AGED CARE LITERATURE REVIEW

COORDINATION AND INTEGRATION OF SERVICES

25 January 2001

Contents

1. Integration

This section on integration reviews attempts across the globe to integrate and coordinate health and disability services for older people. It begins with a selection of general commentary on integration and reform trends across countries. The section then reviews the general national integration strategies of a number of countries: Australia (including a section on initiatives and policies at state and territory level); Canada (including a section on initiatives and policies at territory level); United Kingdom; Japan; Germany; and Denmark. Finally this section on integration reviews a selection of literature which describes, and less frequently, evaluates, specific integration projects in: Australia; United Kingdom; Denmark; the Netherlands; the United States; Italy and New Zealand.

- Stone in "Long Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty First Century" makes the following comments about the importance of integration (his comments are in the US context).

- The following elements are critical to achieving the goal of integration of services:

  1. Broad, flexible benefits, including primary, acute, and long-term care.

  2. Delivery systems that go beyond hospital, physician and post-acute services to include community-based LTC, case management and specialty providers.

  3. Adoption of care management and care planning protocols, interdisciplinary care teams, centralized records and integrated information systems.

  4. Quality systems with a single point of accountability.

  5. Flexible funding with incentives to align payers and minimize cost shifting.

- Barriers to the integration of acute and long-term care:

  1. Fragmentation of funding sources.

  2. No valid and reliable risk adjustment methodology or other techniques to ensure that payments are adequate to cover the costs of providing care to people with chronic illness and disability.

  3. Lack of knowledge, information and training needed by health and long-term care providers to offer, coordinate and manage an array of services.

a. No recognized authority in the current health care system for managing care across time, place and profession and little acknowledgement that individuals with chronic disabilities move back and forth between physicians, hospitals, nursing homes and their own homes.

b. Acute and post acute providers generally do not communicate with long-term care providers, even though an elderly person may be getting services from both sectors.

c. The absence of management information systems and patient databases that span time and place creates a further impediment to the integration of acute and long-term care services.

- In view of strong market incentives to do so, a number of US providers are attempting to create integrated service systems:

  1. Hospitals are vertically integrating – buying up nursing homes, rehabilitation centers and home health agencies – in an effort to become an all-purpose provider in the community.

  2. Skilled nursing facilities and, to a lesser extent, home health agencies are integrating horizontally – building alliances with hospitals, physician groups, assisted living developers and other community-based providers.

- **Note:** Take a look at the National Chronic Care Consortium (NCCC) – a strategic alliance of 31 non-profit health systems in the U.S. and Canada. Its vision is integrated care for individuals with chronic health conditions and disabilities (see Stone for further in-depth discussion of long-term care).

- The importance of integration is almost universally stressed in the literature reviewed on aged care. One approach to coordinating a patient's care is the development of an integrated care pathway. Sulch and Kalra reviewed six non-randomised studies of acute stroke concerning rehabilitation and reduced hospital stay. They concluded that integrated care pathway methodology may facilitate quality and cost improvements in stroke care, but evidence is weak and uncertainty exists so that further evidence is needed before implementation in practice. This conclusion however appears to be limited to the issue of stroke management.

- Coleman in her article on "European Models of Long-Term Care in the Home and Community" observed that "central governments in these countries [Sweden, Denmark, the Netherlands, and Great Britain] have developed long-term care systems that improve the quality of care, ensure more efficient delivery of services, and control or lower costs. They have:

  1. Discouraged the building of additional nursing homes and instead supported the development and expansion of a range of housing alternatives;

2. Shifted greater responsibility to local governments for delivering long-term care services, bringing those services closer to those who need them;

3. Developed care management techniques that enable care providers to better target appropriate services to each elderly client; and

4. Provided incentives for different types of care providers to coordinate their work, resulting in improved service delivery and greater client satisfaction (p 455 Coleman, see article for further country-specific details).

- Butler et al in their review of international literature on assessment of elderly identified a number of trends in countries, which have striven to overcome the problem of fragmentation of services (although there is no single agreed route being followed) (p 8):

  1. Greater central guidance on policy and resources;

  2. A single, local focus for care management;

  3. A holistic view of needs;

  4. Supplying a flexible individual 'service mix';

  5. Linking services and family care.

- Brodsky et al in a comprehensive review of long-term care laws in Austria, Germany, Israel, the Netherlands and Japan, noted several broad strategies that had been employed in those nations to improve long-term care:

  1. Concern about the availability of services was common in all the countries reviewed. A common strategy they have used to expand service availability is to encourage for-profit agencies to enter the long-term care market.

  2. While increasing the range of service providers, competition has been restricted to quality and does not include price (which is mostly fixed). This reflects an effort to avoid the emergence of separate services for the rich and the poor, and to control costs.

  3. The countries use a range of methods to limit costs. They set minimum disability levels for eligibility and maximum benefit levels and they require co-payments. In addition, Israel uses a means test (albeit a liberal one) and the Netherlands takes into account family support.

  4. The basic strategy adopted by most of the countries is to provide coverage of a greater number of people rather than providing more intensive services to a smaller group. This clearly implies that there is no commitment to meet full needs, even when no other source of care is available. The exception is the Netherlands, which combines an entitlement with a discretionary process of assessing eligibility.

- Areas identified as needing further attention and policy development were:

  1. evaluation of the reliability of assessment tools;

  2. ensuring quality and preventing abuse;

  3. defining the options of in-kind and cash benefits and combinations of the two;

  4. ensuring access to fragmented services is better coordinated

  5. the implications for cost, quantity, equity, accessibility and acceptability of different options of contracting and subcontracting services;

  6. further research into the possibility that costs will increase much beyond projected levels (as they have not done in Germany but is a major concern in Israel).

General Strategies at National and State Level

Australia

- The importance of integration of services underpins much of the policy work on aged care in Australia.

- Responsiveness (and the necessary importance of linkages) are stressed in the World Class Care discussion document for the National Strategy for an Ageing Population.

- That document explicitly recognises the need for more effective partnerships and greater communication and coordination between aged and community care services (p 59)

- It is important to note that in the Australian Health Care Agreements (between the Commonwealth and States and Territories), under schedule C specific performance indicators relating to integration of care will be reported on annually (p 60)

- Gething stresses need for integration/removal of boundaries and flexibility

- One example of an attempt at national integration of policies and consistency has been the development of a Commonwealth, State and Territory Strategy on Healthy Ageing by the Healthy Ageing Task Force. The Healthy Ageing Taskforce was established by the Commonwealth, State and Territory Health and Community Services Ministers in October 1996 in recognition of the need for a strong focus on ageing, as well as improved planning and coordination across jurisdictions. The Task Force undertook extensive consultations before compiling its strategy. The Strategy is a broad framework. Its "key result areas" specify a need for Governments to take action to develop policies and initiatives in order for instance, to improve community attitudes to ageing and older people, to improve heath and well-being for all older Australians, to ensure appropriate and affordable support so that older people can meet their needs and aspirations and remain in their own homes for as long as possible, and maximise use of good quality data, including older people's experiences.

- Funding is available through the National Health Development Fund and the Quality Enhancement and Improvement Initiatives Program for the development of projects and programs to improve patient outcomes and integration of care. A number of States are seeking to use the NHD funding to develop information linkages, facilitate joint service planning, assessment and referrals etc. (World Class Care, p 61).

- The National Demonstration Hospitals Program (NDHP) has published a guide to best practice in discharge planning and post acute care coordination (World Class Care, p 62).

- A number of State Governments have policies and strategies aimed at producing consistency and integration of services available to older people (eg <u>A Five Year Plan for Western Australia's Maturing Population</u>)

- The need for better care coordination is a central plank of the National Strategy (<u>World Class Care</u>, p 64).

- The 1999-2000 Federal Budget included initiatives intended to improve and better coordinate primary health care of older Australians eg new Medicare Benefits Scheme items to provide payments for medical practitioners who are involved in case conferencing and care planning for people with chronic illnesses and complex needs. An incentive will also be provided through the Practice Incentives Program for GPs to ensure that their patients aged 65 and over with chronic and complex needs have care plans. Budget also includes funding to improve access for people with chronic illness to activities such as self-care education programs and peer support (<u>World Class Care</u>, pp64-5).

- Another example of a national attempt at integrating services is the network of 140 regionally based multidisciplinary Aged Care Assessment Teams (ACATs), which provide services across the entire continent. ACAT are responsible for determining eligibility for admission to residential aged care facilities and for community aged care packages (an intensive form of home-based support akin to hostel-level care).

- Recent literature on approaches to assessment (see <u>Butler et al</u>) tends to centre on three themes:

- The continuing tension between clinical/medical and social approaches to assessment;

- Tension between the two major purposes of assessment – identification of individual needs and the allocation of scare health and welfare resources; and

- The literature reflects an historical shift away from a perception of assessment as an integral part of service provision to an independent client-focussed process. Despite the emphasis on client focus however, there are few empirical studies, which investigate the process and everyday practice of assessment so further research is needed.

- Assessment is the lynchpin in ensuring coordination of aged care services. However, <u>Butler</u> (p 10) notes: "In Australia, the ACATs provide a single regional focus for assessment [rather than care management by local government authorities as in Finland, Sweden and the UK], but do not provide the long-term care management for clients. Indeed, ongoing care management is normally only provided for older people who are recipients of specific intensive community care packages, such as Community Options or Community Aged Care Packages. There is an increasing trend towards individualised care packages in different regions. Butler argues considerably more work and research is needed in the area of assessment, in particular how it is carried out in practice.

- One ambitious and innovative initiative has been the introduction of Commonwealth Government's Coordinated Care Trials, which are intended to ensure a coordinated approach to complex needs of older people and, through the pooling of resources, to remove distortions that may arise from funding being sourced from different programs and different jurisdictions. Total of 13 initially established. Final evaluation in July 2000 but initial date suggests that pooling funds from different programs may be of benefit for people with significant care coordination needs, but that costs and risks of pooling funds may not be warranted for people with less intensive needs for coordination. There is therefore a need to select people who will most benefit from the high level of care coordination available through the trials.

- The current trials suggest that effective coordination requires an effective primary care team approach, in which GPs play an important and integral part and also suggest local ownership of coordination processes is very important. Would need wide ranging agreement between providers, clients and different levels of government for the lessons to be extended (World Class Care, pp 66-7).

- The MultiPurpose Service scheme, jointly funded by Federal and State and Territory Governments, also provides coordinated and cost-effective delivery of services to people living in rural and remote regions. Currently 35 services and a further 31 sites have been approved (Financing, p 13).

- Another move which can be said to be moving towards better integration is the shift in focus towards focusing on the level of care and services needed rather than the facility where the older person resides.

- However, Howe notes that residential care is a small-scale activity and "these scale factors pose very real constraints on the range of care needs that it is feasible to meet, to a high standard, within any one facility. That the response to the opportunities presented by integration may be cautious, is indicated by 2 papers on ageing in place commissioned by voluntary sector industry bodies which detail a number of difficulties for hostels seeking to provide higher level care" (p 13).

- Vertical integration is reasonably advanced among some larger voluntary sector providers, but the private sector is characterised more by horizontal integration with a few large providers operating substantial numbers of nursing home beds. (Howe).

- Bringing the many small nursing hostels in the voluntary sector and the many small nursing homes in the private sector into some wider organisational structure is a major challenge for the future. (Howe)

- Trends in residential care and retirement housing market have an impact on each other and the population living in hostels is about the same size as the population living in retirement villages (Howe).

- Retirement villages are beginning to compete with hostel care as a choice for older people. Marketing care is far more controversial than marketing accommodation. Also the means-related capital charges applying to hostels mean that retirement housing can compete for value for money. Finally, the extent to which retirement villages enable residents to age in place will reduce demand for the equivalent levels of care in hostels (Howe)

- This is further compounded by the fact that the Residential Classification Scale has resulted in upward classification at the margin between hostels and nursing homes and across the board (Howe).

- Howe supports any moves to integration, not only between hostels and nursing homes. She writes: "hostel accommodation is increasingly sitting alongside a greater range of support in retirement villages and public housing. This trend could be furthered by recasting care in hostels as packages that just happen to be delivered to residents in a particular housing setting. Hostel providers who are already involved in Community Aged Care Packages (CAPCs) should be readily able to apply this model to their residents, and further separating care services in this way would encourage them and other residential providers to become involved in community care…Whereas closer integration of nursing homes and hostels may segregate the formal residential care sector from other care and housing arrangements, greater diversification would promote greater mixing of residents, both socially, and in terms of dependency, in a variety of housing settings, and so foster wider choices." (p 16)

- An example of integrated residential care is Helping Hand, a provider in South Australia, which operates an 100 bed unit with 50 beds each at high and low level care and also provides some community services through operating a pilot for ageing in place (Judy Glackin meeting with Ian Hardy, CEO, Helping Hand, see attached).

- A number of initiatives are addressed in the World Class Care discussion document (pp 45-8), which can be seen as enhancing integration of services. For example:

  1. The Australian Council of Safety and Quality in Health Care has been established as a means of coordinating and building upon many safety and quality issues.

  2. The Home and Community Care (HACC) Program has a Quality Assurance Framework to promote consumer rights and service quality and accountability

Examples of Practice Based Integration Policies at the State or Territory Level

(a) South Australia

- In 1997-8 Commonwealth Government expenditure on residential services in South Australia was $1,804 per older person aged 70 years and over.

- One example of a provider offering coordinated services to people with disabilities is the Western Domiciliary Care and Rehabilitation Service (Western DomCare). It is a regional aged and extended care service in Adelaide, which provides a variety of services. Programs involve care planning assessment (including home-based and centre-based care, respite care and prevention and health promotion activities), ongoing monitoring of the care plan, client and carer support and advocacy, participation in community and service development and in quality improvement activities. (Mykyta et al).

- Western DomCare was originally funded through the States Grants Act 1967. From the early 70s it had a system of assessment in place for the existing Domicilliary care services offered. When the HACC program was introduced in 1985 the same assessment process was used and Western DomCare became a single point of entry into the publicly funded case system as the largest, and virtually only provider in the Western Metropolitan Region.

- In the early 90s, the national aged care assessment team was introduced to provide a gate-keeping service for residential care. This was funded separately in South Australia and operates in accordance with very precise national guidelines (we do not have a copy of these guidelines). Although the two teams were employed and deployed by Western DomCare, use the same clinical records, and have some employees in common, the two systems were quite separate and there was unnecessary duplication.

- Therefore, in 1999 Western DomCare developed an action plan for a new improved single entry point and assessment service called Entry One. This is an attempt to integrate all referral, triage, assessment and entry functions in the area (see further detail in document)

- In 1999 the South Australian Department of Human Services developed a strategic plan for older people to be implemented in five years aimed at improving and integrating services available to this group (Moving Ahead). The strategic directions developed towards this are:

  1. Increase the investment in prevention and the promotion of well being for older people;

  2. Improve access to information and support;

  3. Sharpen the focus on the benefits of integration;

  4. Address specific service gaps;

  5. Develop common entry processes linked to the primary care and community support system;

  6. Integrate acute care with pre and post acute services;

  7. Coordinate care for people with complex/chronic needs;

8. Respond to older people with special needs;

9. Give priority to developing system responses for Aboriginal people;

10. Integrated planning;

11. Effective resource allocation; and

12. Management for quality performance.

(b) Victoria

- Better Access to Services (Victoria) identifies five fundamental approaches for service access, which the state intends to work towards

    1. Engagement of General Practitioners;

    2. Active consumer participation;

    3. Involvement of the full range of services;

    4. Interface with other service sectors, and

    5. Integrated information management.

- This requires

    1. A broad implementation strategy;

    2. An information resource to underpin the draft policy framework;

    3. A Minimum Data Set with common core consumer information, data definitions and data standards;

    4. An initial needs identification tool template;

    5. A Care Planning tool template; and

    6. An evaluation framework.

- The Victorian Policy Framework for Aged Care Services was released in August 1999 and is entitled "Ageing Well". The document has two key themes: ageing well and ageing in place. It also stresses the importance of matching services to the needs of people (p 1).

- In 1992 Victoria created a unified Aged Care Program and appointed a dedicated Minister for Aged Care. Milestones from 1992-1999 included:

    1. Establishment of aged health and extended care services and redevelopment of the State's role in long term care;

2. Establishment of a state-wide aged health service framework providing locally accessible services (this led for instance, to development of community and hospice-based palliative are services in all region, specialist home based geriatric rehabilitation and a new range of specialist clinics providing assessment and treatment for incontinence and dementia);

3. Enhanced and expanded community-based response services (in particular the Linkages program was significantly expanded for people with complex needs together with a major boost in respite and other support services for carers and strengthening of assessment services); and,

4. Planning a society for all ages (increased attention given to seniors' issues and the 1997 parliamentary report of the Inquiry into Planning for Positive Ageing led to the development of a whole of government approach to positive ageing which culminated in the launch of a plan called <u>Creating a Victoria for all Ages.</u>

- The 1999 Victorian Strategy has four main components:

  1. Keeping people healthy and independent;

  2. Supporting independent living;

  3. Managing illness and chronic conditions, and

  4. Modernising long term care.

- The first component involves:

  1. *Implementation of the positive ageing plan*, which will involve enhancing transport and mobility for older people, ensuring that urban design helps minimise social isolation and encouraging the design of age-appropriate housing;

  2. *Implementation of the wide ranging reform of Primary Health and Community Support Services (PHACS)* which will improve coordination and integration of service delivery and introduce new health promotion and disease management programs, *and*

  3. *Improving housing and support for older, vulnerable people.*

- The second component involves:

  1. *Enhancing home care and support* (home care and support services are provided through every local government area in the State and is the mainstay of the community service provision. Key activities include development of a purchasing strategy, development of a standardised suite of core services accessible in all local government areas, improved

coordination of services around the individual through the implementation of the PHACS reforms including more integrated approaches involving GPs, better linkage of community care with acute, sub-acute and other primary health providers, development of new funding models and improved targeting of vulnerable groups);

2. *Improving community care for people in insecure housing* (This involves the implementation of innovative service responses at a range of inner city community housing locations, increasing access by eligible older people living in low-cost accommodation to appropriate, flexible and responsive services, and continued activity to monitor, regulate and work with the Supported Residential Services industry to ensure that the quality and accessibility of services provided through this private sector industry are enhanced and meet community standards); and,

3. *Using technology to support independence* (This involves the expansion of Personal Alert Victoria, a service providing personal response systems to vulnerable older people living independently, improve and increase access to information technology and telecommunications infrastructure by older people with special needs and cooperative work with the industry to encourage application of adaptive technologies to independent living for people with disabilities).

- The third component involves *integrating and targeting levels of care to improve quality and outcomes*. To achieve this the Government will ensure:

  1. Establishment of the sub-acute services system to ensure equitable base access across the State;

  2. Expansion of specialist outpatient clinics to focus on early diagnosis, treatment and management of conditions. The clinics will provide increased support to GPs and other primary care providers;

  3. Improving continuity of care between the specialist aged and extended care system and the wider health and community service systems through client-held records, effective case management, and protocols that enable each client's GP or primary clinical advisor to participate in the client's care within the sub-acute system;

  4. Further integration of aged and community health and support services in small and isolated rural centres;

  5. Development of new funding models aimed at integration and ensuring the money follows the client;

  6. Enhanced and expanded dementia services through continued implementation of the State's dementia strategy; and,

7. Increased focus within aged persons mental health services to respond to the increasing prevalence of depression; and continued support and development of a skilled health workforce.

- The fourth component has the following key initiatives:

  1. Continued devolution of at least 2,500 residential care places to the private or voluntary sectors by 2001;

  2. Continued capital investment in improving the fabric and quality of residential services provided through the public sector;

  3. Continued improvement of the adequacy, efficiency, accessibility and flexibility of the residential care service system in Victoria including the proposition of a bi-lateral approach to a trial of the new Victorian model; and,

  4. Continued support to the health and long term care industry and the building design industry in the promotion of innovative, high quality and efficient designs for health and long term care services for older people.

