U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

Dispelling Some Myths:

A Comparison of Long-Term Care Financing in the U.S. and Other Nations

1990

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This report was prepared Office of Family, Community and Long-Term Care Policy (now DALTCP) within the U.S. Department of Health and Human Services. It was included as part of ***GENERATIONS LTC Financing***, Spring 1990, pp. 10-14. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the DALTCP contact, Pamela Doty at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Pamela.Doty@hhs.gov.

DISPELLING SOME MYTHS:
A Comparison of Long-Term Care Financing in the U.S. and Other Nations

Pamela Doty

Spring 1990

Prepared by
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services

This article compares the organization and financing of long-term care for the elderly in the United States with that of other advanced industrial countries. While the article is based largely on the author's own research (Doty, 1998; Doty and Mizrahi, 1989), including studies carried out from 1983 to 1986 under the auspices of the International Social Security Association and during 1987 and 1988 for the Organization for Economic Cooperation and Development, it also draws on recent studies by other researchers (American Association of Retired Persons, 1986; Monk and Cox, 1989; Dieck, 1989; Moss, 1989; Newman, 1987; and Zappolo and Sundstrom, 1989).

As the United States debates reform of long-term-care financing, examining other countries' approaches to long-term care for the elderly can help expand the range of reform options for consideration. To draw useful lessons from other countries' experiences, however, we must first reexamine many of the preconceived notions we have about how their approaches to long-term-care financing differ from ours.

MYTHS

"America," writes Thomas Jazwiecki (1989), "still lags behind western Europe and several other countries in developing a comprehensive and integrated long-term healthcare plan." Gail Shearer (1989) of the Consumer's Union characterizes U.S. financing of long-term care as different from that of other countries in "requiring impoverishment as a condition of eligibility for public benefits" and being "biased toward institutionalization." According to Brookings Institution researchers Alice Rivlin and Joshua Wiener (1988): "Although most western European countries and Canada cover long-term care along with acute care under their national health insurance or national health service, the United States makes a sharp distinction between the two kinds of care. Acute care is covered by social insurance under the Medicare program, and long-term care is primarily covered by Medicaid, a means-tested welfare program."

Similar comparisons have been made by politicians arguing for enactment of a comprehensive public long-term-care insurance program by the United States. For example, during the 1988 presidential race, one of the candidates in the Democratic primaries, Senator Paul Simon, declared it shameful that the United States--unlike other advanced industrial nations--did not already provide public insurance coverage for long-term care.

The above represent what many American policy analysts and policymakers believe to be true about the organization and financing of long-term care abroad. This author's research indicates, however, that these beliefs are for the most part based on myths, misconceptions or--at best--half-truths.

Myth 1: Other countries provide comprehensive long-term-care coverage along with acute-care benefits under their national health service/national health insurance programs.

In actuality, other advanced industrial countries--like the United States--have been and remain reluctant to expand health insurance coverage beyond medical and nursing home to include long-term care, especially those services considered primarily "social" rather than "medical" in character. No country provides comprehensive long-term-care coverage--that is, services across the continuum of institutional and home- and community-based care--through the same public insurance system that covers acute medical care or through a comprehensive public long-term-care insurance program. Thus, while Israel, for example, has recently implemented a form of public long-term-care insurance, funded like Social Security and medical insurance through payroll taxes, program benefits are limited to nontechnical home care intended to supplement and support family caregiving; nursing home and other residential care continues to be supported by a combination of private and government funding.

In all countries, national health insurance coverage of inpatient (in other words, "institutional") long-term care is limited to medically oriented chronic hospital or nursing home care. Similarly, coverage of noninstitutional long-term care under national health insurance is generally limited to medical daycare ("day hospitals") and home health (professional nursing and therapy) visits. In most advanced industrial countries, home-delivered long-term-care services such as homemaker/chore and personal care ("home help") are labeled social rather than health services. As social services, they are usually organized and--to a very considerable degree--funded at the local or regional level. In Canada, for example, the federal social services funding match to the provinces is 50 percent. In Sweden, only about 35 percent of financing for home care, on average, is provided by the central government. In Denmark the percentage is 25, with the rest coming from municipal revenues. Heavy reliance on regional and local funding, with funding levels left largely to local or regional option, and the absence of nationally uniform service requirements or eligibility standards imposed by the central government result in considerable local and regional variability in publicly funded home- and community-based care.

