U.S. Department of Health and Human Services
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Office of Disability, Aging and Long-Term Care Policy

U.S. Long-Term Care Financing in Comparative International Perspective:

Old Myths, New Ideas

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U.S. LONG-TERM CARE FINANCING IN COMPARATIVE INTERNATIONAL PERSPECTIVE: Old Myths, New Ideas

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Studying or living for an extended period of time in a foreign country is often recommended as a way of seeing beyond customary stereotypes and really learning in what ways Americans are different from or similar to other nationalities. Comparative international policy analysis is valuable for the same reasons. This paper compares the organization and financing of long term care for the elderly in the U.S. with that of other advanced industrial countries. It is based largely on the author's own research (Doty 1988, Doty and Mizrahi 1989), including studies carried out from 1983-1986 under the auspices of the international Social Security Association (ISSA) and during 1987-1988 for the organization for Economic Cooperation and Development (OECD). The paper also draws, however, on recent studies by other researchers (AARP 1987, Monk and Cox 1989, Dieck 1989, Moss 1989, Newman 1987, and Zappolo and Sundstrom 1989).

As the U.S. debates long term care financing reform, 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' experience, however, we must first "unlearn" many of the preconceived notions we have about how their approaches to long term care financing differ from ours.

"MYTHS" ABOUT LONG TERM CARE FINANCING ABROAD

"America," writes Thomas Jazwiecki (1989) "still lags behind western Europe and several other countries in developing a comprehensive and integrated long-term health care plan." Gail Shearer of the Consumer's Union (1989) 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 in 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 U.S. -- unlike other advanced industrial nations -- did not already provide public insurance coverage for long term care.

The above statements represent common beliefs that many American policy analysts and policymakers have about the organization and financing of long term care abroad. This author's research indicates, however, that these beliefs are for the most part 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 or national health insurance programs

In actuality, other advanced industrial countries -- like the U.S. -- have been and remain reluctant to expand health insurance coverage beyond medical and nursing care 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 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 non-technical home care intended to supplement and support family caregiving; nursing home and other residential care continues to be supported by a combination of private, charitable and welfare funding.

In all countries, national health insurance coverage of inpatient (i.e. "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 day dare ("day hospitals") and home health (i.e. 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%. In Sweden, only about 35% 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 central government imposed nationally uniform service requirements or eligibility standards results 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 terms of 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 older institutions originally established to serve poor and socially-isolated but ambulatory residents-but

which increasingly care for older persons with chronic medical conditions and functional disabilities. At issue in the balance of long term care institutions designated "nursing homes" vs. "residential" facilities is the often political will to pay higher costs associated with providing increased medical and nursing services.

In Canada, about 8% of the elderly reside in long term care institutions, of whom only 1-2% 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% of the elderly are institutionalized -- mostly in 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% of elderly in the Netherlands reside in these "AWBZ" nursing homes covered under the Exceptional Medical Expenditures Act. The AWBZ homes were originally intended, like Medicare skilled nursing facilities (SNF) in the U.S., to provide primarily post-acute, rehabilitative and convalescent care, but 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% of Dutch elderly reside in "old people's homes" (many of which provide what in the U.S. would be considered nursing home care) where the cost of care is government- subsidized only for those who cannot pay privately. Forty-four percent of the costs of care in old peoples' homes come from private payments as compared to 4% in AWBZ homes.

In England, about 4.1% of the elderly population is institutionalized -- but only 1 in 5 receive care in geriatric wards of National Health Service (NHS) hospitals, which is the form of inpatient long term care covered under the NKS system.

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

France and Belgium have adopted a different approach to the "medical" vs. "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% 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% of costs.

Myth #2: The U.S. is the only country that "means-tests" access to public long term care coverage or requires that individuals "impoverish" themselves by first exhausting their private pay capacity.

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 further than Medicaid agencies in the U.S. 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 failed to keep pace with growth in the elderly disabled population, with the result that increasing numbers of persons sought care in privately-run nursing homes and residential care institutions. In the early 1980s, Britain created means-tested supplemental Social Security payments for 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 non-medical (room and board) component of daily charges must apply for public assistance. It is estimated that about 50% of residents in "long stay facilities" (i.e. nursing homes) and about 39% of residents in the lower cost retirement homes, including both those with and without nursing units, receive public assistance help.

However, even countries that do not "means-test" access to public funding for long term care typically require income-related patient cost-sharing rather than the fixed rate, percentage of cost co-payments characteristic of health insurance coverage for acute medical care. Patient cost-sharing requirements for institutional long term care also tend to be much higher 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 allowance 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% 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% of other private income, including interest income, toward the cost of care but, as regards assets, they are not required to tap the principal, liquidate investments, or sell their homes.

