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

Nursing Home Care in Five Nations

June 1993

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 article was prepared by HHS's Office of Family, Community and Long-Term Care Policy (now DALTCP) for the ***Journal of the International Federation on Ageing*** ("Ageing International: Long-Term Care Challenges an Aging World" supplement, Volume XX, No. 2, pp 1-5). The article was written as part of a multi-country initiative funded by ASPE and HHS's National Center for Health Statistics. 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 office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. The e-mail address is: webmaster.DALTCP@hhs.gov. The Project Officer was Robert Clark.

NURSING HOME CARE IN FIVE NATIONS

Joan F. Van Nostrand
National Center for Health Statistics

Robert F. Clark
Office of the Assistant Secretary for Planning and Evaluation

Tor Inge Romoren
Norwegian Research Council

June 1993

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

The opinions and views expressed in this report are those of the authors. They do not necessarily reflect the views of the Department of Health and Human Services, the contractor or any other funding organization.

An international collaboration allows countries facing similar situations to exchange experiences and share ideas. Among the questions collaborators are trying to answer is: "What can we learn from other nations to improve nursing home care?"

As the world's population ages, the organization, delivery and financing of long-term care (LTC) increase in importance. Most older people have at least one chronic condition. For some, chronic conditions result in disabilities so severe that they need LTC--that is, assistance from others over an extended period of time in performing daily activities. A common approach to delivering LTC in developed nations is the nursing home. Even Japan, which until recently had few nursing home beds, is increasing its supply. Given that older persons have a substantial risk of entering a nursing home in their lifetime, questions about the delivery of LTC and improved outcomes become crucial. Such questions will become even more salient as the world's elderly population grows older.

QUESTIONS ABOUT LTC SERVICES

What can we learn from international comparisons about LTC? Specifically, what approaches to LTC delivery and to LTC policy can lessen the effects of disability of older persons and improve outcomes, especially of nursing home care? These questions and others are being addressed in an International Collaborative Effort (ICE) on Aging sponsored by the National Center for Health Statistics, part of the Centers for Disease Control and Prevention in the U.S. Department of Health and Human Services. The international emphasis of the ICE on Aging permits exchange of experiences and sharing of ideas among nations facing similar situations and challenges. Through the ICE on Aging, the National Center for Health Statistics is working with other nations to strengthen information about older persons in order to answer questions to guide actions and policy to improve their health.[1] The intent of the LTC research of the ICE on Aging is to use information about LTC services and policy to improve outcomes in nursing home care and, thereby, improve the quality of life of older persons. Researchers working on the LTC project are from Australia, Canada, the Netherlands, Norway and U.S.A. This paper presents an international comparison of their individual work.[2, 3, 4, 5, 6, 7]

---

[1] Feinleib, Manning, Ed. *Proceedings of the 1991 International Symposium on Data on Aging*, National Center for Health Statistics. Vital Health Stat 5(7). 1993.

[2] Clark, Robert F. Home and Community-Based Care in the U.S.A. In *International Comparisons of LTC in Australia, Netherlands, Norway and the U.S.A.* Vital Health Stat 5(8). Forthcoming. [http://aspe.hhs.gov/daltcp/reports/hcbcusa.htm]

[3] Havens, Betty. Outcomes of Community and Institutional LTC in Canada. In *Proceedings of the 1988 International Symposium on Data on Aging*. Vital Health Stat 5(6). 1991.

[4] Howe, Anne L. LTC in Australia. In *International Comparisons of LTC in Australia, Netherlands, Norway and the U.S.A.* Vital Health Stat 5(8). Forthcoming.

[5] Romoren, Tor Inge. LTC in Norway and the Scandinavian Solutions. In *International Comparisons of LTC in Australia, Netherlands, Norway and the U.S.A.* Vital Health Stat 5(8). Forthcoming.

IS HEALTH OF THE ELDERLY SIMILAR AMONG COUNTRIES?

Is the health of older people in Australia, Canada, the Netherlands, Norway and the U.S.A. similar? This is an important question when comparing LTC services. If the health of older people differs so that it is better in some of the countries and poorer in others, then LTC services may differ to meet particular needs. Services may differ not only by type and intensity, but also by number. For example, in a country where health of the elderly is poor and need for intensive LTC services is high, services may consist mainly of nursing homes and the ratio of nursing home beds to persons age 65 and older may be high. In a country where health of the elderly is better and need for personal services is high, LTC services may consist mainly of housing where social and personal care services are provided and the ratio of nursing home beds may be low.