The extent of coverage for institutional long-term care under national health plans depends largely on whether institutional long-term care in a particular country is provided mainly in hospitals or in free-standing facilities and whether the latter are considered primarily "medical" or "social" care settings. Countries differ greatly in the proportion of their long-term-care institutions that are officially defined as "medical" versus "social." These labels are quite meaningful insofar as they reflect implicit political choices about the limits of health insurance coverage for long-term care--but they are not so meaningful in distinguishing types of care provided or clientele served. Thus, a preponderance of "social" care facilities emphasizing residential services may signify a philosophical aversion to the "medical model" of long-term care and an attempt to make long-term-care institutions more homelike. The European literature on long-term care makes clear, however, that many "social" care facilities are in fact older institutions that

were originally established to serve poor and socially isolated but ambulatory residents but that increasingly care for older persons with chronic medical conditions and functional disabilities. Often what is at issue in the balance of long-term-care institutions designated "nursing homes" versus "residential" facilities is the political will to pay higher costs associated with providing increased medical and nursing services.

In Canada, about 8 percent of the elderly reside in long-term care institutions. Of these, only 1-2 percent live in welfare-financed personal-care homes, while the remainder receive care in nursing homes or hospital-based "extended care facilities" that are covered under provincial health insurance plans. Similarly, in Australia, about 6.8 percent of the elderly are in institutions--mostly nursing homes funded through a federal funding mechanism that provides the equivalent of "social insurance" coverage but is separate from coverage for acute care.

In the Netherlands, however, fewer than a third of long-term-care institutions qualify for health insurance funding. Some 3 percent of elderly in the Netherlands reside in these "AWBZ" nursing homes, which are covered under the Exceptional Medical Expenditures Act. Like Medicare skilled nursing facilities (SNFs) in the United States, the AWBZ homes were originally intended to provide primarily postacute, rehabilitative, and convalescent care. However, they have evolved into something that is broader in coverage than a Medicare SNF yet more narrowly specialized and more heavily medical and nursing-oriented than the typical U.S. Medicaid-certified nursing home. An additional 8 percent of Dutch elderly reside in "old people's homes" (many of which provide what in the United States would be considered nursing home care) where the government subsidizes the cost of care only for those who cannot pay privately. Forty-four percent of the costs of care in these old peoples' homes comes from private payments, as compared to 4 percent in AWBZ homes.

In England, about 4.1 percent of the elderly population are in institutions, but only one in five receive care in geriatric wards of National Health Service (NHS) hospitals, which is the form of inpatient long-term care covered under the NHS system.

In the Federal Republic of Germany, where about 4.5 percent of the elderly population reside in homes for the aged and nursing homes, all such institutions are considered to be "social care" facilities and therefore ineligible for coverage by the Sickness Funds.

France and Belgium have adopted a different approach to the "medical" versus "social" care distinction. In these countries, national health insurance covers the medical component of care in long-term-care institutions, but residents themselves are responsible for paying the costs of the residential component of care. In France, national health insurance may cover up to 50 percent of daily charges in the most medically intensive facilities, but, on average across all long-term-care institutions, national health insurance covers only about 14 percent of costs.

Myth 2: The United States is the only country that bases access to public long-term-care coverage on a means test or requires that individuals "impoverish" themselves by first exhausting their capacity to pay privately for care.