- For a fuller discussion of Victoria's initiatives, particularly in the area of sub-acute services see presentation by Calder.

(c) Western Australia

- Western Australia released a five year plan for aged care to celebrate the International Year of the Older Persons (A Five Year Plan for Western Australia's Ageing Population). Plans designed to better coordinate services include:

  1. Generate community and government agency support to establish a Centre for Positive Ageing, with input from the State's five universities, to research all aspects of ageing and improve some services;

  2. Government developing a communications strategy to encourage greater access by seniors to services they are entitled to;

  3. Work at improving and promoting health services, including for instance developing an Active Ageing framework for WA to promote healthy lifestyles, recreation and community participation;

  4. Coordinate the preparation of a State Carers Policy

  5. Review retirement village legislation, develop a plan for seniors housing and provide land and meet construction costs for a pilot seniors housing project.

(d) New South Wales

- NSW government has worked with the Commonwealth Government towards a number of substantial improvements in aged care systems, particularly in enabling ageing in place (Trialing New Ideas).

- There are many services and providers and old people still find gaps, still have problems with coordination and inadequate information.

- Recommendations:

  1. That demonstration projects be developed to trial new ways of funding and delivering community-based aged care services in New South Wales;

  2. That govt agencies give in principle support to the development of the demonstration projects.

  3. That the detail of the projects be determined after further consultation;

  4. That the implementation of projects be overseen by a project coordinating group, involving representatives from consumer organisations, service providers, appropriate government departments and the Office on Ageing. Key focus on improving integration and coordination.

Canada

- "There is now growing support for a rostered approach to primary care, delivered to a defined population by a team of family doctors working in partnership not only with each other but also with nurse practitioners, nurses, midwives, nutritionists, physiotherapists and perhaps others. This would ensure a much more responsive mechanism for primary health care needs, so that people are not forced to go to the emergency room after five p.m. This includes twenty-four hour accessibility and a method of payment for a physician that is other than fee-for-service. It has to be fair compensation, worked out with the involvement of the doctors to respect their professionalism. It has to provide for holidays, continuing medical education, and a fair pension. And it could involve negotiations between a given hospital and a team, depending whether or not physicians wanted to work full time or be on call" (Iglehart, p. 137)
.
- "The most recent positive step we've taken is the creation of the Canadian Institutes of Health Research, which is a new way of conducting and funding health research in Canada. We're moving away from the medical research model, which has been our proud past, and we're building on that achievement toward a broader approach to health research. The Canadian Institutes of Health Research has as its expressed statutory mandate the organizing, encouraging, and funding of health research along lines of excellence devoted to biomedical, clinical, health services and health determinants research. All four of those perspectives will be at the table in every element of the institute's work. Thus, we're building health determinants and population health perspectives into all health research that we fund and conduct in Canada" (Iglehart, p. 138).

- Canada's 1999 budget included $300 million as a first step toward the development and implementation of a health information system.

- $100 million is being used by the Canadian Institute of Health Information to put systems in place to gather, aggregate, and assess information to measure outcomes in the health care system.

- The first annual report, to be published in 2000, will provide an assessment of outcomes in community health care, coast to coast – an inventory of services and facilities that are available and an assessment of their performance.

- The federal government is working with provinces to:

  1. Produce an electronic patient record system that will make patients' information available no matter where they seek treatment, and

  2. Telemedicine – technology that will enable diagnosis at a distance through teleradiology, and continuing medical education at a distance through interactive involvement by physicians in remote places learning about new developments in medical science from specialists at distant centers. (Iglehart, p. 139).

- Bergman et al have claimed that in Canada there has been increasing pressure on the primary care and continuing care networks. However, they argue that "the present system of care for the frail elderly, who are particularly vulnerable, is characterized by fragmentation of services, negative incentives and absence of accountability…..Canada needs to develop a publicly managed community-based system of primary care to provide integrated care for the frail elderly."

- The model they propose is called SIPA (a system of integrated care for the frail elderly). It would be a community-based primary care system based on a patient-focused model. It would be responsible for primary and secondary medical and social services, prevention, rehabilitation, medication, technical aids and long-term care, but not for ultraspecialised services such as transplantation.

- One SIPA center would be responsible for the entire population of frail elderly in a given region. It would serve as a single entry point for all frail elderly, who are deemed eligible if they have severe disability in 1 of the following areas, or mild to moderate disability in 2: activities of daily living, instrumental activities of daily living, mobility, mental status or continence. All eligible people would be registered with SIPA following evaluation. SIPA would use a multidisciplinary team to evaluate needs, plan and deliver services. For contracted services, including those obtained in an acute care hospital or long-term care institution, SIPA maintains its financial responsibility for costs incurred and shares the clinical responsibility. Elderly people would be encouraged to remain patients of their family doctors or to choose the SIPA physician (compare with PACE model below). A single SIPA budget would be based on the number of people enrolled, the socioeconomic and demographic characteristics of the elderly population within its territory, and the budget

available from the regional health board or ministry. The program would undergo independent evaluation.

- The authors argue that the proposed SIPA model that they describe "represents a major challenge and change to the existing system of care". They recommend that demonstration projects be developed to investigate the experience of integrated care in the Canadian context and to evaluate SIPA as an efficient and cost-effective model.

Examples of Practice Based Integration Policies at the State or Territory Level

(a) Quebec

- The government of Quebec is moving into "an integrated service delivery model for the elderly called *systém de soins intégrés pour personnes âgés en pert d'autonomie* (SIPA) or *the system of integrated care for the frail elderly*. This model provides for an integrated system of service delivery with single entry and ongoing case management for a full range of community and facility based Long Term Care and Home Care Services. An innovative aspect of this project is that it may be funded on a capitation basis." (Hollander, p. 12).

(b) Ontario

- Litwin and Lightman have reviewed Ontario's aged care policy.

- Ontario has maintained one of the highest rates of institutionalization among developed countries. The long-term policy toward the senior population over the years was primarily medically oriented and facility based, with less attention paid to the social aspects of aging. There was a mix of private and public offerings, with little overall coherence or programmatic integration.

- Community care and in-home services for the aged have tended to operate as supplements to or substitutes for institutional care, rather than as programs with their own inherent logic.

- In 1990, the government released Strategies for Change, a combined discussion paper and statement of intent that set the framework for the development of what was to be a "coherent, integrated service system based on the foundation of existing in-home, community support and long-term care facility services." In early 1995, Bill 173, An Act Respecting Long-Term Care in Ontario, was passed.

- The scope of the reform in Ontario was limited to the long-term care needs of the elderly and persons with physical disabilities (including respite and palliative care). As the process evolved, the elderly received the bulk of the attention.

- While general access to medical services was available to everyone without user fee as part of Canada's universal medicare program, long-term benefits were limited to persons over 65 and to younger people whose condition required their inclusion in elderly persons' centers.

- It was generally understood that demand for community-based services, such as visiting homemakers, would exceed the available supply and that rationing would be necessary. Criteria were to be determined locally, but a provincially defined minimum basket of services was to be available in each community. Persons with developmental disabilities or with psychiatric histories were excluded from the reforms. Excluded as well were unregulated rest and retirement homes, a primarily private sector response to the 'overflow' resulting from insufficient space in state licensed facilities.

- The clear goal was the development of a 'responsive, integrated and manageable range of services' that would enable individuals to remain at home and delay or prevent unnecessary institutional placement. Social and health services would be integrated and delivered in a community setting. The linkages between community and institutional care would also be strengthened, so as to provide a 'seamless web' of services to consumers.

- Essential to this approach was the expansion of community-based services. The most significant feature of the reform lay in its attempt to bridge the bureaucratic chasm between the separate ministries responsible for health and social services. A new joint division, answering to both ministries, was created.

- The historical overlap of responsibility for services for the elderly between two ministries in Ontario led to duplication, inconsistency, and inevitably, gaps in coverage. Homemaker services, for example, could be ordered by a physician, in which case they would be seen as medically necessary services and hence provided without user fee as part of the universal medicare program. The identical service, provided by the same agency, could also be arranged through the social services ministry, in which case the hours of service provided were limited and means-tested. Hence consumers preferred to secure such services through the physician, an action that had the effect of raising service delivery costs as doctors are compensated on a fee-for-service basis and had no incentive to limit or deny access. The assessment process was largely focused on medical considerations.

- The essence of long-term care reform was to replace this confusing array of services and access points with 'one-stop shopping' – this was to be delivered by Multi-Service Agencies (MSAs) established in each community across the province, the role of which was, through a single point of access to deliver a mandatory basket of services as enumerated in the bill and to coordinate access to long-term care facilities.

- Powers were given to the Minister to designate one or more approved agencies as MSAs for specified geographic settings. Those eligible for designation as MSAs included local municipalities, boards of health, and ethno-specific service agencies. This approach, it was hoped would alleviate the concerns of powerful stakeholders, particularly the major ethnic communities.

- At least 80% of services are provided under the direct MSA umbrella.

- Funding for long-term care programs in Ontario consists of both user fees and direct provincial contributions from general revenues through the two separate ministries. There are no earmarked individual contributions through the tax system.

- The Provincial Bill 173 placed the responsibility for the use of those funds with local district health councils while at the same time requiring the exercise of this responsibility to be performed under the scrutiny of long-term care steering committees representing each local community.

- Litwin and Lightman comment (p 706) "community care reform in Ontario has been addressed in the framework of a general overview of long-term care needs of the elderly in the community. In this respect, policy development in that setting is similar to the British attempt to reform the system through comprehensive legislation. Indeed, Ontario can boast of the successful completion of a systematic policy review that culminated in the passage of a community care bill".

United Kingdom

- Care management – the coordination of services – has been implemented by almost all local authorities, since the passing of the National Health Services and Community Care Act of 1990. It is intended to enable "practitioners to put together creative, individually tailored care packages, purchasing services when necessary."

- There are no standards for care management for the elderly. (Cox, p. 95).

- Cox maintains "Assessments [in the United Kingdom] are intended to be needs-led , that is they start with the needs of the user, not with the services available. But, as government guidance only states that needs be met within available resources, assessments are increasingly dictated by the available money. The result is that assessments are needs-led, but resources-constrained" (p. 92).

- The success of care management in reaching these aims is closely dependent upon resources. Without sufficient funds, the ability of managers to purchase services and develop specialized care packages is sharply curtailed. Resources are closely tied to the quality of care management services, which itself is related to the sheer number of cases. In many parts of the country, the demand for assessments and services that accompanied the new legislation resulted in an unexpected expansion of caseloads.

- The effectiveness of care management is further affected by the fact that many authorities were initially assessing every older person requesting an assessment and each person received care management. Consequently, many managers continue to be responsible for individuals whose needs are slight in comparison to others in the community.

- Care plans tend to be service driven rather than needs driven as service plans are determined primarily by the services available rather than individual needs.

There is an overriding tendency to interpret client needs in terms of concrete tasks and services with less attention to emotional problems and counseling interventions. (pp. 94-95).

- In UK prioritization of high-risk clients results in opportunities for earlier, preventative service interventions being overlooked.

- Tightening of resources has meant that most authorities are unable to provide services such as cleaning and assistance to the less frail. Under community care, most elderly persons accustomed to receiving these services are no longer eligible for assistance.

- The system for long-term care encourages local authorities to place an elderly client requiring home care services into a long-term care institution such as a nursing home, because in doing so local governments receive both the public and private pension benefits of the client, substantially reducing the amount the local authority pays. Local authorities receive additional reimbursements from the central government for those persons placed in private-sector nursing homes. "Thus, depending on the availability and costs of services, it can be easier and more cost effective to place persons in residential care than to develop community care packages" (p. 94).

- The goal of care management, under the reform Act of 1990, was to purchase services according to the client's needs. This goal has not been met because:

  1. *Insufficient funds* curtailed the ability of care managers to purchase services and develop specialized care packages.

  2. *Large caseloads* – the new legislation resulted in an increased demand for services that far surpassed that increase planned for on the part of local authorities. Care managers' caseloads expanded to the extent that they now have insufficient time for care planning and monitoring.

  3. *Every elderly person requesting an assessment received care management.* Many managers are responsible for individuals whose needs are slight in comparison to others in the community.

- Care management weaknesses in the UK:

  1. There are no standards for care management for the elderly;

  2. The focus is on opening cases and designing care plans. The process of monitoring and reassessing to maintain congruence between needs and services is not prioritized;

  3. Because of limited resources, the closing of old cases is essential to the opening of new ones;

4. Client needs tend to be interpreted in terms of concrete tasks and services. Less attention is given to emotional problems and counseling interventions.

5. Limited resources mean that care managers must struggle to provide basic services and are unable to develop innovative care plans that include broad mixing of services.

- One objective of the UK community care reforms, which began in 1993, was better integration and coordination of services through mechanisms such as assessment and care management and a move away from institutional solutions. In a 1995 review of the reforms Henwood (see also Henwood and Wistow) described the findings of focus groups in 1994 and 1995:

1. Improved working relations between health and social services, and between the local authority and the independent sector;

2. The availability of a greater number of flexible and responsive services;

3. There was some concern that individuals with less intense needs were often being overlooked, and that this was increasing pressures and demands falling on users and on carers;

4. Most localities appear to have experienced greater resource pressure and rationing of services has become more explicit;

5. The boundary between health and social care seemed to be increasingly strained, reflecting increased demands falling on the community, the impact of hospital discharge practices, and changes resulting from the impact of GP fundholding which were viewed as being in tension with community care objectives;

6. Uncertain responsibilities for long term care remained an issue in all localities surveyed;

7. In all localities independent residential and nursing home owners reported a fall in business overall and a rise in the dependency of new admissions;

8. Community services were generally perceived to have become more responsive and flexible but there were a number of criticisms, which revealed the failure of much of practice to reflect the promise of change offered in policy (Henwood, pp i-v).

- A study by the Audit Commission in 1995 of treatment of elderly patients with hip fractures stressed the need to work towards better coordination of care at each stage from admission and treatment to rehabilitation and post discharge home services. The Commission stressed that people who need continuing help after discharge need to be identified early and social services should be brought in where necessary. There should be strong links between physicians and

surgeons and one person co-ordinating arrangements can ensure that the care needed is in place at each stage.

Japan

- Local councils have had a key role in planning and coordination at local level due to their close contact with residents. Local councils are responsible for service provision and formulating community care plans. This is in contrast to Australia for example where local-level coordination relies on general practitioners and aged care assessment teams. (Nishimura, conference, p 59).

- In 1994 the National Institute for Longevity Sciences was established. The Japan Foundation for Aging and Health is also promoting in-depth research, which will assist in the provision of appropriate, coordinated services.

- A new aged care insurance system established in the later 1990s aims at further rationalisation and coordination. Under the program individuals or their families apply to the municipal government who sends a person to conduct an on-site physical and mental assessment of the individual. This is done using a detailed assessment form, which allows a government computer program to classify an individual into one of four levels. The eligibility decision is then to be communicated to the applicant within 30 days of applying. If dissatisfied with the decision, applicants may appeal to an agency at the prefectural level and ultimately to the courts. Eligibility is to be reevaluated every six months. Each eligibility level entitles the applicant to a specific monetary amount of services per month (the amounts are quite generous). In theory, the applicant can choose any providers and any services but in practice a major role is played by a "care manager", who writes a "care plan" (a weekly schedule of service provision). Most care managers will be employees of the organisation that provides most of the client's care but the client or their family can change their care manager at any time (Campbell and Ikegami, p 34).

Germany

- Cash allowances offset the limited range of services covered as an entitlement by providing an alternative that can be used for any purpose and thus has maximum flexibility.

- Germany's strong insistence on a uniform national program has meant that there is little variation in services across geographic areas or across individuals in the same disability category. It is a fairly rigid program that does not tailor benefits levels to individual needs or take into account local needs and desires.

- Establishing boundaries between acute and long-term care is difficult because individuals have a combination of acute and long-term care needs. Maintaining a separate funding stream for long-term care has protected those funds from being absorbed by the larger and more powerful acute care system, but has created problems of cost shifting and coordination (see Brodsky et al. For a comprehensive discussion of Germany's policies and services see Scharf, see also Merlis).

Denmark

- In Denmark, each municipality sets its own priorities and designs its own programs; services thus vary from one municipality to another. Programs offered by municipalities include:

    1. Integrated Home Care Service is a program that rotates staff between nursing facilities and home care services, allowing staff resources to be transferred according to need;

    2. Two-thirds of the municipalities offer 24-hour service to frail elderly individuals;

    3. Assistance can be provided at any time of the day by scheduling a visit with a home help worker;

    4. In some municipalities, autonomous groups of 10 – 15 home help workers are assigned to a specific area of the city or to a group of apartments (see Coleman p 455-74 and Social Policy in Denmark and Merlis).

- "In Denmark integrated programs combine nursing home and adult day care services with sheltered housing; nursing home staff serve residents in all settings" (Merlis, p 147).

(b)   Specific Integration Projects
Australia

- One example of a demonstration project aimed at achieving integrated health for a target population is the *Healthy Older People Program (HOPP)* established in eastern Sydney in 1990. To reach the most needy who, when interviewed, identified few needs and were proud of their ability to cope, project organisers adopted a model of advocacy as an intervention strategy. Workshops for providers in the inner city were held to identify barriers for the targeted group. The workshop proposed that agencies re-orient their existing services to advocacy and outreach. Importance of housing, access to fresh food eg emphasised in workshop (Hill and Baser).

- Sadler and Owen describe the development of other demonstration projects in NSW aimed to trial, and develop systematically, models of community care that replace fragmented and over-specialised services with more coherent integrated local service delivery arrangements.

- The main objectives of these demonstration projects are to assess the ability of alternative funding and service arrangements to:

    1.   Enhance consumer satisfaction;

    2.   Improve service delivery, including assessment, case management, coordination, support for carers, targeting, and responsiveness to individual clients; and,

    3.   Encourage development of the most cost-effective services.

- Models proposed for demonstration projects:

    1.   Mandated cooperation;

    2.   Integrated community care agency (one-stop shop for consumers);

    3.   Area-based budget holder - The budget holder model, in the form of a community care board, was not able to be sustained through local area consultations. As a result, this model has been postponed and implementation is proceeding with cooperation and integrated agency models.

- An independent evaluation is being conducted by the Social Policy Research Centre.   Stresses importance of consultation and involving community in process of reform.

- Evaluation issues, which have arisen:

    1.   Difficulties agreeing on the scope of programs to be included, despite a commitment to 'loosen up' program boundaries to allow greater flexibility;

2.   Small agencies, perhaps inevitably, feel threatened by a reform process involving possible amalgamation or other loss of independence;

3.   Gaining access to consumer viewpoints that are not mediated by provider selection, and getting the point of view of non-users of services, is difficult.

United Kingdom

Peterborough 'hospital-at-home' scheme:

- This is a district wide service, which as of 1995, had been running 17 years. (see description in United They Stand, p. 45).

- "Responsibility for medical care lies with the patient's GP, who has immediate access to a hospital bed if there are problems. For hip fracture patients, hospital-at-home offers:

  1.   Discharge soon after surgery;

  2.   Assessment by a district nurse;

  3.   Support according to the patient's needs – nursing care may initially be available 24 hours a day;

  4.   Physiotherapy;

  5.   Occupational therapy; and

  6.   Patient aides to provide help and support"
.
- No outcomes and/or evaluation of the service were discussed in the literature.

Cornwall Community Assessment, Rehabilitation and Treatment Project

- Teams were designed to offer skilled multi-disciplinary assessments of health and social care needs under the NHS and Community Care Act, particularly for people on the threshold of institutional care.

- "Two teams were established, consisting of physiotherapy and occupational therapy staff, and a specialist support nurse, with referral to a consultant elderly care physician as needed. Significant improvements in patients' Barthel scores were observed compared with a control group, and there were fewer admissions to institutional care" (United They Stand, p. 44).

- The date of this project is not mentioned.

Kent Community Care System

- B. J. Coleman describes this system in her article "European Models of Long-Term Care in the Home and Community."

