pension levels and leaves even the poorest pensioner with a modest spending allowance. These lodging charges for institutional care have long been a feature of long-term care in most provinces, and they are justified on the basis of equity since permanent institutional residents do not have to maintain a separate residence. For most home and community care services that are not considered medical, individuals pay modest, income-related copayments.

Managing Supply

Recently the provinces have directed spending control efforts at expensive institutional care. They have imposed limits on the number of beds eligible for public reimbursement and have restricted the construction of new nursing homes. However, home care and community support services are beginning to be developed and expanded.

Sweden Seeks Better Value Through Consolidation of Public Long-Term Care Spending

Sweden has historically financed long-term care as a socially insured benefit that is paid for through taxes, as is acute health care. Services are funded primarily by local governments; the national government's share of public spending for long-term care is less than 10 percent.

In 1992, Sweden enacted the Adel Reform, which consolidated responsibility for long-term care at the municipal level. Prior to reform, county councils and municipalities shared responsibility for long-term care, with county councils responsible for home health and hospital geriatric care and municipalities responsible primarily for social services. In 1992, municipalities assumed primary responsibility for all aspects of long-term care, including that provided in hospitals, nursing homes, people's homes, and the community. Municipalities also gained new taxing authority to fund services and additional staff resources to provide them. In 1992, nearly 55,000 county employees became municipal employees, and more than $2 billion in annual taxing authority was transferred from the county to the municipal level.

Consolidation and Tax Caps

Swedish officials point out that, since municipalities are now required to pay for hospital expenses when an individual no longer needs acute medical treatment, they have a clear financial incentive to find the least costly alternative to meet individual needs. Officials believe that the decentralized and consolidated approach has been successful in reducing unnecessary or inappropriate institutionalization. For example, officials documented a dramatic reduction (50 percent) in the number of individuals in hospitals who no longer require hospitalization but may need either nursing home or community-based care.

To stem the rising tax burden on its citizens, the Swedish government limited for 3 years, beginning in 1990, the amount of taxes that municipalities could raise for all public services. While Swedish officials credited the tax caps with encouraging improved efficiency, they expressed concern about their ability to meet new responsibilities for long-term care if the government continues the restriction on raising taxes.

Cost Sharing

Despite a tradition of heavily subsidizing long-term care services, Sweden is shifting a greater share of the costs to consumers—from 4 percent in 1991 to about 10 percent in 1993. Officials expect consumer charges will increase further in response to growing budgetary pressures and the recent limits on the ability of municipalities to raise taxes. Income-related

charges and copayments are increasingly being applied for home and community-based care and vary considerably among municipalities. In addition, municipalities are now charging individuals for the lodging component of residential or nursing home care.

Managing Supply

Because municipalities finance most long-term care, they also control the supply of services. Recent reform efforts have concentrated on restricting the supply of institutional services, expanding home and community-based services, and reducing the use of hospital beds for long-term care patients. They also call for supporting the construction of specialized housing, to house people of lesser disabilities to avoid their placement in more expensive, resource-intensive nursing homes.

Countries Seek to Enhance Access and Improve Services Within Limited Budgets

Several concerns—in addition to burgeoning costs and limited budgets—have prompted the countries reviewed to seek enhanced access and improved service delivery for long-term care services. Among the concerns, which parallel problems in the United States, are that (1) the administration and delivery of services are fragmented among agencies and levels of government and not well coordinated, (2) in some countries individuals must meet overly strict financial criteria to qualify for public assistance, and (3) public long-term care spending favors institutional over home and community care.

To simplify access to care and target public resources more efficiently, the countries have acted to decentralize the responsibility for long-term care and consolidate the administration of services at the local government level (or, in the case of Germany, through a network of regulated authorities). Except for Germany, consolidation has meant that an individual can obtain initial access to services at a single public agency. These agencies can capitalize on the case management approach to coordinating health and social services, where one or more professionals assess an individual's needs and coordinate the provision of services for the individual.

Decentralization and consolidation have been most pronounced in the United Kingdom, where the financing of services has shifted from a national welfare program with uncapped entitlements to decentralized authorities with well-defined or global budgets. In the United Kingdom, the administration of long-term care services has shifted from multiple agencies and levels of government to a single local authority. In Germany, long-term care funds within the sickness fund structure have assumed the responsibility for administering services from locally administered public welfare schemes and an array of public agencies and private organizations. In some Canadian provinces, the responsibility for administering services and allocating resources is shifting from provincial to subprovincial (regional, district, and local) governmental levels. In Sweden, the administration of long-term care services, once divided between county councils and municipalities, has shifted almost exclusively to municipalities.

