



WHO European Ministerial
Conference on Health Systems:
"HEALTH SYSTEMS,
HEALTH AND WEALTH"
Tallinn, Estonia, 25-27 June 2008

HEALTH SYSTEMS AND POLICY ANALYSIS

POLICY BRIEF

How can the settings used to provide care to older people be balanced?

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Keywords:

HEALTH SERVICES FOR THE AGED - organization and administration

HEALTH CARE FACILITIES, MANPOWER & SERVICES

DELIVERY OF HEALTH CARE - trends

HEALTH POLICY

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This policy brief, written for the WHO European Ministerial Conference on Health Systems, 25–27 June 2008, Tallinn, Estonia, is one of the first in what will be a new series to meet the needs of policy-makers and health system managers.

The aim is to develop key messages to support evidence-informed policy-making, and the editors will continue to strengthen the series by working with authors to improve the consideration given to policy options and implementation.

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The authors and editors are grateful to the reviewers who commented on this publication and contributed their expertise.

Key messages

Policy context

- All European countries project dramatic growth in the costs and use of formal and informal care as the number of dependent older people with long-term chronic illnesses rises.
- The rising future financial burden of care for older people requires the optimum use of resources with care settings tailored and customized to both individuals and communities.
- The projected decline in the supply of informal care will require investment in home-based self-care and increased caregiver support in the home environment.
- The projected increase in the utilization and cost of institutionally based care can be partly offset by investment in formal home-care and home-environment alternatives.

Policy options, dividends and implementation

Creating an intellectual platform for planning

- Policies that promote independence and prevent people with common chronic conditions from deteriorating can be effective in containing costs and promoting health and well-being.
- Planning care requires more sophisticated planning processes that combine population-based needs assessment, resource allocation and the customization of care.
- Eligibility of access should be sensitive to individual needs and linked to a more integrated and personalized set of care providers.

Developing arrangements for service delivery

- Individual needs should be assessed at a single coordinated point of adjudication and be comprehensive and multidisciplinary. Combining individual needs assessment with broader (national) eligibility criteria has advantages.
- Individualized care planning should enable services to more closely match needs and may limit the growth in costs. Information hubs on locally available services enable older people, caregivers and people providing home care support to tailor care packages effectively.

Establishing client-based financial arrangements

- Consumer-directed payments can enable individualized care but require support structures that help optimize appropriate choices and enable support to be given to caregivers.
- The role of informal caregiving needs to be formally recognized and supported through financial incentives and caregiver-support programmes.

Developing incentives for informal care

- Fragmented and episodic care should be replaced with integration and coordination across the spectrum of care providers, and an individualized care pathway should be established at the point of assessment. This may be encouraged through funding and commissioning processes that yield incentives to integrate service delivery from a network of care providers.
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Executive summary

The optimal balance between institutional, home-based and community care for older adults requires an effective mix of organizational, funding and delivery mechanisms for target populations. This spans health and social care, and the coordination of care must respect older people's care preferences and that of their families and friends as well as limits on the available resources to support and fund service provision.

Care settings used to provide long-term care for older people and how they are defined vary greatly across Europe. This policy brief addresses the appropriate balance between three main components of long-term care: home care services; institutional care (formal and informal sectors); and care provided by family and friends (informal care).

The dramatic upward trend in the cost and use of long-term care, the projected impact of ageing populations and the prevalence of age-related chronic disease and dependency ratios have catalysed proposals to redesign the funding, organization and delivery of affordable, effective and equitable health and social care for older people.

Evidence from Europe suggests that the numbers of dependent older people requiring long-term care will rise significantly during the next 50 years. Although managing and preventing chronic illness may lower utilization and dependence rates, pressure on health and social care will still be increased. Consequently, besides the promotion of healthy ageing, a series of other policy conclusions may be drawn.

- The projected decline in the supply of informal care provided to older people will result in greater demands for care at home and in facility-based settings. This highlights the need for self-care strategies and home-based services to support older people.
- The projected growth in the number of dependent older people with chronic conditions and the resulting need for formal care will create an urgent need to expand the range of non-residential services, such as home care, day care and respite care.
- Resource constraints mean that efficiency considerations will become more important and will require more closely matching services to recipients' needs.
- The historical provision of fragmented and episodic care needs to be replaced by more integrated and coordinated long-term care across the spectrum of care providers.

- Decision-makers must plan ahead to take account of technological innovations that modify care pathways and settings.
- Policy-makers need to be aware of the uncertainty in demand resulting from morbidity and lifestyle trends that will affect future patterns of long-term care utilization.

An appropriate balance between institutional care and other less intensive forms of care requires a trade-off between enhancing the quality of life and potentially improving efficiency. When an older person needs little care, providing care in their own home is probably more likely to enhance their health and well-being, and at less cost, than equivalent institutional care. Once the person's care needs reach a higher threshold, efficiency and quality of life considerations for both the care recipients and their family and friends are more likely to favour an institutional environment. The level of this threshold depends on the contextual circumstances of the care recipient, their caregivers and the available service providers. The appropriate care will thus vary according to the characteristics of the population to be served and the region in which care is to be provided. Consequently, as societies strive to make the best use of their scarce resources, care settings should be tailored to optimize services to meet older people's needs.

