



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

LONG-TERM CARE IN INTERNATIONAL PERSPECTIVE

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Office of the Assistant Secretary for Planning and Evaluation

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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 findings of a study of long-term care policies in 18 countries are reported in this article. Initial data were collected by a questionnaire survey under the auspices of the International Social Security Association. These data were supplemented by published documents and government statistics obtained while researching long-term care for the International Social Security Association and, subsequently, for the Organization for Economic Cooperation and Development. The principal focus is a cross-national comparison of institutionalization rates for the elderly. Differences in use rates for medically oriented facilities are less than those for nonmedical residential long-term care facilities. Only a small amount of variation is related to demographic differences, such as older or more female elderly populations in those countries with higher institutionalization rates. Included also is a description of the modes of financing long-term care.

INTRODUCTION

As life expectancy at older ages increases, the United States and other developed countries are experiencing what Olshansky and Ault (1986) term the fourth stage of the epidemiologic transition, the "age of delayed degenerative diseases." Accordingly, the organization and financing of long-term care for the elderly is becoming a priority issue for health policymakers. This article is based on the findings of a 1986 cross-national study of long-term care policies by the Health Care Financing Administration for the Permanent Committee on Medical Care and Sickness Insurance of the International Social Security Association (ISSA), supplemented by more recent research for the Organization for Economic Cooperation and Development (OECD).

METHODOLOGY AND ISSUES

A questionnaire was sent to ISSA member organizations concerned with the financing of health services in their respective countries. Data obtained from the replies were supplemented with data from published sources, including government statistics and reports obtained from a network of contacts in the various countries.

The questionnaire was distributed in October 1984 to ISSA member organizations in 27 countries, covering all regions of the world and including less developed as well as more developed countries. The 18 replies received were primarily from the more developed countries. Great Britain did not participate in the original ISSA survey (and therefore is not included in some of the comparative tables presented, but it was included in subsequent research for OECD that focused on long-term care financing policies.

Analysis of the questionnaire replies and supplemental material covered a wide variety of issues, not all of which will be discussed. The focus of this article is on what was learned with respect cross-national variations in elderly institutionalization rates. These differential patterns of institutional use are of particular interest because the most frequently cited long-term care policy concern in most of the countries surveyed was the high cost of institutional services. In addition, most of the advanced industrial countries surveyed considered their institutional long-term care use rates to be higher than necessary or desirable. Most also reported pursuing deliberate policies to expand home- and community-based long-term care services as a means of reducing institutional use.

COMPARATIVE INSTITUTIONALIZATION RATES

Institutionalization refers to extended stays in any type of inpatient facility or residential care setting. Nearly all the advanced industrial countries judged their elderly institutionalization rates to be too high. However, the actual reported institutionalization rates in these countries varied considerably--from a low of 3.6-4.5 percent in the Federal Republic of Germany (FRG) to more than double that rate at 8.7-10.5 percent in Sweden and 10.9 percent in The Netherlands.

DEFINITIONAL ISSUES

The questionnaire asked ISSA member agencies to report use rates among the elderly population (those 65 years of age or over) for long-term care in medically oriented residential facilities (e.g., chronic-care hospitals, geriatric wings of acute care hospitals, nursing homes, rehabilitation hospitals) and nonmedical residential facilities (e.g., homes for the aged, frail ambulant homes, personal care homes, board and care homes). In addition, the questionnaire asked for use rates for the following:

- Other sheltered living arrangements (e.g., foster care or family-style living arrangements with nonrelatives who are paid to provide such services, and small group-shared housing for the elderly).
- Subsidized housing for the disabled elderly (e.g., apartment complexes with special services or design features).
- Professional nursing and therapy services at home (provided by licensed or certified nurses and therapists specializing in physical, speech, or occupational therapy).
- Nonprofessional nursing services at home (aides who help with bathing, dressing, eating, toileting, mobility, or who provide day or night sitting services).
- Homemaker or chore services (help with shopping, cooking, cleaning, laundry, and errands).
- Day care for the elderly (day program of social and/or medical services).