- Kent County in southeastern England pioneered an extensive community care system from 1977 – 1986, the goal of which was to maintain frail elderly

individuals in the community as long as possible. To be eligible for services under the program, an elderly person had to be of retirement age or older and be at risk of admission to a long-stay hospital or old people's home.

- The core of the program was the use of community care organizers – case managers – each responsible for organizing services and controlling an individualized budget for 25 – 30 clients.

- Expenditures for each client were limited to two-thirds the equivalent cost of a bed in a nursing home. Clients paid a share of the cost of the program, based on their incomes.

- Case managers were social workers who coordinated a care network – pulling together services developing community resources, and consulting other home care workers – in general, developing a client-centered service package. They supervised members of a care team: community care assistants, home help organizers, social workers, social work assistants, and a worker for the visually handicapped. Community care assistants provided social support and some personal care; the home help workers assisted with household chores. Care was available 24 hours a day, seven days a week.

- Referrals came mainly from the area social workers. The project covered 92 persons, whose average age was 80. The statuses of these 92 clients were compared throughout the experiment with 116 persons in a control group. The district from which both the experimental and control cases were drawn consisted of three towns. One town received community care; the control cases were drawn from the other two towns.

- After one year 66% of the clients in the Kent Community Care program (61 of 92 persons) were still in their homes, compared with 45% (52 of 116 persons) of the control group. The study also tracked the location of 74 matched cases over a four-year period.

- In the first year, the proportion of persons who died was 14% for those under the community care project and 33% for those who were receiving standard services. During the second year, there was still a substantial difference in favor of the experimental group: 26% compared with 40% from the control group. By the end of four years, this advantage still held: 53% for the experimental group compared with 63% for the control group.

- In terms of those who entered residential care over the four years, the results were similar. A smaller proportion of persons receiving community care services went into residential care than the proportion of persons in the control group. In the first year, for example, 12% of the experimental group entered residential care, compared with 27% of the control group. In the fourth year, the proportion was 15% to 20%. (see further discussion of the Kent project and other similar attempts to integrate services in Malcolm Payne "Care Management and Social Work", pp 277-84 in Bornat et al).

Bexley Community Care Scheme

- This scheme was started in 1984 to provide an alternative to residential care by the flexible use of informal paid carers to supplement or replace formal care. It was based on care management, psychological and medical assessment, together with the release of financial resources to pay for informal care.

- The scheme was reviewed in a study by <u>Black et al</u> in 1995. Using the CAPE survey dependency scale the study demonstrated that clients on the scheme were at least as dependent as those receiving residential care in other areas. The study revealed that a strikingly large number of hospital admissions were needed to support frail older people at home. There was no evidence that going onto the scheme prevented hospital admissions, although there was evidence that after starting on the scheme subsequent hospital admissions were significantly shorter. The cost data available from the scheme did not allow <u>Black et al</u> to assess the cost-effectiveness of the services. Therefore, they were "unable to add to the debate on whether the cost of care in the community on schemes such as this is lower for society as a whole than institutional placement for all such patients.

- The study concluded: "frail elderly people maintained at home have a significant mortality and morbidity rate and continue to need a high use of NHS inpatient resources. Standardised descriptions of functional state and dependency need to be agreed on in order to compare outcomes and the effectiveness of supporting frail elderly people in the community as opposed to institutional care."

Darlington Project

- This project is described and commented on in an article by <u>Challis et al</u> called "An Evaluation of an Alternative to Long-stay Hospital Care for Frail Elderly Patients: I. The Model of Care".

- The project was set up in the 1980s following the introduction by the UK Government of the Care in the Community initiative. As part of the objective of developing community care *Age and Ageing* funded a series of 28 pilot projects to explore different ways of providing community based services for people discharged from long-stay hospital care

- "The project built on some of the case management approaches already undertaken in the Kent and Gateshead Projects. However, it sought to extend these activities into the realm of a joint health and social services model of provision, based upon a geriatric multidisciplinary team and using multi-purpose care workers to reduce overlap between personnel" (p 237).

- Case managers, with devolved budgets, employed by the social services department, were located in a geriatric multidisciplinary team to provide an alternative for patients requiring long-stay hospital care. As well as coordinating packages of care, case managers were responsible for deploying the time of home care assistants, multi-purpose workers who assisted health care staff and undertook home help tasks. For further description of the role of case managers and the tasks undertaken by home care assistants see article by Challis et al. Note that home care assistants undertook a wider range of activities (after

receiving some full time training) than either home helps or nurses, covering both personal and domestic tasks.

- In the second part of the paper it was concluded that elderly people in the Darlington Project receiving community-based care had a higher quality of life (as compared to long-stay hospital care), and there was no evidence of greater stress upon their carers. The community-based service, although it involved extra costs to the social services department, had lower costs for the health service and society as a whole than long-stay hospital provision. It was concluded that the model of care can effectively integrate the new approach of case management into an existing geriatric multidisciplinary team".

Denmark

- In *Skaevinge*, a rural community with a population of 5,000, the nature of the nursing home was radically changed so that it is now managed by a project team consisting of representatives from home help, home nursing, public health nursing and the nursing home. These were providers who had seldom worked together previously. 24-hour nursing service for the whole community is available. Through the conversion of nursing home rooms with bath, toilet and cooking facilities, sheltered residences for elderly persons are provided.

- Residents of the sheltered residence receive their pension directly and are expected to pay for food, hair dressing, personal purchases, and medicine (Coleman, p 462, also see Coleman for a description of an alternative housing project in Aalborg).

The Netherlands

(see van den Ven and van Linschoten and Ruissen)

- *The Individual Care Subsidy for the Elderly project in Rotterdam* was a three-year demonstration for 75 elderly persons who were on waiting lists for homes for the elderly. For evaluation purposes the 75 participants in the experiment were compared with 150 elderly persons in a control group (made up of people with the same characteristics). The two key elements of the Rotterdam project were:

    1. A care mediator - responsibilities included development of a care plan and coordination of services;

    2. (a) A personal care budget - an individual care subsidy was provided to cover services not otherwise covered through the Dutch social welfare system

        (b) The maximum subsidy for a recipient was set at about one-fourth the average annual cost of care in a home for the elderly.

- Of the 75 persons in the experimental group, 38% moved to a home for the elderly or a nursing home during the three-year period, compared with 73% in the control group.

- The cost of living and care for the participants in the experiment was lower than for persons in the control group.

- An index of disability, based on ADLs and IADLs, showed no difference in the extent of disability in the two groups during the first round of interviews; the extent of disability had increased in the group, but not in the experimental group, by the third round of interviews.

Home & Community Care in Groningen
- This experiment was conducted in southeastern Groningen, a rural area of the Netherlands with a population of 49,000 – 17% of whom were aged 65 or older. The object of the project was to provide integrated community care through a single home care organization. In Groningen, the projected was initiated by the service organizations themselves. By enlisting government support for their project, they became eligible for extra financial grants.

- Identical geographical areas were designed and home help and home nursing efforts were coordinated in those areas through the organization of district teams.

- A common needs assessment method was developed.

- The project was also given resources to expand home care services - service capacity consequently increased by 12%.

- Interviews were held at the start of the experiment and at its close with elderly people (75 and above) who lived in the experimental area and a comparable group of elderly people who did not. Project evaluation showed that chronically ill and severely disabled persons "were relatively more often able to remain living in their own homes for a relatively longer period of time with an acceptable quality of care" (see van Linschoten and Ruissen).

An Integrated Planning Model in Nieuwegein
- The municipality of Nieuwegein (population 60,000) lies in the center of the Netherlands. The objective of the project was to improve care to older persons through intensive cooperation among providers.

- Representatives of five community groups worked together through a network organization to coordinate their efforts and concentrate their services on the elderly persons (aged 75 or older) in the municipality who needed assistance to remain in their homes.

- Each of the community groups remained autonomous, but its workers came together to assess an individual's need for services and to plan and coordinate the delivery of those services.

- A central budget was created, pooling the resources of the service organizations for the care of the experimental group clients in Nieuwegein. Management of

the network organization has authority to allocate these resources according to the need for services and the type of services.

- Elderly persons seeking assistance could call one centralized telephone number for all requests for help. The person taking the call had been trained to assess needs and to know the appropriate providers to help the person calling.

- A nurse might be sent to the person's home to do an assessment. Based on that assessment, home and nursing help might be provided.

- If a determination about nursing home placement needed to be made, a local committee made the decision. These committees were composed of physicians, nurses, social workers, physical therapists and older persons in the community.

- The statuses of the elderly persons in the experiment were compared over a three-year period with those of comparable elderly persons (in age, household composition, and chronic health problems) in a control group, selected from a random sample in other municipalities. Home help, home nursing, or institutional services for persons in the control group were provided by separate organizations without any of the coordination or special planning directed to participants in the experimental group.

- Severely disabled persons in the experimental group received more home care services and the services were more precisely targeted to their needs than was the case for persons in the control group.

- The demand for homes for the elderly and nursing homes decreased significantly in the experimental group, while this demand remained relatively constant in the control groups.

- The use of additional home care services such as day care and meal services remained relatively constant in the experimental group over the three-year period, but volunteer help increased significantly – from 5% to 20% - especially for those with very severe disabilities, while no change took place in the control group.

- In addition to the projects described above, nursing homes in the Netherlands are experimenting with changes – night admission, weekend and day treatment, and respite care.

- The most persistent criticism of long-term care in The Netherlands is its lack of flexibility (van Linschoten and Ruissen and van den Ven).

United States
Qualitative Analysis of the Program of All-Inclusive Care for the Elderly (PACE) (Robert Kane, Laurel Hixon Illston, Nancy A. Miller)

- The Program of All-Inclusive Care for the Elderly replicates On Lok – a working model of capitated comprehensive, risk-based acute and long-term care.

- The On Lok Model goals are to:

  1. Provide to the frail elderly care that improves or maintains participants' functional independence, enabling them to avoid institutional care and remain at home.

  2. To remain at home at the same or less cost as other traditional long-term programs.

- To accomplish these goals, there is strong emphasis on the use of day health care and a reliance on an interdisciplinary team to manage and deliver services.

- The On Lok program is premised on a belief that the costs of the extensive services, including a strong emphasis on preventive care and rehabilitation, provided in the day health center or home, can be more than offset by reduced use of expensive services in hospitals and nursing homes.

- On Lok relies heavily on the day health center as the primary delivery setting for:

  1. Monitoring participants;

  2. Controlling services and costs;

  3. Providing stimulation to participants who are otherwise homebound and isolated.

- Transitional housing plays an important role in keeping participants out of hospitals or in reducing their stays. Rather than placing a participant with an uncomplicated medical condition in the hospital for medical monitoring and observation, On Lok uses transitional housing units to provide 24-hour supervision and attendance. These units are also used for respite.

- The heart of the On Lok model is the multidisciplinary team. It both manages and provides care. The team is composed of professionals and paraprofessionals and has a wide range of responsibilities:

  1. Assessment and periodic reassessment of participants' needs.

  2. Development of care plans, including relative need of adult day health, in-home, medical and social services.

  3. Oversight and delivery of all services.

  4. Ongoing monitoring of quality, costs, and treatment results.

  5. Considerable staff time is devoted to both formal and informal exchange of ideas and information about participant care.

  6. Each week formal meetings account for about 8 hours of each staff person's time.

7. The paraprofessional as well as the professional is included in discussions of participant status and change.

- Recruitment and retention of physicians is difficult because the salary scale is modest and also because of the combination of characteristics necessary to work within the On Lok environment.

  1. Many physicians are uncomfortable in a milieu where medical skills are not immediately recognized as the pre-eminent elements and extra deference is not paid to their rank;

  2. On Lok physicians need to be skilled and comfortable in managing chronically ill elderly participants and to practice aggressively enough to manage them outside the hospital;

  3. They need to be able to work as members of a multidisciplinary team in which decisions are made by the group;

  4. The physicians must have the ability to work within an environment that requires strong oversight.

- The core of the On Lok approach is capitation. On Lok controls services by delivering the majority of outpatient services directly and by contracting only for inpatient hospital and nursing home care and specialty medical services. To ensure the continuity and quality of care for contracted services, On Lok maintains close communication with the contract providers and monitors a participant's care directly when anyone needs inpatient services.

- An important piece of the continuum of services is supportive housing.

- The day health center is the primary delivery setting. To strengthen the integration of services, participants are required to come under the care of On Lok physicians.

- On Lok targets a very specific high-cost long-term care population who would otherwise be very likely to enter nursing homes. The average On Lok participant is 81 years old and has five medical diagnoses. Participants must be ICF or SNF eligible.

- On Lok places a great deal of emphasis on keeping participants in their own community and encouraging the ongoing involvement of the community – particularly the family – with On Lok. Most important is the high expectation for the family to remain active in the care planning as well as the actual care of the frail elderly. On Lok also sponsors joint projects with local schools, supports a volunteer program, provides community education and holds regularly scheduled open houses for participants and their families and the community.

- A vital issue is building and retaining teams with strong clinical skills and an ability to work in a multi-disciplinary setting. Staff turnover has been high among physicians and adult day health center directors. For directors, special

attention needs to be paid to finding acceptable management arrangements that clearly define lines of authority and responsibility and that capitalize on work styles and existing structures. Close attention must be paid to recruiting physicians who can practice to a standard they are comfortable with while taking the risks necessary to maintain the participants in the community and to practicing in an environment where medical dominance is not the mode. It is too early to tell whether the presence of a large number of demented clients in the day health center will create for the non-demented client a barrier to enrollment and how different the program will look if it has to accommodate the needs of a heavily demented population.

The PACE Model (described by <u>Rich</u>*)*

- PACE was originally developed by On Lok Senior Health Services in San Francisco's Chinatown in the late 1970s.

- <u>Rich</u>'s article describes the further use and development of the model.

- The program's underlying principle is to keep participants in the community for as long as medically, socially and economically possible and to preserve and support the older adult's family unit

- The program involves management of an enrollee's care by multidisciplinary team of health providers. Financing is through monthly capitation payments rather than fee-for-service payments, with the provider at financial risk. The program has been authorised as a fully integrated managed care system

- PACE enrolees must be at least 55 years old, be eligible for nursing home care, reside in a defined geographical area, and have a desire to live at home, which they are able to do safely in terms of the PACE protocol. In June 1997, 27 PACE sites in 15 states served 4,471 enrollees. The characteristics of PACE enrolees are similar to nursing home residents on average.

- Despite PACE's enrollees' level of frailty, their rate of hospital use is lower than that of the Medicare 65-plus population, which includes healthy older persons.

- The PACE multidisciplinary team consists of the Primary Care Physician, Gerontological Nurse Practitioner, Nurses, Social Worker, Physical Therapist, Occupational Therapist, Recreational Therapist/Activities Coordinator, Dietician, Day Health Centre Supervisor, Home Care Liaison, Health Aides, Personal Care Attendants and Drivers/Van Monitors. The team assesses the needs, develops the care plans, and directly delivers or coordinates the delivery of services. Services not directly provided by the team are arranged through contracts and are coordinated by team members. PACE enrolees agree to receive all their primary care from the multidisciplinary team and therefore give up previous primary care physicians. Most continue relationships with specialists; however, the multidisciplinary team acts as the gatekeeper to medical specialities

- The article then describes the workings of a particular PACE site in Massachusetts called the Elder Service Plan of the North Shore (ESPNS) (see pp64-8)

- The successes of PACE include: reducing hospital days, reducing number in nursing homes, increased use of personal services, lower mortality cf nursing home residents, very high patient satisfaction, excellent quality of care. Limitations and challenges include: need to prove PACE is cost-effective, limited attraction for middle-income older adults, inherent problems of a capitated system, potential fostering of dependency, developmental issues, challenges of a team approach, difficulty in recruitment of primary care physicians, loss in freedom of choice of primary care provider, no well-defined admission criteria and analysis of outcomes, slow growth rates in some area, housing issues, and dual-diagnosed clients (mental health dollars are not calculated into monthly capitated payments received by PACE)

- Eng et al, in their description and evaluation of the PACE model, also report steady census growth, good consumer satisfaction, reduction in use of institutional care, controlled utilisation of medical services, and cost savings to public and private payers of care, including Medicare and Medicaid. However, starting up a PACE program requires substantial time and capital, and the model has not yet attracted large numbers of older middle income adults. They conclude that "the PACE model's comprehensiveness of health and social services, its cost-effective coordinated system of care delivery, and its method of integrated financing have wide applicability and appeal".

Italy
Integration Project, Vittorio Veneto, Italy

- Landi et al reported the findings of a quasi-experimental study with a six-month follow-up of 115 frail older people in Vittorio Veneto, Italy.

- The Italian National Health Plan requires that older people be offered a broad array of services: a hospital geriatric evaluation unit, a skilled nursing home, and integrated home care. Although the required services are generally present, they are not coordinated or integrated with one another. The Health Agency of Vittorio Veneto decided to participate in a specific nation home care program called Silver Network Home Care project. The purpose of this project was to reorganise the care of the frail older people living in the community by adopting an integrated social and medical care program along a case management approach and using, as a screening and geriatric assessment tool, the MDS-HC instrument

- The MDS-HC instrument (Minimum data set for home care) contains over 300 items that explore all of an individual's problematic areas and are linked via a triggering process to 30 Client Assessment Protocols. These protocols contain general guidelines for further assessment and individualised care plans. The validity and reliability of the MDS-HC have been documented and the instrument has been successfully implemented in different countries worldwide.

- With the implementation of the integrated home care program, there was a significant reduction in the number of hospitalisations and hospital days. This resulted in a 29% cost reduction with an estimated savings of $1,260 per patient. Landi et al concluded that "the implementation of an integrated home care

program based on the use of a comprehensive geriatric assessment instrument guided by a case manager has a significant impact on hospitalisation and is cost-effective.

New Zealand
Elder Care Canterbury (From Information On ECC In Folder Held By Pam Fletcher, More Specific Information On Individual Projects Available)

- Elder Care Canterbury Project was set up in 1997 to provide ongoing incremental improvement and innovation in the delivery of a comprehensive patient-focused health service for older people in Canterbury. It is one of the HFA's National Demonstration Integration Projects.

- The key objectives are to: 1. develop a comprehensive health service for older people in Canterbury 2. to work with the community in an inclusive and collaborative way to develop the best possible service 3. to focus the skills, knowledge, enthusiasm and commitment of the existing local providers and the wider community to design a service that meets the specific needs of the older people of Canterbury.

- The target population is people in Canterbury over the age of 75 years but including those younger who have health disorders associated with or complicated by the aging process. Canterbury is a defined geographical area.

- There are three stakeholder groups that meet on a monthly basis: 1. The Community stakeholder group has representatives from a range of community groups including Age Concern and Greypower 2. The clinical and disability support provider group has representatives from community and Residential Care providers, and 3. a primary care focus group includes GP's and Practice Nurses.

- The Crown is also a Stakeholder. Representatives from ACC and the HFA are actively involved in individual projects and ACC, Crown Public Health, the HFA, the MoH, and Ministers and local politicians are kept fully informed.

- There are five people on the Executive which has overall responsibility for the project: the CEO's of Canterbury Health and Healthlink South, the Chair of the Pegasus Medical Group, the Professor of Health Care of the Elderly and the Project Facilitator.

- The Project Facilitator is responsible for the leadership of the project, chairs the Steering Group and leads the Project Coordinators. This position is independent of any of the organisations involved in the project.

- A Steering Group of nine people representing clinicians and management from the HHSs, Primary Care and Community and Residential Care set objectives and time lines.

- There are five Project Coordinators employed in each of the following: Canterbury Health, Healthlink South, Primary Care and Community and Residential Care. They are seconded by their organisation to the project for up

to 10 hours per week and are responsible for ensuring that objectives and timelines are achieved. There is also a full time Project Administrator

- Individual projects include: acute confusion, broken hip, stroke, assessment and funding, coordinated equipment service, discharge planning, and ongoing care in the community. A standard methodology has been developed for the project and is applied to each individual project.