Policy options

Consensus is emerging that integrated community-based care needs to move away from an overly acute (hospital) or institutional (nursing home) focus to one that embraces managing and coordinating both the long-term care needs and chronic illnesses of older people. We focus on four main policy options to facilitate this rebalancing of care provision.

- **Creating the intellectual platform for planning.** This warrants developing and implementing information systems for the purposes of monitoring services, evaluation and planning (that is, investment in system stewardship should be significant). There is little standardization and consistency in approaches to service planning, planning exercises frequently lack sophistication and policy decisions are rarely informed by evidence.
- **More integrated approaches are needed to assess long-term care needs and entitlements.** Funding and organizational mechanisms that determine the nature of an older person's eligibility for long-term care, the setting in which such services are delivered and, ultimately, the quality of their experiences are usually fragmented. There is no conclusion on how best to combine such mechanisms, but the case for more integrated models of care is strong. A more integrated approach to assessing service

needs and entitlements that is linked to a more integrated and personalized set of care providers is needed to yield an enhanced menu of long-term care choices tailored to the individualized needs of both care recipients and caregivers.

- **Client-tailored funding arrangements.** These may enhance service efficiency and effectiveness. Consumer-directed payments, in which older people may be offered the option of receiving a cash payment or individual budget in lieu of formal care so that they can choose, manage and pay for their own social care, perhaps from an evidence-informed long-term care menu tailored to their unique circumstances, are an option here.
- **Incentives for informal care are needed.** Unpaid caregivers must be involved in supporting older people since society has insufficient resources to rely on formal care services. Nevertheless, the availability of unpaid care is predicted to decline. Caregiver allowances, respite care, flexible employment arrangements and benefits in kind have been suggested as possible support mechanisms.

This policy brief highlights the local considerations and adaptations that may be required to customize each of the policy options to local circumstances.

Policy brief

Long-term care requirements for older people: implications for policy

The optimum balance between institutional, home-based and community care for older adults requires an effective mix of organizational, funding and delivery mechanisms for target populations. This policy brief assesses at least three dimensions of care for older people: first, health and social care; second, within health care (the balance between preventive care, curative care and health maintenance); and third, within social care (the balance between formal and informal care). This brief examines how an appropriate balance of care for older people may be developed, assesses the alternative methods that may be used to bring about change in the provision of care for older people and considers how such models need to be adapted flexibly to meet local circumstances.

Defining care settings for older people

The care settings for providing long-term care for older people, and how they are defined, vary greatly across Europe. However, they have generally been characterized in one of three main ways.

Older people receive informal care from themselves, family members or friends within the residence. The overwhelming majority of care received by older people is informal, much being basic social care, such as feeding, washing, dressing and emotional support (1). Informal care is non-professional and usually provided without financial compensation. However, many countries have recognized that tailored support, advice and education need to be offered to informal caregivers to help them discharge their caring activities in an effective manner. Indeed, much of what could be defined as paid home-based care is often provided to support the provision of informal care activities rather than to substitute for such care.

Home-based care takes many forms but can generally be divided into: care provided directly within the home (such as respite care); and care that is provided within a home-like environment (such as domiciliary and/or day care in the community). Home-based care is predominantly provided by a paid health or social care provider (either privately or state-provided) within a care recipient's place of residence. It is commonly provided to maintain independence and to prevent deterioration into ill health (continuing care) but may also include rehabilitation services following hospitalization (post-acute home care recipients, including individuals who receive episodic care).

Institutional care is characterized by continuing long-term care in a residential or hospital setting that aims to assist in maintaining health. The boundaries between the various traditional settings of institutional or home-based care are

blurred. For example, new forms of housing arrangement, such as extra care housing in the United Kingdom (2), are effectively hybrids that illustrate the point that a continuum of care services exists between home-based and institutional settings.

Trends in the utilization, cost and settings of care for older people

The old-age dependency ratio has been rising in virtually all European countries except for Ireland. For the 25 countries in the European Union before 1 January 2007, the ratio has increased from 22.7% to 25.3% in the past decade alone and is expected to continue to rise. Coupled with this trend is the fact that the cost and use of long-term care by older people has grown dramatically in all European countries and is projected to grow exponentially in the future. These trends have resulted in concerns about the affordability and sustainability of existing forms of service provision. Projections of future demand and spending on long-term care and the treatment of age-related chronic illness are therefore important to inform the continuing debate about how best to fund and deliver care to older people (3).