- Meals (e.g., meals delivered to the elderly person's home or in a readily accessible central location).

Most countries were able to supply institutional use rates, but only a few countries were able to supply rates of use for noninstitutional services. Only for Australia, Israel, France, The Netherlands, Sweden, and New Zealand (and in later research, for Britain), was it possible to obtain reasonably up-to-date national measures of use rates for nonmedical long-term care services (principally, homemaker or chore services).

The questionnaire defined institutionalization in terms of generic facility categories (i.e., medically oriented versus nonmedical residential care) and presented examples of what such facilities might be called. This was done because an initial literature review and discussions with experts on particular countries had revealed a wide variety of terminology used to label long-term care institutions. It quickly became apparent that a question about nursing home use, for example, could produce misleading results. In many countries, this term is not used to characterize long-term care facilities for the elderly or has a much more limited meaning than it does in the United States. In Britain, for example, the term "nursing home" is only used to refer to freestanding, private proprietary facilities of which, until quite recently, there were still very few. Thus, a British reply to a question about nursing home use would exclude information about hospital-based long-term care provided in geriatric wards of National Health Service hospitals or care provided in "local authority" homes for the aged.

Indeed, an analysis of the various terms used to describe long-term care facilities and the reality that lies behind these labels reveals much about the changing nature of long-term care as a distinct service. To get a sense of the evolution of long-term care policy both within and across countries, one must understand what different types of facilities are called in a given country, whether their names reflect the type of care they provide now or the type of care they provided in the past, and how the balance of care provided in different types of institutional settings has shifted. It is through this type of analysis, that one comes to understand that Belgian "rest homes" are no longer purely residential facilities as the name would imply; but, through a deliberate policy referred to as "medicalization," they are being converted into facilities similar to what we in the United States would call nursing homes.

The questionnaire also sought to uncover hidden forms of institutionalization by asking questions about the use of mental hospitals for long-term care of the elderly (especially elderly suffering from dementia disorders) and about the unintended use of acute care hospital beds for long-term care. It is important to distinguish between care provided in hospital-based long-term care facilities and long-term care that is provided in general hospitals simply because there is no place for an older person in need of long-term care to go following an acute episode. The former is a deliberate component of the long-term care delivery system; the latter is a problem arising out of the health-care system's failure to address explicitly the long-term care needs of the elderly. Both Britain and the FRG are quite concerned about such inappropriate use of hospitals for

long-term care. The problem appears particularly severe in Britain, where so-called bed blockage by the elderly is blamed for limiting the access of younger patients to hospital care. In particular, it is said to cause excessively long waiting times for elective surgical procedures. A still different situation is represented by Japan. Until very recently, when concerns about rising hospital costs began to emerge, the difference between acute care and long-term care had not been considered particularly significant. Neither policymakers nor practitioners thought it important to ensure that only acute illnesses were treated in the hospital and long-term care needs met in separate settings.

The role of the hospital and the mental hospital in long-term care is an important question, again, for understanding how the nature of the medical, social, and other care needs of the elderly have been and continue to be redefined. Analysis of historical institutionalization rates of the elderly in the United States, for example, show a very different pattern if one looks at nursing home use in the broader context of changing use rates for mental hospitals, county homes for the aged, and retirement hotels. (Office of the Assistant Secretary for Planning and Evaluation, 1981). An examination of nursing home use alone gives the erroneous impression that institutionalization of the elderly rose dramatically during the 1950's and after 1965 with the passage of Medicaid. If one looks at the broader pattern of institutionalization of the elderly, however, it becomes clear that (with the exception of the elderly 85 years of age or over among whom actual rates of institutional use did increase) institutionalization of the elderly did not increase with the passage of Medicaid. Rather, what actually occurred was a massive shift in the types of institutions in which the elderly were to be found--a shift away from State mental hospitals as well as religious or county-run homes for the aged that provided little medical or nursing care toward the use of private for-profit or nonprofit nursing homes that conformed to a medical model of institutional long-term care. At the same time, the declining availability of retirement hotels since the 1950's decreased the supply of sheltered housing alternatives available to low-income, frail elderly not in need of medical or nursing services.

