Help Wanted?
Providing and Paying for Long-Term Care
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Chapter 10

Can We Get Better Value for Money in Long-term Care?

It is well established that ageing populations will lead to increases in the demand for services in the years to come, thereby putting upward pressure on total expenditure on formal long-term care (LTC) systems in a context where large spending items such as pensions and health are also expected to grow. This may well create pressure on governments to ensure that spending in the sector is well worth the expenditure, or, in other words, that systems of long-term care deliver value for money. A review of OECD countries' experiences reveals different policies aimed at improving the efficiency of LTC systems and the "interface" between LTC and health care. However, it is evident that this is an area for further work: often, no definite conclusions can be drawn.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

10.1. What is value for money in long-term care?

In theory, two different concepts of value for money would be relevant for long-term care (LTC) services. One relates to cost efficiency, which implies maximising output for a given amount of resources, and the other relates to cost-effectiveness or value for money, which implies maximising outcomes for a given amount of resources. However, in the social-service sector, the concept of value for money does not come easy. LTC services present complexities which make it difficult to evaluate efficiency – for example, what concept of efficiency to use, how to measure outcomes, or what elements of cost should be included. As a matter of fact, many OECD countries do not have at present operational concepts, measures or indications of efficiency in LTC systems. This chapter does not seek, therefore, to provide a quantitative assessment of efficiency in long-term care. Rather, it offers an overview of what OECD countries are doing under the broad umbrella of policies to improve efficiency in long-term care (Table 10.1). Often, there is no evaluation of impact of such policies, making it difficult to draw conclusions about how to improve value in long-term care.

The next section of this chapter concerns measures within LTC schemes, such as those seeking to balance institutional and home care, payment mechanisms, the impact of competition across providers in LTC, and productivity improvements linked to the use of technology in long-term care. The third part considers measures aimed at improving efficiency at the "interface" between LTC and health care. This section considers aspects such as the promotion of healthy ageing, co-ordination and integration between health care and LTC, and the incentives to avoid the use of acute care services for LTC needs. The last section of this chapter discusses challenges related to the governance of LTC systems and ways to improve administrative efficiency. Where it exists, the chapter points to evidence on the strengths and weaknesses of different measures.

10.2. Towards more efficient delivery of long-term care

Important measures to improve efficiency in long-term care services and systems have focused on three main areas: *i)* the choice of settings; *ii)* the incentives facing providers (payment mechanisms and incentives for provider competition); and *iii)* the impact of technology on productivity.

Encouraging home care

Over the past couple of decades, nearly all OECD countries have been encouraging "ageing in place" policies. The trend reflects the preference of older people to receive care at home. Institutional care can be associated with psychological and social costs for seniors. Home care, on the other hand, is believed to increase patients' satisfaction and their quality of life. Still, waiting times for admission to nursing homes can be quite long, for instance 7-8 weeks in the Netherlands and up to 2-3 years in Japan (Caris-Verhallen and Kerkstra, 2000; Byrne *et al.*, 2008; OECD, 2005). The trend also reflects policies to limit the cost of institutional care which causes a high financial burden on families and represents

a significant cost for public payers. In 2008, institutional care accounted for over 60% of total LTC costs, while on average less than three every ten LTC users received care in institutions, across OECD countries. This is partly because of the lower labour and capital cost of home care, and partly due to the higher severity of institutionalised recipients.

Policies to encourage home care involve a mix of demand and supply-side interventions (see Table 10.2):

- direct expansion of home-care supply;
- regulatory measures;
- financial incentives.

Table 10.1. **Policies to improve value for money in long-term care in OECD countries: An overview**

	Encouraging home care	Ensuring care co-ordination and continuity of care	Discouraging use of acute care for LTC	Changing payment incentives for providers	Encouraging independent living and healthy ageing	Improving administrative/ institutional efficiency
Australia	No	√	√	No	No	No
Austria	√	No	No	No	No	No
Belgium	√	√		No	No	No
Canada	n.a.	√	√	No	√	No
Czech Republic	√			No	No	No
Denmark	n.a.				No	No
Estonia	√				No	No
Finland	√	√	No	No	√	No
France	√					
Germany	√		√			
Hungary	√	√	√	√	No	√
Ireland	√		√	√	No	No
Japan	√	√		√	√	√
Korea	√	√	No	√	√	No
Luxembourg	√	No	No	No	No	No
Mexico	√	No	No	No	√	No
Netherlands	√		√	No	No	No
New Zealand	√		No	No	√	No
Norway			√	No	No	No
Poland	√	√	√	No	√	No
Portugal				No	No	No
Slovak Republic	√	√		No	No	No
Slovenia	No	√	No	No	No	No
Spain	√			No	No	No
Sweden	√	√	√	√	√	√
Switzerland	√			No	No	No
United Kingdom	√	√	√	No	√	No

n.a.: not available.
Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing.

Direct expansion of home-care supply

Several countries have expanded community-based services, as well as home-care coverage and support, to enable LTC users to continue living in their own homes (*e.g.* Canada, Ireland, New Zealand, Sweden and Poland). The Japanese government passed in 2006 a reform emphasising comprehensive community support, organised by

community members, LTC workers and volunteers, to enable seniors to continue living in a familiar environment. This has encouraged the development of alternative forms of home care, with professionals from residential homes visiting people at home. A similar programme also exists in Belgium. Other government strategies involve training and supporting informal caregivers to reduce demand for institutionalisation *(e.g.,* Mexico, New Zealand, Finland and the Slovak Republic).

Regulatory measures

Incentives related to regulations or institutional structures can take different forms. Finland[1] and the Czech Republic, for example, have developed guidelines to promote home care and enforce admission of those with high-care need only. Similarly, Hungary has restricted budgets and imposed stricter criteria for admission to nursing homes. In Sweden, the Act on Support and Service for Persons with Certain Functional Impairments (1995) moved a large number of people with functional impairments from hospitals into their own flats in the municipalities.

In the United Kingdom, the 2009 report *Use of Resources in Adult Social Carer* provided examples of the savings that could be achieved by promoting a better balance between institutional and home or community-based care. These included the development of new approaches to supported housing. The 2010 draft social care outcomes framework suggests a way for local authorities to benchmark their progress, including indicators on the proportion spent on residential care, and the proportion of older people who are still at home 91 days after discharge from hospital (UK Department of Health, 2010).

Another example is the 2007 Austrian Home Care Law. To avoid the proliferation of illegal or undeclared work, the Law established a legal basis for 24h home-care by legally qualified workers. Family members were also allowed to provide home care under formal arrangements.

Financial incentives

Financial incentives directed either at users or providers are increasingly used in OECD countries to enhance user choice and stimulate a rebalancing towards home and community-based care.

In the United States, where Medicaid mandatory benefits target institutional care, the 2010 Affordable Care Act (ACA) provides new incentives for the expansion of home and community-based LTC services (Reinhard *et al.*, 2010). The Home and Community-Based Services (HCBS) Plan Option provides states with flexibility to expand home and community-based services' benefits. Under the "Community First Choice Option", states providing supports and services for home carers can receive higher federal funding. States also receive additional funding for each Medicaid beneficiary transitioned from an institution to the community under the so-called "Money Follows the Person" initiative. Finally, the "State Balancing Incentive Program" incentivises states to increase the proportion of Medicaid spending on home and community care, through increased federal financial aid (Silow-Carroll *et al.*, 2010).

In several OECD countries, cash benefits have been increasingly used to promote home living for frail and dependent people. Cash benefits, including payments and individual budgets, help LTC recipients organise home care and promote choice *(e.g.,* Austria, the Netherlands, Sweden and the United Kingdom).