- In 2000 the initiatives planned were a new acute stroke service at Christchurch Hospital and rehabilitation unit at Princess Margaret Hospital, a uniform patient discharge procedure and the launch of a 'health and home services' folder to show patients exactly who is responsible for providing what care and services.

- Christchurch GPs (the Pegasus Medical Group) have praised ECC for leading to improved healthcare services for older people through increased cooperation between community GPs and other regional healthcare providers (27 January 2000)

Integrated Care Services for Older People (*Information Pack prepared for Judy Glackin and Pam Fletcher*)
- This project is a joint venture set up in 2000 between the IPA Pro Care and Auckland Healthcare, A+ Links, Older People Services, Community Home Health and the Pharmacy Guild.

- The purpose of the project is to develop processes to enable patients and health providers to work together to maintain or improve the independence and quality of life of older people.

- The target population of the project are people who are increasingly 'not coping' (does not include people in crisis or needing immediate attention), who have multiple or complex contributing factors (with no immediate solution available), who are 65 years and older (Maori 55+) and who are living at home in Central Auckland.

- As at 5 September 2000 30 GPs and their practice nurses in Central Auckland had agreed to participate in the project.

- The process is that a practice nurse will coordinate the registration processes, the planning meeting and the compiling of the individualised treatment plan of each patient. She or he will follow-up with the patient for the duration of the project and manage the updating of the treatment plan. The gerontology nurse from A+ Links Community will do a nursing assessment and medication concordance for each patient. The information will be used to assist in the development of each patient's plan. Auckland Hospital's A+ Links Geriatricians will support the project by provision of information and consultations to GPs as required as part of the planning process. A project pharmacist will complete a pharmaceutical review which will be used to identify potential medication problems and how to best manage the patients medication at home.

- In August 2000 a <u>Disease Management Working Group (Primary Health Organisations/South Auckland Health)</u> produced a document, which focussed on the importance of chronic care management and how to plan policies and guidelines to achieve cost-effective, successful chronic care management.

2. Assessment

This section reviews approaches to assessment around the world. It begins with a selection of general commentary on the role and importance of assessment and description of worldwide trends. <u>Butler et al</u>'s review of assessment literature is a very comprehensive one, which should be referred to for further detail. The section then describes the various approaches to assessment and particular assessment mechanisms operating in: Australia; Canada, the United Kingdom; Japan; Germany; Denmark; the Netherlands; the United States; and Finland.

- The need for good systems of assessing patient needs is a key theme throughout much of the literature.

- One US study (<u>Silverman et al</u>) showed that multidisciplinary outpatient unit-based geriatric assessment, in comparison with usual community care assessment by a physician, resulted in the identification of a significantly greater number of patients with cognitive impairment, depression, and incontinence. The group of elderly people receiving a geriatric assessment had greater improvement in anxiety levels at 1 year. Caregivers of participants in the geriatric assessment group had less caregiver stress at 1 year. No outcome differences in mortality, nursing home admissions, cognitive health, functional health, or health services utilisation were observed. Some evidence of greater patient satisfaction with respect to qualities of the physician was found for the geriatric assessment group. The authors concluded that consultative outpatient geriatric assessment led to significantly improved diagnosis of the common health problems of cognitive impairment, depression, and incontinence, to psychological and emotional benefits for patients, and to reduced levels of caregiver stress. Even with limited follow-up care and control of treatment, outpatient geriatric assessment has potential for significant positive effects.

- The need for standardised assessment tools is clearly a key concern but there appears to be a range of tools supported.

- For instance, <u>Wade and Collin</u> advocate the acceptance and standard use of the Barthel ADL (activities of daily living) to increase awareness of disability, to improve clinical management of disabled patients, and perhaps even to increase acceptance of published research.

- <u>Norstrom and Thorslund</u> note that the most well known measure of disability is Katz' Index of Independence in Activities of Daily Living (ADL). Another distinct measure used is to confine the focus to instrumental activities of daily living (IADL) eg cooking, cleaning. <u>Norstron and Thorslund</u> argue from their study that both dimensions should be measured if an overall assessment of disability in an elderly population is desired and one shouldn't be used as a proxy for the other.

- <u>Hebert et al</u> conducted a study of the Functional Autonomy Measurement System (SMAF) instrument of measuring the needs of elderly and the

handicapped. They concluded that the scale is reliable for evaluators from different professions in the community as well as in institutional settings and that there is a strong correlation between the disability index obtained by the SMAF and the amount of required nursing-care time.

- Early and comprehensive assessment plays an important role in disease prevention by enabling services to be targeted at people exhibiting risk factors. For instance, in a study by Tinetti et al., a multi-risk-factor intervention strategy resulted in a significant reduction in the risk of falling among elderly persons in the community.

- In September 2000 Brodsky et al (for the World Health Organisation) carried out a review of long-term care laws in five developed countries: Israel, Germany, Austria, the Netherlands and Japan.

- The review team made a number of observations about eligibility assessment (pp 19-20):

    1. In most of the countries, a structured, uniform assessment instrument is used nationwide. The use of a uniform assessment tool helps standardise the assessment process. The Netherlands, unlike the other countries, allows the person performing the assessment to exercise his or her discretion in suiting benefits to the individual applicant. At present, there is no national set of assessment tools, although one is being developed.

    2. Each country has delineated a number of levels of eligibility, and in most countries, the level is determined by the number of hours of care an applicant is expected to require per day or month….The greater the number of levels into which eligibility is divided the greater the extent to which resources may be allocated according to functional level.

    3. Responsibility for assessing eligibility may fall upon the insuring agent or an external agency. The use of an external agency is designed to assure objective, autonomous and uniform assessment. In some countries the system is semi-independent.

    4. In each country, eligibility assessment is performed either by professionals from a single field – eg. Physicians, nurses – or by a multi-professional team. In part this depends on the nature of the criteria: The narrower the criteria, the less the need for a multi-professional approach. There is a tradeoff between the costs of eligibility assessment and the biases of a specific professional approach, even with the use of a structured tool. Assessment of eligibility by a multi-professional team facilitates a mutli-dimensional perspective on an applicant's needs, which may help those involved later (after eligibility is determined) in planning an appropriate programme of care.

    5. Assessment should be uniform and consistent, whether determining eligibility for care in the home or eligibility for institutionalisation.

- In 1998 Butler et al undertook a comprehensive review of recent international literature on the assessment of older people in order to determine emerging issues for Australia.

- The review revealed that the medical and gerontological literature on outcomes and assessment "tools" which characterised the 1970s and 1980s has been supplemented in the 1990s by a new and more sociological literature which focuses on the changing role of assessment within an environment of health and welfare policy, and on the implications for assessment of the client rights movement.

- Three major themes emerged from the literature:

  1. the continuing tension between clinical/medical and social approaches to assessment, with the literature pointing to attempts to resolve this tension at the philosophical, policy, organisational and practice levels.

  2. the tension between two major purposes of assessment: identification of the needs of individual clients and allocation of scarce health and welfare resources

  3. the literature reflects an historical shift away from a perception of assessment as an integral part of service provision towards the establishment of assessment as an independent client-focused process.

- The review also revealed that there are surprisingly few empirical studies, which investigate the process and everyday practice of assessment.

Australia

- From a New Zealand perspective the Australian approach to assessment is perhaps particularly instructive.

- In Australia there is a network of 140 regionally based multidisciplinary Aged Care Assessment Teams, which provide services across the entire continent. ACATs act as "gatekeepers" to services and are responsible for determining eligibility for admission to residential aged care facilities and for community aged care packages (an intensive form of home-based support akin to hostel-level care). 1996-7 the equivalent of 108 assessments per 1,000 people aged 70 and over in the Australian population. Teams also can recommend (and often do) a range of Home and Community Care services, including the Community Options Program, but doesn't determine eligibility for these. (At a Glance, sheet 25) Older people cannot enter residential care until they have been assessed by ACAT.

- Australia has been described as having taken a "leading role from the mid 1980s…in the use of assessment as a central element in the reform of its aged care system" (Butler et al, p 12).

- Assessment teams contain a range of professionals. Nationally around 150,000 people a year are assessed. Assessment teams are frequently based in local hospitals and therefore have a key role in ensuring continuity of care through involvement in the discharge planning process. In 1994 Psychogeriatric Units were established to meet the needs of elderly people in residential care. The units are linked to Assessment Teams. They provide expert diagnosis, assessment, advice and support to assist Assessment Teams, services, and individuals and their families (Financing, p 3).

- Assessment teams do not engage in ongoing regular monitoring of those they have assessed but instead rely on further referrals from services eg GPs when a patient's needs increase or change.

- 1999/2000 Federal Budget provided for free annual voluntary health assessments for people 75 years and over. Where possible, these assessments will be undertaken in the home and are designed to ensure early detection and prevention. Funding is available to GPs, also for case conferencing involving at least 3 providers, and also case management (not much used – NB there is no equivalent of practice nurses). Many GPs contract out the non-medical parts of the assessment. Concerns about quality control. Could be seen as GP income protection, but positive side is that it pulls in GPs to sharing responsibility with providers. Too early to see if it is successful – evidence that some unmet need is being uncovered; also some concerns about medicalising problems people would otherwise live with. (Judy Glackin, meeting with Peter Fleming and Jeff Feibig in Australia).

- According to Butler et al assessment for Home and Community Care (HACC) services is largely unsystematised and left to the discretion of service providers (p 12)

Canada
- In Canada. all provinces offer client assessment, case coordination, and case management. The literature reviewed did not discuss specific provincial programs for assessment and care coordination.

- No national standards of eligibility exist in Canada according to Merlis.

United Kingdom
- Geriatric assessment developed in 1930s as a hospital based technology, which was part of the universal health care system (Butler et al p 14-15).

- In the United Kingdom, The National Health Services and Community Care Act 1990, implemented in 1993, focused on multidisciplinary needs assessments (Cox, pp. 89-92)

- Prior to the act, local authorities were the main providers of services.

- After the Act, social service purchasers and service providers were separated as a means of improving service quality and choice. Lack of suppliers, the

preference of local authorities for in-house providers, and political uncertainty have frequently kept this split from occurring.

- Local authorities have overall responsibility for assessment and care management, but can delegate their execution to professionals and organizations (Glendinning). Local authority Social Services Departments headed up by social workers have lead authority to undertake comprehensive assessment where necessary (Butler et al p 14-16 for further detail).

- Assessment and care management are the main methods for improving the coordination of services for the elderly.

  1. The elderly client and his/her caregiver are involved in the development of the care plan;

  2. The caregiver has a right to his/her own assessment;

  3. Assessment is intended to be need-led – that is to start with the needs of the user – rather than with the services available;

  4. Case management is intended to deliver services that respond to individual needs;

  5. Government guidance states only that needs be met within available resources – assessments have therefore been dictated by the amount of money available – resulting in needs-led, but resources-constrained assessments. (Cox, p 92).

- Care managers have not been successful in coordinating:

  1. Services funded by other organizations;

  2. Services with their own assessment and eligibility criteria;

  3. Services provided by other professionals with their own management and accountability structure (Cox).

- Two assessments are usually required for the elderly beneficiary who requires both home nursing and home care services. This is because the local social services staff providing the home care services cannot purchase nursing services from the NHS. One assessment is performed by local authority social services staff A second is performed by NHS community nursing staff (Glendinning).

- Local authorities are required to assess people requesting assessments (Cox).

- The request for a needs assessment can come from the older person themselves, their carer or family and those working within NHS acute care, primary care, social services, voluntary organizations, charities and others (Cox).

- Warburton has noted that more older people were assessed and care managed in 1998 than in 1990 but argued that in that time while assessment and care

management had developed to a considerable extent in name, they had only developed to a limited extent in practice. While there had been good progress, there was considerable local variations, assessment was not differentiated, care plans were not clearly focused on outcomes, case reviews were not done, users were not involved and information about services was not accessible. Generally multi-disciplinary assessments need to be improved.

- The key figure in access to community care services is the social worker, who may be based in a hospital medical department for care of elderly patients or old age psychiatry, in a general practice or health center, or in the local social services office (social welfare officers or social work assistants have information on all services available locally, and act as a liaison between the various agencies involved in the provision of care (Renwick).

- When an individual who may need extra support at home is referred, the social worker will usually start a formal assessment procedure. The complexity of the assessment process varies from an initial assessment of mobility, personal care abilities, current environment, and support network to a more comprehensive process involving input from other members of the interdisciplinary team (including medical staff) and including assessment of finances (Renwick).

- The focus of attention has shifted in recent years to the primary care level and to preventive health care, with the introduction of the new GP contract in 1990, which requires GPs to offer all patients aged 75 and over an annual home visit and assessment…It is not yet clear whether the GP assessments can be seen as contributing towards greater integration between the health and welfare sectors in the provision of care for older people…. Moreover, there does not appear to be any formal connection between the community care assessments and GP assessments, suggesting that the old division between health and welfare assessments may have been recreated in the UK in a new form" (Butler et al, p 15).

Japan

- "In Japan, the municipalities are responsible for assessment, but they use care managers, who may be employees of organisations that provide services. It has been argued that because of the overlap between their roles as care managers and providers, there may be a conflict of interest, and the process of eligibility determination may have an inbuilt bias towards severity, to favour providers. The plan is that final decisions about eligibility will be made by an expert committee" (Brodsky et al, p 19).

- Japan has set six levels of disability using a point system (ranging from 25 min to 110 mins of long term care per day) (p 19).

- In Japan the decision has been made to provide some training to professionals from various fields to carry out the specific function of assessment of eligibility (so-called care managers). Who these professionals may be has been defined very broadly; they include nursing home aides and care workers with experience who have received in-service training only (p 20).

- Responsibility for care planning may reside with the individual and his family, or with a care manager, who will advise patients on planning their care (care plans must be approved by the patient or his family), coordinate service provision, and monitor services and claims. For practical reasons it is expected that this responsibility will rest primarily with the care manager, to prevent clients from having to pay for services out of their own pockets and wait for reimbursement. (pp 78-9).

- Assessment of eligibility may be made in the community or in an institution. Applicants will be expected to require care for at least 6 months. Once care has begun, the recipient will be re-assessed every 3-6 months (p 78).

- To ensure fair and equitable assessment, a national uniform standard of eligibility has been developed. Assessment will be made using an 85-item form that measures performance in activities of daily living (ADLs) and cognitive, sensory (visual and verbal), and functional abilities (p 78).

Germany
- Maximum expenditures per person are capped at levels that vary by disability and institutional status. Germany has set three levels (from 1.5 to 5 hours or more of care per day) (Brodsky et al, p 19).

- Program outlays do not depend on the amount of services used per person or provider payment levels, but on whether a person is eligible, what disability level they are categorized as having and whether beneficiaries choose cash or services

- In Germany, medical boards are directly responsible for assessment; however, care funds conduct the assessment for eligibility through the sickness funds' medical services and reimburse the sickness funds for the use of the service (Brodsky et al, p 19)

- Assessments may be performed by physicians or nurses (Brodsky et al, p 20, see also p 48).

Denmark
- Denmark has a comprehensive system of assessment and management.

- Everyone age 75 and older is entitled to at least two preventive visits a year from a municipal worker, to evaluate needs and assist with planning for functional independence.

- Those in need of formal care are assessed by a home care manager. The manager develops a plan, which amounts to a quasi-contractual specification of needed services.

- The quasi-contract replaces municipal discretion in service delivery with an entitlement (Merlis).

The Netherlands

- Since 1998 external agencies (RIOs – Regional Assessment Organisations) have been established locally; they comprise representatives of applicants, consumer groups, service providers, physicians, and staff of the local authority. RIOs employ professionals from various fields for the assessment (Brodsky et al, p 19).

- Assessments are valid for a finite period, except for application for long-term institutional care….Based on the team's assessment, the RIO will determine whether institutional or community care is required, as well as the urgency of its provision. In the Netherlands, long-term care insurance does not set a clear limit on the total benefits per beneficiary, although it limits the amount of specific services (such as home nursing) (p 57).

United States

- There is no universal health care system, no universal access to assessment for older people. Geriatric assessment is used by large health care groups to gatekeep services and care coordination. The predominant model is inpatient geriatric assessment units in acute hospitals. Contribution has predominantly been in development and testing of standard instruments (Butler et al, p 15).

- Assessment tools, criteria for assistance, and available services vary by locality (Merlis).

Finland

- Assessments and allocation of care allowances are carried out by home care coordinators, social workers and managers, managers of old people's homes and members of social welfare boards – or any combination of these (Martimo).

3. Community Care

This section on community care reviews different approaches to provide care to people in the community (which generally means in their own home). This section begins with some general commentary and summaries of studies on the role and the effectiveness of community care options. The section then reviews community care/home support services available in a number of countries: Australia; Canada; the United Kingdom; Japan; Germany; Denmark; the Netherlands; the United States; and Finland.

- Peter Townsend (see Bornat et al, p 221-6) has argued that social policy development in the twentieth century in Western countries regarding the concepts of retirement, pensions, institutional residents and community care, in which the recipient plays a passive role, has created and reinforced a structured social dependency of the elderly.

- Townsend argues that "Empirical studies of capacity and desire for productive occupation, reciprocations of services, and familial and social relationships, as well as self-care, challenge the assumptions which prevail." Therefore, "there is clearly room for an alternative interpretation of the roles to be played by the elderly whereby many more of them continue in paid employment, find alternative forms of substantial and productive occupation, have rights to much larger incomes, and have a much greater control over the place and type of accommodation where they live, and the kind of community services to which they contribute as well as have access".

- Integration through "care management" has been a common feature of community care services in a number of countries (see section one on integration and section two on assessment).

- Malcolm Payne (Bornat et al, p 284) has reviewed American and English approaches to managing community care.

- He concludes that as the idea of case management has been transferred from the American context to the British system "the concept of care management has come to embody the central conflict in community care policy: between individualised, responsive care and the containment of costs. At the end of this process, need and the responsibilities of care management are defined always within the context of control of expenditure. Consequently care management has moved away from the American conceptualisation of case management as a form of social work. The possibility of seeing a 'new social work' as a more empowering and facilitating practice, as offered by brokerage approaches, has been imperilled. Instead UK care management for a 'new social work' focuses on cost control, assessment and restriction through bureaucratic and market mechanisms"

- Community care is also an important component of discharge planning after hospitalisation, particularly for the very old. A study by Dansky et al of 70 older people indicated that people aged 80 and over who received skilled

nursing home services after hospitalisation were less likely to report health problems or complications than those who did not.

- Means maintains that while it has been argued for some time that older people should stay in their own homes this has not been backed up in the UK with domiciliary services because of concerns that this would enable families to push caring responsibilities onto the state. Means argues that "local authorities as the lead agencies in community care should help to foster such independence and that this requires them to develop a broad vision of community care which covers issues such as transport, leisure and household maintenance"

- Weissert in Deber and Thompson reviews 32 studies of home care services. He concluded that home care services are not actually cost effective. While carer satisfaction (in the short term) and patient life satisfaction rises somewhat so too does the overall cost of care (by about 15-18%). Weissert concludes from the study that home care has no effect on survival or on functioning in terms of activities of daily living (using a variety of measurement tools). It does reduce nursing home use but the studies suggest that most people who use home care are not at risk of going into a nursing home. Therefore, Weissert concludes more work needs to be done into looking at how to make such services cost-effective, particularly through effectively targeting them at those who would otherwise require more expensive forms of care.

- Parker et al in 2000 undertook a systematic review of 84 papers from 45 studies to evaluate the evidence available on what is the best place of care for older people after acute and during subacute illness. They concluded that despite considerable recent development of different forms of care for older patients, evidence about effectiveness and costs is weak. However, evidence is also weak for longer-standing care models. This review confirms the need for a service evaluation agenda and also raises questions about the efficacy of systematic review techniques, such as was undertaken, in the area of service delivery and organisations.