Given the current emphasis on alternatives to institutionalization for the elderly as a policy goal in most developed countries, it is especially important to capture--insofar as possible--the full range of institutions and sheltered housing arrangements that provide long-term care to the elderly. From this, it can be determined whether institutionalization is actually on the decline or whether one type of institution is declining only to be replaced by another as the nature of the long-term care needs of the elderly are redefined.

For all the countries included in the study, data were requested that would permit the computation of a global institutionalization rate that included all major institutional settings. For some countries, the questionnaire reply supplied reasonably complete data on the full range of institutional settings. In other cases, it was possible to fill in the gaps in the questionnaire reply from other sources. In a few cases, most notably the Federal Republic of Germany, the data supplied were incomplete and/or not up to date. Where different sources of data on institutionalization rates cite different figures, a country's

institutionalization rate is given as a range between the highest and lowest reported figures.

EXPLAINING VARIATION IN INSTITUTIONALIZATION RATES

The study sought to gauge how much of the variation in reported cross-national institutionalization rates can be attributed to demographic factors such as population age or sex structure (that is older and more heavily female populations). This was done by projecting the institutional use rate of the elderly 65 years of age or over for each country as if its age- and sex-specific institutional use rates were the same as those in the United States as measured by the National Center for Health Statistics (1979). This procedure, in effect, adjusts elderly medical institutional use rates for cross-national differences in the age structure of the elderly population (i.e., relative proportion of the population 65 years of age or over that is in the age cohorts 65-69 years, 70-79 years, and 80 years of age or over) and for differences in male versus female longevity and use of services.

In projecting use rates for nonmedical institutions (variously known in the United States as personal care homes, domiciliary care facilities, and board and care homes), I was unfortunately hampered by the lack of an equally precise, reliable source of U.S. data as exists for nursing homes. Although I might have chosen to use age- and sex-specific rates for residence in nonmedical group quarters from the U.S. census, there is good reason to believe, based on other surveys, that census figures somewhat underestimate the percentages of U.S. elderly in nonmedical residential long-term care facilities. Accordingly, I have used the best estimates of the elderly 65 years of age or over in these facilities in 1980 derived from special studies (Sherwood, Mor, and Gutkin, 1981; Stone, 1984). These estimates are for the population 65 years of age or over as a whole; they are not age- or sex-specific. Then future projections were based on the ratio of residents in nonmedical facilities to residents in medical facilities (0.27).

Use of U.S. age- and sex-specific institutionalization rates as the comparison standard should not be interpreted as having normative significance. That is, I do not in any way mean to imply that other countries' institutionalization rates should be more like those of the United States. The study employed U.S. age- and sex-specific rates of nursing home use as the standard of comparison only because these rates were more readily available.

Two methodological points should be noted before moving to a discussion of the tables. First, for purposes of consistency, United Nations (U.N.) population figures have been used to make the projections. Use of U.N. population figures results in a slightly lower use rate for nursing homes in the United States than the official figures typically quoted in U.S. publications. U.S. Government reports typically round off the institutionalization rate found in the 1977 Nursing Home Survey (National Center for

Health Statistics, 1979) to a flat 5 percent. More specialized publications present slightly varying figures, depending on the year being projected and whether or not projections forward from 1977 have been age adjusted only or also sex adjusted. Thus, Manton and Liu's (1984) age- and sex-adjusted projection for 1980 is 4.6 percent, whereas the U.S. Bureau of the Census (Taeuber, 1983) age-adjusted projection for 1982 is 4.9 percent. The United Nations' population figures for the United States used in this analysis yield a projected rate of 4.5 percent for 1980 because they slightly underestimate the numbers of elderly in older age cohorts, compared with the Social Security Administration's figures that Manton and Liu used in making their projection of institutionalization as of 1980. In addition, U.N. population figures do not disaggregate age cohorts above 80 years of age. The institutionalization rate for the U.S. elderly in the age cohort 80-84 years is a little more than 10 percent--the institutionalization rate more than doubles to almost 24 percent among the elderly 85 years of age or over. Lack of age breakdowns for cohorts over 80 years of age in the U.N. population figures will likely result in some underestimating of the effects of population age structure on institutionalization rates in the following analysis.