Table 10.2. **Policies to promote home care in OECD countries**

	Policies or incentives to encourage home care	Notes
Australia	N	
Austria	Y	The long-term care allowance should improve the opportunity for LTC patients to remain in their customary surroundings.
Belgium	Y	Policies include diversification, specification and innovation of home care services, for example, by broadening the eligibility criteria for admission to day-care centers, providing co-ordinated and personalised care for the patient, support of informal caregivers and financial incentives for palliative home care.
Canada	Y	The agreement between the federal and provincial governments 10-Year Plan to Strengthen Health Care in Canada states that governments are committed to provide first dollar coverage for various home-care services, based on a needs' assessment.
Czech Republic	Y	Residential facilities are motivated to accept preferably people with higher need for care and support and thus entitled to higher care allowance.
Finland	Y	Guidelines on services for older people are currently provided in many social and health care policy documents, all including the following key objectives: maintaining the functional capacity of older people, supporting living at home and prioritising non-institutional services.
France	Y	Home-care services are promoted by offering tax deductions. There are also benefits given to parents who stop working to take care of a disabled child.
Germany	Y	The 2008 Care Reform (*Elften Buches Sozialgesetzbuch*) further enforced the principle of "outpatient over inpatient" care.
Hungary	Y	Institutional care is restricted by budgetary measures and with stricter criteria of admission.
Ireland	Y	Expansion of community-based services for older people, in 2006 and 2007, was promoted through increased funding for home help, day and respite care.
Japan	Y	Establishments that succeed, through active support, in enabling a certain percentage of people who used to receive institutional care to return home can receive additional payments from the LTC insurance system.
Korea	Y	The Act on Long-term Care Insurance for the Elderly encourages home care. Also, institutional care is provided only to beneficiaries with the highest care need/disability level (1st and 2nd class).
Luxembourg	Y	Home care is promoted through regulation and legal provisions.
Mexico	Y	Government strategies promote active ageing and preventive care, thereby ensuring that the senior population minimises hospitalisation. In addition, training of care workers for elderly care has been targeted at families, in order to ensure that those taking care of a long-term patient have the basic knowledge needed.
Netherlands	Y	Personal care budgets encourage home care. The costs of living and the costs of care are going to be accounted for separately, to reimburse people just for care, while requiring them to pay the cost of lodging themselves.
New Zealand	Y	There has been a policy shift to encourage home care in lieu of institutional care, although with limited incentives. The aim is to keep people at home by assisting with home support, equipment and home modification. The (negative) incentive is that residential care is income and asset tested above a certain threshold.
Norway	Y/N	Municipalities are free to organise their LTC home-service as they see fitted.
Poland	Y	Within the social assistance system, some home services are offered to people in need of care due to sickness and/or old age. These services may include care and assistance in daily activities of life.
Slovak Republic	Y	The Act on Social Services and National Priorities promotes home care and the Act on Direct Payments supports informal carers, with the aim to retain the elderly in their home environment.
Slovenia	N	
Spain	Y	Article 3 of the *Ley de Dependencia* explicitly states that the elderly should remain in their home environments for as long as posible. Also, according to Article 14, home help and day-care centers receive financial benefits.
Sweden	Y	This is the prime policy direction at all levels of government in Sweden.
Switzerland	Y	At the federal level, the independence of older people is supported through subsidies given to institutions that provide courses for physical and cognitive maintenance and improvement of the elderly. Also, the level of allowance is higher for people living at home, than those residing in institutions. At the regional level, subsidies are also given to organisations that provide home care services.
United Kingdom	Y	The draft social care outcomes framework, which offers a way for local authorities to benchmark their progress, includes indicators on the proportion spent on residential care, and the proportion of older people who are still at home 91 days after discharge from hospital.
United States	Y	Home and Community-based Services (HCBS) Plan Option; Community First Choice Option, Money Follows the Person initiatives, and the State Balancing Incentive Program encourage home and community care via primarily financial incentives for states.

Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing.

Until 2006, the payment of LTC services in Japan differed according to the activity limitations of the resident; but the difference in payments from the severest to the lightest case was initially less than 20%, so providers had an incentive to admit patients with mild disability (Ikegami *et al.*, 2003). To correct that, the payment for those with the lowest level of care – who accounted for more than half of all patients in LTC beds – has been set below the care production cost since 2006. Additional payments are offered to institutions that have been successful in enabling a certain percentage of recipients to return home.

Evaluation of policies to encourage home care

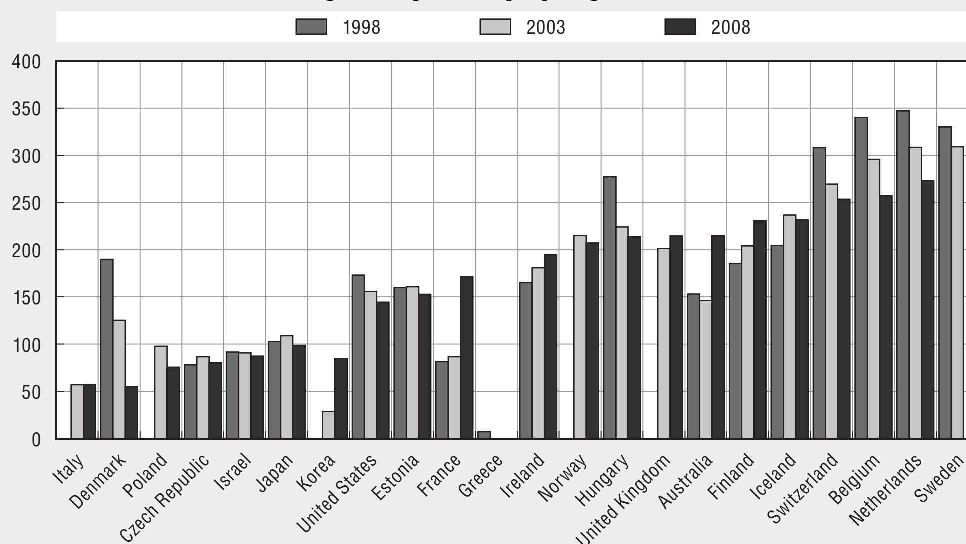
The share of over 65 years old LTC users receiving care at home has increased in most countries, although trends in the share of old people living in an LTC institution vary across countries (Box 10.1).

Box 10.1. Trends of institutional and home care use among OECD countries

In the past decade, the density of beds in nursing homes has been reduced in nearly all OECD countries (Figure 10.1) (Reinhard, 2010; Barton Smith and Feng, 2010), while the share of home-care users increased (see Figure 10.2). These trends reflect policies to encourage home care, as well as measures to reduce cost. However, they have not necessarily been accompanied by a decrease in the number of old people receiving care in an institution, as shown in Figure 10.3. This apparently contradictory result can be explained by an increase in occupancy rates in institutions in many countries.

Figure 10.1. **The density of LTC beds in nursing homes has decreased in the past decade**

LTC beds in nursing homes per 1 000 people aged 80 and over, 1998-2008



Note: 1998 data refer to 2000 for the Czech Republic and to 1999 for Germany. 2003 data refer to 2004 for Norway. 2008 data refer to 2006 for Belgium, 2007 for Luxembourg, Germany and Australia. OECD averages are based on data for 14 countries in 1998, 20 countries in 2003, and 22 countries in 2008.

Source: OECD Health Data 2010.

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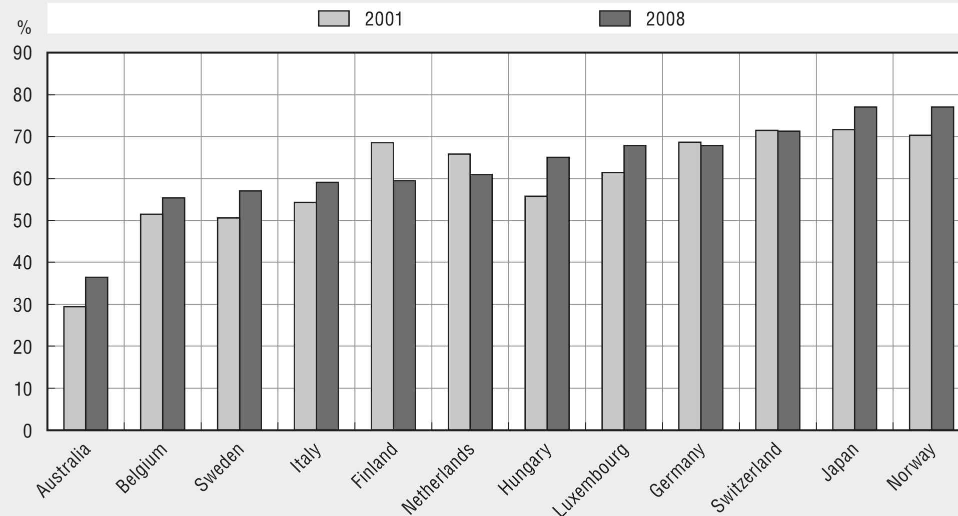
Box 10.1. **Trends of institutional and home care use among OECD countries** *(cont.)*

Figure 10.2. **The share of home-care users has increased accross the OECD**

Home care users as share of all LTC users, 2001 and 2008

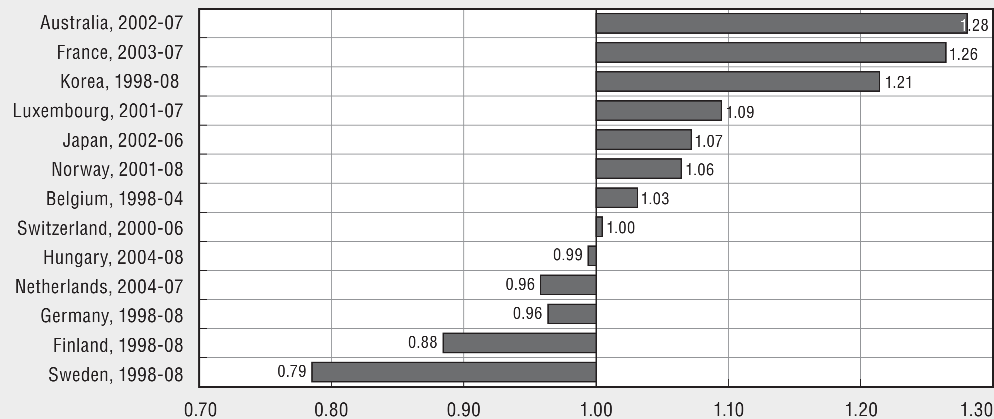


Notes: Data for Austria refer to 2007 instead of 2008. Data for Belgium refer to 2007 and 2001. Data for Sweden refer to 2006. Data for the Netherlands refer to 2007 and 2004. Data for Luxembourg refer to 2007. Data for Japan refer to 2006 and 2001.