International variation in the systems and definitions of long-term care for older people poses significant barriers to developing and interpreting projections of the utilization and cost of long-term care (4). This includes the definition of long-term care (including the boundary with mainstream health care); types of service; and varying approaches to assessing need and severity (5). The examination of trends in the use of health and social care services is also made more complex because data are not collected and reported consistently and uniformly. Some countries combine, and others separate, data pertaining to long-term care services for older people (primarily dealing with social issues related to functional dependence) and data on health service utilization designed to help older people manage long-term chronic conditions.

Comparative analyses of long-term care policies in Europe reveal that historical precedent, funding mechanisms and levels of entitlement to long-term care provision play a crucial role in defining the settings for service provision (4–7). Such patterns of care, when set against projected demographic change and other pressures, enable future costs and service provision needs to be estimated. A study prepared for the European Commission on future expenditure on long-term care services in Germany, Italy, Spain and the United Kingdom (4) projected dramatic increases in the use and costs of long-term care (Table 1). Although informal care was considered the most important source of support for dependent older people, it was likely to decline in all the countries as a proportion of overall care. The reasons include a downward trend in older people living with their children; an upward trend in older people living alone; and a decline in female caregiving potential and rising female employment

Table 1. Projected percentage increases in the numbers of older people, service recipients and expenditure between 2000 and 2050 under a common core set of assumptions (central base case)

	Germany	Italy	Spain	United Kingdom
Number aged 65 years and over (% increase)	64	56	76	67
Number aged 85 years and over (% increase)	168	168	194	152
Number with dependence ^a (% increase)	121	107	102	87
Number of recipients of informal care only (% increase)	119	109	100	72
Number of recipients of home-based care (% increase)	119	119	99	92
Number of recipients of institutional care (% increase)	127	81	120	111
Total expenditure (% increase)	437	378	509	392
Total expenditure as a % of GDP (% increase)	168	138	149	112
Total expenditure as a % of GDP in 2050	3.32	2.36	1.62	2.89

^a Dependence is defined in relation to the ability to perform activities of daily living and/or instrumental activities of daily living. GDP: gross domestic product.

Source: Comas-Herrera & Wittenberg (4).

rates. A reduction in the relative share of informal care was anticipated to generate greater demand for formal care, thereby inflating long-term care expenditure (4).

Research suggests that increased public funding for in-home and residential care in Europe reduces the likelihood of receiving informal care from family members or friends who do not reside with the care recipient (8). Similar results

have been reported in North America, where informal care may decline with the increased availability of formal care but does not tend to disappear altogether (9, 10). Caregivers may continue to provide personal care for reasons of love and/or duty. The financial impact of substituting formal care for informal care depends on the setting in which formal care is provided – wider admission to institutional care, for example, is claimed to have more significant financial consequences than a wider application of home-based care (4).

Studies suggest an emerging European trend in attempting to reduce the increase of institutionally based care (residential and nursing home care) while promoting care provided in the home or home environment (4–7, 11, 12). Concern also appears to be growing over the burden shouldered by informal caregivers, a trend that predictive models suggest is not sustainable.

Older people – especially very old people – use substantial health care. According to a study of eight countries in the Organisation for Economic Co-operation and Development (OECD) (13), between one third and one half of total health care expenditure is attributed to older people. It is acknowledged that (age-related) chronic disease now represents the major disease burden on the cost and use of health care services globally, and a chief driver is the growing numbers of older people living and coping with one or multiple long-term chronic conditions (14). This is reflected in:

- a growing proportion of treatment and expenditure being associated with care for older people;
- a growing proportion of treatment and expenditure being associated with managing long-term chronic illnesses, most of which are age-related; and
- an increase in the use of institutional (hospital-based) care and corresponding growth in the development of intermediate or home-based alternatives, including supported self-care.

Trends in hospital capacity and utilization across Europe since the early 1990s have consistently shown, where data permit, the more intensive use of facilities, the presence of fewer hospital beds and shorter lengths of stay (15). At the same time, hospital admissions are generally increasing and day-care activity is developing widely. Much of this is associated with increasing pressure on hospital management to reduce costs per patient but also with changes in the pattern of care provided to older people. This includes a common policy of earlier discharge to nursing homes or own homes with help from community-based health and social care services (15, 16).

Care should be taken in extrapolating known trends to regions that are absent in the current data sources. Recent work on deinstitutionalization and community living offers insights that highlight the challenges of engaging in

efforts to rebalance care in central and eastern Europe, as shifting resources away from long-stay care facilities is frequently difficult (17).

One of the most comprehensive analyses of international trends and consequences in care for older people was undertaken in England (18). In England, older people (aged 65 years and older) account for nearly two thirds of bed-days, and the rate of growth of emergency admission was highest in older age groups. Significantly, the study found growing evidence internationally that hospital admission and length of stay could be reduced by a range of social care interventions, such as early transfer of people from hospital to the community and providing ongoing home-based care. Good nutrition, hygiene, support with mobility, help with medication and reducing environmental hazards were all factors limiting some of the common causes of hospital admission among more dependent older people.

In view of the above, several policy conclusions may be drawn.