Although the availability of comparable data on the health of older persons is limited, life expectancy at older ages and the percent of the elderly who are the oldest-old provide a basic indication of health status and risk of needing LTC. To put this information in context, we compared the percent of the population in each country that is elderly (65-plus years) and found it similar. For Australia, Canada, the Netherlands and the U.S.A. in 1985-1990, about 11% to 13% of the population was elderly. For Norway, the figure was slightly higher at nearly 16%. Life expectancy in these countries is high. Although there was some variation, the differences in 1986 were small. At birth, life expectancy ranged from 78 to 80 years for females and from 72 to 74 years for males. At age 65, the differences in life expectancy among countries narrow to one year or less: for females it was about 18.5 years and for males about 14.5. Differences at age 85 remain at one year or less. Life expectancy was about 5.7 years for females and 4.8 for males. These long life expectancies at older ages, especially for those 85 and older, have important implications for LTC. This is because the risks of needing LTC are highest for this older group. To gain another perspective on the size of the population at risk of needing LTC, we compared the percent of elderly who were the oldest-old. Australia, Canada and the Netherlands had 8% to 9% who were oldest-old, while Norway and the U.S.A. had 10%. After examining all this information we concluded that there were some basic similarities in the health of older persons in the five countries and in the percent at risk for needing LTC.

---

[6] van den Heuvel, Wim J.A. Long Term Nursing Home Care in the Netherlands. In *International Comparisons of LTC in Australia, Netherlands, Norway and the U.S.A.* Vital Health Stat 5(8). Forthcoming.

[7] Van Nostrand, Joan F. LTC in the U.S.A.: Nursing Home Care. In *International Comparisons of LTC in Australia, Netherlands, Norway and the U.S.A.* Vital Health Stat 5(8). Forthcoming.

WHAT IS A NURSING HOME?

The question of whether or not we are comparing similar phenomena is a critical one for international comparisons of health services. Is what is called a "nursing home" in Australia similar to one in the Netherlands, or one in the U.S.A.? After much analysis, we concluded that comparisons should focus on the *highest* levels of nursing home care provided. The goals, care provided and characteristics of residents in this class of LTC institutions were the most comparable across the countries. In contrast, the lower levels of institutional LTC were judged as the most dissimilar because there were so many gradations of services and different arrangements for their provision. For Australia, we included nursing homes, but excluded hostels. For Norway, we included nursing homes and excluded homes for older persons and sheltered housing. In the Netherlands, we included both psychogeriatric and somatic nursing homes and excluded homes for the aged. In Canada, we included nursing homes types 2, 3, 4, (either singly or in combination with type 1) and excluded type 1 alone. In the U.S.A. we included homes certified for Medicare or Medicaid and excluded non-certified homes, board-and-care homes and assisted-living arrangements. Although the definition of a nursing home differs from country to country, in all cases the institutions we included provided nursing care, assistance with personal care activities, and room and board. We recognize, of course, that nursing homes can differ in the type of services and intensity of care not only among countries, but sometimes within countries as well.

OVERVIEW

Table 1 provides an overview of LTC services as used by the frail elderly for a range of settings, from less to more intensive, within the five countries. As context, we included two other categories. The first was hospitals, where medical services are very intensive, because in some countries the frail elderly with LTC needs receive their care in hospitals. The second contextual category was "own home." this includes the elderly living in their own homes without formal LTC services. These elderly could either be independent in that they had no need for LTC or be receiving LTC informally from family and friends. (We could find no comparable data to tell us how many elderly fell in the independent versus informal care subcategories.) The LTC settings ranged from the less intensive setting of living at home with formal LTC to the most intensive setting of nursing home care. Only those LTC institutions we named earlier when we defined a nursing home are included in this most intensive LTC category. The places we named earlier that we decided should not be included as nursing homes (because they provided less intensive institutional LTC services) are counted in the category of homes for the elderly. In the category of supportive housing, we included places that were housing arrangements rather than health care institutions.

We stress that the kinds of housing and service combinations gathered under any particular setting are not *identical* from one country to another. The table provides at most an approximate look at LTC settings and service use and how they vary from country to country. We selected 1985 as the year for which comparable national data

were most easily found. We recognize that in each of the countries, the LTC system has evolved considerably since 1985 and will continue to do so. However, the 1985 data reveal some interesting comparisons and some surprising similarities.