Source: *OECD Health Data 2010*.

Figure 10.3. **Trends in institutionalisation rates among OECD countries**

Change in share of over 65 years LTC recipients using institutional care, earliest year index = 1



Source: *OECD Health Data 2010*.

While the shift towards home-based settings holds considerable promise, there are several potential challenges in rebalancing LTC away from institutional care. First of all, there needs to be a market for, or an adequate number of, home-care providers. In Greece, for example, there is universal eligibility to institutional care services, but few home-care providers. The lack of home-care providers has led to the growth of a migrant-carers

market in Italy (Lamura, 2010) and Austria, raising the need for better regulation of home-care labour markets. Secondly, there can be risks related to the fragmentation of care organisation and lack of co-ordination, particularly where different home-care providers visit the same user (OECD, 2005). Emphasis on care co-ordination and information to improve the continuity of care has been identified as crucial (Caris-Verhallen and Kerkstra, 2000; Grabowski *et al.*, 2010). Thirdly, in cases where multiple home-care providers exist, choice can be hard for users, as they may not have sufficient information to base their choice upon, unless information support systems for home care are developed. The use of financial incentives can also create unintended consequences. For example, financial incentives in Japan lowered admission of low-need users, but also resulted in institutions up-coding patients to higher disability levels, in order to receive higher payments (OECD, 2009).

It is unclear to what extent and under what conditions home care is less expensive than institutional care. Expansion of home and community-based services entails a short-term rise in spending, followed by a decline in institutional spending and long-term cost savings (Kaye *et al.*, 2009). Some evidence, such as the Canadian National Evaluation of the Cost-effectiveness of Home Care, has shown that home care is less costly than institutional care (Hollander and Chappell, 2002). However, home care consumes an increasing share of long-term care expenditures (Byrne *et al.*, 2008). A decrease in nursing-home use may be more than offset by higher home-care utilisation, including by individuals who would have not entered an institution in the first place (Miller and Weissert, 2010). There are also questions about the appropriateness or cost-effectiveness of home care for high-need users requiring round the clock care and supervision (Wiener *et al.*, 2009), and for users residing in remote areas with limited home-care support. Despite the will of patients to live independently in their own homes and communities, users with significant impairments may still need continuous care in a nursing-home environment (Miller and Weissert, 2010) or in adapted-living, service-housing arrangements with 24h care, as in Finland. Indeed, some countries have cost threshold above which a user is shifted from home to institutional settings. In some cases, inappropriate or inadequate home care may lead to higher and more costly institutionalisation in the future (Long-term Care Reform Leadership Project, 2009).

Improving incentives for care providers: Pay-for-performance and provider competition

Can LTC providers be paid based on performance?

The issue of payment of providers in long-term care has received little attention to date. In institutional settings, per-diem reimbursement and salaries to pay LTC workers are commonly used, while in home-based settings, fee-for-service is also used. All these methods are not entirely effective in aligning financial incentives with the goal of increased efficiency or quality of care for the user (Busse and Mays, 2008). There is a growing interest in adjusting LTC payment mechanisms to steer providers towards desired goals for the system.

Fee-for-service schemes are not very frequent in LTC, particularly in institutional settings. Where they are used, incentives to provide as many reimbursable services as possible may arise. These can be mitigated by need-assessment procedures, which cap how much care the user will be provided with. However, if fees do not vary according to the user's dependency level or his/her place of residence, there can be incentives for providers to prefer easy-to-serve or lower-need users. Capitation payments[2] are used in

managed-care schemes in the United States (Grabowski, 2007). While they can encourage underuse of services and "skimming" of high-risk individuals, the prolonged duration of LTC acts as an incentive to offer services that maintain or improve the population's health (Busse and Mays, 2008; Christianson *et al.*, 2007). The introduction of risk-adjusted capitation in the United States, whereby providers do not receive higher payments for patients with higher needs, may diminish the incentives for risk selection (Busse and Mays, 2008; Pope *et al.*, 2004). Salary payments are a common method for paying LTC workers. Often, these are accompanied by quality-related procedures and norms (Christianson *et al.*, 2007; Busse and Mays, 2008; Gold and Felt-Lisk, 2008).

Public LTC systems typically reimburse institutional providers *(e.g.,* nursing homes, organisations hiring LTC workers) on a per diem basis. In France per diem are flat rates, and it has been suggested that a case-mix payment would provide nursing homes with stronger incentives to treat more severely impaired patients. In Belgium and Canada, per diem payments are adjusted to reflect the risk of the LTC user. However, if the risk adjustment is made ex-ante on the basis of forecasts of users' need-profiles, providers may end up running a deficit if they admit a larger cohort of severely disabled users. This was a concern raised by nursing homes in Belgium, for example. Negotiated budget processes are commonly found among government administered LTC systems. This is an effective cost-control method, but it may result in unmet needs and leave providers at risk for budget over-runs.

An interesting new development is the idea to link payments to quality and efficiency in so-called pay-for-performance schemes (P4P). While there is much experimentation with P4P in health care, only a few examples can be found in nursing homes in the US Medicaid programme (Arling *et al.*, 2009; Briesacher *et al.*, 2009). Despite little empirical evidence that P4P programmes increase quality, one of the few evaluations in Iowa indicates improvements in resident satisfaction, employee retention rate, and nursing hours. Similar results were obtained from an analysis of Minnesota's P4P system, although a systematic evaluation has not yet been completed (Arling *et al.*, 2009).

Still, concerns have been raised regarding P4P programmes in LTC, for example regarding the incentives to focus only on particular services, the providers' self-reporting of performance data leading to unreliable or dubious results, or the incentives to admit users that will increase chances of achieving a good benchmark. Various programmes in nursing homes were terminated after a few years of operation, indicating that political or practical barriers hinder the implementation of P4P in this setting. Credible performance measures addressing a broad range of quality and quality of life indicators in long-term care are still under development (Arling *et al.*, 2009; Briesacher *et al.*, 2009).

Seeking efficiency gains from choice-based competition across providers

Providing users with choice over the carer they prefer can stimulate providers' competition and encourage them to deliver better care or care at lower cost. To date, however, there is limited evidence on the impact of such choice-based models on providers' efficiency. In the Japanese LTC insurance system, LTC users can choose freely among providers – including for-profit companies – and competition is regarded as one of the strengths of the system (Campbell and Ikegami, 2000; Campbell and Ikegami, 2003; Campbell *et al.*, 2010). A similar situation is also observed in Germany. In the Netherlands, personal budgets to pay for services or employ home carers, introduced in 1995, have increased users' control, autonomy and satisfaction over the care they receive. However, gains in efficiency

and free competition have not yet been observed, mainly due to monopoly powers and the increased bureaucracy of the system (Kremer, 2006).

The use of voucher schemes for long-term care in Nordic countries is an interesting experience (see Box 10.2).[3] Generally, a voucher can be defined as a subsidy that can be used by the consumer to purchase restricted or regulated goods or services (Steuerle, 2000). It can, therefore, take the form of a printed check, electronic card or an authority's payment covenant (Volk and Laukkanen, 2007). Vouchers enable users to choose the provider that best meets their needs, leading, hopefully, to higher user satisfaction, improvements in quality and cost-effectiveness. However, concerns have been raised, for example, regarding the asymmetric and imperfect information available for consumers to make informed choices (Folland *et al.*, 2001). Providers may discriminate prices among those who use a voucher and those who do not, or they may discriminate across different users (Volk and Laukkanen, 2007).