- A study by Richmond and Northey - *Comparing Homecare Options with Long Term Resthome Care in the Care of Frail Older People* - in the Northern Region of New Zealand found that the death rates for the two groups were comparable, there was no significant difference at exit in ADL status, quality of life score or intellectual function. At exit the majority of subjects from both groups believed that they were living in circumstances best suited to their needs. Significantly more of the homecare group were satisfied with their involvement in decision making about services they should receive. The use of secondary medical services (admission to a public hospital or outpatient clinic/day ward) was significantly greater for the homecare group. However, average cost per week including costs of administering and running the case managers and all secondary health care costs was 30% lower for the homecare group.

- The conclusions of the study were that:

  1. Homecare monitored and purchased by budget-holding case managers is a practical option for a selected group of older people;

2. People in homecare are not disadvantaged in respect of support needs level, intellectual function or quality of life;

3. Satisfaction with homecare may be greater for the clients than for their carers;

4. Homecare people utilise secondary health services more than do resthome residents;

5. Nevertheless there is a distinct cost advantage to home care even when the major identifiable service costs including administration of the case managers are included.

- In 2000 the <u>Centre for Housing Policy, University of York</u> undertook a comprehensive systematic literature review of the effectiveness of low intensity support services in enabling people to live independently in ordinary housing. This was undertaken because "despite some recent policy acknowledgment of the potential role of low intensity support services in assisting people to live independently, community care resources continue to be targeted mainly on high level, often crisis interventions."

- The findings were as follows:

  1. Users, across all types of these services, consistently reported that services had a positive effect on their lives, particularly improved self-esteem;

  2. Despite a general lack of data on housing-related issues, qualitative research indicated that how a service is delivered (eg attitudes, time, support etc) heightens the likelihood of successful tenancy;

  3. Research stressed the importance of social support. While there were evident benefits from worker-user relationships, evidence that social networks and activities increased was limited;

  4. Few studies looked at how services affected health or the use of more acute services but some suggested some low intensity services eg befriending could maintain health or lead to improvement in the users' perceptions of their health;

  5. The existing research in this area has a number of limitations making conclusions difficult. More robust methods of assessing effectiveness needs to be given a higher priority.

- Two US studies indicate the potential value of community-based involvement with primary care providers in aged care services. <u>Bula et</u> al conducted a study of 81 patients enrolled in a program of in-home comprehensive geriatric assessment combined with a health promotion program. It was found that physician cooperation was likely to lead to higher adherence by patients to program recommendations. In another study of 201 chronically ill people over

70 (see <u>Leveille et al</u>) participants met with a geriatric nurse practitioner on average 3 times per year as part of a targeted, multi-component disability prevention and disease self-management program. The project provided evidence that "a community-based collaboration with primary care providers can improve function and reduce inpatient utilisation in chronically ill older adults."

- Research indicates that some more intensive forms of community care may not be more effective in terms of cost and patient outcomes than in-patient hospital care. <u>Shepperd and Illiffe</u> in 1997 reviewed 5 studies (866 patients) and concluded that health outcomes are not improved in patients who receive hospital-at-home care compared with inpatient hospital care. Patient satisfaction is increased but caregiver satisfaction is not. However, in commentary below Masters points out that the studies were limited to hospital-in-home services, had small sample sizes, were considerably heterogeneous and that the review process also led to the exclusion of several trials of interventions that appear to be effective in managing acutely ill patients in home settings.

- Furthermore, a study by <u>Grande et al</u> could not show that hospital-at-home services allowed more people to die at home when there was good provision of standard community care services in the area. Further investigation of cost-effectiveness is needed.

- In the 1999 <u>WHO</u> report on home-based and long term care Havens reviewed the available evidence on homecare. She concluded (p 1): "The overall goal [of home care] is to provide high quality, appropriate and cost-effective care to individuals that will enable them to maintain their independence and the highest quality of life. Virtually all studies have found home care to be associated with higher quality of life and some studies have found it to be cost-effective. Cost-effectiveness has been found most frequently in home care that substitutes for acute care and less frequently in home care that substitutes for long-term institutionalisation. Cost-effectiveness is more difficult to demonstrate in home care programs that maintain individuals in their own homes when they need care but are not candidates for institutional care." This report includes information on findings from the literature concerning, for instance, payment of informal caregivers, homecare for those with dementia or HIV/AIDS, homecare staffing, training, the use of technology, health care planning, and day and respite care issues.

- <u>Higgins</u> in her 1989 essay "Defining Community Care: realities and myths" makes the following points:

  1. Many care settings have elements of institutional and so-called community care and there is no clear dichotomy between the two;

  2. The real distinction is not between the institution and the community but between the institution and home. Community care is not provided by anonymous, altruistic others but comes from specific individuals (usually women) in domiciliary settings)

3. Careful individual assessment is required to ensure that dependent people are not offered housing or residential solutions when what they need (and want) is care and services.

- Litwin and Lightman have commented: "Community care of the frail elderly – and of other people with multiple long-term needs – is a currently favored response of western countries to two fundamental considerations: a rapidly aging population and the increased costs incurred by the expanding but faltering welfare state. A key feature of community-based care is the development of individualised needs-driven packages of services delivered in the locality of residence of the elderly client. The community care approach is believed to maximise both formal and informal resources as a cost-effective alternative to the expensive provision of state-funded care in long-stay institutions, whilst simultaneously improving the quality of life of the individual (p 691)".

- For a comprehensive, detailed review of benefits available (including a discussion of cash allowance schemes), programme operation, coverage of services and financing for long-term care services (including community services and other services, not restricted to a discussion of services available only to older people) in five developed Western countries see pp 20-34 of Brodsky et al.

Australia
- The Australian Aged Care Policy document entitled At a Glance comprehensively describes community services available for older people in Australia.

- There are two main types of community care programs in Australia, which are available to older people: the Home and Community Care Program (HACC) and Community Aged Care Packages (CACPs). There also exists a wide spread pilot program called Extended Aged Care Packages (EACH) (see Butler et al for further discussion of aged care reforms in Australia).

- Home and Community Care Program (HACC) is the most comprehensive, widely available community care program in Australia. It provides community-based support services, such as home nursing, personal care, respite, meals and transport to people who can be appropriately cared for in the community and can remain at home (not only older people are eligible). 4,000 organisations providing services to 240,000 patients.

- Before 1985 home-based services in Australia were scant and poorly coordinated. HACC was aimed at substantially improving the quantity and range of services available to frail and disabled older people living at home. In addition to the more commonly available areas of home nursing, home help and delivered meals, there was an expansion of centre-based and in-home respite services, transport services, gardening, and home handyman assistance. In 1996-7 434 hours of home help was provided per 1,000 persons aged 70 and over, 167 hours of home nursing and 131 hours of personal care.

- Perhaps one of the most pronounced differences in the age profiles of HACC and residential care clients is to do with the proportion aged 90 and over. Only 7% of HACC clients are 90 years old or over. In comparison 11% of those receiving community aged care packages are in this age group and 16-18% of those people in residential care are 90 or over.

- 1998/99 major developments:

  1. Implementation of a national fees policy for HACC services;

  2. A quality appraisal process for HACC services, based on performance against the HACC services,

  3. Work has been undertaken on classifying the care needs of HACC clients; and

  4. The feasibility and appropriateness of establishing a national system of independent assessment of eligibility for HACC services is under review.

- In 1997 965 hours of HACC services per month were provided for every 1,000 people 70 years and older.

- Work continues to be undertaken at more effectively targeting the HACC program (Bundoora).

- "There is still considerable work to ensure coordinated planning between various areas of community care…Because the amount of funding each service receives is fixed, services may not be able to provide for everyone, and service providers may face difficult decisions about their priorities…Work is currently underway between Commonwealth, States and Territories on developing a community care classification which could form the basis of a funding system which funded people according to their assessed needs, rather than funding specific services." (World Class Care, p 28).

- Community aged care packages support people who prefer to remain at home but require care equivalent to that provided in hostels. 540 organisations provide over 10,000 packages. A benchmark of 10 packages per 1000 people over 70 was announced in April 98 as part of the Staying at Home initiative. The Community Options (COPs) scheme also is available to all ages. It is aimed at reducing inappropriate admissions to institutional care among highly dependent people and those with complex needs, who nevertheless can remain in the community.

- Community aged care packages are for in home support. Providers are funded for these in packages of 30-40 ie providers manage risk and sort out actual care delivered. Almost all providers are community or church organisations. Services include visits, arranging meals, personal care, medication and supervision. Those dependent on the pension retain about 15% after fees (meeting between Judy Glackin and Ian Hardy, CEO of Helping Hand).

- People aged 70 and over are eligible for a CACP. Introduction of ageing in place CACPs packages have effectively increased the community care places available from 40 per 1,000 to 52 per 1,000. Effectively services are rationed by a cap on places – some people are being sustained in the community with high levels of support; there are some bed blockers in hospitals; beds largely filled with those aged 80+. (Judy Glackin's meeting with Peter Fleming and Jeff Feibig in South Australia).

- Unlike HAAC services, CACPs are aimed at older people only. In 1999 there were 10.5 CACPs per 1,000 persons aged 70 years and over. An example of the level of funding is the Commonwealth government expenditure on CACPs for older South Australians, which is currently around $28 per day. (South Australia – The Facts).

- Around 12% of people aged 70 years and over receive care in the community through HACC, Community Aged Care Packages (CACPs) and services for veterans and their widows.

- Home Nursing Care Packages have been recently introduced as a widespread pilot program to test the feasibility and cost effectiveness of providing a community substitute for high level residential care, by providing nursing home level care to people in their own homes. Initially established in South Australia, pilot projects now operate in South Australia, Western Australia, New South Wales, Victoria and ACT. The pilot is cost neutral and funded by the federal Government by replacing an equivalent number of nursing home places for the period of the pilot. The pilot programme for these packages is called Extended Aged Care at Home Packages (Financing, p 14).

- Commonwealth funding of $805m in 1999-00 for the Home and Community Care Program which provides community nursing, allied health services and personal care, community aged care packages, meals on wheels, home help, transport and community-based respite care.

- The Commonwealth Government will also provide up to $60m over four years in upgrading and new facilities in rural and remote areas of Australia (At a Glance).

Canada

- Home care is included in the federal Canada Health Act as an "extended health care service," but home care services are not publicly insured in the same way as hospital and physician services. Provinces and territories provide and publicly fund home care services at their discretion (Minister of Public Works & Government Services Canada, 1999).

- Home Care includes an array of services, which enable clients, incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying, or substituting for long-term care or acute care alternatives.

- Home care is a health program, with health broadly defined; to be effective it may have to provide services, which in other contexts might be defined as social or educational services. Home care may be appropriate for people with minor health problems and disabilities and for those who are acutely ill requiring intensive and sophisticated services and equipment.

- There are no upper or lower limits on the age at which home care may be required, although as in other segments of the health system, utilization tends to increase with age.

- Purpose of Home Care Programs is to provide a substitute for services provided by hospitals and long-term care facilities. To provide maintenance services to enable clients to remain independent in their current environment rather than moving to a new and more costly venue. To provide preventative services which invests in client service and monitoring at additional short-run but lower long-run costs.

- Jurisdictional responsibility for providing home care services rests with the provinces and territories. Since each program has undergone its own unique development in response to community needs, service delivery varies across the country.

- Control is maintained under the provincial jurisdiction of the Ministries of Health and/or social/community services. The trend is for provinces to allocate health funds using a population needs-based funding model with funding levels determined by population needs-based characteristics rather than on past service use. Another emerging trend is for provinces to specify that community health budgets cannot be reduced, while hospital acute care and institutional supportive budgets can be decreased to provide additional funding for community budgets.

- Most provinces have similar basic requirements for eligibility for home care services

  - Proof of residence

  - A comprehensive needs assessment conducted prior to any service being provided

  - The care is a response to unmet needs

  - The home is safe and suitable for service delivery

  - Consent of the client or guardian is obtained.

- Range of Services to support people at home

  - All provinces provide both acute and long-term home care services.
  - All provinces offer a similar range of basic services:

- o Nursing services
- o Personal care
- o Homemaking
- o Meals-On-Wheels

- Shapiro in <u>Deber and Thompson</u> describes Manitoba's Continuing Care provincial, no-cost-to-consumer program, which assesses persons requiring community or nursing home care, coordinates and delivers services at home, or places individuals in a nursing home. It serves persons requiring care on a short- or long-term basis. Eligibility does not require an M.D referral or the specific need for a medical service. Nursing home care is insured, with persons paying a room and board per diem. Home care consumes about 3% of the provincial health care budget, a percentage which has remained almost constant despite the growth in the number of elderly who are the predominant consumers".

- She concludes from available data that in this situation "clearly, home care is less costly than nursing home care".

- Shapira then describes recent develops which she believes are increasing the pressure on home care to expand without a proportionate expansion of resources. These developments are:

  1. Growth in physician supply, coupled with governments' decision to reduce the ratio of acute beds/population;

  2. Increasing use of outpatient surgery;

  3. Increasing numbers of elderly, particularly older elderly who are the main users of community care;

  4. Increasing efforts by governments to reduce the ration of long-term beds;

  5. Increasing prevalence of dementia as the size of the very elderly population increases; and,

  6. Financial constraints.

- Shapira stresses the importance of maintaining the community-based model of elderly care. She criticises hospital-based models of care. She notes that "two recent systematic evaluations cast doubt on the assumption that hospital-bed replacement services could be provided more efficiently or most cost-effectively by hospitals than by the community-based program. In Montreal, the Verdun Hospital's "hospital-in-the-home" program proved more expensive than in-hospital treatment, whereas Victoria's Quick Response Team, run by the community-care program, was cheaper than in-hospital care…"

- Shapira argues that some problems have emerged in Canada because most provinces have not included representation from their community care program in the overall planning for health care".

United Kingdom

- After a critical report in 1986 identified problems with coordination and flexibility of community care services, the white paper Caring for People (1989) stated the government's aim to provide a "needs led," responsive range of service, promoting maximum independence of those wishing to live at home rather than enter institutional care. New arrangements were introduced in 1993, involving a formal assessment procedure and the production of a personalized care plan for each individual, incorporating services provided by private and voluntary agencies as well as by social services departments (Renwick).

- The community care reforms in the 1990s were aimed at encouraging the growth in the community care sector, which would take the burden off residential care, reduce costs, and offer individuals more options and opportunities for staying at home. These aims were at least partially achieved in that day care and home care provided by local authorities increased by 25% between 1993 and 1995. The use of private day and home care increased from 4% to 17% of the total services provided. There is no absolute cost limit in terms of money to the package of community services but in most instances, service packages are not permitted to exceed the cost of residential care (Cox, p 93)

- There remains a financial incentive to place dependent persons in residential care. In contrast to community care services in which local authorities are responsible for total costs except for the charges they may impose, local governments receive both public and private pension benefits for persons in residential care. This reimbursement substantially reduces the amount the authority actually pays. Local authorities also receive reimbursements from central government for those placed in private-sector homes. Thus, depending on the availability and costs of services, it can be easier and more cost effective to place persons in residential care than to develop community-care packages (p 94).

- A range of services to support people at home are available.

- "Since 1971, local authorities have been required to provide essential care in the home for those unable to care for themselves, including home help, visiting nurses, social work and warden services. Social service departments became responsible for domestic help, residential accommodation, general welfare, meals and recreation, registration of old people's homes, and social work support" (Coleman, p. 469).

- Nonprofit associations and public housing authorities build and manage sheltered housing. "Different models of sheltered housing have been developed to accommodate the varying needs of older people. One design contains flats with or without adjoining communal spaces for people who are relatively active. For people with greater needs, another type of sheltered housing consists of a

block of 'bed-sitting' or one-bedroom flats linked by interior corridors with a communal lounge, kitchen (for group meals), and laundry" (Coleman, p. 468)

- Henwood and Wistow, (p. 120) state that "the number of home care hours provided per week has risen by 56% between 1992 and 1997. However, this has not translated into a rise in the number of people cared for at home as the number of households receiving care in a week has actually fallen by 11%."

- Caldock argues that the reassuring connotations of the phrase 'community care' may not be reflected in its reality and that the policy rhetoric shouldn't be accepted unquestioningly.

- Because hospital care is free under the NHS, but residential and community care services are not, there is two-fold resistance to the progression from hospital to local community care services. Geriatric patients resist the move because it entails them assuming some costs of treatment after discharge. Likewise, local authorities do not encourage the progression which, when it occurs, may involve them in also bearing some of the costs of patient treatment after discharge. (Merlis, p. 146).

- In July 2000 the UK Government announced that "more money will be available for care and rehabilitation services at home. Short-term care services will also be improved, so that people who rely on relatives or friends to look after them will be catered for if their carers fall ill." Free intermediate care will also be offered to old people leaving hospitals. "It is estimated that 20 per cent of hospital beds are taken up by elderly patients who do not need them but who cannot leave because they have nowhere to go to recuperate" (Merlis).

- Warburton argues that between 1990 and 1998 reforms in the UK have led to more intensive home care services benefiting a wider range of people and a more planned approach to older people. But the objectives of the reforms in relation to helping people live at home have only been met "to some extent". There continues to be considerable local variation in the availability and quality of services generally. Warburton comments that GPs and primary health care need to become more involved in community care although work at the interface is improving and roles are clearer and that there needs to be more joint investment in community-based options in the UK.

Japan
- In Japan a high proportion of older people still live with their children although the proportion of three-generation households is decreasing (Nishimura, p 59).

- The biggest issue concerning service provision in 1998 was the need to establish care assessment and planning in Japan (Nishimura, p 137).

- Some of the aims of the New Gold Plan, developed in 1988, were: to ensure that 24 hour continuous (mobile) home help services are widely available; to promote the establishment of small scale day service centres; to strengthen comprehensive counselling and care management functions of in-home care

support centres; to promote home-based medical treatment by upgrading professional standards for personal physicians and, to implement service quality evaluation programs to examine in-home and facility services from the users' viewpoint as well as promoting the drawing up of care plans to provide individual elderly persons with appropriate care.

- The New Gold Plan also aimed at the implementation of comprehensive measures for dementia patients and the implementation of measures to support the independence of the elderly needing care services.

- Finally the New Gold Plan aimed at promoting measures to involve the elderly socially and providing them with a fulfilling life.

- The development and use of technical aids in Japan is promoted (New Gold Plan. p 22).

- Under the new system, established in late 1990s, everyone aged 65 and older, and anyone from 40-64 suffering from an age-related disability is eligible for benefits. It is estimated that 12.4% of the elderly population will be eligible for benefits in 2000 (Campbell and Ikegami, p 33).

- Community-based service covered by the new scheme include some former social services such as home help for caregiving or housekeeping, bath service, loan of devices such as wheelchairs, and home reconstruction; some former health insurance benefits such as visiting nurses, rehabilitation, and "medical management", and some services that have been available from both sectors, such as adult day care and temporary "respite" stays in an institution (Campbell and Ikegami, p 35).(see also Brodsky et al, p 79).

Germany
- Home care benefits are intended to supplement the care and attention rendered to the beneficiary by his family, friends, and other informal carers.

- As a general rule, home care is preferred to institutional care.

- The Long Term Care (LTC) program focuses on providing benefits that improve conditions for home care and relieve the burdens on carers

- Regardless of the level of care a person receives, prevention and rehabilitation are given priority over care.

- Beneficiaries may choose freely between nursing homes and home care agencies. Persons electing home and community-based services choose among providers having contracts with sickness funds.

- Assistance with personal hygiene, eating, mobility and household chores is available.

- The number of home-care provider agencies has risen significantly, with most of the growth occurring among private, for-profit agencies. The home-care industry employs 60,000 more workers than it did before the launching of the LTC program.

- See Vollmer for further discussion of LTC program.

- See also Merlis and Brodsky et al.