The tables of cross-national projected institutional use rates, based on U.S. age- and sex-specific institutional rates, indicate that the differences in use rates that would be anticipated because certain countries have older, more female elderly populations are considerably less than the variations in actual use rates (Tables 1-3). As for 1980, only France and The Netherlands would be expected to have higher use rates of long-term care facilities based on population characteristics alone, although the differences (0.3 percent in the case of France) are minor. Only Costa Rica, Israel, and Japan would be expected to have more than negligibly lower institutional use rates based on elderly population characteristics (Table 1). By 1985, however, somewhat greater differences begin to appear, with Belgium, France, the Federal Republic of Germany (FRG), and Switzerland showing increases in projected use rates of long-term care institutions that are more than slightly above U.S. rates because of population aging and greater proportions of elderly females (Table 2).

When the actual use rates reported for each country are compared with the projected use rates (Table 3), it appears that differences in age and sex population structure alone explain little of the variance. Population characteristics alone would suggest quite similar use rates for the United States, The Netherlands, and Sweden, yet both of these countries use institutional services at almost twice the rate of the United States. In The Netherlands, however, use of medical institutions is one-third less than the U.S. rate, and the use rate of nonmedical institutions is 6½ times greater. The Swedish use rate of medical institutions is quite similar to the U.S. use rate of such facilities, but the Swedish use rate of nonmedical facilities is four to five times as great as the U.S. rate. In contrast, the use rate of all long-term care institutions in the Federal Republic of Germany--but especially medical facilities--is considerably less than that in the United States, at least 20 percent less and perhaps as much as one-third less.

The institutionalization rate reported here for the FRG is the only rate in the study that I have reason to suspect represents significant underreporting. The questionnaire

reply from the FRG indicates that as much as 10 percent of acute hospital days represent inappropriate use of the hospital for long-term care. OECD (1985) data on average length of hospital stays further indicate that the average lengths of hospital stay in the FRG was--at 18.4 days as of 1980--the highest among European countries and more than twice as high as the average length of stay in U.S. hospitals (7.3). In contrast to Japan, where an estimate (Ikegami, 1982) of the amount of long-term care provided in general hospitals was obtained, I was unable to factor this into the institutionalization rate for the FRG.

It is noteworthy that the use rates of long-term care facilities in the less industrialized countries of Costa Rica, Spain, and especially Argentina, Greece, and Turkey are considerably lower than the U.S. rate. Although population characteristics alone would make Costa Rica's actual use rate appear 20 percent lower were it actually the same as the U.S. rate, it is, in fact, less than one-half the U.S. rate. Very little of the differences in institutional use rates among the United States, Greece, and Spain appear to be attributable to population characteristics.

In sum, relatively little of the cross-national variation in institutionalization rates can be explained by such demographic factors as the differential age and sex compositions of the elderly populations in different countries. It is important to bear in mind, however, that I was unable to obtain sufficient data to test the explanatory power of certain demographic variables that might prove to be more significant predictors of institutional use--in particular, differential rates of the never-married and childless elderly. Thus, according to Rosenwaike (1985), a cross-national comparison of marriage rates among women 85 years of age or over found that 21 percent in Sweden had never married, compared with 11 percent in France and 8 percent in the United States. It may be, for example, that the unusually high percentages of elderly Swedes who never married is a significant factor explaining why Sweden has such comparatively high use rates of institutional long-term care. If this is the case, then I would expect that, as future age cohorts with higher marriage rates reach the age when long-term care needs become prevalent, Sweden's institutional use rates will naturally decline, regardless of social policy efforts.