It should already be clear from the above discussion of limits on national health insurance coverage of long-term care that the United States is not alone in means testing eligibility for publicly funded institutional care. To the extent that care in long-term-care institutions is considered "social" rather than "medical," residents are frequently expected to exhaust their private-pay capacity before public funding is made available. In the Federal Republic of Germany, for example, nursing homes and homes for the aged are funded by private payments or through public assistance provided by the individual *Lander* (states). Welfare authorities in Germany carry means testing even farther than Medicaid agencies in the United States in also assessing the resources of adult children to determine whether they should be required to contribute toward the costs of their parents' care. It is estimated that about half the residents of German nursing homes and old age homes receive some welfare support. In England, the great majority of institutionalized elderly reside either in local authority homes or in private nursing and residential care homes. Residents of local authority homes have traditionally been supported by local welfare funds; however, in recent years the supply of such places has failed to keep pace with growth in the older disabled population, with the result that increasing numbers have sought care in privately run nursing homes and residential care institutions. In the early 1980s, Britain created means-tested supplemental Social Security payments to help residents of private facilities who could not afford to pay the full costs of care. In France, individuals who cannot afford to pay the nonmedical (room and board) component of daily charges must apply for public assistance. It is estimated that about 50 percent of residents in "long-stay facilities" (that is, nursing homes) and about 39 percent of residents in the lower-cost retirement homes, including both those with and without nursing units, receive public assistance.

However, even countries that do not require means testing for access to public funding for long-term care typically require income-related cost sharing on the part of patients rather than the fixed rate, percentage-of-cost co-payments characteristic of health insurance coverage for acute medical care. Cost-sharing requirements for patients also tend to be much higher for institutional long-term care than for acute hospital care--in recognition of the substantial component of costs that goes toward basic living expenses. Thus, in Canada and Australia, resident fees are set in relation to Social Security benefits. In Canada, for standard care in a long-term-care institution, the resident is usually charged a monthly fee equal to the maximum federal monthly income security benefits less a comfort of about $50. For additional services or upgraded accommodations (such as a private room), the resident may be charged more. In Australia, residents' fees are set at 87.5 percent of the Social Security pension. In the Scandinavian countries (Sweden, Norway, Denmark), nursing home residents must contribute their Social Security pensions plus between 60 and 80 percent of other private income, including that from interest, toward the cost of care. However, they are not required to tap the principal of investment assets, liquidate investments, or sell their homes.

Like the U.S. home health benefit under Medicare, similar benefits in other countries that provide home nursing typically require no co-payments. However, unlike the United States, where means testing usually limits access to publicly supported homemaker and personal care services to the poor or "near poor," most European countries (for example, Sweden, Norway, Denmark, the Netherlands, and France) offer these types of home help to all citizens on a sliding scale, income-related fee basis (which in some countries can reach 100 percent of costs for individuals with higher incomes). In England, where home care is primarily aimed toward the low-income elderly, some local authorities charge no fees, while others charge on a sliding scale. In Canada, co-payments for home care are charged by some provinces on a sliding scale, while others, such as Manitoba, offer these services free of charge.

Myth 3: Long-term-care service systems in other advanced industrial countries are more integrated and "rational," not fragmented like the U.S. system.

Clearly, since other countries do not offer comprehensive long-term-care coverage under national health insurance, then national health insurance funding cannot provide the mechanism for coordinating acute medical and long-term care or for integrating institutional and noninstitutional long-term-care services into a cohesive long-term-care service "system." Indeed, as in the United States, the financing, organization, and delivery of the various long-term-care services in other countries also tends to be fragmented and poorly coordinated. Which levels of government, which agencies and programs, and which provider organizations become involved and what roles they play depend on whether the long-term-care service in question is perceived as predominantly a housing, income support, medical, or social service. Only Denmark and, to a lesser degree, New Zealand and some Canadian provinces such as Manitoba and British Columbia have managed to superimpose organizational structures that systematically coordinate assessment of need and delivery of long-term-care services to individual clients. In Denmark, this coordination appears to have been achieved by purposefully rejecting a "medical insurance" model of financing and organizing the delivery of long-term care in favor of a "municipal social services" model. Linkage between acute and chronic medical care and long-term care is maintained, however, through the use of hospital-based geriatric assessment units as the principal transfer/coordination point between the two otherwise separate care systems.