- A projected decline in the supply of informal care provided to older people is likely to result in increased admissions to residential, nursing or hospital care with considerable financial consequences. This highlights the importance of developing supported self-care strategies and home-based services to support older people in their own homes or home environment.
- Projected rising numbers of dependent older people with multiple chronic illnesses means that formal services need to be increased substantially. The development and expansion of non-residential services, such as home care and day care, will be important.
- Efficiency in care provision will be important to limit real rises in unit costs. This may require more closely matching services to needs.
- Fragmented and episodic care provided by institutions needs to be replaced by more integrated and coordinated long-term care across the spectrum of care providers.
- Policy-makers need to plan for potential uncertainty in the future demand for long-term care by older people and people with chronic conditions. Although the trend towards additional older people may raise demands, technological innovations, lifestyle changes and compressing morbidity into the last years of life may attenuate these pressures.

Principles to guide the determination of care settings for older people

The main trade-off to consider in determining an appropriate balance between the use of institutional and other less intensive forms of care is between enhancing the quality of life and potentially increasing efficiency. Providing care

at home shifts costs to care recipients and their caregivers but tends to enhance the quality of life more than institutional care, especially when people need less care. As people need more care, the difference in the quality of life between care at home and institutional care tends to decline. Further, although the cost of providing health and social care increases with the needs of recipients, the relative cost of home care tends to rise faster than that of institutional care (19). In theory, when the difference in cost between care at home and institutional care exceeds the difference in the enhancement of the quality of life, then institutional care would be the preferred care setting. As people's care needs increase, expectations therefore increase that institutional care is the optimal balance of care. Tailoring the choice of care settings to individual circumstances and the needs of care recipients and their caregivers offers the best opportunity to utilize society's scarce resources.

Policy measures to address balance in services for older people

In Europe, consensus is emerging on the need for radically redesigning services in health and social care towards integrated community-based care: moving away from an overly acute (hospital) or institutional (nursing home) focus to one that embraces managing and coordinating the needs for long-term care and care for chronic illnesses among older people.

Create the intellectual platform to guide service planning

The dominant approach to long-term care planning in social care has been to establish some ratio of institutional care beds to area residents beyond an age threshold, such as 100 long-term care beds per 1000 residents older than 75 years of age, to mechanically forecast future bed requirements (20). However, these ratios and thresholds are rarely modified and not continually updated to take account of: underlying trends in health status; the relative cost of alternative delivery settings; the availability of new technologies; changing clinical and caring practices; or even changes in societal attitudes towards the appropriate location of care. Projections are thus often of limited value in offering ongoing guidance to efforts to plan long-term care. The move to more sophisticated planning tools has been pioneered through the development of predictive modelling techniques in health care (18,21,22). For example, a growing emphasis in the United States of America and some parts of Europe is managing long-term conditions by identifying people and communities at risk and designing upstream interventions to prevent people with chronic conditions from deteriorating and thus avoid the need for institutional care (23).

A host of approaches for guiding service planning exist, but there is little standardization and consistency in the methods used. The factors used in planning models may best be categorized as based on needs (factors that

predispose an individual to require care) or preferences (those that influence a recipient's willingness to seek or demand care, the type of care and the setting in which it is received) (24). However, one review (25) has identified the key concepts necessary in planning architecture, leading to a composite three-stage planning framework combining needs assessment, allocation, and customization (Box 1).

Box 1. Planning framework for long-term health and social care

Stage one: population-based assessment of needs

The first stage is to identify the distribution and determinants of long-term care needs for older people and to create projections of underlying needs. Services are then planned as a care package within the limitations of local capacity currently present in formal and informal caregiving resources. Administrative and survey-based data may be used to yield a predictive model of long-term care needs applicable at varying levels of aggregation.