PERCENT OF ELDERLY (65+) BY LONG-TERM CARE SETTING, 1985					
-	Australia	Canada	Netherlands	Norway	U.S.A.
Number of Elderly	1,647,700	2,699,700	1,729,700	652,900	28,536,000
Own home, independently or with informal care only	83.8	88.2	57.5	67.3	88.5
Own home, with formal care	6.2	3.2	14.5	22.1	4.8
Supportive housing	3.2	1.0	15.0	3.5	1.2
Homes for Elderly (low levels of care)	2.4	1.3	9.0	2.3	0.9
Nursing home (high level of care)	4.4	4.2	3.0	4.8	4.6
Hospital	---	2.0	1.0	---	---

The most striking similarity is the finding that the percentages of older persons (age 65-plus) living in nursing homes are quite comparable. In four of the five countries, 4% to 5% of the elderly were in nursing homes. Nursing homes themselves have undergone changes in their role and function. In some countries, *e.g.*, the Netherlands and Norway, they are developing into more rehabilitation and respite-oriented facilities.

Among the five countries, the provision of nursing home care is lowest in the Netherlands; 3% of the elderly were in nursing homes. In the U.S.A. the distinction between skilled and intermediate care facilities has been eliminated in the law since there is no longer federal reimbursement based on different levels of care; however, both types of home continue to exist. In Norway, which has a medical care orientation, nursing homes endeavor to treat patients without transferring them to hospitals, except for cases requiring surgery.

In all five countries, the percentage of elderly people living at home either independently or with informal LTC support is high, exceeding 80% in three countries. In the Netherlands, it is 58%, indicating perhaps the greater availability of formal at home services and supportive housing there. In the Netherlands, 15% of the elderly live at home and receive formal care on site. The figure is even higher in Norway--over 20% live at home and receive formal care there.

Supportive housing is also a major setting for the provision of LTC in the Netherlands. About 15% of older persons live in supportive housing. This is in contrast to 3% in Australia and Norway and 1% in Canada and the U.S.A.

Generally, incentives have been created to expand home and community-based care options and reduce or even reverse the rate of growth in nursing home beds. Australia, for example, has instituted standardized pre-admission assessment procedures to control nursing home admissions and has expanded the range of nursing-related services (*e.g.*, dementia care) in hostels. In Canada, the provinces

(notably Manitoba) took the lead in developing and financing integrated community care systems for the frail elderly as an alternative to nursing home care.

STRUCTURE OF LTC SYSTEMS

By the structure of LTC systems we simply mean the elements in their composition, that is: administration, sector of provision, and balance of formal services between higher versus lower levels of institutional care. All five countries in the study have a LTC sector composed of institutions and community services. Community services are complex and heterogenous, but home help and home nursing services are the core items in all the countries, though the volume of these two differ.

In all LTC service systems, institutions generally provide two levels of care. These levels differ in their history, goals, degree of medical orientation and staffing. Typically, there will be a 24-hour nursing service at the highest level, usually called nursing homes. The Netherlands differs from all the other countries in the study by having formally divided its nursing home sector into somatic (general) and psychogeriatric homes. The average size of nursing homes has a wide range. The Netherlands has the largest size with 150 beds, and Norway with its 40 beds has the smallest. The other countries have an average between these figures.

The next level of LTC institutions typically have less staffing and tend to be more of a common household for frail elderly with some personal care services available. Thus, in Australia, this lower level or institutional care is called the "hostel." In Canada and Norway, it is called "homes for the aged;" in the Netherlands, "home for the elderly." In the U.S.A. it is called "home not certified for Medicare and Medicaid." The countries differ by the proportion of LTC beds allocated to the lower level of care. The Netherlands has the greatest allocation--75%. In the other countries the percentages are much lower: about 35% in Australia and Norway and less than 25% in Canada and the U.S.A. Australia is in the process of changing the balance between the two levels, planning to make the highest level of care the smallest part of the institutional sector by 2006.

The balance between the institutional and community parts of LTC is difficult to measure and express comparatively. One measure is their share of the total LTC costs. In 1989, Australia and Canada spent about 90% of their total LTC costs on institutions; the Netherlands and U.S.A. about 85%; and Norway about 75%.