Myth 4: Other countries do a better job of preventing institutionalization through generous public funding of home- and community-based alternatives.

European and other advanced industrial countries vary greatly in the emphasis they have placed on home- and community-based care or, for that matter, on preventing institutionalization as a goal. Historically, alternatives to institutionalization have been accorded a much stronger policy emphasis in Britain and the Scandinavian countries than in France, Belgium, or Germany, and publicly funded home care remains largely nonexistent in Japan. Moreover, while Britain and the Scandinavian countries have traditionally provided much more in the way of publicly funded home care for the

disabled elderly than we have (Kane and Kane, 1976; Kahn and Hammerman, 1976; Senate Aging Committee, 1984), the lack of available home- and community-based care in the United States tends to be overstated. For example, a number of states--California, Illinois, Oregon, and Massachusetts, in particular--have statewide programs that do not limit services to cash assistance for people who are eligible for Medicaid.

A lack of good data makes it difficult to accurately compare U.S. and European rates of provision of home- and community-based services. Use of available data often makes for comparisons of the apples versus oranges variety. For example, Scandinavian and British statistics on home- and community-based long-term-care services regularly include local social services provisions because most funding is of this nature, whereas American statistics generally include only Medicaid-funded services and exclude those with funds from Social Services Block Grants and the Older Americans Act and state- and county-funded services because national statistics for these programs are difficult to obtain. Two recent reports (Intergovernmental Health Policy Project, 1988; World Institute on Disability; 1987) based on surveys of the states found, however, that Medicaid figures represent only half of total public spending on home- and community-based care in the United States. Similarly, in discussing home- and community-based long-term care in the United States, American analysts frequently exclude the over $2 billion annually spent on Medicare home health benefits because this is considered primarily "postacute" rather than "long-term" care. Yet, statistics on home care in Europe regularly include home nursing as well as home aides services.

Arguably, policies promoting home- and community-based alternatives to institutionalization should be compared and judged mainly on outcomes not inputs. This means looking at comparative institutionalization rates--not just rates of use of publicly funded home- and community-based services. It is so often said that public financing for long-term care in the United States is institutionally biased that it comes as quite a surprise to discover that the United States, the Federal Republic of Germany, and the United Kingdom have the lowest institutionalization rates among Western industrialized countries--around 4 to 5 percent. Sweden, Norway, and the Netherlands have the highest rates--ranging between 9 and 11 percent. France, Belgium, Denmark, Australia, and Canada have institutionalization rates in the middle range of 6 to 8 percent.

If we look in depth at the factors that appear to be responsible for these variations in institutionalization rates, we find that the countries that have invested more in publicly funded home- and community-based care are not generally those with the lowest institutionalization rates--if anything, the correlation is in the opposite direction. The Scandinavian countries claim to have reduced their institutionalization rates during the 1970s by expanding availability of home- and community-based care, but some Scandinavian observers believe that reductions in bed supply may have been more significant. Moreover, these countries started at a higher level of institutionalization than the United States and remain at a higher level even after the reductions. Finally, most of the reductions in institutional use have been achieved by phasing out nonmedical homes for the aged in favor of service flats with home-delivered care. There is little evidence to suggest that public funding for home- and community-based care has

resulted in less use of nursing homes. According to Sundstrom (1985) home- and community-based long-term care largely serves a different population, as was found by the National Channeling and other demonstrations of home- and community-based alternatives in the United States (for a thorough review, see ***Health Services Research***, 1988).

CONCLUSIONS

This article has attempted to dispel some myths concerning how much greener the grass is in long-term-care systems on the other side of the U.S. border or across the ocean. The purpose is not to deny that other countries could have some better ways of doing things--only to suggest that we stop berating ourselves for failing to live up to excessively idealized images of what other countries have achieved. In considering reforms for long-term-care financing in the United States, Americans can benefit from studying the experiences of other countries. The more we broaden our horizons and examine the variety of approaches employed in other countries, the more we will be in a position to consider a broader range of options and to understand their respective advantages and disadvantages.