Stage two: developing a menu of long-term care choices

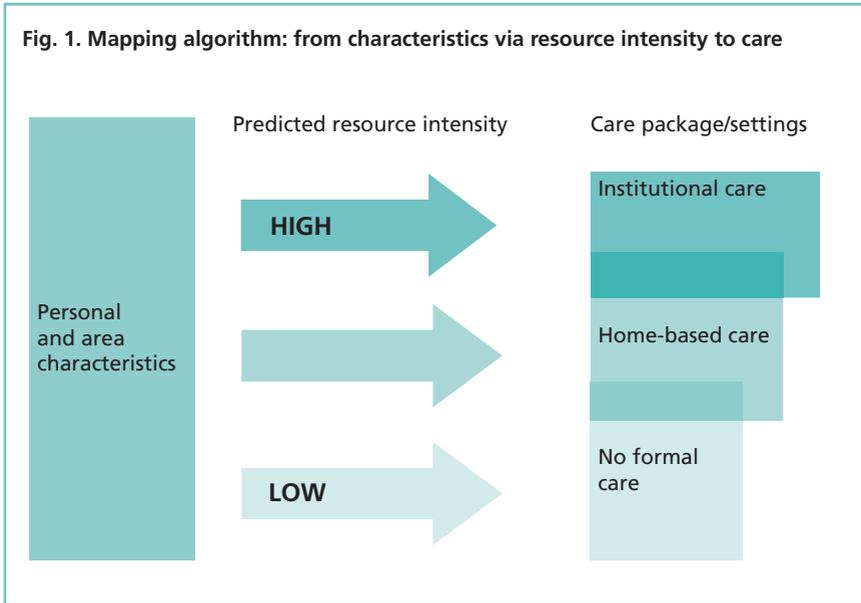
The second stage is concerned with developing a mapping algorithm linking the assessed needs of the population to packages of long-term care services and settings. This requires establishing thresholds of assessed needs (both minimum and maximum) for each long-term care setting and the potential care packages themselves. Information on the cost-effectiveness of alternative care packages for targeted populations would be important in setting priorities among these potential care packages. The aim is to establish a menu of packages of long-term care services and settings from which to choose. It is argued that improving the forecasts of assessed needs and using them in the algorithm that allocates assessed needs to a long-term care choice menu (Fig. 1) provides greater shared decision-making on services by older people. The assessed needs of older people, here represented by their predicted resource intensity, depend on their characteristics (including their caregiving resources) and the areas in which they reside. Predicted resource intensity enables a menu of choices of long-term care services and settings to be set across the spectrum of home-based, home-environment and institutional care.

Stage three: customization of care

A menu of long-term care choices represents the first component in customizing care that matches services and settings to the assessed needs of older people. The second component provides opportunities to incorporate the choices and preferences of care recipients and those of their families and friends to determine where long-term care will actually be delivered and received. This choice of where long-term care will be received represents a constrained but preference-based response that yields customized long-term care services and settings for older people.

Source: adapted from Baranek (25).

Fig. 1. Mapping algorithm: from characteristics via resource intensity to care



An important final part of an overall framework is generating information on trends in the utilization of long-term care that further enables sophistication in local planning strategies (26,27). Not all jurisdictions have access to data to populate such planning models, but efforts are required to give priority to such data collection exercises to implement evidence-informed long-term care planning.

More integrated approaches to assessing the need for and entitlement to long-term care

There are three important aspects in the delivery of national long-term care systems: provision; funding; and needs assessment. The combination of these determines the nature of an older person's eligibility for long-term care, the service delivery setting and, ultimately, the quality of their experiences. No definitive conclusion has been made on the most effective combination of these delivery components. Nevertheless, the evidence suggests that future models of care ought to develop a more integrated approach to service needs and entitlements linked to a more integrated and personalized set of care providers from a menu of long-term care choices.

Assessing the need for and entitlement to care

How the needs of an individual client are assessed directly affects the equity, efficiency and the sustainability of any particular system. Internationally, the levels and definitions of entitlement to care and the subsequent procedures of assessing needs and the availability of services vary significantly. Evidence from Europe and elsewhere (4–7) suggests that there is no simple solution and that governments face trade-offs. For example, in terms of entitlement, should publicly funded support for long-term care be universal or available only to those with low incomes or assets? What is the appropriate balance between national eligibility criteria (which may be insensitive to certain needs and may inhibit cost-effectiveness if inflexible) and individualized needs assessment (which may produce inequity)?

Both national eligibility criteria and needs-based entitlements have weaknesses as well as strengths (6). There have been concerns, for example, about inequity in diagnosis in Germany and Japan, where the national eligibility criteria do not adequately capture the needs of people with dementia. National criteria can also disadvantage those just above the eligibility thresholds for any given level of care dependence (as assessed in Germany and Austria). Additional mechanisms may therefore be needed to direct resources towards people with low-level needs, for whom small amounts of extra support could be cost-effective in generating improvements in various outcomes. This may be particularly pertinent to the older people who do not necessarily exhibit a limiting long-term chronic illness and remain somewhat independent yet are frail and need care support (28).

Systems based on national eligibility criteria must therefore be sufficiently flexible and sensitive to a range of individual needs. Similarly, countries that favour individual needs-based (and means-tested) assessment can obtain benefits by combining this assessment with some broad eligibility criteria that may take into account geographical variation in the costs and availability of care and stipulate assessment protocols to ensure quality and equity in the adjudication of service needs.

Assessing needs as the gateway to providing care

In most countries, a needs-assessment process provides the gateway to care services (and/or to the budget from which to buy them). There has been a trend across Europe towards integrated health and social care assessment for older people. This follows recognition that, as older people's needs for long-term care transcend the boundaries of services provided by both health and social care, a sole assessment by a health or social care professional team tends to influence the nature of the resources allocated (29).