The countries reviewed have also modified or developed one or more strategies to improve access to care and efficiency in service delivery, including

- basing eligibility for public assistance on functional rather than financial need;
- emphasizing the use of home and community-based care over expensive institutional care, where appropriate; and
- supporting family members and other informal caregivers through financial or other benefits.

Of the countries reviewed, only Germany has added new funds to expand coverage and benefits. The other countries hope to expand access largely through reallocating existing resources and increased efficiency in service delivery. Officials in these countries were hopeful that broadening home and community care options, in conjunction with the consolidated, single agency delivery approach, would make the most efficient use of long-term care resources. Officials in some countries were skeptical, however, about the likelihood of expanding services with policy changes that allow for the use of only existing funds.

Germany Will Administer Long-Term Care Services Through Sickness Funds

Currently in Germany, public welfare funds institutional care, and several charitable organizations provide support for most home and community-based services. Germany's fragmentation of responsibility for administering long-term care services has created access disparities across geographic areas. When Germany's national health insurance system begins covering long-term care in 1995, the 1,200 sickness funds will assume responsibility for administering services. Each fund will be required to offer a standard package of long-term care benefits, including institutional care and a range of home and community-based services. (See table III.1.)

Table III.1: Germany's New Long-Term Care Benefits

Home and community-based care	Institutional care
Cash benefit to recipient ranging from $182 (DM 400) to $592 (DM 1300) per month[a] or 25 to 75 visits per month by professional nursing staff	Up to $1,274 (DM 2800) per month for care-related services[a]
Up to 4 weeks per year of professional home care for informal caregiver's vacation	Lodging costs paid by residents[b]
Informal caregivers are included in all social insurance schemes	
Grants to adapt recipient's home for special needs	

[a]The 1993 purchasing power parity exchange rate for GDP was 2.197 deutsche marks (DM) per U.S. dollar.

[b]Welfare will pay the lodging component for those unable to afford full costs.

Functional Need Eligibility Criterion

Currently, Germany's welfare system for providing long-term care benefits requires means testing. To qualify for public assistance, individuals must exhaust personal income and assets, and family members, such as adult children, are legally obligated to contribute as well. Under the long-term care reforms, sickness funds, in conjunction with physician associations, will determine eligibility for benefits primarily on the basis of a person's inability to perform certain basic self-care functions due to physical or cognitive impairments. This change in eligibility determination, along with the universal provision of standard long-term care benefits, will most likely result in expanding the number of individuals obtaining services. Over $7 billion a year will be added to combined sickness fund and government long-term care budgets in anticipation of expanded coverage.

Home and Community Care

Germany's reforms state explicitly that people in need of long-term care should, to the greatest extent possible, be able to live at home. This inclusion of home and community care benefits and funding in the nation's universal health insurance system will be a major change in Germany's provision of long-term care. German officials believe that the sickness funds, which must cover the standard package of services within a prescribed budget, will have the incentive to promote home and community care when it is an appropriate alternative to the generally more expensive institutional care.

Informal Care Support

Germany will also provide economic and other types of support to informal caregivers. As part of the proposed reform, individuals requiring home care can choose cash benefits to pay either formal or informal caregivers on the condition that adequate home care is being received. Relatives will be entitled to 4 weeks of vacation a year. During this time, the sickness funds will pay up to set limits for professional home care services. Relatives, friends, or neighbors who provide care on a regular basis and who do not receive payment will be entitled to certain employment benefits, such as public pension credits.

United Kingdom Consolidates Responsibility for Care in Local Authorities

Prior to the 1993 long-term care reforms, responsibility for administering long-term care in the United Kingdom was fragmented among multiple agencies and levels of government, including the National Health Service and local authorities. No single entity was responsible for determining the population's need for care or for allocating resources.

With the implementation of reforms, local authorities are now responsible for producing a comprehensive plan for meeting the community's long-term care needs. In preparing these plans, local authorities are expected to consult with and coordinate the efforts of various public and private organizations involved in providing care.

Functional Need Eligibility Criterion

In the United Kingdom, local authorities now serve as the single point of an individual's initial access to social care services. Local case managers are required to assess the individual's care needs; determine eligibility for services based on functional criteria; and obtain, to the extent possible, the necessary array of services. Local authorities are relying on case management to ensure the care individuals receive is appropriate and necessary. Because of concerns over the adequacy of fixed budgets, however, country officials worry that case management may be used more to ration services than to ensure that individual care needs are met. Some also expect that insufficient funds may result in local authorities again applying financial criteria, such as some form of means testing, following the initial assessment of functional need.