Pamela Doty, Ph.D., is a senior analyst, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Washington, D.C.

Note: An earlier version of this article was presented at the Brookings Institution's National Issues Forum, "Caring for the Disabled Elderly: Who Will Pay?" May 18, 1988. The opinions expressed are those of the author and do not represent the official position of the U.S. Department of Health and Human Services.

REFERENCES

American Association of Retired Persons, 1986. *Income Security and Long Term Care for Women in Midlife and Beyond: U.S. and Canadian Perspectives*. Proceedings of the U.S./Canadian Expert Group Meeting on Policies for Midlife and Older Women. October 8-10.

Dieck, M., 1989. "Long-Term Care for the Elderly in the Federal Republic of Germany." In T. Schwab, ed., *Caring for an Aging World*. New York: McGraw-Hill.

Doty, P., 1988. "Long Term Care in International Perspective." *Health Care Financing Review* 1988 Annual Supplement: 145-55. Available at http://aspe.hhs.gov/daltcp/reports/intpersp.htm.

Doty, P. and Mizrahi, A., 1989. "Long-Term Care for the Elderly in France." In T. Schwab, ed., *Caring for an Aging World*. New York: McGraw-Hill.

Health Services Research, 1988. Special Issue: The Evaluation of the National Long-Term Care Demonstration. 23:(1) (April). Available at http://aspe.hhs.gov/daltcp/reports/hsres.htm.

Intergovernmental Health Policy Project, George Washington University, 1988. "Long-Term Care for the Elderly: State Financing of Services." *Intergovernmental Health Policy FOCUS ON...* 21(June).

Jazwiecki, T., 1989. "Long-Term Care for the Elderly in the United States." In T. Schwab, ed., *Caring for an Aging World*. New York: McGraw-Hill.

Kahn, A.J. and Kammerman, S.B., 1976. *Social Services in International Perspective: The Emergence of the Sixth System*. Washington, D.C.: U.S. Department of Health, Education and Welfare, Social and Rehabilitation Service, Office of Planning, Research and Evaluation (SRS)76-05704, Government Printing Office.

Kane, R.L. and Kane, R.A., 1976. *Long-Term Care in Six Countries: Implications for the United States*. Fogarty International Center Proceedings No.33. Washington, D.C.: U.S. Department of Health, Education and Welfare, DHEW Publication No. (NIH)76-1267, Government Printing Office.

Monk, A. and Cox, C., 1989 (June). "Transfer of International Innovations in Home Care." Final Report to the Administration on Aging (Grant No. OHD AOA 90-AR-0109-01). New York: Brookdale Institute on Aging and Adult Development and Columbia University School of Social Work.

Moss, B., 1989. "Long-Term Care for the Elderly in Australia." In T. Schwab, ed., *Caring for an Aging World*. New York: McGraw-Hill.

Newman, S.J., 1987. "Long-Term Care in Australia and the United States." *Home Health Care Services Quarterly* 8:3(Fall):11-29.

Rivlin, A.M. and Wiener, J.M., 1988. *Caring for the Disabled Elderly: Who Will Pay?* Washington, D.C.: Brookings Institution.

Shearer, G., 1989. *Long-Term Care: Analysts of Public Policy Options*. Washington, D.C.: Consumers Union.

Sundstrom, G., 1985. *Community Care of the Aged in Scandinavian*. Tampa, Fla.: The International Exchange Center on Gerontology.

U.S. Senate Special Committee on Aging, 1984. "Long-Term Care in Western Europe and Canada: Implications for the United States." Washington, D.C.: Government Printing Office. Information paper.

World Institute on Disability, 1987. "Attending to America: Personal Assistance for Independent Living." Berkeley, Calif. Unpublished.

Zappolo, A. and Sundstrom, G., 1989. "Long-Term Care for the Elderly in Sweden." In T. Schwab, ed., *Caring for an Aging World*. New York: McGraw-Hill.