Box 10.2. **Provider choice and the use of vouchers for long-term care in Nordic countries**

Sweden. Sweden has encouraged LTC users' freedom of choice since the early 1990s, but this was further reinforced in 2009 under the act on "System of Choice in the Public Sector", which was implemented by approximately one fourth of the municipalities. According to this act, LTC clients can choose their service provider among those the municipality has contracted with. The municipalities then reimburse providers according to a timesheet that a user signs upon service delivery. Some fundamental acceptance criteria for providers are defined by the act and all applicants meeting the criteria have to be accepted. If a municipality decides to introduce such choice system, it has to disclose this decision on the national website, mentioning details on providers, acceptance criteria, quality information and contracts (Svensk författningssamling, 2008). Municipalities have the obligation to inform LTC customers about their freedom of choice and their right to change providers. They are also responsible for maintaining the same prices across providers. Enrolled individuals have the right to opt out of the voucher system and are guaranteed an alternative public service.

Finland. An optional voucher system was introduced in Finland in 2004, as part of a broader legislative change in health and social care. Subsequent changes in 2008 and 2009 made the system more uniform and expanded the range of available services (Paasivirta, 2009). In 2006, around 29% of the Finnish municipalities used a voucher service (Volk and Laukkanen, 2007). The voucher can be used to purchase only privately provided services, leaving the municipal production out of the system. The value of the voucher for purchasing regular home help and home-nursing services is determined by a formula that takes into account household size and income, with the service users paying the difference between the value of the voucher and the full price of the service. The amount of the co-payment also differs across providers, as they are allowed to price their services competitively (FINLEX). In temporary home help and home nursing, as well as in other social and health services, the value of the service voucher is not regulated. Broad criteria regarding the provider's eligibility are set in legislation. Although municipalities can set additional criteria, they do not discriminate against any provider. Similarly to Sweden, municipalities have the responsibility to supply individuals with information regarding suppliers, in the absence of a national registry (Volk and Laukkanen, 2007).

Box 10.2. **Provider choice and the use of vouchers for long-term care in Nordic countries** *(cont.)*

Denmark. Consumer choice and private provision of personal and practical help were introduced at the national level in 2003. In 2009, amendments to the Consolidation Act of Social Services made Denmark the only Nordic country where free choice of providers is mandatory for municipalities (Karlsson and Iversen, 2010). As early as 2005, 90% of individuals aged 65 years and over had the opportunity to choose between two or more home-help providers (Ankestryreseln, 2005). A municipality can choose three methods of implementing a consumer choice model. The first and most common entails a local council having a contractual relationship with each service provider that meets the locally defined standards, without an option to restrict provider's entry. In the second model, a municipality contracts with at least two but no more than five qualified service providers, by tendering (Government of Finland, 2009). The third model is a combination of the first two. It involves the first provider being found through a tender, and any other provider being allowed to enter the market, subject to price competition (Eriksen, personal communication). The municipality is responsible for setting the local quality standards (Ministry of the Interior and Health, Ministry of Social Affairs, 2005). These should be posted on two national webpages, along with other information regarding approved service providers and prices. The Consolidation Act gives the municipalities an additional option to increase freedom of choice by implementing a so-called "servicebevis" (service certificate). This certificate gives eligible individuals the opportunity to employ their own personal carers. The payment to the service provider is then made by the municipality. The size of the service certificate market is not known yet. Some local authorities were also allowed in 2003 to launch experimental systems with personal budgets for personal and practical care (Karlsson and Iversen, 2010).

Source: Viita (2010).

Customer surveys performed in Denmark and Finland indicate a general satisfaction among LTC voucher users, particularly among those who had chosen a private provider, although this satisfaction was related to freedom of choice rather than the service itself (Kaskiharju and Seppänen, 2004; Ankestyrelsen, 2005; Volk and Laukkanen, 2007). However, individuals are not always aware of the information provided by the municipality regarding the voucher system. For example, 16% of Danish users were unaware of the opportunity to choose a provider (Ankestyrelsen, 2005) and tended to choose a provider that had been recommended, rather than making their own informed choices (Kaskiharju and Seppänen, 2004). They rarely used their right to change providers, but more often opted out of the system altogether (Kastberg, 2001; Ankestyrelsen, 2005). Some evidence of providers' risk selection was also found in Finland (Volk and Laukkanen, 2007). In some rural areas in the Nordic countries, voucher schemes have proved unfeasible due to lack of private providers (Volk and Laukkanen, 2007). Some urban municipalities in Sweden are dominated by an oligopoly of private providers, hindering free competition (Sveriges Kommunen och Landsting, 2009).

Evidence of efficiency gains attributed to the voucher system in the three countries is not compelling. In many municipalities, the introduction of consumer choice lead to quality improvements and forced them to seek options for containing the cost of their service production. However, the design of services changed with the introduction of a voucher system, making it difficult to make comparisons across time, and across municipalities (Ankestyrelsen, 2005; Sveriges Kommunen och Landsting, 2009). Another drawback is the higher administrative work after the implementation of a voucher scheme

(Kastberg, 2001; Ankestyrelsen, 2005; Volk and Laukkanen, 2007; Kaskiharju and Seppänen, 2004), which could be overcome with technical solutions, such as electronic management tools (Ankestyrelsen, 2005).

In conclusion, studies on existing voucher schemes have shown greater satisfaction among participants, but provide limited evidence regarding efficiency increase. In most cases, free competition is hindered, either due to monopoly powers, or inability of individuals to make informed choices.

The impact of technology on productivity in long-term care

Caring for frail or disabled elderly can be a rich and emotionally rewarding task, but can rapidly become stressful and time consuming. Technological solutions could assist in reducing the workload and stress of carers and improve work co-ordination, allowing caregivers to allocate their valuable working time more efficiently (Valkila and Saari, 2010). Technology hence raises hopes for potential substitution of specific tasks and increased quality of life for the elderly and their carers (Haberkern *et al.*, 2011). The open question is to what extent this would result in productivity improvements. Some evidence can be found across the OECD, but it remains sparse at best.

Technology can have a wide range of applications in LTC (Haberkern *et al.*, 2011). To begin with, technology can be used to optimise medication, *i.e.* manage medication information, dispensing, tracking and adherence. Monitoring devices, such as glucometers and blood pressure monitors, help to manage care from a long distance. Assistive technologies can promote LTC users' independence and safety. Productivity of LTC workers could also be enhanced through remote training and supervision technologies. Newly emerging technologies include cognitive fitness and assessment games, as well as social networking programmes, enabling communication, organisation and sharing among older adults and their caregivers (Centre for Technology and Aging, 2009). The introduction and diffusion of information and communication technologies (ICT) could be particularly helpful in the future years.

Despite the large knowledge gap, some research results have shown a positive correlation between technology introduction, job satisfaction and productivity. A study in Australia indicated that paper work was perceived by LTC workers as time-consuming, keeping them away from their LTC recipients and contributing to diminished job satisfaction and productivity (Moyle *et al.*, 2003). A pilot voice-system linking frail elderly to their caregivers was introduced in a Finnish nursing home. The new technology made it easier and quicker for caregivers to complete their task without interrupting their work and arrange priorities, as they had instant voice contact with the resident in need of assistance. This led to better organisation and improved work productivity. Residents felt safer, too, leading to a 60% decrease in the number of alarm calls. This enabled caregivers to dedicate more time to attend to residents needing further assistance (Valkila and Saari, 2010).

In South Korea, the introduction of electronic equipment for home-care management was associated with better and more precise patient evaluations by nurses (Lee *et al.*, 2009). In the United States, the Green House Project offers an alternative to nursing homes. Among other features, Green Houses use sophisticated technology, such as smart technology computers, wireless pagers, electronic ceiling lifts, and adaptive devices. Although evidence on their effectiveness is preliminary, staff felt more empowered to assist residents and had greater job satisfaction (OECD 2009-10 Questionnaire on Long-term Care Workforce and

Financing; Kane *et al.*, 2005; Cutler and Kane, 2009). Hydraulic lifts reduce the time and effort required to transfer a frail elderly from the bed to a chair. A study from the United States showed that old people who do not use such technological equipment require approximately four additional hours of help per week, compared to those who use them, irrespective of the user's impairment level and LTC services received.