Denmark
- Each locality makes its own decisions about eligibility and the types of care provided. Everyone age 75 and older is entitled to at least two preventive visits a year from a health care professional to evaluate needs and assist with planning for functional independence. Treatment is equalized: people living at home and in institutions pay for their own food, accommodation costs and comfort items. Personal and health care are supported equally in both. Home help services: include free and permanent home help, meals-on-wheels, alarm systems, gardening, snow clearing (Brodsky et al).

- All home care services, whether nursing, health visitor, technical aids or home help are generally provided free of charge. Most local authorities now provide a 24 hour home care service (Merlis).

- "Home help to frail and disabled people is now regarded as a basic right of the Danish welfare state on a par with health care. In the early 1990s a charge for home help was introduced, but quickly rescinded as it was extremely unpopular (Royal Commission Report on Long Term Care, p 181).

The Netherlands
- See van Linschoten and Ruissen and van den Ven for discussion of community services available in the Netherlands.

- Community-based services (home help and home nursing) and intermediate care services – provided for by a combination of national care fund and user charges.

- Adapted and sheltered housing is regulated by government and provided by social housing organizations and residential homes.

- Technical aids such as wheelchairs are provided by local government and social welfare services are subsidized by local government.

- Home help agencies, health care societies that provide district nursing, nursing homes, and residential homes, were originally established as private, nonprofit agencies with a strong church-based orientation. Today, even though these organizations rely in part on government funding, they are still largely private. The Dutch system has been described as a "combination of elaborate government regulation on the one hand and the mainly private provision of facilities on the other." Two kinds of private voluntary associations deliver home care services:

1. Home care organizations for home nursing and personal care.

2. Home-aid organizations that provide household services.

- Because these organizations seldom work together, the care for older people has been fragmented.

- Home help includes a few hours a week of assistance with household tasks such as cleaning, laundry and shopping. Demand for home care services exceeds the supply of personnel due to difficulty recruiting workers, particularly in urban areas.

- Service providers:

  1. Regular service providers face little competition. They receive a yearly budget from the national care fund in exchange for agreed levels of activity in the provision of home care, nursing care, residential homes and intermediate care services.

  2. Home care providers have developed a monopolistic structure as an intended consequence of central government's policies of rewarding economies of scale.

  3. On average a healthcare region covers 500,000 inhabitants and will have only a few certified home care provider organizations. These provide nearly all publicly funded professional home help and home nursing services. Few for-profit providers have entered the market of home care and their small market share is limited to more affluent older people.

  4. Home care services have been accused of being inflexible and inefficient. Individual older people often receive care from a number of different employees from the same provider, creating coordination problems.

- The two types of home care – home nursing and home help – are provided mainly by non-profit organizations, which operate in defined areas; there is no competition among them. A few for-profit agencies also provide home care, primarily in the large cities. Providers of home care must meet three critieria:

  1. They must provide a range of service including nursing care, personal care (assistance with ADLs), homemaking, and the assistive devices;

  2. They must comply with a set of uniform standards of quality (measuring primarily by personnel qualifications); and

  3. They must uphold collective labour agreements with professional home help aides and nurses. (Brodsky et al, p 58)

- Home nursing includes nursing care and the loan of assistive devices. The services are provided by qualified nurses with a background in public health.

There is no specification of the minimum length of time the service is to be provided…however, there is a limit on services of 3 hours a day (in exceptional cases, such as the terminally ill, this service may be extended to a maximum of 8 hours per day).

- Home help is defined as assistance with housekeeping and personal care, and emotional support. The hours of care provided are determined by the individual's needs.

United States

- A comparative study by Schoen et al on *The Elderly's Experiences with Health Care in Five Nations* found that the United States does relatively well in providing home health care to the frail elderly. American caregivers and frail elderly were more likely to report getting paid home health care than their counterparts in Australia, New Zealand, the United Kingdom and Canada. "However, burdens faced by informal caregivers – often the children, spouses, or friends of those they serve – continue to be a problem, and frail elders' needs sometimes go unmet" (p vii).

Finland

- The main primary health care services used by older people are GP services and trips to the health care center with the most common consultation among those over 65 being for high blood pressure and diabetes.

- Home nursing is more widely used in Finland compared with the rest of Europe and is offered mostly to people over 75 to avoid hospitalization.

- As well as GP services, home nursing and some beds in health centers, health services also include long-term institutional care and services for younger and older with mental health problems.

- Social services include home help, other support services – meals on wheels, transport, sauna and bathing, laundry and security services – day centers, sheltered housing and residential care homes.

- Municipalities also provide care allowances in lieu of services to support home care of some frail older people.

- The fastest growing elements of social welfare services for older people are the home help and domiciliary support services.

- Finnish home helps are a quasi-professional group. Their training involves a full-time 2½-year course and most are employed on a full-time basis. In areas with few older people or with high numbers of hospital beds, municipalities use hospital beds instead of home helps and domiciliary support services. In the north of Finland where long distances create major problems in delivering domiciliary social welfare services, it is more economical to provide long-term institutional care.

- See <u>Martimo</u> for detail.

4. Carer Support/Respite Care

This section on carer support and respite care looks at the different ways carers are, and can be, involved and supported in the care of the elderly. The section begins with some general comments about informal carers. The section then addresses some of the programmes designed to support carers and offer respite services in: Australia; Canada; United Kingdom; Germany; Denmark; the Netherlands; and Finland.

- According to the WHO report entitled *Home-Based and Long-Term Care*, "the available evidence suggests that families and informal network members want to continue to care for their members who require care…However, the level of care required by home care users has increased and is likely to continue to do so in the foreseeable future; therefore, both the amount and intensity of care provided by informal and formal caregivers are also increasing. The question is whether caregivers can continue to provide the care required without themselves becoming consumers of health care….While many formal home care delivery systems provide some relief and support to informal caregivers, the amount, frequency and duration of this support vary widely. When support to the informal caregiver is not both an explicit goal and a legitimate function of the formal system this support often begins too late in the process of delivering service to delay or prevent caregiver burnout." (p1-2)

- Litwin and Lightman, in their comparative review of community care policies, noted that both Ontario and Israel have in common a paucity of current efforts to address the needs of family caregivers (p 691)

Australia

- Respite care is funded by the Federal Government through community programs and can include community-based day care, in-home services, and short-term care in residential aged care facilities and is commonwealth funded. (World Class Care, p 18)

- Federal Government initiatives in 1999/2000:

- An additional $82.2m over the next four years to further boost respite care services for carers of people with dementia and other cognitive and behavioural disorders.

- The Budget also allocated around $41.2m over 4 years for an exciting Carelink initiative. These funds will support single regional contact points across Australia for community care service.

- Throughout Australia care for older people still relies heavily on the work of primary caregivers eg family members and volunteers. This allows ageing in place but NSW (Trialling New Ideas) for instance in 1991 identified a number of problems:

  1. Inadequate residential/home respite and day care;

2. Inadequate information about services, facilities, entitlements etc;

3. Lack of coordination between services and programs;

4. Inflexibility;

5. Insensitivity and incompetence on the part of some service providers;

6. Lack of acknowledgement of the work of carers;

7. Insensitive or inadequate referral skills on part of medical personnel;

8. No reliable source of unbiased advice and information;

9. Insufficient income support and compensation for loss of income and exclusion from paid labour force; and

10. Lack of recognition of caring responsibilities of a member of the paid workforce (p 17).

- "The Government's policy is to support primary carers through information services, respite services and financial assistance. A national network of Carer Resource Centres has been established to provide information and advice to carers, which complements a national network of carer respite centres which assist carers to access the wide range of respite services provided through different programs and by different levels of government.

- Financial assistance and income support is available through the Carer payment (a pension paid to full-time carers), other income support payments such as Age Pensions (NB many carers are older persons themselves) and the Carers Allowance, which is paid to carers of people living at home who qualify for nursing home-level care (At a Glance and World Class Care, p 18).

- Comprehensive information and referral services through Carer Resource Centres and Carer Respite Centres are available (World Class Care, p 18).

- A wide range of active support, both through services specifically targeted to carers and through the top-up care services provided through mainstream service such as HACC and Community Aged Care Packages (World Class Care, p 18).

- Initiatives such as the Federal Government's $270m staying at home – care and support for older Australians package was slammed for offering ageing carers of people with a disability only $9 per week (Link Magazine).

Canada
- The literature reviewed did not discuss provincial day care programs. Respite services are offered in all provinces. The literature reviewed did not discuss specific provincial respite programs.

- Initiatives to keep people at home (rapid response teams, hospital avoidance schemes) British Columbia has developed quick response teams. Their purpose is to avert admissions of elderly people to hospital by providing recuperative support at home. Clients served by the quick response teams tend to retain their sense of independence ansd the need for permanent institutional care has been substantially delayed (see Iglehart, Merlis, and Hollander).

United Kingdom

- Family placement schemes is a program providing respite to family caregivers by placing the elderly family member in another private home for a while. The short-term caregivers are typically middle-aged women with residential home or nursing background. They are paid by the local authority, which then either charges the client or the social security system. (Coleman, p. 469).

- Attempts are made to "match" each client with an appropriate household. A fixed weekly charge is made to the client; the family receives a small payment. This allows people to enjoy a break in a domestic setting rather than have respite in a home (Renwick).

- Some social services departments run schemes where volunteers "sit" with an elderly person in his or her home. This is usually free of charge, although the volunteers will have travel expenses reimbursed.

- Day centers are run by some social services or by voluntary organizations. Transport and lunch are provided at a small charge.

- Respite care may be arranged in either a local authority residential home or a private nursing home. A fixed charge is payable for local authority homes; social services may meet a proportion of the cost of intermittent care in a private home, after financial assessment.

- Rehabilitation services for people who are visually impaired or deaf may also be available.

- In some areas, social services departments have arrangements with local authority homes in different regions (for example, in a seaside resort) to allow a period of respite care to be taken as a holiday.

- On the subject of informal caregiver support, the Royal Commission Report takes this position: "On the grounds of equity and justice we believe carers need more support. They need to be actively engaged in the process of needs assessment, and where possible services to support them must be considered" (1999, 8.24, p. 89)

- In their "Note of Dissent" located at the end of the Royal Commission Report, Joffe & Lipsey comment: "Another area in which sensible additional spending is needed is in support for informal carers, and for those for whom they care. Though more help with caring is recommended by the [Commission] majority in their report too, in their scheme of things, it will have to compete for priority

with their free care proposal. As we do not live in a have-it-all world, the likely consequence is that support for the informal care sector will continue to be minimal (1999, 119, p. 133)…But it would be unwise to take informal care for granted. Twice as much care is provided informally as is provided formally. It follows that a reduction in informal care would tend to mean a more than proportional increase in formal care. The consequences of a reduction in informal care for spending would be alarming. If 20% less informal care than projected by the Commission materializes, then public expenditure in 2051 would be ≤ 3.8 billion, and total expenditure ≤6 billion higher than on the Commission's projection (1999, 122, p. 133)….“It is hard to demonstrate any link between any particular package of help for carers and its outcomes. However, equally it must be true that it is more likely that people will continue to care if they are valued, supported and given incentives to do so. And this particularly so at the crucial point where the carer is struggling to cope. Prompt help then could forestall a breakdown in the caring relationship. Besides its social benefits, this could save many years of expenditure on expensive residential care" (1999, 123. p. 133).

- Respite care –in the words of the <u>Royal Commission Report</u>, "Carers had been helped little, and that often services were not being offered where there was a carer in evidence" (1999, 4.47, p. 43).

- <u>Warburton</u> claims that the 1993 reforms have only supported carers to a limited degree and support is very variable.

- A 1987 discussion paper by <u>Wright</u> entitled *The Economics of Informal Care of the Elderly* evaluated alternative methods of costing informal care. The paper argued that different types of households are likely to generate different problems and warrant different methods of costing. However, the valuation of time as developed in transport appraisals is probably the closest method to the helpers' own valuation of their own time. In the survey reported in the paper helpers had little difficulty in estimating the hours of working and non-working time they would have free if their charge were admitted to a different form of care.

- Furthermore, <u>Wright</u> concluded that "the evidence from this rather limited study is that carers can often be kept happy in their work for quite small amounts of weekly expenditure. In fact, if the formal caring system were more attuned to identifying the strains placed on carers or were able to make the nature and scope of its services more widely known and more easily accessible and, of course, had the resources available to satisfy the resulting demands then the net advantage of the time spent caring for many carers would be greater than the net advantage of other uses of time…However, some studies suggest that increased service provision does not discourage some groups of carers (eg not closely related to or not living in the same household) from preferring the admission of the patient to long-term institutional care. (p 29)"

- Since 1993 however, assessments for community care services are required to take account of the caregiver's ability to continue providing care on a regular basis. The Carers Recognition and Services Act 1996 gives caregivers a right to

an assessment of their needs. The tightening of resources has meant however, that assessments tend to be "increasingly dictated by the amount of available money" and services are available to the most frail who have the least existing caregiver support (Cox, p 93)

Germany

- People receiving care outside an institution have a choice of cash rather than services. Cash benefits are paid directly to the beneficiary. Cash benefits are only granted if the beneficiary is able to secure adequate home care for himself through relatives, friends or neighbours. Persons electing cash receive less than half the value of the service benefits. Persons electing cash benefits do not have to account for how the funds are spent and there is no requirement that funds be used to buy long-term care services. Dementia is not a reason to deny cash and require services. People who elect professional care in the community rather than care from neighbours, family members etc, receive a greater amount of benefit, which is paid directly to the service provider. Note: 67% of beneficiaries prefer the lower cash benefits to the much higher non-cash benefits, a fact that has contributed to the LTC program running initially well below original estimates and in achieving significant surpluses. Although cash benefits do not often cover the complete cost of care, surveys show that they are perceived by a great majority of family, friends and other informal carers as a token of recognition for voluntary or informal care.

- *Stand-in care* (Holiday care) – Relatives, friends, neighbors or other informal carers providing home care may take a four weeks holiday a year during which time the care insurance will pay for professional home care service up to a specified DM amount. The same applies if the normal carer is ill or otherwise prevented from providing care

- *Part-time care* – must be granted in a day or night center if a person in need of long-term care is unable to obtain adequate help at home

- *Short-term care* – If home care or part-time care does not suffice, the beneficiary is entitled to care in a short-term facility for up to four weeks a year

- Sickness funds are required to provide free nursing care courses for relatives and volunteer carers.

- Social security insurance for informal carers – relatives, friends or neighbours performing informal, non-professional home care on a regular basis are included in the German pension scheme. Statutory pension insurance cover informal caregivers who are either not employed or work less than 30 hours/week in a regular job, and who provide unpaid home care for at least 14 hours/week.

- See Vollmer for further in-depth discussion of the German long term care insurance system. See also Scharf and Brodsky et al.

Denmark

- Day care centers are available.

- Allowances for caregivers are paid for by the government and are based on the caregiver's previous earnings, but the program is limited to persons caring for the terminally ill (Royal Commission Report on Long Term Care, p 180).

The Netherlands

- The Dutch government was anxious to prevent the occurrence of socially undesirable consequences such as spending personal budget money on items for private consumption rather than care services, or employing caregivers outside of general labor market regulations.

- Personal budgets are allocated to persons in need of home nursing and/or home help services if the need is for longer than three months and clients continue to live in their own home.

- Personal budgets can be used to purchase professional help from established home care organizations or new providers. They can be used to contract with and pay informal caregivers.

- Apart from a small fixed sum, which can be spent on care entirely at the older person's discretion, the older person is not actually in direct control of their personal budget. An Association of Personal Budget Holders acts as an intermediary between the client and the provider organization. Both the established non-profit provider organizations and the for-profit providers can deliver services.

- The personal budget experiment has been implemented on a small scale – only 3% - 5% of the total care budget is currently spent on personal budgets. Waiting lists for personal budgets are common.

- 54% of recipients use personal budgets for domestic help only. 14% use their budget for personal or nursing care. 32% use the budget for a combination of services.

- Recipients allocate their budgets to a range of formal and informal caregivers. 37% hire informal caregivers or private domestic help. 63% contract with a professional agency.

- Some beneficiaries consider the personal budget to be primarily a way of rewarding informal caregivers who have already been providing support over a long period. The vast majority of beneficiaries are positive about the personal budget program. The main complaints have been about the lengthy and bureaucratic procedures for processing applications and inadequate information about entitlement and eligibility criteria. Clients feel that personal budgets have led to better services, more control over how the job is done and more choice over who provides the care.

- Clients can now dismiss an employee or provider organization if they are not satisfied (see Tunissen and Knapen).

Finland

- A feature of social welfare provision in Finland for both home care for older people and day care for children is the provision of cash allowances instead of services in kind.

- Cash allowances are paid directly to the caregiver. The caregiver enters into a contract with the municipality to provide an agreed level of care to the older person in return for the allowance. Care allowances provide for intensive home care services needed to keep a frail older person out of institutional care, which would be particularly difficult to provide in sparsely populated areas. They are effective in capping expenditure on long-term care services. Even in a case where 24/day attention is needed, a care allowance is considerably lower than the cost of providing professional home help and home support services.

- In 1994, 394 out of 402 municipalities paid care allowances. 13,000 disabled and elderly people received a home care allowance – 2/3rds were over age 65. Without the allowance 2/3rds would have had to enter long-term institutional care. Of the caregivers, 31% were spouses, 64% were relatives and the rest were unrelated. Most caregivers were over 50 years old and a third were over 65. The average monthly allowance was approximately 1,496 FMK with variations between 250 and 5,500 FML/month. Increasingly stringent means-testing has increased the targeting of the allowance to the poorest older people and caregivers and reduced the overall numbers of care allowance recipients (Martimo).

5. Residential Care

This section on residential care concerns institutional options for caring for the elderly. It begins with a comment on the general trend towards deinstitutionalisation. It then goes on to briefly review the residential care systems of Australia, Canada, the United Kingdom, Japan, Denmark, Germany and the Netherlands.

- Deinstitutionalisation from long-term to community care is a world-wide trend (Jacobzone et al) (see Jacobzone et al, occasional papers no 37 and 38 for further discussion of worldwide ageing trends). The trends they found led them to the conclusion that "where it can be objectively measured, these trends indicate a need for a proper streamlining of existing capacities, rather than further expansion of the number of proper nursing home beds (p 21).

Australia

- Private (for-profit) organisations provide 48% nursing home-level care places; not-for-profit organisations provide 38% of nursing home-level care places. Access to residential care and to community aged care packages is determined by Aged Care Assessment Teams, which assess medical, physical, psychological and social needs (At a Glance).

- Nursing home-level care (high level care) provides accommodation and other support services; it targets frail older people with needs that cannot be met in the community and need ongoing access to nursing care. There are approximately 75,000 places in Australia. High level care usually involves 24 hour nursing care, delivered by registered nursing staff (Financing, p 4).

- Hostel-level care provides accommodation and associated support services, such as domestic services, assistance with daily tasks and some nursing care. It targets less frail older people with needs which cannot be met in the community, but who do not need 24 hour access to nursing care; 65,000 places in Australia.

- There has been a movement away from the strict separation of nursing homes and hostels since 1997. Nursing homes and hostels are now referred to as facilities providing high level and low level care. Flicker comments "The situation has been somewhat muddled by legislative changes enacted in October 1997 allowing residential care facilities to house residents of any degree of dependency, and in fact 18% of residents in hostels are classified as requiring "high level" care. (Flicker, p 77)

- Gibson et al also discuss the substantial decrease in the number of residential beds available since 1985. Since 1997 all residential care services have been administered and funded under one system and an increasing number of facilities offer the full continuum of care (World Class Care, p 21).

- This change confirmed studies such as that of Mykyta et al which argued there is no clear-cut progression between different levels of community and residential care and "although entry into residential levels of care is strictly (and effectively) controlled to the higher levels of disability, there is no clear dividing

line or distinction between people who reside with support in the community and those who are in residential care" (p 135)

- 1 in 5 residential facilities offered both high and low level care in 1994 and 1 in 3 hostels were linked with other hostels. However, generally residential care is still a small-scale activity at the point of delivery (Howe).