Home and Community Care

A stated goal of the United Kingdom's reforms is to improve access to a broader range of long-term care services, including home and community-based care. Although national welfare funds have been reallocated to local authorities to fund expanded services, no assessment

of the population's needs has been performed and no minimum package of benefits has been guaranteed. Consequently, local officials are doubtful that the reallocation of existing funds, despite being earmarked for long-term care, will be sufficient to significantly expand public support for home and community services. In addition, because local authorities are prohibited from raising additional revenues through taxes to pay for services, country officials express concern that while reforms will succeed in controlling overall public costs, they will not broaden access.

Canadian Provinces Consolidate and Localize Long-Term Care Responsibilities

In some Canadian provinces, responsibility for long-term care is fragmented among multiple agencies and providers, while others have long histories of coordinated and integrated systems of long-term care. Ontario exemplifies the former; British Columbia, the latter.

Ontario is in the process of undertaking a major consolidation of long-term care services at both the provincial and local levels. Until recently, both the Ministry of Health and the Ministry of Community and Social Services separately funded and administered long-term care services. As part of the restructuring reform, the health and social services components of long-term care are being consolidated in a newly created long-term care division at the provincial level, which will formally report to both Ministries. In addition, at the regional (subprovincial) level, responsibility for long-term care services, currently fragmented among government agencies and community providers, is scheduled to be consolidated in multiservice agencies under the direction of District Health Councils by 1995.[15] The intent is for each community to have at least one multiservice agency that will serve as the individual's single point of access to care and provide most long-term care services. The agencies will also conduct individual needs assessments, authorize and arrange for institutional placements, and directly provide home and community services.

Unlike Ontario, British Columbia has a history of comprehensive and coordinated long-term care delivery going back more than 15 years. Since federal grant funding for long-term care became available in 1977, a single division within the Ministry of Health has funded and administered most services at the provincial level. The Ministry's regional offices (with a few

[15]Approximately 32 District Health Councils serve as regional health planning bodies, which advise the provincial ministries on health needs and resource allocation. With the restructuring reform, multiservice agencies will be responsible for integrating health and social service planning for long-term care and for allocating resources to meet local long-term care needs.

exceptions) manage the delivery of services.[16] They serve as single points of access to care, conduct individual needs assessments, and authorize the provision of services including facility placement. Most long-term care services (other than skilled nursing and medical therapy) are provided primarily by private organizations under contract to the government.

Functional Need Eligibility Criterion

Since the late 1970s, coverage for a broad range of long-term care services has been provided as a universal benefit in most Canadian provinces. Eligibility for covered services is based on functional need. Although the package of covered services may vary among provinces, most provide home health care, nursing home care, and a range of home and community-based supports without regard to ability to pay. As of 1991, only the less wealthy Maritime provinces still applied some financial eligibility criteria for nursing home care.

Home and Community Care

Government officials in Canada generally agreed that the government would not be able to raise overall spending on health and long-term care, but they do believe that a redistribution of funds would better meet the needs of the population. They would like to reallocate some funds from acute to long-term care and from institutional to home and community-based care. For example, British Columbia is decreasing provincial budgets for hospital and physician care while increasing funding for home and community-based services. Further, the province encourages, and in some cases requires, local case managers to fully consider home and community care options before authorizing institutional placement. Ontario is also realigning budget priorities and plans to increase public spending for long-term care, despite a general climate of fiscal restraint. The provincial government's stated goal is to increase public spending on home and community care from 20 to 30 percent of all long-term care spending by 1997.

Sweden Consolidates Responsibility for Long-Term Care in Municipalities

In Sweden, where long-term care historically has been a social insurance benefit, the 1992 Adel Reform consolidated responsibility for long-term care at the municipal level. Municipalities assumed from counties the primary responsibility for most aspects of long-term care, including that provided in hospitals, nursing homes, and the home and community. Prior to reform, 23 county councils and 286 municipalities shared responsibility

[16]Four municipalities and one district—rather than regional Ministry offices—manage service delivery in certain locations.

for long-term care, with county councils responsible for home health and hospital geriatric care and municipalities responsible primarily for social services. Because Swedes have traditionally enjoyed universal access to care, eligibility on the basis of financial need has not been a feature of the system.

Swedish officials believe that the decentralized and consolidated approach, which gives municipalities responsibility for the full range of long-term care services, has been successful in reducing unnecessary or inappropriate hospitalization. As discussed in chapter 2, officials documented a dramatic reduction (50 percent) in the number of individuals in hospitals who no longer require hospitalization but may need either nursing home or community-based care.

Home and Community Care

Historically, Sweden has provided generous support and invested considerable resources to support the elderly and disabled in the community, including ample pensions, housing allowances, home modifications to meet individual care needs, and specialized housing arrangements that integrate supportive and social services and offer 24-hour personal assistance. Sweden spends a higher percentage (approximately 35 percent) of its long-term care resources on home and community care than the other countries reviewed. The Adel Reform has led to further expansion of home and community services, including a greater array of home nursing, personal care, adult day care, supportive housing services, meal services, and transportation.