The use of ICT could result in a more productive time management for the caregivers (Hoenig *et al.*, 2003). A Swedish study demonstrated that the implementation of ICT in residential care for dementia leads to improvements in personal development, reduced workload, and higher worker motivation (Engström *et al.*, 2005). However, the introduction of ICT in community nursing in Slovenia lead nurses to spend more time on computers than with patients (Bitenc *et al.*, 2000). Similarly, home-care nurses in a Korean study evaluated electronic records as being burdensome and confusing (Lee *et al.*, 2009). ICT may be better suited for recipients with relatively mild disabilities. Evidence from Finland shows that reminders for taking medicine may be useless for mentally impaired people and telecare would be inefficient for the elderly needing cleaning and change of bandages (Söderlund, 2004).

The impact of ICT on family carers was also examined in Norway. ICT can facilitate contact with other carers, through which they can receive information and emotional support. Carers could increase their knowledge about the care recipient's illness and symptoms, and be better prepared to meet future changes in behaviour and care needs. Telecare technology implemented in Scottish community-care LTC services lead, among other things, to reduced pressure and stress on informal caregivers (Beale *et al.*, 2009). However, the effect of ICT on stress and mental well-being associated with caregiving were somewhat contradicting (Torp *et al.*, 2008).

In conclusion, evidence from OECD countries shows that there is a potential for greater use of technology in LTC. The majority of the studies remain pilot programmes, and further systematic assessment is needed to validate the findings. LTC remains a highly labour intensive sector, with technological assistance often being a help or supplement to labour force, rather than a substitute (Torp *et al.*, 2008). To facilitate the introduction and diffusion of technology, several main barriers need to be addressed, including infrastructural readiness and investment costs (Heberkern *et al.*, 2011), as well as resistance to change by workers (Virmalund and Olve, 2005).

10.3. Is it possible to optimise health and care?

Long-term care systems operate in close link with health care. However, it can be hard for the user to navigate the health and care crossroad, care continuum is not always guaranteed, and providers face inefficiencies and cost-shifting incentives. Three areas of "interface" between health and long-term care systems can be examined: *i)* incentives for appropriate use of LTC *vis-à-vis* acute-care settings; *ii)* co-ordination of health and care; and *iii)* healthy ageing and prevention. Table 10.3 summarises some countries' measures.

Appropriate use of LTC versus acute-care settings

For over 20 years, debates regarding the appropriateness of elderly's referrals to acute health-care services have flourished (Kurrle, 2006). Not only frail elderly may encounter risks of nosocomial infections or undergo unnecessary medical treatments during hospitalisation (Kurrle, 2006), but also acute care can be an unpleasant environment over an extended period of time. It is too costly of a setting for care of long duration. Estimates

Table 10.3. **Policies to avoid the inappropriate use of acute care services and co-ordinate LTC programmes in OECD countries**

		Policies/incentives to avoid inappropriate use of acute health care services for LTC needs	Co-ordination of LTC services provided by different providers or under different LTC programmes
Australia	Y	The Transition Care Programme helps older people complete their restorative process. The Long Stay Older Patients' Initiative targets older people whose care needs may be better met outside the hospital system.	The State and Territory Governments are responsible for the co-ordination and provision of programmes. In the area of home and community care services, client care co-ordination is delivered by the provider.
Austria	N		
Belgium	Y	The inappropriate use of acute health care services for LTC needs is limited by the provision of financial incentives, based on the AP-DRG system.	Care co-ordination for home-care services is ensured by the "Centers for Co-Ordination" (SIT) and the "Integrated Home Care Services" (SISD/GDT). Other pilot home care co-ordination initiatives include case management and crisis services.
Canada		Explicit policies/incentives regarding the use of acute health care services for LTC needs do not exist on a national level as health care is primarily a provincial and territorial responsibility.	Co-ordinated access is used in all provinces to provide individuals with a single point of access to LTC information and services. Each province determines how they co-ordinate LTC in their jurisdictions.
Finland	N		
France			Care co-ordination takes place through the individual, the caregiver or through services such as SAD (Service à domicile) and SSIAD (Service de soins infirmiers à domicile). Also, Houses for the Autonomy and Integration of Alzheimer Patients have been developed for co-ordination purposes.
Germany	Y	Under the Competition Enhancement Act, rehabilitation services have been promoted. Further measures include on-time provision of rehabilitation services, financial incentives, improved management and counselling.	Since 2009, individuals are legally entitled to care consultant and case management services. This can take place at Nursing Points, which receive support and funding from the govenrment. Training for the consultants is also provided.
Hungary	Y	Policies include active capacity reduction.	Care co-ordination has been attempted but faces various difficulties.
Ireland	Y	Under the Nursing Homes Support Scheme, a person who remains in an acute hospital bed when their acute phase of care is over may be required to pay charges.	
Japan	N		LTC services are provided by establishments designated by governors/mayors. The division of services is co-ordinated based on the work programme set out by the prefectural or municipal government.
Korea	Y	Based on needs assessment.	
Luxembourg	N		
Mexico	N		
Netherlands	Y	Although implicit, insurers bear the risk of acute health care services.	
New Zealand	N	Explicit policies or incentives do not exist, but there are recognised gaps and issues that will be worked on.	
Norway	Y	The Norwegian government has recently launched a strategy to combat such inefficient use in the public health sector.	
Poland	Y		The Ministry of Labour and Social Policy co-ordinates care support in the social assistance homes.
Slovenia	N		
Sweden	Y	Municipalities are legally obliged to take care of "bed blockers" in acute and geriatric hospitals. When the medical treatment ends at the hospital, the municipality has to arrange necessary further care, for those needing it.	Co-ordination of services and care by GPs, nurses and OTs/PTs working in primary health care and the home help services is recognised as an issue to address.
Switzerland	Y	The LAMal (Loi fédérale sur l'assurance-maladie) has been amended to contain a clear definition of acute care and transition needs. Following an acute care treatment, if a LTC patient continues to be hospitalised, compulsory health insurance will cover only the tariff for LTC services.	
United Kingdom	Y	Two of the main policies are "Intermediate care" and "re-ablement". Intermediate care can promote faster recovery. Re-ablement is defined as "Services for people with poor health to help them accommodate their illness by learning or re-learning the skills necessary for daily living".	Services are co-ordinated at a national, regional and local level. At the national level, structures that enable partnerships of local authorities are put in place. At a regional and local level, services tend to vary as they become more locally focused.

Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing.

suggest that "inappropriate referrals" may range from 48% in the United States, to 36% in the United Kingdom, and 7% in Canada (Jensen *et al.*, 2009).

Several OECD countries have implemented explicit policies to avoid the inappropriate use of acute healthcare services, such as:

- *Health-system support measures.* For example, Australia, Hungary, Israel, the United Kingdom and Sweden arrange support of care outside the hospital. They also promote the acceleration of patient's recovery for those whose needs could be better met outside the hospital. Evidence from the literature suggests that increased involvement of primary care providers and GPs could result in fewer hospital admissions of frail elderly.
- *Financial measures to limit acute-care service use for LTC needs*. Ireland imposes additional charges for those who remain in acute hospitals when their acute care phase is over. Japan has introduced case-mix based payments in hospitals to reduce so-called *social* hospitalisations. However, results still lag behind the initial goals and there is evidence of patients up-coding by providers to receive higher reimbursements (OECD, 2009). In the United States, higher per diem reimbursement in some nursing homes seems to have contributed to lower hospitalisations from nursing homes. Pay-for-performance schemes hold some promises, too (see Box 10.3) (Intrator and Mor, 2004). In Sweden, under the Act on Support and Service for Persons with Certain Functional Impairments, municipalities receive a strong financial incentive to find care for the elderly outside hospitals (Trydegård, 2003).

Box 10.3. **Avoiding unnecessary acute-care use for LTC needs: Some examples from the United States**

In the United States, 19.6% of all Medicare beneficiaries were rehospitalised within 30 days of discharge to a post-acute care setting in 2004 – which includes rehabilitative services delivered by a skilled nursing facility, home health care, or inpatient rehabilitation facilities. About 90% of these readmissions were unplanned, with a cost of USD 17.4 billion to the Medicare programme. Between 2000 and 2006, the rate of rehospitalisations grew by 29% (Mor *et al.*, 2010).

A significant proportion of readmissions could be prevented. Payment reforms, such as bundling could help to reduce rehospitalisations, but they could also lead to providers' up-coding of patients' severity (Mor *et al.*, 2010). Pay-for-performance schemes exhibit some appeal, but Medicaid would not sustain the full cost of rewarding nursing homes with such an incentive-based system, and, at the same time, would gain little from any savings resulting from reduced hospitalisations. The lack of data sharing between Medicaid and Medicare also hinders the success of pay-for-performance schemes (Grabowski, 2007).