- In 1997 as part of the Aged Care Reform Strategy the Commonwealth Government transferred responsibility for monitoring standards from the Commonwealth Department to an independent Aged Care Standards and Accreditation Agency. The agency developed a single set of standards. This has led to considerable improvement in the base level quality of care (Howe)

- It is important to note than more than 80% of people aged 70 years and over do not receive Government-funded aged or community care services and are relatively healthy and independent (World Class Care, p 18)

- Gibson and Liu have used demographic analysis to show that the Australian benchmark of around 100 residential care places per 1000 persons 70 and over will lead to a general shortage of residential care. This is particularly true of nursing home care for high dependency aged persons, particularly in the period 2006-2016.

Canada
- "Residents pay income-based charges but are not required to use their assets. A proposal in New Brunswick to impose spend-down requirements was dropped after meeting strong opposition" (Merlis, p. 143).

- Data relating to residential bed numbers per population were not available from the literature reviewed. In his article "Caring For The Frail Elderly: An International Review" Merlis makes this statement: "Canada has reduced nursing home beds, both in absolute numbers and in proportion to the population. However, the population remaining in institutions is more severely disabled and requires more care. At the same time, strict standards for nursing home admission have left a highly disabled population in the community. Further pressure on the system is created by sharp reductions in inpatient hospital stays; priority in home care is shifting toward post-acute services and away from long-term care (p 144).

United Kingdom
- "An over-supply in the residential sector and the effect of Local Authority purchasing power meant that costs were low and made residential care seem attractive in cost terms compared to home care" (Royal Commission Report on Long Term Care, 4.47, p. 43).

- "Prior to 1993, admission into residential care was determined primarily by a person's finances, with less attention given to the level of functioning and need for assistance. With local authorities now responsible for funding placements, the criteria for eligibility includes an assessment of needs and whether or not they can be met in the community. There are no standardized forms for

assessments or criteria for admissions. However, local authorities are required to assess anyone requesting an assessment"" (Cox, p. 93).

- For those accepted into residential care, fees are determined through national guidelines and users are means-tested (p 93-4).

- "The percentage of older Britons residing in institutions has remained fairly stable at 5% over the last decade. Private-sector involvement has increased significantly, however. The number of beds in private nursing facilities increased from 51,760 in 1983 to 116,668 by 1988" (Coleman, p. 468).

- In 1999, The Royal Commission placed the number of older Britons in care homes at 480,000 – about 1 in 20 of all elderly people. (2.5, p. 8). Note: Discussion of older Britons in the literature reviewed is most generally a discussion of people 65 and older, although reference is occasionally made to those 60 and above.

- In July 2000 the UK government announced that nursing care for elderly, previously means-tested and costing an average of 337 pounds a week, will be available free to everybody in homes under a 1.3b Government plan to reform the long-term care system. The elderly will also be allowed to spend three months is a nursing or residential home before the means testing rules, which can force people to sell their homes, comes into force. After that, accommodation charges will be calculated according to residents' means, but nursing care will remain free (Sparrow).

- This move was criticized by Age Concern as failing to address the needs of older people in nursing homes who would benefit from free personal care, thereby rejecting the main proposal of the Royal Commission on Long Term Care for the Elderly ("Age Concern's response to the Government's announcement on long term care for older people and the NHS National Plan).

- Warburton, when reviewing the success of the 1993 reforms in the UK aged care sector at a conference in 1998, noted that services have improved between 1990 and 1998 in that the number of older people in residential care has stabilized and residential care spending is under control. However, numbers of older people admitted to hospital are growing and pressure on beds in hospital and in residential care is increasing.

Japan
- Since 1973, medical care, including hospital care, has been free for those aged 70 or over (and those who are bedridden and age 65 or over); in other words, they are exempt from co-payments. It should be noted, however, that small co-payments were reinstituted. In 1983, the Health Medical Service Act for the Elderly was enacted to provide comprehensive health and medical services for people aged 70 and over, and to balance the burden of medical expenditures for the elderly among the various insurance schemes. Under this law, the national government contributes 20% of the cost of medical care of the elderly, the prefectures and primary local government contribute 5% each, and health insurance associations cover the remaining 70%. Until the implementation of

the new law, social services, including nursing homes and home care remained means-tested and targeted at those without family support (<u>Brodsky et al,</u> pp 76-77)

- Hospitals are the main providers of care in Japan. However, traditionally, the Japanese concept of hospitalisation has differed from the Western one. Japan has no exclusively "acute"hospitals: Patients with chronic illnesses who in the West would find themselves in long-term care institutions have been treated as in-patients in Japanese hospitals….The lack of a system of assessment or triage of elderly patients and the uniform fee system (which does not take into account the severity of a patient's illness or disability) have resulted in the placement in hospitals and nursing homes of many patients who are only slightly disabled and need minimum care." (<u>Brodsky et al</u>, p 77).

- Previously, there were no for-profit organisations operating nursing homes, which receive government subsidies. (<u>Nishimura, conference</u>, p 59)

- Japan however has promoted domiciliary services operated by for-profit organisations.

- Until 2000 "older people [could not] choose nursing homes because they enter[ed] them through an allocation system and since the co-payment is graduated according to income, middle-class workers bear the brunt of the burden. Meanwhile there [was] an overlap of services because many people needing long-tem care are admitted into hospitals for long-term care, which results in a waste of medical care expenses because the cost of hospitals is higher than nursing homes and hospitals are not adequate for long-term care" (<u>Nishimura, conference</u>, p 59)

- The New Gold Plan aimed to improve the nursing environment in facilities and hospitals, for example, the expansion of private room areas of special nursing homes for the elderly. The Plan also involved the Government taking supportive measures to promote facility development in urban areas and promoting the comprehensive development of health and welfare facilities and other public facilities (<u>New Gold Plan</u>, p 7).

- The Long-term Care Insurance Bill was passed in December 1997 and was implemented from 1 April 2000. In the public (compulsory) long-term care insurance system all persons aged over 40 pay premiums and everyone aged 65 and over is eligible (regardless of income or family situation) for benefits based on physical and mental disability in six categories of need. Benefits are all services, with no cash allowance for family care and are generous, covering 90% of need. 10% of the cost will be paid by users and the rest is halved by the governments and the public insurance funds. The average insurance premium is $24 per month and half of the premium is paid by employers (<u>Nishimura, conference</u>, p 59). According to Campbell and Ikegami "long-term costs seemed not to be a major consideration in program design…Consumers can now choose the services and providers they want, including use of for-profit companies."

- It is estimated that 705,000 persons will be eligible for residential care under the new program in three types of facilities: 1. nursing homes (43% of beds), previously under social services; and two types previously covered by health insurance – health facilities for the elderly (29% of beds) and designated long-term-care beds in hospitals (28%). The intention is eventually to merge the three types. This makes sense because neither the residents or the care they receive differs very much currently between facilities (Campbell and Ikegami, p 35). (for further detail of new scheme see pp 78-82 Brodsky et al).

Denmark

- "In Denmark community-based services have more clearly replaced institutional care. A freeze on nursing home construction and an expansion of community-based services led to significant drops in institutionalization in the 1980s and early 1990s. Whereas 20% of persons aged eighty and older were in nursing homes in 1982, only 12% were by 1996; among all persons aged 67 and older the rate dropped from 6.6% to 4.6%. The savings have been sufficient to allow provision of community-based services to nearly a quarter of all elderly persons, while long-term care spending dropped from 2.6% of GDP in 1982 to 2.3% in 1994 (Merlis, p 145).

- Residents of nursing homes make payments of up to 20% of their income; they are not required to spend their assets (Merlis, p 143).

- Elderly individuals, whether they live in institutions or at home pay for some of their housing and food and personal costs but personal care and health care are paid by public funds (Merlis, p 143).

- A Government commission that studied the living conditions of older Danes from 1979-1981, laid the groundwork for the Danish government's subsequent focus on developing housing and community services that encourage independence for older people. In its report it recommended that all elderly Danes had a right to independent housing – "as long as possible in one's home" (Gottschalk).

- The 1987 Housing for the Elderly Act prohibited construction of institutional facilities such as nursing homes and sheltered housing from 1988. Local authorities were required to provide services or housing improvements to older persons to help them remain in their homes or in a type of multi-unit housing suitable for their needs. Since the enactment of the Housing Act, special financing has been provided to local authorities to provide appropriate housing for frail elderly persons, either through new construction or by refurbishing existing housing (Coleman, pp 460-1).

- Although no new nursing homes were built for several years following the passing of the 1987 Housing for the Elderly Act, the original plan to phase them out entirely has given way to replacing conventional homes with different types of dwelling organized in such a way as to create a small group dwelling. For example, one such dwelling in the municipality of Farm is a home to 96 elderly people living in units of eight people, with each unit having its own daytime

area, garden, and dedicated staff (<u>Royal Commission Report on Long Term Care,</u> p 180).

Germany

- Institutional care benefits are intended to relieve the beneficiary, as far as possible, from care-related expenditures. Includes basic care, medical care and therapeutic social activities, but not room and board.

- Beneficiaries are responsible for paying their own living and accommodation costs, normally at a flat rate, which is basically the same for all people living in the nursing home. Sickness funds pay flat monthly amounts for institutional care, depending on the level of disability. If the costs exceed the flat payment, residents must pay the remainder.

- The proportion of costs that a beneficiary must cover rises with disability level, because program payment does not increase as sharply as nursing home costs do. Consequently, persons with the highest levels of disability may have the greatest disincentive to live in institutions.

- A goal of the long-term care program, introduced under the social Dependency Insurance Act 1994, was to increase the availability of nursing home and home-care services and to foster competition across providers. Since the LTC program was initiated, more Germans have elected to receive treatment in their homes and communities. This has been a factor contributing to the disappearance of waiting lists for nursing home placement. Note: The average age of the German citizen entering a nursing home is 85 years. 70% of Germans being cared for in a nursing home are suffering from some kind of dementia – increasingly from Alzheimer's.

- Improvement in the long-term care insurance plan is seen as necessary in two areas: Quality of care and Care of people suffering from dementia

- In November 2000 <u>Vollmer</u> reported that a Care Quality Improvement Bill and a Bill on the Protection of People living in Homes for the Elderly are being drafted, as is a bill, which intends to improve the care of people suffering from dementia.

- For more detail on available benefits, the insurance scheme, and financing of costs see <u>Brodsky et al</u> pp 46-55.

The Netherlands

- Costs of long-term care are paid from a specific National Care Fund and cover all citizens.

  1. Control of the Fund rests with regional health insurance agencies, supervised by a national board.

  2. Within fixed spending limits, the Fund covers the supply and needs-test use of services for the chronically ill, physically disabled and elderly

people, people with severe learning disabilities and people with long-term psychiatric disorders.

3. The National Care Fund is based on tax-related premiums from all citizens, supplemented by central government funding.

- In the Dutch model every citizen has access to the broad basic benefits of care

- Besides the 5% of care not included in the basic benefits package – e.g. supplemental care – the Dutch population pays 10% of the total health care expenditures via user charges.

- Institutional care is provided for through a combination of national care fund and user charges. The minimum age for admission to a nursing home is 75. Nursing homes have high occupancy rates and elderly individuals may have to wait nearly a year for admission to a facility.

- Nursing homes provide diagnosis and assessment, nursing care, rehabilitation and terminal care. Care in residential homes is limited to those 65 or over. These homes provide an appropriate environment for people who cannot live alone and provide assistance with ADLs, activity therapy, and medications. Sometimes they provide services to the community such as hot meals, alarm systems and emergency assistance, help with bathing and showering, recreational day care programmes and respite care. Adjacent to many residential homes for the elderly are sheltered housing projects for people who are capable of living independently if they have a supportive and adapted environment. The national insurance scheme covers most services in these accommodations (Brodsky et al p 59).

- The distinction between nursing homes and residential homes for the elderly has become blurred over the years. Both types of facilities are now expected to help organize programmes for the community. Most of them have "day hospital" or day care programmes that service elderly people residing in the community who need supervision for part of the day.

- For more detail see Brodsky et al pp 57-64.

• Other Services Available

This section provides a short overview of some of the other health and disability services for older people available in Australia, Canada, the United Kingdom; and Germany. The purpose of this section is not to offer a comprehensive list of available services, but to demonstrate that a number of benefits, which might not traditionally be included in descriptions of "community care" or "residential care", may be available to older people and may be integrated into the packages of services they receive.

Australia

- **Palliative care** may be provided in a range of settings through hospital and health services. Some basic palliative care services are also provided through HACC and in nursing homes and hostels (World Class Care).

- **Dementia services.** Around 60% of people in nursing homes, 28% of people in hostels and 19% of HACC clients have dementia. The Commonwealth Government has introduced the following measures:

  1. Revised funding arrangements for residential aged care facilities that provide a better recognition of the care needs and costs associated with residents with dementia;

  2. Additional funding for ACTs to retain the psychogeriatric expertise needed for the early and accurate recognition of signs of dementia;

  3. The establishment of psychogeriatric units to provide support and training for residential staff caring for people with dementia as well as information and advice to carers in the community;

  4. A dementia education and support program for people with dementia and their carers; and

  5. Enhanced respite care services for carers of people with dementia (World Class Care, p 22)

- Also there is an early intervention approach for people with dementia and their carers through peer support groups and national behaviour helpline (Financing, p 11). This is Commonwealth funded.

- **Free hearing rehabilitation services** Eligible clients including age pensioners and veterans may chose their own service provider through a voucher system.

- **Veterans**. A wide range of separate and additional health care and other services are provided to war veterans and their dependents through the Commonwealth Department of Veteran's Affairs (see World Class Care, p 20).

- **Complaints resolution service** Residents of aged care facilities have access to a complaints resolution process. The system is overseen by independent committees. The Federal Government also funds advocacy services in each State and Territory (Financing, p 12).

- **Safe at Home Initiative**. The Federal Government is trialing a new initiative with the aim of giving older Australians more security in their own homes through funding of easy to operate communication aids.

- **Community Visitors Program.** Funded by Federal Government. Targets lonely and isolated residents in facilities who can benefit from contact with a volunteer.

- **Day Therapy Centres.** These were established by the Federal Government to assist the frail aged to remain as independent as possible. They offer a range of therapy services such as physiotherapy, occupational therapy and podiatry. The centre may charge a modest fee. Most centres are located at residential care facilities. There are 152 centres in Australia. (Financing, p 13)

- For example Helping Hand in South Australia provides a Healthy Lifestyle Centre which offers practical therapies eg podiatry, social integration and social development – recapturing lost skills (Meeting between Judy Glackin and Ian Hardy, CEO, Helping Hand).

- **Depression** is more prevalent among older people, particularly those in residential care. The Federal Government is providing $17.5m over five years towards an Australian Depression Foundation, which will work to disseminate information and link professional help for depression (World Class Care, p 12).

- The literature identifies a need for comprehensive **health promotion** strategies to meet the specific needs of older people and argues that attempts so far in Australia have been unsuccessful and currently attract only modest funding (Nutbeam, p 121, also see Kendig et al)

- Individual States have taken varying interest in health promotion with older people. Some have begun to develop more comprehensive and sophisticated approaches to supporting health promotion activities with seniors eg Victoria, Western Australia.

- At federal Government level and in most States, however, health promotion for older people has regressed into many ad-hoc projects associated with specific issues (eg prevention of falls) (Nutbeam).

- Nutbeam argues the need for a strategy that is population-based rather than targeting at-risk individuals focusing on outcomes through working in partnership with older people.

- The lack of health promotion strategies for aged care may be due in part to the difficulty in measuring the success of such strategies. Harris et al undertook a literature search of studies concerning the effectiveness of preventive programs for older people living in the community. They found that more research was needed, for while existing research suggests that there is at least some potential for cost savings and improved health outcomes, the existence of a net benefit from health promotion schemes is unclear.

- Nonetheless commentators such as <u>Byles et al</u> conclude preventive assessment programs for older Australians including regular functional assessment to identify and address potential problems early in order to maintain optimal independence and quality of life, have great potential and could lead to considerable savings. <u>Hahn and Smith</u> for instance describe Wellness Centres for older people, which have been successfully operating in parts of NSW since 1991 (9 centres). They provide a forum where older people can socialise and learn more about improving their health and well-being. The centres seem to be fulfilling two key objectives:

  1. Broadening social networks of participants; and

  2. Dissemination of health information and reinforcement of positive health attitudes. (see also <u>Tang et al</u>)

- Victoria and NSW have health promotion for older people strategies. More research is needed on the relationship between ageing and beliefs and attitudes to health, especially in relation to aboriginal people. In Australia (cf Canada and US), evaluation of health promotion programs for older people has largely been neglected (<u>O'Connor et al</u>, p 66). Successful programs overseas have involved home assessment by the general-practice linked health visitor and referral for appropriate follow up services. However, to date programs have tended to be single focus eg education and/or information or community based activities with no routine evaluation of programs.

- A study by <u>Kendig et al</u> show childhood and adult experiences and intergenerational relations were important factors in the use of health services by older people. The Health Status of Older People (HSOP) survey in 1994 of 1000 persons aimed to research attitudes to health – showed most older Australians lead independent, positive and satisfying lives. p 178 "Outcomes in old age are heavily influenced by whether or not one has a wife (less so a husband), has cared for or lost a spouse, or has children or not. These findings indicate that health promotion policies need to take careful account of the different needs of people along the life span". Therefore, <u>Kendig et al</u> conclude that Government needs to consider importance of families in crafting care and health promotion policies (p 179).

- In October 1999 the Minister for Aged Care released a <u>"Healthy Ageing Discussion Paper"</u> as part of the work towards the National Strategy for an Ageing Australia. The discussion paper identified several key areas in promoting healthy ageing and preventing illness that could be given further consideration; including:

  1. maintaining physical and mental health;

  2. Engaging in physical activity;

  3. Preventing falls and injury;

  4. Maintaining adequate nutrition;

5. Detecting sensory loss early;

6. Managing incontinence;

7. Evaluating alcohol and other drug usage; and

8. Undertaking further research and data collection.

- Key challenges for the future included:

    1. Dispelling the negative myths around ageing;

    2. Convincing older Australians that healthy lifestyles have benefits;

    3. Determining the motivational factors to undertake health activities and turning these into actions; and

    4. Promoting the design aspects of both communities and houses to foster healthy lifestyles.

Canada

- "Canada has focused more attention on the nonmedical determinants of the population's health status than perhaps any other Western country has. The famous Lalonde Report of some twenty-five years ago placed great emphasis on nonmedical determinants; more recently, the **Population Health Program** of the Canadian Institutes for Advanced Research has given voice to this subject" (Iglehart, p. 139).

- **Community Activities** "Many seniors become involved in community activities and these have an effect on their autonomy and quality of life. Such activities have a major, positive impact on individual well-being and indirectly contribute to reducing health and social services costs. The funding of community programs plays a determining role in promoting individual commitment and partnership formation, and in preventing seniors' social isolation. Society as a whole, including government and the private sector, receives many benefits and services by guaranteeing the sustainability of community projects that meet ongoing community needs. Unfortunately, the government withdrawal that has been taking place for several years is endangering the gains of the past. For example, since the abandonment of the **New Horizons** program which funded 39,000 projects from 1972 to 1995, governments and communities have not been able to support seniors' community programs as they did in the past. There is a pressing need to adopt another strategy to support this type of senior empowerment and encourage their social involvement" (National Advisory Council on Aging, 1999, p. 6).

- **Rehabilitation, convalescence** – not specifically discussed in the literature reviewed.

- **Palliative care** Palliative care services may be included either under the acute home care program or as a separate program. (Minister of Public Works and Government Services Canada, 1999).

- The literature reviewed did not discuss Canadian health promotion programs beyond making statements recognizing its value.

United Kingdom

- **Health promotion:** According to the Royal Commission Report on Long Term Care, "There has been more home care, but targeted at the most dependent. It was felt that prevention was squeezed out." (4.47, p. 43).

- "The tightening of services has meant that services are now increasingly targeted to the most needy cases with little priority given to prevention. Thus, most authorities are unable to provide services such as cleaning and assistance with home chores to the less frail" (Cox, p. 92).