The PROCARE study (7,29,30), which examined integrated services for older people across nine European countries, concluded that individual needs assessment was a crucial step to effectively attain integrated long-term care. The study favoured a single coordinated point of adjudication in which:

- care supply should not form the basis of needs assessment – the primary consideration should be towards comprehensively assessing the needs of each older person (supply should follow demand);
- the quality of needs assessment must be improved to ensure that clients' needs are met and that the equity of eligibility and access to care is maximized;
- assessment should cover all life domains by considering both social and health aspects and should be comprehensive and multidisciplinary;
- professional territorialism that impedes the flow of information must be minimized to reduce duplicate assessments and enable more coherent care packages to be designed – objectivity and independence need to be guaranteed;
- information systems to facilitate the exchange of information about older people between agencies are important in achieving more integrated responses to needs;
- older people need advocates to protect and assert their rights to care since they generally poorly understand needs assessment – procedures should be understandable for clients; and
- assessors need to understand the nature and availability of local facilities – this may be aided by centralized points of information to help people find the services they require (such as in France and the Netherlands).

Developing a simple and conveniently arranged multidisciplinary assessment process is probably the most preferable approach. However, this is complex and time-consuming and has often not materialized in countries that have aspired to it (30). Ensuring that older people receive (or purchase) the right form of care suited to their needs also favours the need for a single point of access to (independent) counselling and information. Comprehensive needs assessment must be understandable and negotiable to users and manageable for professionals (29).

Policy measures to (re-)balance service provision for older people

This section considers two main options for change to balance service provision for older people: funding arrangements that may be tailored to the needs of older people; and, in the light of the anticipated shortfall in informal care,

incentives and support that may enhance the provision of informal care.

Funding arrangements tailored to clients' needs

A major dilemma facing health care systems is associated with the fractured nature of service funding and delivery, with hospitals focusing on in-house acute care, home-based providers focusing on home care, general practitioners addressing clinic-based primary care and institutional providers focusing on the needs of their residential clients. The introduction of more flexible funding arrangements and, more specifically, arrangements for the continuum of care for designated care recipients, yield opportunities to enhance the efficiency and effectiveness of services. For instance, funding based on episodes of care for acute-care hospitals (beginning at admission to hospital and ending after post-acute in-home care) provides hospitals with the choice of extending in-hospital care or further reducing lengths of stay in accordance with the relative cost and effectiveness of each care setting. Commissioning integrated care across a range of services and settings may offer the prospect of more cost-effective services than the current segmented funding arrangements. Indeed, the policy has been piloted for specific chronic diseases (care pathway commissioning) across Europe with varying degrees of success – key limitations being enduring organizational and professional divides (31).

Consumer-directed payments offer older people the option of receiving a cash payment or individual budget in lieu of formal care so that they can choose, manage and pay for their own social care. Such arrangements are often assumed to maximize cost-efficiency since they promote independent living. There is currently much interest and variation in such payments in Europe. A study conducted for the OECD (32,33), for example, found variation in the extent to which each older person has a right to opt for direct payments or individualized budgets and in the regulations governing how they may then use them (Table 2).

The experience of direct payments in Europe has not led to a definitive answer as to whether they enable more appropriate caregiving. A review of cash for care systems in Austria, France, Italy, the Netherlands and the United Kingdom concluded that no single scheme had a simple outcome or advantage but that all had commodified formerly unpaid informal care and enabled flexible mixes of informal and formal care where regulation was low (34). A result of the approach in Germany is that some older people elected to receive cash (at a lower value than benefits in kind) because they preferred to receive care from family and friends rather than strangers and because such income is tax exempt (35). In the Netherlands, the personal budget scheme is expanding rapidly because it enables older people to bypass waiting lists for some services (6).

Table 2. Take-up of direct payments and individual budgets in selected European countries

Country	Type of payment	Employment of relatives allowed?	Percentage of people >65 years receiving payment
Austria	Cash allowance	Yes	100
England	Voucher or direct payment opt-out from local authority care to clients "able to manage" with assistance	Yes (but not if the caregiver resides in the same home as the care recipient)	1
Germany	Option of a cash allowance or care in kind or combination of the two	Yes	80 (including those with a combined care package)
Luxembourg	Option of a cash allowance to cover the first seven hours per week	Yes	91 (including those with a combined care package)
Netherlands	Personal budget option when eligible for long-term home-based care	Yes (but not if the caregiver resides in the same home as the care recipient)	7
Norway	Personal budget for care assistants when the local authority considers this option better than formal care	Yes	2
Sweden	Cash payment from local authority (if the care recipient is assessed as needing at least 17 hours per week of care)	Yes	1

Sources: developed from material in Lundsgaard (32) and Poole (33).

The potential hazards of direct payment systems include:

- how a lack of regulation in Austria and Italy led to additional income being used for general household use rather than for care (33);
- that beneficiaries who chose full cash benefits could not then subsequently gain access to and/or afford formal care when needed (36); and

- that responsibility for securing care, while increasing control and rates of satisfaction, led to problems in the support needed to manage the subsequent administrative burden in coordinating care (6).