REDEFINING CONCEPTS OF CARE

Earlier, in the section on definitions, it was observed that attempts to arrive at standardized definitions of "institutional long-term care" both within and across countries can help reveal the evolution of long-term care policy. An earlier study by Project Hope (U.S. Senate, 1984) of comparative cross-national institutionalization rates noted the much higher use of nonmedical residential facilities in Europe, compared with the United States. The author interpreted this as an indication of the U.S. tendency to impose a medical institutional model on long-term care. The Project Hope study considered only medically oriented facilities as institutions and classified both the older (indeed "old-fashioned") nonmedical homes for the aged and the newer forms of

sheltered housing (what the Europeans call "service flats" and we in the United States call "congregate care" or service-enriched senior citizen apartments) as group quarters.

The classification framework used in the present study was quite different because, in this author's view, it is important to look behind labels to see whether the care being provided in a given setting is actually medical or social and whether, in the particular country in question, a setting is considered to be institutional or noninstitutional. In the course of this study, it was often difficult to differentiate medically oriented from nonmedical residential long-term care settings. It was also difficult, in some instances, to decide which nonmedical residential facilities should be counted as institutions and which as sheltered housing. This was particularly the case for Sweden, where many elderly persons are being deinstitutionalized in place as older homes for the aged are converted into service flats with supportive services. Swedish officials insist that, unlike the older homes for the aged, the service flats are not institutions.¹ The distinction between institutional and noninstitutional housing often is a matter of interpretation. For example, the central office of a complex of service flats may be equipped with a lightboard so that the management can monitor the flushing of residents' toilets: Failure to record a toilet flush at least once per day triggers an investigatory visit to make sure that the resident is all right. One could question whether this sort of bureaucratic monitoring of intimate bodily functions is correctly classified as noninstitutional in character. Yet Swedish officials maintain that this system represents a much less obtrusive form of protective surveillance than the methods typically used to keep tabs on residents in institutional settings. Similarly, service flats with supportive services are not considered institutions because the providers of nursing, personal care, and homemaker or chore services do not work for the building management but rather are municipal employees whose service district for in-home care happens to be a particular building.

In grappling with these sorts of definitional problems, it became increasingly clear that they stemmed only in part from difficulties of distance and ambiguous or untrustworthy secondary data. Rather, the more fundamental problem is one of trying to classify phenomena in process of change. In many instances, facilities whose names suggest that they provide nonmedical care turned out either to have been deliberately medicalized in recent years (France, Belgium) or the literature on resident and/or staffing characteristics indicates that they have turned into de facto nursing homes because their populations have become more disabled and the facilities have been forced to respond by adding appropriate staff (FRG, Britain). A recurrent theme in the European literature is the problem of homes built to care for the independent elderly that are increasingly forced to cater to disabled populations without sufficient funds to provide needed nursing care.

¹ This information was obtained by personal communication in 1987 with Aurora Zappolo, then with the Office of Research and Demonstrations, Health Care Financing Administration. Ms. Zappolo visited Sweden in October 1986 at the invitation of the Swedish government to provide technical consultation for a planned national nursing home survey. In the course of the visit, she toured several nursing homes, homes for the aged, and service flat complexes, including facilities in the process of being converted from residential institutional care to service flats. She had numerous conversations with national and local officials and University-based researchers about the definitions of institutional versus noninstitutional care in Sweden.

Why European countries historically developed so many more nonmedical institutions than the United States, Canada, Australia, and New Zealand is an issue the author does not have space to go into in detail here. A major factor was clearly Europe's older, less modern housing stock. Until quite recently, large numbers of elderly people in Europe, especially in rural areas, lived in housing without such things as running water, indoor plumbing, or modern bathing facilities. Moreover, in The Netherlands, during the post World War II period of severe housing shortages, government policy encouraged the elderly to move into homes for the aged to free up housing for young families. As housing in Europe has been modernized and the economic position of the elderly has improved, the need for purely residential institutions has greatly decreased.