Like the U.S. home health benefit under Medicare, other countries that provide home nursing typically require no co-payments for this benefit. However, unlike the U.S., where means-testing usually limits access to publicly supported homemaker and personal care aide services to the poor or "near poor", most European countries (e.g. Sweden, Norway, Denmark, the Netherlands, 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% of costs for higher income individuals). In England, where home care is heavily targeted toward the low-income elderly, some local authorities charge no fees, others charge sliding scale fees. In Canada, sliding scale co-payments for home care are charged by some provinces, 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 U.S., 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 depends 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 "rationalize" the 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, 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 Kammerman 1976, Senate Aging Committee 1984) -- the lack of available home and community-based care in the United States tends to be overstated. A number of states, in particular -- e.g. California, Illinois, Oregon, and Massachusetts -- have state-wide programs that do not limit services to cash-assistance/Medicaid eligibles.

It is difficult to make accurate comparisons of rates of home and community-based service provision between the U.S. and European countries due to lack of good data. Use of available data often makes for comparisons of the apples vs. 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 reference only Medicaid funded services and exclude Social Services Block Grant, Older Americans Act and state/county-funded services because national statistics for these programs are difficult to obtain. Two recent reports (Intergovernmental Health Policy Project 1989 and 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 U.S. similarly, in discussing home and community-based long term care in the U.S., American analysts frequently exclude the over $2 billion dollars annually spent on Medicare home health benefits because this is considered primarily "post-acute" rather than "long-term" care. Yet, statistics on home care in Europe regularly include home nursing as well as home help care.

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 publicly funded home and community-based service use. It is so often said that public financing for long term care in the U.S. is institutionally biased that it comes as quite an unexpected result to discover that the U.S. ha s one of the lowest institutionalization rates among the industrialized countries. Japan has the lowest institutionalization rate -- for reasons that Japanese experts see as fast eroding under pressures created by the world's most rapidly aging and longest-lived population and decreases in the traditional extended family living arrangements that facilitate informal home care. The U.S., the Federal Republic of Germany, and the United Kingdom have the lowest institutionalization rates among Western industrialized countries -- around 4 to 5%. Sweden, Norway, and the Netherlands have the highest rates -- ranging between 9% and 11%. France, Belgium, Denmark, Australia and Canada have institutionalization rates in the middle range of 6-8%.

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 1970's 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 U.S. and remain at a higher level even after the reductions. Finally, most of the reductions in institutional use have been achieved by phasing out non-medical homes for the aged n 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 lesser 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 home and community-based alternatives demonstrations in the United States (Kemper, Applebaum, and Harrigan 1987).

SOME IDEAS FROM ABROAD

What can we learn from this review of how other industrialized countries finance long term care? If other countries' long term care systems are not necessarily models of comprehensive, integrated and coordinated coverage, some aspects apparently work well enough that they can give us some new ideas to work with in considering long term care financing reforms in the U.S. At the very least, looking at other countries' approaches to familiar problems can help U.S. policy analysts see beyond the narrow confines of most current thinking about long term care financing reform options. Thus, there are alternatives for expanded public coverage of long term care that do not simply expand on our current Medicare or Medicaid approaches or depend on the unlikely adoption of national health insurance coverage.

In the U.S., we are used to thinking of patient cost-sharing either in terms of means-tested "welfare" models such as Medicaid or, according to Medicare's "insurance" model, as flat-rate percentages of costs or absolute dollar limits. As we have seen, a number of other countries, however, adopt a sliding scale fee approach to cost-sharing, especially for home and community- based services, and/or tie patient cost-sharing for institutional care to Social Security pension payments. Income-related, sliding-scale payments for home and community-based care do not typically raise sizable revenues to offset public payments. They are believed, however, to curb excessive demand that can develop if services are made available without charge or at negligible cost.

On the more macro level of long term care financing, it is striking that most other countries rely on a combination of central and local government revenues (formula or block grants) to fund long term care. Translated to the American context, this would argue for looking more toward "Title XXII formula grant or SSBG block grant approaches to stimulate local development of home and community-based long term care services instead of thinking only about Medicare/Medicaid models of expanding access to such care.