The debate in Japan over cash payments concluded that the approach had the potential to save money (if they were set at a lower level than the cost of formal services, as in Germany); maximize consumer choice; and reward the role of family caregivers. However, the cash payments also inhibit the demand for formal services; they depress the market and reduce the range of service providers for those who want to use outside help; they would not change existing (oppressive) caregiving patterns in the informal sector; and the system could end up costing more because everyone would apply for cash whereas only those who really wanted services would ask for them (37).

Four key issues emerge regarding the usefulness of direct payments as a policy option in Europe.

- People value being in control, but the burden of administration and risk falls on the user and their family. Support is necessary to facilitate care provision and, to some extent, enable appropriate care choices.
- The quality of personal care purchased is uncertain – an incentive is created to underuse potentially needed formal professional care that is more expensive. Informal caregivers need formal training to ensure quality standards.
- Consumer-directed payments are not necessarily cost-effective to the system – they encourage the take-up and use of cash payments to those who otherwise would not have claimed state support; and formal provider agencies may offer more expensive services to individuals than to public-sector departments who, for example, may broker lower hourly prices through block-bookings.
- Direct payments offer choice, but many people choose to spend resources for practical or lifestyle outcomes as much as for personal care needs (33).

Incentives for the ongoing provision of informal care

The services of unpaid caregivers provide a substantial component of support for independent living. Their involvement in delivering services is often necessary to provide for ageing in place, but the provision of such care is frequently stressful, resulting in burnout and potential withdrawal or reduction in labour market activities, especially if caregiving responsibilities are extensive (38). A key policy issue for the future is whether there will continue to be enough unpaid caregivers. The following trends in the demands for and

availability of informal care fuel this concern over the availability of sufficient informal caregivers.

- The increasing proportion of older people means that the number of available younger caregivers will decline.
- The caregiving populations themselves are becoming older and will require more support in delivering care and perhaps in supporting care for themselves.
- The predicted greater intensity of caregiving will impose a significant burden on the mental and physical well-being of unpaid care providers (29), especially those caring for individuals suffering from cognitive impairment such as dementia (39).
- More older people are living alone rather than in family units, a factor exacerbated by the greater distances between family members (and associated monetary and time costs) and increased rates of divorce and separation (40–43).
- Although most caregivers maintain work alongside their caregiving priorities (5,29) and the need for caregiving restricts decisions to work or not (44–45), there is a trend towards greater participation of caregivers, particularly women, in the labour force (8,40,44), especially when caregivers do not live with the care recipient (46).
- The expense associated with informal care delivery in systems in which charges for supplies and equipment must be borne privately raises the potential for inequity in care access and quality by socioeconomic status (47).

Providing entitlement to a range of benefits is an important future step in promoting and maintaining the supply of informal caregivers (Box 2). Some countries, such as Austria, Germany and Japan, have opted to address this through long-term care insurance schemes that provide national entitlements to cash allowances and caregiver support functions (48). Mandatory long-term care insurance in Germany was instituted in 1995. Advocates celebrated its passage as the fifth and final pillar of its social security system after health, unemployment, pension and accident insurance systems. Contributions are fixed at a given percentage of income and financed equally by employers and employees. Insurance covers financial incentives, training, social security and pension contributions for caregivers as well as the care and requisite home infrastructure. Care recipients are responsible for service needs exceeding the defined benefits, but the social services pay for these if the cost is too high. Similarly, mandatory long-term care insurance for older people in Japan was established in April 2000. It is currently funded via out-of-pocket payments

Box 2. Various national and regional initiatives to promote informal care**Respite care and caregiver support**

In the Netherlands, support is provided for unpaid caregivers in the form of in-home respite care and advisory services (40). Barriers to the take-up of these services include lack of information about service availability and service access (50,51). California established caregiver resource centres, and Australia established a network of Commonwealth Carelink Centres that aim to provide a single point of access to an array of caregiver support and information services (40,52,53). The Caring about Carers initiative in the United Kingdom provides similar facilitated support to day centres and helps arrange formal in-home care.

Cash or direct payments

In Finland, payments are provided based on income and the intensity of care required (54). Similarly, in Australia, a means-tested allowance is available for co-resident caregivers, and an allowance is available for co-resident caregivers who provide substantial amounts of care (42,43). Although the scheme is promoted based on improving choice and flexibility of resource use to individuals, evidence indicates that the policy has increased the demand for respite care so that it exceeds supply (41). Australia has emphasized respite care through the National Respite for Carers Program introduced in the late 1990s (42,43), and the United Kingdom has similar programmes via its Caring about Carers initiative. Caregiver allowances, direct payments and protected rights to a state pension for caregivers are its most notable features.

Benefits in kind

Many countries enable caregiving by protecting or providing entitlement to state benefits. For example, in the Netherlands, caregivers may accrue a pension if they do not have one and they may receive accident insurance. The United Kingdom has protected rights to state pensions (41,55).

Employment law

Flexible working arrangements for caregivers, including paid leave, part-time work and the ability to work from home, have helped caregivers to simultaneously work and provide care (53). The Work and Care Act in the Netherlands, for example, was designed to make it easier for people to combine caregiving with employment by allowing for leave.