The administration, provision and balance of formal LTC services form distinct profiles that have evolved through different historical and political traditions. These elements in their structure stand out. The Australian system is the most centralized one, giving it more authority to change the balance of formal institutional services to a lower level of care. The Canadian and the U.S.A. systems stand out with the largest internal variations between provinces/states. In addition, the U.S.A. system has the highest proportion (75%) of private for-profit ownership of LTC institutions. The most striking

structural element in the Netherlands is a very large and mostly voluntary institutional LTC sector. There is a strict division between somatic and psychogeriatric nursing homes. At 150 beds, the average size in LTC institutions is very large. The most characteristic elements in the Norwegian system are a decentralized administration, small institutions (about 40 beds), and a dominating public, nonprofit ownership (85%). Norway's LTC system is more oriented to home-care than in the other countries.

COMMON THEMES IN LTC POLICY

As diverse as the history and growth of the LTC service systems are for these five countries, there are some common policy themes. Two major themes are shifts in levels of intensity and improvements in quality. Policies to shift away from the highest level of institutional LTC are common to all the countries. In some countries, the shift is to lower levels of institutional care. In others, the shift is to home and community care. In others, the shift is to home and community care. Since 1985, the Australian government has sought to support the frail elderly in their own homes and communities where possible. Plans call for a shift in the ratio between nursing homes and hostels. In 1985, there were two nursing homes for every hostel. By 1991, this ratio had fallen to 1.6 to 1. The target ratio for the year 2006 is 1.0 nursing home to 1.5 hostels. In Canada between 1972 and 1987, all but one province developed home care services. Based on Manitoba's experience, publicly insured nursing home care coupled with subsidized universal home care has not led to neglect of familial or financial responsibilities by clients' families. More often the opposite has proven true. With the support of services like respite care and adult day care, families continue to cope with elderly relatives with heavy care needs rather than place them in nursing homes.

In the Netherlands over the 1975 to 1985 period, there was a decrease in capacity for institutional services, except for psychogeriatric nursing homes. Conversely there was an increase in community care, except for home help services. In Norway during the 1980s more and more resources are being channeled to community care. Service flats, which may offer community-based care day and night, are partially replacing nursing homes in the LTC system.

In the U.S.A., growth in the number of nursing home beds began to slow in the 1970s under a federally-established health planning system which required a certificate of need before a hospital or nursing home bed could be built.

While the National Health Planning and Resources Development Act of 1974 was repealed in the early 1980s, many states continue to employ its certificate of need provisions to control the growth of nursing home beds. Such control is important to the states because restrained growth of beds lessens the demand for greater state expenditures for nursing home care. At the same time, the availability of home and community-based care assistance has been expanded through various waiver provisions to Medicaid, a federal-state program that provides LTC benefits to some, but not all, low-income elderly.

Another common theme is policies to improve the quality of care. In Australia, in recognition of the advanced age of nursing home residents--some two-thirds of whom are over age 80--the Australian government adopted age 70 for planning purposes in 1986. Eligibility for admission is first determined by a geriatric assessment team, once admitted, each resident's care needs are further assessed by the director of nursing. In the U.S.A., under 1987 legislation that became effective in October 1990, the U.S. Congress acted to improve the quality of care in nursing homes. They created one level of care by eliminating the distinction between skilled and intermediate nursing care. In addition, a standardized assessment by a multidisciplinary team and a care plan is required for each resident. Norway's effort to increase the intensity of care is worthy of note here. Nursing homes are being used in new ways. More of their capacity is being shifted toward rehabilitation, respite care, care of the terminally ill and care of patients with cognitive impairments. Transfers to hospitals are generally for surgery only.

QUESTIONS FOR INTERNATIONAL COMPARISONS

Now that we know more about differences and similarities of LTC services in our countries, we can begin work to answer our basic questions. What can we learn from other nations to improve the outcomes of nursing home care? What steps can we take in LTC service delivery and public policy to lesson the effects of disability and improve outcomes? To answer these questions, we plan to compare outcomes of nursing home care in our countries for specific groups of residents--for example those with hip fractures, impaired cognitive functioning, stroke. If the outcomes for similar groups of residents differ by country, we will identify possible reasons for the differences, using the information about the LTC systems to help us draw conclusions. By concentrating on LTC approaches and policies which influence improved nursing home outcomes, we will be able to pool our knowledge to improve the quality of life of older persons.

Joan F. Van Nostrand, M.P.A., is a health statistician at the National Center for Health Statistics of the Centers for Disease Control and Prevention at the U.S. Department of Health and Human Services.

Robert F. Clark, D.P.A., program analyst with the Office of the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services.

Tor Inge Romoren, M.D., is a physician at the Norwegian Research Council for Applied Social Science.