The Fallon Community Health Plan in Massachusetts launched the Healthy Transitions pilot programme in 2009. Under this programme, pharmacists are sent to patients' homes within 72 hours of discharge from hospitals, they review the prescribed medication and explain it both to the patient and to the caregiver. Pharmacists play an expanded role, serving as patients' care co-ordinators for a 30-day transition period after hospital release. Thereafter, patients have the option to enrol in LTC management schemes. The Healthy Transition programme has been so far well-received and the preliminary results indicate a positive impact on both preventable hospital readmissions and patient satisfaction (Bayer, 2010).

- *Changes in administrative responsibilities for care.* Again in Sweden, the Act on Support and Service for Persons with Certain Functional Impairments transferred the responsibilities for LTC to municipalities, who became financially responsible for older people remaining in hospitals (OECD, 2005).
- *The use of ICT*. The use of transfer sheets or electronic referrals can help overcome the problems associated with transfers of LTC users to acute-care settings (Kurrle, 2006). However, concerns have also been raised relating to the security and privacy of information, computer system response times, and operational costs (Soar *et al.*, 2007).

Table 10.4 shows a decrease in the average length of stay for acute care in hospitals for conditions linked to dementia and Alzheimer in most OECD countries. Given the information available, it is not possible to draw conclusions regarding the effectiveness of different interventions in reducing the use of acute care for LTC needs, but these data are encouraging.

Table 10.4. **Average length of stay for dementia and Alzheimer's disease in acute care (in days)**

	Dementia				Alzheimer's disease			
	1994	1999	2004	2008	1994	1999	2004	2008
Australia[1]	44.8	42.3	27.8	24.4	51.4	48.2	30.5	27.4
Austria	48.4	17.2	15.5	14.9	27.4	11.5	13.5	12.8
Belgium[1]			27.7	29.2			29.0	28.8
Canada[1]	48.6	33.2	36.5	41.2	47.8	33.5	34.6	42.3
Czech Republic				27.7				29.8
Denmark			14.2	10.3			11.3	8.8
Finland		121.9	116.3	118.7		89.7	68.0	83.9
France		12.9	14.0	13.1		11.0	12.7	12.2
Germany			17.7	16.1			18.7	17.5
Greece[2]		60.0	76.0	77.0				
Hungary			13.0	11.6			9.1	10.0
Iceland		17.1	26.2	28.6		16.0	24.4	22.1
Ireland		50.1	43.1	39.9		22.1	37.0	51.6
Italy[1]			11.2	10.7			8.6	8.7
Korea		58.1		128.0		55.8		101.3
Luxembourg[1]		20.5	17.4	21.2		19.7	15.7	19.0
Mexico		34.9	16.3	34.6		9.1	14.1	7.5
Netherlands	44.3	48.0	27.0	21.7	31.6	22.0	17.0	22.8
Norway			8.6	7.0			7.6	5.3
Poland			19.6	17.9			17.0	10.4
Portugal			13.0	17.8			10.5	14.3
Slovak Republic	27.7	33.8	28.4	28.0	14.0	12.4	31.3	15.9
Spain	90.1	104.5	63.7	66.3			38.1	37.1
Sweden[1]		19.8	16.4	14.6		27.7	23.7	21.8
Switzerland			54.3	42.6			99.8	72.6
Turkey				8.5				7.9
United Kingdom			74.3	62.2			77.5	66.9
United States[2]	13.4	11.3	10.5	9.0		8.2	8.4	8.0
OECD average[3]	**29.1**	**26.8**	**19.2**	**16.7**	**51.4**	**28.2**	**19.5**	**17.7**
OECD average[4]	*29.1*	*31.0*	*24.3*	*23.2*	*34.4*	*25.5*	*25.4*	*24.2*

1. Data for 2008 refer to 2007; data for Canada: A break in series in 2006 leads to longer reported average length of stay.
2. Data for 2008 refer to 2006.
3. Unweighted average on countries reporting data, per respective year.
4. Unweighted average for all countries that report data as of 1994 (six for dementia; five for Alzheimer's disease).

Source: *OECD Health Data 2010*.

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Co-ordinating or integrating health and care

The need to co-ordinate health and long-term care is obvious, but the way to achieve that is not. A key question is whether co-ordination would work better by keeping health and long-term care into separated systems, or by integrating settings and "silos".

There are several *co-ordination* challenges in long-term care. First, at the interface between health and social care, it can be difficult to organise continuity of care. Second, within LTC services themselves, there are often different coexisting payers, types of reimbursement, providers, and governing systems, acting as obstacles to care co-ordination (Pratt, 2010). For instance, as long-term care implementation is often left to lower-level jurisdictions, there can be important geographical variations from one area to the other. Care providers in some countries receive payments from various sources, and as a result face conflicting incentives for quality improvements and little incentives for cost-efficient delivery of care (Konetzka and Werner, 2010). In the absence of good information and direction for people needing care, consumers may end up interacting with different health and long-term care providers at the same time, unable to determine the best way to organise the services they need. When individuals do not receive timely care, they may end up in more expensive care settings, such as a hospital emergency departments, with increased costs imposed on the system and the patients (Long-term Care Reform Leadership Project, 2009). Indeed, hospitals are often a first point of contact for users needing LTC, but transfers across settings can be delayed or not optimised.

Most OECD countries have created co-ordination tasks or assigned responsibilities to guide users through the care process (see Table 10.3). These include mechanisms to provide individuals with single points of access to LTC information (Canada), the allocation of care co-ordination responsibilities to providers *(e.g.,* Australia, France, Sweden) or to care managers[4] *(e.g.,* Japan, Germany, Denmark, the United Kingdom), or the use of dedicated governance structures for care co-ordination *(e.g.,* Belgium, the French *Caisse nationale de solidarité pour l'autonomie*, Japan).

Even though much of the care co-ordination takes place at the local level, it is not uncommon to have national mechanisms or centrally-set regulations or guidelines. The Norwegian government, for instance, has issued policy suggestions to improve LTC co-ordination, including among others, better-defined priorities, focus on early intervention, changing the funding system, developing the specialist healthcare services and introducing new ICT and education for LTC professionals (Norwegian Ministry of Healthcare and Services, 2008-09). In the United Kingdom, LTC services co-ordination is primarily at the national level, where regulations are put in place. Local authorities, however, also work with LTC services to decide on the needs of each community, to make improvements and shape new developments. In the United States, an important feature of the March 2010 health reform legislation is the idea of Accountable Care Organisations (ACOs), involving health care providers in general, and LTC providers in particular. Their aim is to improve care co-ordination, benefit patients and minimise inefficiencies. They collaborate with private insurers and specifically focus on preventing chronic diseases, improving transitions between caregivers and avoiding preventable hospital re-admissions. Providers would share savings achieved through eliminating unnecessary expenses and improving quality. However, ACOs is a relatively new intervention, with cost and quality targets not having been established yet. Their diffusion is still quite limited, although an example can be found in the state of Montana. The policy implications of this intervention remain to be seen (Klein, 2010).

Despite these mechanisms, the challenge of how to organise the appropriate mix of health and long-term care services remains. Long-term and chronic care patients tend to be high users of health services, as they have numerous contacts with the healthcare system, usually not in the most cost-effective way. Patterns of care co-ordination change as individuals transfer from acute to LTC settings. This is sometimes due to the fact that LTC is the responsibility of local governments, while the oversight of acute care is at the regional or national level. Medical professionals discharge patients, and usually assess their needs and define care plans. During transitions from ambulatory to long-term care settings, neither ambulatory specialists, nor GPs, seem to have a leading role in many countries.

Around two thirds of the OECD countries have reported that they experience difficulties with transitions from ambulatory care to LTC; and four fifths face problems with transitions from acute care to LTC (Hofmarcher *et al.*, 2007; Oxley, 2009b). While care managers play an important role, there is little evidence on the cost-effectiveness of the care management or care co-ordination process (Hutt *et al.*, 2004). Care co-ordination could be improved by a better bridging of administrative and other obstacles that hinder easy transitions from acute care to LTC (Oxley, 2009b). Health care providers can also play an important role in giving support to family carers. This could range from providing advice and counselling to more specific interventions.

This discussion shows that while the separation of health and LTC can avoid the provision of LTC via the health care system, it can also lead to difficulties in organising care across a continuum of services. An alternative way would be to work through *integration*, for example by integrating funding and delivery of health and long-term care. The aim here is to combine care management, information systems, and incentives to minimise cost-shifting across health and care (Stone, 2000).