- Warburton has noted that following the 1993 reforms in UK aged care in 1997 there was less money in 1997 for preventative services.

- **Rehabilitation**, convalescence: The Royal Commission Report on Long Term Care noted that there are marked disparities in the provision of rehabilitation between geographical areas in the United Kingdom and that rehabilitative services may be denied to people who live in residential and nursing homes. (8.18, p. 87)

- Warburton in 1998 commented on the need for more rehabilitation services, particularly after hospital discharge. Warburton also noted in 1998 that black older people and older people with mental health problems continue to be poorly served in the UK.

- **Palliative care** – There is no discussion of palliative care in the UK literature reviewed.

- **Housing adaptations** Each social services office has a disability services team which deals with applications for home adaptations. These will be funded by the social services department or the housing department, depending on cost. Private home owners undergo financial assessment and may have to meet a proportion of the costs. (Renwick).

- **Equipment for daily living** - The disability services team can also give advice on, assess the need for, and arrange provision of various types of equipment.

- Social Services departments in localities may also organize free telephone installation, emergency alarm systems and meals at low cost.

Germany

- Proposals are being considered, within the existing financial limits, to improve the care of older people suffering from **dementia**. As an alternative to formal

care in a day care center, an informal type of care would be offered in a "lower threshold" setting. Voluntary organizations, such as the German Alzheimer Society offer care in informal family-like surroundings. To foster innovative initiatives, some state governments grant funds to volunteer organizations – the ministry of health proposes to make more funds available by co-financing such projects.

- **Technical aids** – to facilitate long-term care persons in need are entitled to nursing aids such as special beds. Grants are available to adapt the normal home to the special needs of care, e.g. lifts, steps, bathrooms (see Merlis).

REFERENCE LIST

(A Five Year Plan for Western Australia's Maturing Population), Office of Senior Interests, Western Australia, *Time on Our Side – A Five Year Plan for Western Australia's Maturing Population,* 1998-2003

Age Concern's response to the Government's announcement on long term care for older people and the NHS National Plan, 27 July 2000.

(Ageing Well) Aged, Community and Mental Health Division, Victorian Government Department of Human Services, Ageing Well – *A Policy Framework for Aged Care Services in the New Millenium,* August 1999 *

(Better Access to Services) Aged, Community and Mental Health Division, Victorian Government Department of Human Services, *Better Access to Services – A Draft Policy Framework for Discussion,* 2000

Audit Commission, United They Stand – Co-ordinating Care for Elderly Patients with Hip Fracture", National Report (UK) November 1995

(At a Glance) Australian Institute of Health and Welfare and the Office for Older Australians in the Commonwealth Department of Health and Aged Care, *Older Australia at a Glance,* 1999 *

Bergman, Howard, Beland, Francois, Lebel, Paule, Contandriopoulos, Andre-Pierre, Tousignant, Pierre, Brunelle, Yvon, Kaufman, Terry, Leibovich, Ellen, Rodriguez, Rosario, Clarfield, Mark, "Care for Canada's Frail Elderly Population: Fragmentation or Integration?", *Can Med Assoc J* 15 October 1997, 157(8)

Black, DA, Foster, CJ, Maitland, N, "Community Care Outcomes", *BJCP,* January/February 1995, 49(1):19-21

Bornat, Joanna, Johnson, Julia, Pereira, Charmaine, Pilgrim, David, Williams, Fiona (ed) *Community Care: A Reader*, 2nd edn, The Open University

Brodsky, Jenny, Habib, Jack, Mizrahi, Ilana, for WHO, *Long-term Care Laws in Five Developed Countries: A Review*, September 2000

Bula, Christophe J, Alessi, Cathy A, Aronow, Harriet U, Yuhas, Karen, Gold, Marcia, Nisenbaum, Rosane, Beck, John C, Rubenstein, Laurence Z, "Community Physicians' Cooperation with a Program of In-Home Comprehensive Geriatric Assessment", *Journal of the American Geriatric Society,* 1995, 43:1016-1020

Bundoora Extended Care Centre and National Ageing Research Institute, *Targeting in the Home and Community Care Program – Report on a consultancy carried out for Commonwealth, State and Territory Departments administering the Home and Community Care Program (HACC),* July 1999

Butler, Alex, Dickens, Elizabeth, Humphries, Susan, Otis, Nancy, Russell, Heather (Aged Care Group, Lincoln Gerontology Centre, La Trobe University), *Emerging Issues for Australia in the Assessment of Older People: A Review of Recent International Literature,* Vol 38, 1998

Byles, Julie E, Harris, Margaret A, Nair BR, Butler, JRG, "Preventive Health Programs for Older Australians"*, Health Promotion Journal of Australia*, 1996, 6(2): 37-43

Calder, Rosemary, Manager, Aged Services Redevelopment, Department of Human Services, State Government of Victoria, *The Continuum of Care – Acute, Sub-Acute and Community, Australia/Japan Partnership in Health and Family Services, Joint Meeting of Expert Groups, Tokyo, 2 August 1999, Presentations by Australia*

Caldock, Kerry, "Policy and practice: fundamental contradictions in the conceptualization of community care for elderly people?", *Health and Social Care,* 2:133-141

Centre for Housing Policy, University of York, *Low Intensity Support Services: A Systematic Literature Review*, **http://www.jrf.org.uk/knowledge/findings/socialcare/640.htm**, June 2000

Challis, D, Darton, R, Johnson, L, Stone, M, Traske, K, "An Evaluation of an Alternative to Long-stay Hospital Care for Frail Elderly Patients: 1. The Model of Care", *Age and Ageing* 1991: 2-; 236-244

Coleman, B. J. (1995). European models of long-term care in the home and community. *International Journal of Health Services*, 25, (3), 455-474.

Cox, C. (1997). Long-term care: a comparison of policies and services in Israel and the United Kingdon and implications for the United States. *Journal of Aging & Social Policy*, 9, (2), 81-99.

Campbell, John Creighton, Ikegami, Naoki, "Long-Term Care Insurance in Japan", *Health Affairs*, 2000, 19(3): 26

Dansky, Kathryn H, Dellasega, Cheryl, Shellenbarger, Teresa, Clark Russo, Patricia, "After Hospitalisation: Home care for Elderly Persons", *Clinical Nursing Research,* May 1996, 5(2), 185-198

Deber, Raisa B, Thompson, Gail G (ed), "Restructuring Canada's Health Services System: How do we get there from here?", *Proceedings of the Fourth Canadian Conference on Health Economics,* 1992

Disease Management Working Group (compiled by), *Chronic Care Management: Policy and Planning Guide*, August 2000

Eng, Catherine, Pedulla, James, Eleazer, Paul, McCann, Robert and Fox, Norris, "Program of All-inclusive Care for the Elderly (PACE): An Innovative Model of Integrated Geriatric Care and Financing, *Journal of the American Geriatric Society*, 45:223-232 (1997)

(Entry One) *Entry One, Single Entry Point and Assessment Service – Western DomCare – Action Plan*, 21 December 1999.

(Financing) Federal Department of Health and Aged Care, *Financing of Australia's Aged Care System,* 2000 *

Flicker, Leon, "Healthcare for older people in residential care – who cares?", *MJA*, 173, 17 July 2000 *

Gething, Lindsay (Community Disability and Ageing Program, The University of Sydney), *We're Growing Older, Too – Quality of Life and Service Provision Issues for People with Long Standing Disabilities Who Are Ageing,* June 1999

Gibson, Diane, Liu, Zhibin, Choi, Ching, *The changing availability of residential aged care in Australia,* 1995, Health Policy 32: 211-224

Gibson, D, Liu, Z, "Planning Ratios and Population Growth: Will There be a Shortfall in Residential Aged Care by 2021?", *Australian Journal on Ageing,* Volume 14(2):57-62

Glendinning, C. "Health and social care services for frail older people in the UK: changing responsibilities and new developments" in *Rights and Realities: comparing new developments in long-term care for older people,* 1998, Bristol: The Policy Press, 1-27.

Gottschalk, G, "Housing and supportive services for frail older persons in Denmark" in J Pynoos and P Liebig, *Housing frail elders: problems, perspectives and prospects,* John Hopkins University Press: Baltimore   Quoted in BJ Coleman 1995 European Models of long-term care in the home and community International Journal of Health Services 25(3) 455-74

Grande, Gunn E, Todd, Chris J, Barclay, Stephen IG, Farquhar, Morag C, "Does hospital at home for palliative care facilitate death at home?   Randomised controlled trial", *BMJ* 319:1472-5

Hahn, Andrew, Smith, Julie, "Evaluating a Wellness Program for Older People", *Health Promotion Journal of Australia*, 1995, 5(2): 18-21

Harris, M, Byles J, Higginbotham, N, Nair, BR, "Preventive Programs for Older People: How Effective Are They?"*, Australian Journal on Ageing*, 1994, 15(4)

(Health Ageing) The Hon Bronwyn Bishop MP, Minister for Aged Care, *The National Strategy for an Ageing Australia – Health Ageing Discussion Paper,* October 1999

Hebert, R, Carrier, R, Bilodeau, A, "The Functional Autonomy Measurement System (SMAF): Description and Validation of an Instrument for the Measurement of Handicaps", *Age and Ageing.* 1988; 17: 293-302

Henwood, Melanie, *Making a Difference? Implementation of the Community Care Reforms Two Years On*, June 1995, Nuffield Institute for Health, Community Care Division and King's Fund Centre

Henwood, M. & Wistow, G. "Evaluating the impact of caring for people.*" With Respect to Old Age Research Volume 3.,* (1999, March).

Higgins, Joan, "Defining Community Care: realities and myths" *Social Policy and Administration*, 1989, 23(1)

Hill, Brenda J, Basser, Margaret L, "Ageing in the Inner City: Advocacy for the Voiceless"*, Australasian Journal on Ageing*, February 1998, 17(1)

Hollander, M. J**.** Canadian Policy Research Networks, *Assessing the impacts of health reforms on seniors*, 1997

Howe, Anna, "Future Directions for Residential Care", *Australasian Journal on Ageing*, 1999, 18(3) Supplement 12-18

Iglehart, J. K.,"Restoring the status of an icon: a talk with Canada's Minister of Health", *Health Affairs*, 19, (3), 132-140.

Jacobzone, S, "Ageing and Care for Frail Elderly Persons: An Overview of International Perspectives", *Labour Market and Social Policy*, OECD, Occasional Paper No 38, 1999

Jacobzone, Stephane, Cambois, Emmanuelle, Chaplain, Emmanuel, Robine, Jean-Marie, "Long Term Care Services to Older People, a Perspective on Future Needs: The Impact of an Improving Health of Older Persons", from Maintaining Prosperity in an Ageing Society: the OECD study on the policy implications of ageing, working paper AWP 4.2

Jacobzone, S, Chambois, E, Chaplain, E, Robine, J.M, "The Health of Older Persons in OECD Countries: Is it Improving Fast Enough to Compensate for Population Ageing?", Labour Market and Social Policy, OECD, Occasional Paper No 37, 1998

Kane, Robert L. Laurel Hixon Illston, & Nancy A. Miller. "Qualitative Analysis of the Program of All-inclusive Care for the Elderly (PACE)", *The Gerontologist*, 1992. Volume 32, Number 6, pp. 771 – 780.

Kendig, Hal, Browning, Collette, Wells, Yvonne, "Australian Research on Ageing, Families, and Health Promotion", *Social Policy Journal of New Zealand*, 1998, 11

Landi, Francesco, Gambassi, Giovanni, Pola, Roberto, Tabaccanti, Sandro, Cavinto, Tullio, Carbonin, PierUgo, Bernabei, Roberto, "Impact of Integrated Home Care Services on Hospital Use" *Journal of American Geriatrics Society,* 1999, 47:1430-1434, 1999

Lagergren, Marten, "ASIM: A System for Monitoring and Evaluating the Long-Term Care of the Elderly and Disabled", *Health Services Research,* 1993, 28(1)

Leveille, Suzanne G, Wagner, Edward H, Davis, Connie, Grothaus, Lou, Wallace, Jeffrey, LoGerfo, Marianne, Kent, Daniel, "Preventing Disability and Managing Chronic Illness in Frail Older Adults: A Randomised Trial of a Community-Based Partnership with Primary Care', *Journal of the American Geriatrics Society,* 1998

Link Magazine, *Strategy launch on ageing population kickback,* May 1998, 7(2): 9

Litwin, Howard, Lightman, Ernie, "The Development of Community Care Policy for the Elderly: A Comparative Perspective", *International Journal of Health Services*, 1996, 26(4): 691-708

Martimo, Kristina, "Community Care for Frail Older People in Finland" in 1998, Bristol, United Kingdom: The Policy Press, pp 67-81

Means, Robin, "Home, Independence and Community Care: time for a wider vision?", *Policy and Politics* 1997, :409

Merlis, M. "Caring for the frail elderly: an international review", *Health Affairs*, 19, (3), 141-149.

Minister of Public Works and Government Services Canada. *Provincial and territorial home care programs: a synthesis for Canada*. Cat. H21-147/1999E. ISBN 0-622-27936-0, June 1999

(Moving Ahead) Department of Human Services for South Australia, *Moving Ahead – A Strategic Plan for Human Services for Older People in South Australia 1999-2004,* June 1999

Mykyta, LJ, Loan, AD, Thompson, R, Dickson, S, Allerby, J, Fort, A, Riesson, K and Tyler, C, "Towards equity in long-term care", *Australian Health Review,* 1997, 20(3): 133

National Advisory Council on Aging. 1999 and beyond: challenges of an aging Canadian society. Cat H-88-3/28-1999E. ISBN 0-662-27985-9. http://www.hc-sc.gc.ca/seniors-aines), 1999

(New Gold Plan) Health and Welfare Bureau for the Elderly, Ministry of Health and Welfare of Japan, *New Gold Plan,* 1995

Nishimura, J, "Aged Care in Japan and Australia: A Comparative Overview", *Australian Journal on Ageing*, 16(3): 135

Nishimura, J, *Aged Care System and Policy Issues in Japan – Comparison with Australia,* Community, state or family – A Question of Responsibility, Health and Community Care in a Changing Era, National Summit Conference, Carers Association of Australia, Canberra, 2nd and 3rd April, 1998, Conference Proceedings

Norstrom, Thor, Thorslund, Mats, "The Structure of IADL and ADL Measures: Some Findings from a Swedish Study", *Age and Ageing,* 1991: 20:23-8

Nutbeam, Don, "Comprehensive Strategies for Health Promotion for Older People: Past Lessons and Future Opportunities"*, Australasian Journal on Ageing*, August 1998, 17(3)

O'Connor-Fleming, Mary Louise, "An Evaluation of Healthy Ageing Programs"*, Australasian Journal on Ageing*, 1999, 18(3), Supplement

Parker, Gillian, Bhatka, Padma, Katbamna, Savita, Lovett, Caroline, Paisley, Suzy, Parker, Stuart, Phelps, Kay, Baker, Richard, Jagger, Carol, Lindesay, James, Shepperson, Billie, Wilson, Andrew, "Best place of care for older people after acute and during subacute illness: a systematic review", *Journal of Health Services Res Policy* July 2000, 53, pp 176-189.

Renwick, D, "Community care and social services", *British Medical Journal*, 1996, 313:869-72

Rich, Michael Leonard, "The PACE Model: Description and Impressions of a Capitated Model of Long-Term Care for the Elderly", *The Care Management Journal,* 1999, Springer Publishing Company, pp 62-70

Richmond, David, Northey, Robin, Moor, Jenny, Kerr, Murray, Kelsall, Lisa, *Comparing Homecare Options with Long Term Resthome Care in the Care of Frail Older People – The Northern Region Case Management Study*, 1997

Royal Commission Report on Long Term Care, With respect to old age: long term care – rights and responsibilities, 1998, London: The Stationery Office Limited.

Sadler, P, Owen, A, "Directions in Community Care Reform: a NSW Example", *Australian Journal on Ageing*, 15(2): 87

Scharf, Thomas, *Ageing and Ageing Policy in Germany*, German Studies Series, General Editor Eva Kolinsky, 1998, ISSN: 1354-3571

Schoen, Cathy, Strumpf, Erin, Davis, Karen, Osborn, Robin, Donelan, Karen, Blendon, Robert J, *The Elderly's Experiences with Health Care in Five Nations: Findings from the Commonwealth Fund 1999 International Health Policy Survey*, May 2000

Sheppard S, Illiffe, S, "Effectiveness of hospital at home compared to inpatient hospital care" *Cochrane Review*, latest version 18 November 1997 in Evidence Based Medicine, November/December 1998

Silverman, Myrna. Musa, Donald, Martin, David C, Lave, Judith R, Adams, Janet, Ricci, Edmund M, "Evaluation of Outpatient Geriatric Assessment: A Randomised Multi-site Trial", *Journal of the American Geriatric Society,* 1995, 43: 733-740

(Social Policy in Denmark), Ministry of Social Affairs, Copenhagen, *Social Policy in Denmark,* 1995

(South Australia – The Facts) Department of Human Services for South Australia, *Older South Australians – The Facts, Selected Information and statistics for the general community,* 1999

Sparrow, A. *Free nursing for elderly in homes*, 17 July 2000, Electronic Telegraph. http://www.telegraph.co.uk.

Stone, Robyn I, "Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century", *Milbank Memorial Fund,* 2000

Sulch, David, Kalra, Lalit, "Integrated care pathways in stroke management", *Age and Ageing*. 2000, 29:349-352

Tinetti, Mary E, Baker, Dorothy I, McAvay, Gail, Claus, Elizabeth B, Garrett, Patricia, Gottschalk, Margaret, Koch, Marie L, Trainor, Kathryn, Horwitz, Ralph I, "A Multifactorial Intervention to Reduce the Risk of Falling Among Elderly People Living in the Community, *NEJM* September 29 1994, 331:13; 821-7

(Trialing New Ideas) Office on Ageing, New South Wales, *Changing Care for Older People – Trialing New Ideas,* Social Policy Directorate, January 1994, Best Practice, Paper 3

Tunissen, C and Knapen, M, "The national context of social innovation – The Netherlands" in RJ Kraan et al (ed) *Care for the elderly: significant innovations in three European countries* Boulder: Westview Press

United They Stand. "Coordinating Care for Elderly Patients with Hip Fracture." London: HMSO, 1995

Van den Ven, Wynand PMM, "Equity, Cost Containment and Efficiency in Health Care: Can They Be Achieved By Regulated Competition?" in *Ageing, Social Security and Affordability*, Hants, England: Ashgate Publishing Ltd ISBN 1 84014 817 9

Van Linschoten, P, Ruissen, R, "Coordination of community care: two experiments in rural regions", Coolen, J (ed), *Changing Care for the Elderly in the Netherlands* Assen: Van Gorcum, 91-106

Vollmer, Dr Rudolph J, (Under Secretary, Federal Ministry of Health, Bonn), "Long-Term Care Insurance in Germany- Background Paper, including issues related to dementia and the quality of care", prepared for the Meeting of the OECD Workshop "Healthy Ageing and Biotechnology" in Tokyo, Japan, 13,14 November 2000

Wade, D T, Collin, C, "The Barthel ADL Index: a standard measure of physical disability?", *International Disability Studies*. 10, 64-67

Warbuton, Raymond (Policy Section Head, Older People) Social Care Group, Department of Health, England, *Developing and Informing Government Policy for the Care of Older People in England*, ASA Conference, San Diego, USA, December 1998

(World Class Care) The Hon Bronwyn Bishop MP, Minister for Aged Care, *The National Strategy for an Ageing Australia – World Class Care Discussion Paper,* April 2000

World Health Organisation (WHO), (prepared by Betty Havens, University of Manitoba), *Home-Based and Long-Term Care: Home Care Issues and Evidence*, 1999

Wright, Ken, "The Economics of Informal Care of the Elderly" Discussion Paper 23, Centre for Health Economics, March 1987