(10%), national and local taxes (45%) and insurance premiums (45%). Those aged 65 years and older pay a monthly fee based on income (or pension) that varies by jurisdiction and service type. Those aged 40–64 years pay a monthly fee co-shared with employers through their health insurance premiums (49). Eligibility is based solely on need, and the system provides for formal care in institutions and respite care in the home. Unlike Germany's system, the scheme has no cash benefits.

The insurance arrangements in Germany are designed to encourage caregiving, but there is concern that the insurance arrangements do not address the growing proportion of older people because they are designed as a pay-as-you-go scheme. If benefits remain uniform, the scheme may become insolvent unless benefits are reduced, premiums raised or the insurance fund is supplemented with taxation. Similarly, when confronted with escalating costs, the Government of Japan considered several modifications, including reducing benefits, raising premiums or increasing the number of contributors (56). For such schemes to remain viable in the longer term, long-term care insurance may need to move away from pay-as-you-go schemes, become broader in scope and develop flexibility.

Tailoring change to local circumstances

The context for care varies enormously across Europe and varies substantially among individuals in a given jurisdiction. The prospect of sustaining the current level of service provision or even modifying and reforming such services, settings and supports is therefore challenging. Although there are numerous options and approaches, this policy brief has focused on four important policy initiatives that might be pursued to advance the health and well-being of older people, their caregivers and society more broadly.

The mechanisms used to fund, organize and deliver health and social care adopt different shapes in different contexts and depend critically on locally specified policy goals and objectives. Moreover, the funding and organizational arrangements used in one location cannot generally be applied to another unless they are customized to that region. This raises an additional set of issues.

Historically, in most European countries, the social contract implied that current (younger) generations pay taxes or insurance contributions now to fund services for older people, and the next generation would pay into the system to fund services required by the current generation when it reaches retirement. Nevertheless, what is more important than the growth in the number of older people is the changing distribution of the population across age groups. As changes in old-age dependency ratios highlight, the number of older people relative to the number of taxpayers and/or insurance contributors has been rising. Thus, the financial burden on younger generations to pay for older people's care may potentially become large enough to threaten the social contract.

Much of health care has been funded on a pay-as-you-go model in which current revenue is used to fund current programme expenditure for older people. The implicit rate of return on the contributions paid when people are young to support social security payments and health care to older people were

taken to equal the rate of population growth. This assumes that the population would grow at a constant rate and that the age distribution would remain the same. The rather rapid changes in dependency ratios in some high-income countries have strained governments in meeting future service and quality expectations.

Most European countries did not experience a prolonged baby boom in the way North America has and have therefore been grappling with the population imbalance for a longer period of time. Germany, like Japan, with high dependency ratios, has introduced long-term care insurance as a means of funding the current and expected increased demand for long-term care services. Nevertheless, current premiums may not be sufficient to fund current use because of the population imbalance. Pay-as-you-go schemes may therefore not work in the future. Thus, most high-income countries will have to begin (to differing degrees) to encourage people to save for their own future health services rather than relying on taxing the next generation. Australia has now taken active steps in this direction through its introduction of mandatory private superannuation funds. This may represent the general direction of long-term sustainability of long-term care provision for older people.

Integrated markets such as the European Union will also potentially impact the distribution of population by facilitating cross-border migration of workers. Young people may increasingly leave countries with a high social security burden for ones that impose lower taxes. The current generation of workers being less captive taxpayers than previous generations may limit the capacity for national governments to secure long-term stable funding from one generation for another.

The shift in population distribution also affects the future supply of health care workers and the availability of informal care providers. The move towards providing direct payments to health care clients allows them to compensate informal care providers. Nevertheless, the extent to which care systems can rely on a ready pool of such providers will vary across jurisdictions, and the supply will probably decline. As delivering care in a more decentralized manner (compared with institutionally provided care) may require even more labour, capacity shortages among professional workers may also attenuate a shift to home and community care in the future.

One result may be that some jurisdictions will have to rely more heavily on immigrants, with the consequence for poorer jurisdictions that they become net exporters of such labour. Another result may be that certain jurisdictions rely more heavily on institutionally based care or supportive housing. This could in part be driven by labour shortages but also by the average quality of the home environment. Ageing in place is a laudable goal but must be weighed against

the material capacity of the care recipient to live in a home that is conducive to the receipt of high-quality health care and the capacity of governments to fund the infrastructure necessary to deliver care in the home and community sector. This is particularly pertinent to the countries with emerging economies, such as in eastern Europe, where the capacity to fund, plan and provide effective long-term care services is unlikely to enable policy-makers to act on the recommendations for change emerging from this policy brief in the short to medium term.

Whatever the local circumstance, the future trajectory is in some sense already built in. The trends are evident and governments must be encouraged to act now to make the best use of the mix of resources they have in terms of skilled labour, infrastructure, technology and informal care networks to deal with the rapidly changing population demographics and the expectations of their constituents.

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