Examples of LTC integration can be found in Sweden, the United States, Canada and Japan. The Swedish government has developed a safe-care continuum especially for elderly with complex health problems and severe needs. As this group of frail elderly is a major user of LTC services and care, targeting this group is a key element of a value-for- money strategy. In the United States, integration of health and care for Medicare beneficiates takes place in the S/HMO, PACE and SNPs schemes. These, however, showed mixed results in terms of cost savings for Medicare and Medicaid, despite an increase in enrolees' satisfaction (Box 10.4). In Canada, the SIPA (French acronym for *System of Integrated Care for Older Persons*) is a

Box 10.4. **Health and long-term care integration initiatives in the United States**

The structure of Medicaid and Medicare creates conflicting incentives for the so-called dually eligible (for both Medicare and Medicaid) beneficiaries. These are among the most expensive beneficiaries, often requiring both acute and LTC services. It has been estimated that over one out of every five dually eligible person lives in nursing homes, compared 2% for Medicare beneficiaries. Both Medicare and Medicaid cover certain home and institutional care services. Medicare pays for acute care services for dually eligible individuals, while Medicaid pays for LTC services. There is evidence of some cost-shifting within home health care and nursing homes, and across chronic and acute care settings (Grabowski, 2007).

To reduce cost and improve care co-ordination for this population group, several "integration" interventions have been suggested. These include federal managed care initiatives such as the Social Health Maintenance Organisation (S/HMO), the Programme of

Box 10.4. **Health and long-term care integration initiatives in the United States** *(cont.)*

All-Inclusive Care for the Elderly (PACE) introduced in the 1990s, and the Medicare Advantage Special Needs Plans (SNPs), such as the EverCare Programme. State managed care initiatives that combine Medicare and Medicaid financing also exist, such as the Minnesota Senior Health Options (MSHO) and others (Grabowski, 2007; Gross *et al.*, 2004).

Both PACE and S/HMO emphasise home and community-based services. S/HMOs were set up in 1984 to test whether providing LTC benefits to Medicare HMO enrollees could save money by co-ordinating care. S/HMOs provide both standard Medicare benefits, and restricted long- term care benefits to Medicare beneficiaries who voluntarily enrol. Despite the programme's almost 20-year history, its success is quite limited, with only four programmes currently operating, still as pilots (Gross *et al.*, 2004). Evidence suggests that S/HMO projects had lower levels of un-enrolment than Medicare's HMOs in general; but evidence that the S/HMOs were less costly than fee-for-service plans was mixed.

On the other hand, PACE has been more successful in integrating acute and LTC financing and delivery of care, as well as maintaining participants' independence. PACE receives capitated funding from both Medicare and Medicaid and is responsible for providing both primary and LTC to its participants. The combination of the patients' regular contact with the staff, and the integrated care delivery and financing, helps the PACE programme monitor chronic conditions, avoiding re-hospitalisations and deferring institutionalisation (Gross *et al.*, 2004). PACE enrolees have shown greater satisfaction with care services, as well as better functional status and fewer hospital admissions compared to their counterparts receiving the conventional fee-for-service care (Mui, 2002; Grabowski, 2007). This led to its designation as a permanent Medicare programme in 1997.

However, the PACE scheme has attracted a disproportionate number of healthy individuals. There is evidence that the total capitated payment to PACE beneficiaries was 9.7% higher during the first year of enrolment, compared to the corresponding Medicare and Medicaid cost, if the individuals had continued to receive care in the fee-for-service programme. It is estimated that PACE resulted in a 42% lower Medicare spending, but a 86% higher Medicaid spending. Possible reasons for these results could be the failure to target the appropriate services to enrolees through a stringent pre-admission process, or the inability to control expenditure on specific services (Grabowski, 2007).

One recent initiative to co-ordinate Medicare and Medicaid is the introduction of Medicare Advantage Special Needs Plans (SNPs) in 2003. SNPs work through private plans, which are most commonly health maintenance organisations. States have the opportunity to combine Medicaid's and Medicare's managed care, contracting for dually eligible beneficiaries (Grabowski, 2009). Despite the potential of SNPs to increase system's efficiency and strong entry into the market, there has been a rather modest enrolment, partly because SNPs offer little additional value to dual eligible beneficiaries, compared to the conventional Medicare Advantage plans (Grabowski, 2009). In addition, while the federal Medicare scheme emphasises consumer choice, state Medicaid programmes usually offer a limited number of plans. This may hinder care co-ordination if dually eligible individuals choose different Medicare and Medicaid plans. Misalignment of incentives may exist as well, since SNPs profit from any lower Medicare hospital costs, but the states do not directly benefit (Grabowski, 2007).

community-based scheme responsible for the provision of primary and secondary medical and social services. The scheme is publicly managed by the Provinces and financed by capitation. Evaluations of SIPA have shown that, despite being cost neutral, it can reduce acute care utilisation and increase community care (Bergman *et al.*, 1997; Béland *et al.*, 2006). The Japanese government tries to integrate LTC and health care in different ways. Emphasis is primarily placed on community-based care to ensure continuum of care. A GP's assessment is required as part of LTC needs' assessment. There are maximum separate monthly out-of-pocket payment ceilings for LTC and health care, but also another ceiling for those with high expenditure in both LTC and health care together.

It is difficult to draw firm conclusions from different country initiatives involving co-ordination and integration. In the United States, the PACE scheme has shown the most success in terms of quality of care and access to services. There are, however, concerns regarding its ability to contain costs. A similar programme in Canada shows promising results, but is only at an experimental stage. In Japan, the LTC insurance system includes co-ordination mechanisms, but there is relatively little evaluation of outcomes for users and costs. With growing LTC and health care cost, particularly for people with multiple chronic conditions, the co-ordination of health and long-term care deserves considerable policy attention in the future.

What can LTC systems do to encourage healthy ageing and prevention?

The most obvious way to reduce cost in long-term care systems would be to reduce potential dependency in later life through lifelong health promotion. Healthy ageing[5] corresponds to the notion of maintaining the older population in good physical, social and mental health, facilitating their autonomy and independence for as long as possible, throughout their remaining years (Oxley, 2009a). This is easier said than done, as demographic ageing is not always accompanied by good health (Thorpe and Howard, 2006; Lafortune and Balestat, 2007). Still, recent survey work by WHO indicates very large national variations in age-specific self-reported dependency rates, suggesting greater scope for fostering healthy and active ageing. Without entering in a discussion of the wide range of policies available to promote healthy ageing, some interesting recent country initiatives in long-term care are worth focusing on.

In 2006, the Japanese government introduced a community-based, prevention-oriented LTC benefit in their long-term care insurance system. The aim was to prevent seniors in need of low levels of care from becoming dependent, by providing services targeted at improving the individual's physical strength, mental health, oral function and nutritional status (Tsutsui and Muramatsu, 2007). All elderly requiring low-need care are eligible to receive this preventive benefit (so-called, Support Levels 1 and 2 in the LTC insurance). An estimated 40% (1.7 million) of the seniors certified as needing LTC support belong to these two categories (Tsutsui and Muramatsu, 2007). The benefit amount is lower than what people with similar care needs would have been entitled to before the 2006 LTC insurance reform (Morikawa *et al.*, 2007). Services, such as strength training, nutrition management and mental education, are offered at day-care facilities (Morikawa *et al.,* 2007). The management of prevention benefits is under the responsibility of local support centres established by municipalities for every community with a population of 20 000 to 30 000. These centres are responsible for the need assessment and care planning for people with Support Levels 1 or 2, the development of community support projects for seniors, and co-ordination between various professionals (Tsutsui and Muramatsu, 2007).

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Evaluation of the preventive benefits scheme is encouraging, showing a drop in the enrolment and use of services by people with lighter care-need levels, after its implementation. The growth rate of total LTC beneficiaries in Japan now matches the growth in the population aged seventy-five and older, as they are the main users of LTC services. The reform also contributed to savings in the LTC insurance (Campbell *et al.*, 2010).

An interesting case of providing incentives for rehabilitation is the 2008 *Long-term Care Further Development Act* in Germany (Rothgang, 2010). Prior to the reform, both providers and sickness funds faced disincentives to finance rehabilitation, because successful rehabilitation resulted in the care level of an individual being downgraded, with subsequent reduction in reimbursements. Although there was a potential for rehabilitation among individuals receiving LTC services, the Medical Review Board would transfer only 6% of the cases to rehabilitation centres. Each sickness fund had to bear the cost of any rehabilitation measure it granted. However, savings from downgrading of an individual's level of care were spread among all funds, so that sickness funds still had few incentives to finance rehabilitation (Rothgang, 2010).

The 2008 reform introduced a financial incentive of EUR 1 536 when a resident is transferred from a nursing home to a lower level of care setting, as a result of rehabilitation. Sickness funds also face a EUR 2 072 fine, if they do not provide rehabilitation services, even though it has been recommended by the Medical Review Board. Still, it is too early to assess the effects of these financial incentives on the promotion of rehabilitation (Rothgang, 2010).