It is also interesting to note that while some European governments voice strong commitment to the concept of "universal entitlement" to home and community-based long term care, program administrators are nevertheless typically required to honor this commitment within fixed funding allocations. How they manage to do so is worthy of

further study -- since the very notion of a "capped entitlement" sounds like a contradiction in terms to many Americans. Abraham Monk and Carole Cox (1989) investigated this question in the Swedish context. They found that the entitlement to home health and home care supports guaranteed in Sweden's 1982 Social Services Act represents a moral duty imposed on Municipal authorities that is taken very seriously. At the same time, this legislative mandate is not interpreted as requiring detailed rules and regulations to spell out the volume, range, or threshold of services to which individuals are entitled. while the law stipulates support to the functionally disabled to insure them a "meaningful life and a reasonable standard of living", it also states that the municipal social welfare authorities are to be providers of last resort -- only when other potential sources, both public and private, have been exhausted or are unavailable. Although the Swedish central government matches local spending on an open-ended basis (in contrast to the block grant approach adopted in Norway), it does not mandate how much of their own funds the localities must spend on home care. Thus, muncipal governments have a great deal of discretion in setting and determining who meets criteria of need for care and what level of service will be provided. When funds become tight or personnel scare, applicants may be placed on a waiting list for service. Individuals who believe that they have not received the services they are entitled to may take their case to administrative courts. According to Monk and Cox, administrative court rulings in such cases indicate that the courts are sensitive to inequities in service provision but also take into account the budgetary contraints faced by the municipalities.

LEARNING FROM OTHER COUNTRIES' REFORM EFFORTS

This article has only been able to briefly touch on the lessons to be learned from studying other countries' approaches to the organization and financing of long term care. It is important to note, however, that several countries have recently reformed or introduced innovations into their long term care systems. Such policy initiatives can be looked on as "natural experiments" or, alternatively, as demonstration projects someone else is paying for. Currently, the implementation of Israel's long term care insurance law promises to be of particular relevance because this new home care benefit closely ressembles the late Congressman Claude Pepper's popular proposals to expand Medicare's coverage of long term home care. (See Israeli National Health Insurance Institute 1988).

Even studying other countries, inconclusive reform efforts may prove enlightening. Both Britain and the Netherlands have had major study commissions that addressed long term care issues in the past several years but it is not yet clear which, if any, of the ensuing recommendations will be adopted. Watching others struggle with the same dilemmas that plague American policymakers -- e.g. determining the "right" balance between public and private financing and between federal and local funding and control -- can help us realize that some problems really are universal and not the "fault" of any one political system, ideology, or party in power.

Policymakers in other countries, by the way, are very interested in studying and learning from U.S. experience. The United States is a leader in policy research and demonstrations and other countries have shown particular interest in our long term care case-management ("channeling") and social health maintenance organization (S/HMO) demonstrations. Sweden is considering casemix related nursing home reimbursement along the lines of New York's Resource Utilization Group System (RUGS). The Japanese, who have virtually no insurance coverage for home health care, are interested in how the Medicare home health benefit has helped shorten U.S. hospital stays. Japanese and German insurance companies have begun offering private long term care insurance and the Italian legislature has commissioned a study of private long term care insurance.

CONCLUSIONS

This article has attempted to dispell 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. This 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 U.S., Americans can nevertheless benefit from studying other countries' experience. 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 understand their respective advantages and disadvantages.

REFERENCES

American Association of Retired Persons. 1986 (October 8-10). 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.

Doty, Pamela. 1988. "Long-Term Care in International Perspective." Health Care Financing Review. 1988 Annual Supplement:145-155. [Available at http://aspe.hhs.gov/daltcp/reports/intpersp.htm]

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

Consumer Union (Gail Shearer). 1989 (January). Long-Term Care: Analysis of Public Policy Options. Washington, D.C.: Consumers Union.

Dieck, Margaret. 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.

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

Israeli National Insurance Institute. 1988 (June). Social Security: Journal of Welfare and Social Security Studies. "Towards the Implementation of the Long-Term Care Insurance Law in Israel". Special English Edition. Jerusalem, Israel: The National Insurance Institute.

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

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

Kane, Robert and Kane, Rosalie. 1976. Long-Term Care in Six Countries: Implications for the United States. Fogarty International Center Proceedings No.33. U.S. Department of Health Education and Welfare, Public Health Service, National Institutes of Health, John E. Fogarty International Center for Advanced Study in the Health Sciences. DHEW Publication No. (NIH) 76-1267. Washington, D.C.: Government Printing Office.

Moss, Brian, 19891 "Long-Term Care for the Elderly in Australia." In T. Schwab, ed., Caring for a Aging World. New York: McGraw-Hill.

Monk, Abraham and Cox, Carole. 1989 (June). "Transfer of International Innovations in Home Care." Brookdale Institute on Aging and Adult Development. Columbia University School of Social Work. Final Report to the Administration on Aging (Grant # OHD AOA 90-AR-0109-01).

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

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

Sundstrom, Gerdt. 1985. Community Care of the Aged in Scandinavia. Tampa, Florida: The International Exchange Center on Gerontology.

World Institute on Disability. (Simi Litvak, Hale Zukas, and Judy Heumann). 1987 (April). Attending to America: Personal Assistance for Independent Living. Berkeley, California: World Institute on Disability.

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