Informal Care Support

The level of support Sweden has provided for informal care appears to be the greatest of the countries reviewed. Caregiving families are eligible for both direct economic assistance and support services. Sweden requires employers to grant up to 30 days of paid leave for individuals to provide care for elderly or disabled family members. In addition, Sweden uses public funds to provide salaries to family caregivers for whom caregiving is a regular full-time or part-time job. The most recent estimate available indicated that 6,300 or 2.6 percent of all those receiving home-help services were helped by relatives or close friends employed by the municipality.

The commitment to expand support for family caregiving is explicit in the 1992 Adel Reform. The legislation requires municipal case managers to integrate the role of informal caregivers in the planning and delivery of

long-term care. Municipalities will receive additional funding from the national government to support a greater number of family caregivers. The national government is also recommending that municipalities expand outreach to identify family caregivers and better target services to meet their needs, such as providing special assistance when the caregivers are ready to reenter the general workforce.

Chapter 4

Concluding Observations

The steady demand for long-term care in the United States over the next few decades will force policy choices about how to expand access to a range of services while keeping public costs manageable. Policy decisions will need to be made about the division of responsibility between the public and private sectors and about the appropriate role of these sectors in both the financing and delivery of care. Observations made on how other countries have responded to long-term care financing and delivery concerns may help inform these decisions.

Challenges associated with aging populations, growing demand for long-term care services, the rising costs of those services, and dissatisfaction with access to care have propelled reform efforts in each country. While it is too early to determine the outcomes of recent reforms, it may be useful to recognize certain common themes in approaches to cost control and service administration. Following are the principal themes we observed.

1. Fixed budgets or spending caps, coupled with other controls, may control costs but could also threaten access. Faced with economic and budgetary strains, the countries reviewed are hoping to limit overall public cost growth and create incentives to efficiently target services through capped spending, global budgets, greater consumer cost sharing, and price controls. Recognition of budgetary limits may encourage governmental and service agencies to weigh service needs and more carefully allocate services among individuals. However, capped budgets and other cost controls may not be viable over time if resources are not based on the assessed needs of the population. Without such safeguards, countries could achieve cost control at the expense of sufficient access to needed services.

2. Consolidating the administration of long-term care is expected to make service delivery more responsive to the individual. Reforms seek to simplify access and make the system more responsive to individuals by consolidating the administration of services into single agencies and locating these agencies within local governments. Consolidation of responsibility within the same organization for long-term and acute care or institutional and home care services acknowledges the potential to substitute different services in meeting individuals' needs. It encourages officials to make efficient and appropriate care choices, using the least costly service in individual cases. Further, it denies officials the opportunity to shift responsibility for care to more expensive alternatives financed by other bodies.

3. Increased public support for home and community care may improve individual satisfaction with services while avoiding costly institutional care. The countries' reforms have recognized the importance of individuals and families in several ways. Reforms seek to improve the well-being and satisfaction of persons with disabilities by shifting resources away from institutional care to preferred home and community-based services. They also support family and other informal caregivers through economic compensation—either paying a salary or providing benefits. Such support underscores the essential role of informal caregivers in providing the majority of long-term care and acknowledges the sacrifice caregiving can entail.

Expanding access while containing growth of public costs may constitute competing goals. Success may depend upon how vigorously each is pursued. The countries we reviewed aim primarily at slowing the increases in costs, rather than seeking reductions in long-term care resources. With this objective, countries that have historically spent more, such as Sweden and certain Canadian provinces, may have greater flexibility in their attempts to improve access and a higher probability of success. The same may be true for a country like Germany, which is willing to invest new funds to establish a larger base of resources and is focused on future control of cost growth.

Appendix I

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Long-Term Care: Private Sector Elder Care Could Yield Multiple Benefits (GAO/HEHS-94-60, Jan. 31, 1994).

Older Americans Act: Title III Funds Not Distributed According to Statute (GAO/HEHS-94-37, Jan. 18, 1994).

Health Care Reform: Supplemental and Long-Term Care Insurance (GAO/T-HRD-94-58, Nov. 9, 1993).

Long-Term Care Insurance: High Percentage of Policyholders Drop Policies (GAO/HRD-93-129, Aug. 25, 1993).

VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (GAO/HRD-93-68, July 27, 1993).

Long-Term Care Reform: Rethinking Service Delivery, Accountability, and Cost Control (GAO/HRD-93-1-SP, July 13-14, 1993).

Massachusetts Long-Term Care (GAO/HRD-93-22R, May 17, 1993).

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