Another example can be found in Mexico, where the ISSSTE (Institute of Social Services for State Employees) began to promote healthy and active ageing among its beneficiaries aged over 40 years in 2008. This lead to the development of the *Active Ageing Program*, and, in 2009, of the *Healthy Ageing Program*, which is now being carried out in 35 geriatric centres across the country. The centres aim at providing rehabilitative services and physical therapy to the elderly.

Although several polices fall under the broad umbrella of healthy ageing *(e.g.,* increasing community activities, improving lifestyles and health literacy, as well as better adapting health care systems to the needs of the elderly) only few countries seem to have integrated specific healthy ageing objectives or interventions as part of their LTC systems. There is still uncertainty regarding which interventions aimed at keeping seniors in good health lead to better payoffs or are cost-effective (Oxley, 2009a). This uncertainty acts as a deterrent to implement potentially valuable initiatives in LTC systems. There is clear scope for more initiatives targeting health promotion for seniors and evaluation of practices.

10.4. Addressing long-term care systems governance

LTC services and systems are quite complex, posing significant difficulties for their management and regulation. When obtaining care services becomes too bureaucratic and imposes administrative burdens on users, this may undermine public confidence or inappropriately discourage individuals from seeking formal care (Fernández *et al.*, 2009).

A potential way of countering this complexity is the establishment of comprehensive information platforms, available to LTC users and providers. A study in the United States showed lack of public awareness and confusion regarding the availability of care services. Information databases defining more precisely the care eligibility criteria, the types of available care and financial support would be useful for users, and for providers, too, to assess the benefits and risks of various forms of care for patients with given characteristics.

Widely available information could improve users' informed choices and providers' decision-making (Fernández *et al.*, 2009; Miller *et al.*, 2008; Kane and Kane, 2001).

Explicit printed and audio material describing financial LTC entitlements can be found in Scotland and Ireland (Fernández *et al.*, 2009; Miller *et al.*, 2008). In Sweden, the need for better information platforms is well acknowledged, and specific initiatives already in place include "Open Comparisons" tools and "Guide for the Elderly" manuals, among others (Government of Sweden, 2010). Information support tools are more likely to gain widespread acceptance if they are more trustworthy than provider-generated web sites, and more comprehensive and less medically focused than reports from government regulatory agencies. It has been suggested that public-private partnerships may be tested to undertake such an information task, combining public and private data (Kane and Kane, 2001).

The implementation of evidence-based guidelines is another tool to support decision-making. This involves reviewing scientific knowledge and ranking by experts, based on different features such as patients' needs, benefit-risk ratios, cost-efficiency and the soundness of the evidence. Such clinical guidelines can be found in some OECD countries, as for example in Sweden and the United States. Structuring guidelines for the elderly population can be challenging, as they often need to address complex co-morbidities, and studies on younger populations without multi-morbidity may have limited generalisation value for older populations. Nevertheless, by encouraging standardisation among providers, the benefits to patients may be optimised (Ekerstad *et al.*, 2008; Boyd, 2005).

Another possible way to improve institutional efficiencies in LTC is care planning. One of the aims of LTC systems is to enable patients to receive tailored care, according to their needs. Those needs are determined by an assessment of the individual's current and past physical, mental and emotional condition. Collaborative work across health professionals is required. The definition of LTC care planning or care management differs across countries, however some core components include patient assessment, care plan development, monitoring, care co-ordination and responsiveness to crisis situations. In some cases, psychosocial support may also be included (Sargent *et al.*, 2007; Challis *et al.*, 2010).

Care planning programmes exist in several OECD countries, such as the United States, United Kingdom, Canada and Sweden (Sargent *et al.*, 2007; Challis *et al.*, 2010). In the United Kingdom, the National Service Framework for Older People (NSFOP) introduced in 2001 promoted individual care planning for the senior population, either in hospitals or in the community. Evaluations of this programme have shown that, although older people might not perceive improvements as a result of the NSFOP, they do observe improvements in the LTC systems as a whole (Manthorpe *et al.*, 2007).

Information sharing across government administrations may enhance the administrative efficiency of LTC services. These may include LTC financing, targeted personal-income tax measures and transfers, such as pensions, as well as existing social assistance or housing subsidy programs. In Japan, the introduction of LTC insurance in 2000 aimed, among other things, at promoting information sharing between LTC and other social sectors (Matsuda and Yamamoto, 2001).

A wide range of factors may influence inter-agency information sharing. For example, the policy and legislative context will have an effect on the balance of sharing and protecting information. The existing governance structures are likely to shape the links between LTC and social care systems, with respect to data sharing. Technical considerations play an important role as well; for instance, the degree to which computer systems are

compatible and the extent to which one organisation has access to personal records held by another. Information exchange could be facilitated with the use of integrated records, including shared assessments and care procedures. The need of training and support to professionals on this issue is evident (Richardson and Asthana, 2006).

The organisation of health and LTC systems, as well as the presence of multiple payers, can lead to cost-shifting incentives for providers, which may in turn have negative implications on efficiency and other aspects of care. In order to address these problems, several policy initiatives, such as capitation payment and pay-for-performance, have been considered in the United States, although they all have strengths and weaknesses (Grabowski, 2007).

In sum, some possibly useful approaches to enhance institutional efficiency include the establishment of good information platforms, the setting of guidelines, the use of care planning processed, the sharing of data within government administrations and minimising the cost-shifting incentives. Given that all these interventions are dependent on other system features, this issue is likely to be a continuing focus of policy makers in the years to come.

10.5. Conclusions

Ageing populations will result in increased demand for LTC services in the future, placing a higher burden on the expenditure of formal LTC systems. Governments have, or should, become increasingly concerned with improving the value for money of their LTC systems. But there is still little measurement and evaluation of this important dimension of performance.

Nearly all OECD countries have been encouraging home care, in order to limit institutional costs and satisfy peoples' preferences to receive care at home. They have done so through the direct expansion of home care supply, and the implementation of regulatory measures and financial incentives. Obstacles such as limited home-care providers, fragmentation of care, and lack of incentives for providers and users have been identified in some countries. Some evidence suggests that home care may become more expensive than institutional care for severely disabled people.

LTC payment mechanisms can be used to steer providers towards desired goals for the system. Here, pay-for-performance initiatives may hold some promise, although their use in LTC is still limited. Efficiency gains could also be achieved from choice-based competition across providers, such as in the case of vouchers used in the Nordic countries to stimulate private providers. The introduction of new technologies could improve the productivity of LTC workers, but there is a dearth of evaluation of cost-effectiveness of many "smart" technologies and often technology appears useful as a supplement rather than a substitute of labour.

Inefficiencies may arise from the interactions of the LTC system with the health care system. Several OECD countries have targeted the inappropriate use of acute services for LTC needs via financial measures, changes in administrative responsibilities and the introduction of information technology. Many OECD countries have attempted to co-ordinate or integrate health care and LTC services, but the difficulties faced are not trivial. Policies promoting healthy ageing and prevention have been adopted, among others, in Japan and Sweden. There is still uncertainty regarding which interventions would generate the highest health gains for each dollar: this is an area where priority should be placed in the future.

LTC systems' governance is complex and can lead to institutional inefficiencies. Various approaches could be adopted for improvement, such as establishing comprehensive information platforms, implementing evidence-based guidelines to support decision-making, introducing care planning programmes, sharing of information across government administrations and minimising cost-shifting incentives of providers.

Finally, there is a need to engage with wider societal and public attitudes towards meeting LTC needs, since these often frame decisions about public funding. Population ageing requires a change of the "caring mindset", so that care for older people comes to be viewed as a priority for society as a whole. Without such a change in attitudes, older people with LTC needs may be left particularly vulnerable to domestic neglect and unwanted institutionalisation.

Notes

1. PAI (Plan, Assess, Invest) groups make the assessment.
2. Providers receive a fixed amount for the services provided over a specific period of time, irrespective of the volume.
3. The discussion on voucher systems in LTC in Nordic countries is based on an analysis carried out for OECD by Viita (2010) during the summer of 2010.
4. A care manager is typically involved in the screening, assessment, planning, implementation, and review of individuals living with long-term conditions. Often, the managers are in charge of organising the services. There is nonetheless variation in the role and tasks of care managers across countries.
5. *Active Ageing,* placing greater emphasis on prolonging labour market activity and functional capacity (WHO, 2002) and *Successful Ageing,* concerned more specifically with ensuring that individuals are in good physical and psychological health to endure tense experiences in later life, are also used in the literature (Oxley, 2009a).

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