Accordingly, the balance both of medical to nonmedical institutions and of nonmedical institutions to less institutional forms of sheltered housing is shifting. Increasingly, it appears that the low-income elderly who are still independent in activities of day living, though perhaps in need of help with instrumental activities of daily living, are residing in service flats and other sheltered housing arrangements rather than in nonmedical institutions. The movement to phase out nonmedical institutions in favor of service flats has been particularly striking in Britain and, most recently, in Scandinavia. The medicalization of the institutional sector has been particularly strong in France, Belgium, and Great Britain. The net result is that, within the institutional sector of the advanced industrial countries, there is a growing emphasis on medically oriented facilities, which reflects the older, more functionally dependent populations in these countries.

In the less industrialized countries of Greece, Spain, Turkey, Argentina, and Costa Rica, long-term care institutions tend still to be largely nonmedically oriented and, indeed, often accept only the independent elderly. This then raises the question of where the chronically impaired elderly are receiving care. It is difficult to imagine that all the functionally impaired elderly who in the United States or The Netherlands or France would be in a nursing home or equivalent facility are being cared for at home by family members when institutions exist for the care of nonfunctionally impaired elderly. One hypothesis is that medically oriented long-term care of the elderly is not differentiated from acute inpatient care and that both types of care are provided in general hospitals (although care of the demented may be provided in mental hospitals). Data on length of stay in general hospitals collected by OECD (1985) indicate that average lengths of stay in Turkish and Greek hospitals are similar to that of the FRG (18 days). This would indicate that, as in Germany, there is more long-term care provided in hospitals than is typical of other European countries, but much less long-term care is provided in hospitals in Greece and Turkey than is the case in Japan.

EVOLUTIONARY TRENDS

Overall, the issues that emerged in the course of trying to define and measure use rates for institutional long-term care suggested that patterns of use of various kinds

of institutions for long-term care should be viewed in a developmental perspective. In the past, efforts to interpret the rise of nursing homes and homes for the aged in a historical, developmental perspective emphasized the alleged breakdown of family structure and the social isolation of the elderly brought about by industrialization. Subsequent research on patterns of family caregiving in the industrialized countries have shown these interpretations to be, at best, greatly exaggerated (Shanas, 1979; Brody, 1985; Doty, 1986). That is, there is considerable evidence from research on family caregiving in the United States, Australia, and Europe, (e.g., Stone, Cafferata, and Sangi, 1986; Kendig and Rowland, 1983; Conférence des Ministres Européens chargés des Affaires Familiales, 1985) that informal caregiving remains at a very high level in industrialized countries. The perspective being suggested here is one that focuses rather on the evolution of health care policy and the organizational structure of the health services sector both in the light of each country's own individual history and relative, cross-national stage of development.

Medically oriented long-term care institutions, as distinct from residential homes for the aged, appear to arise within a country's health care system as hospitals develop more and more of a short-term, acute care versus chronic care focus, as hospitals become more specialized and more technology intensive; as hospital costs rise; and as the level of concern mounts in regard to the cost and health insurance financing implications of lengthy hospital stays.

Indeed, it appears that a prime force in the development of specialized medically oriented long-term care facilities has been the drive to cut hospital costs. This policy has been most explicitly pursued during the 1980's in Belgium and Great Britain. In most countries, hospital costs for the elderly are covered under public health insurance programs, whereas only in The Netherlands is nursing home care given anything approaching comparable coverage. Thus, a movement to create specialized medically oriented long-term care facilities to replace care given in geriatric or regular wards of hospitals or in mental hospitals can be a means to relieve rising costs experienced by the health care scheme if, as is typically the case, the health care scheme is not then given responsibility (or is given only very limited responsibility) for financing the costs of specialized medically oriented facilities. Conversely, a few countries--most notably the FRG and Japan--appear to have a higher political and economic tolerance for rising hospital costs than others. So long as this tolerance is sustained (there are indications that it is breaking down in Japan because of the rapid aging of the population), the drive to cut hospital lengths of stay and costs by banishing chronic care from the hospital setting is not as strongly in evidence as it is elsewhere.

FINANCING MODES

In the United States, health services analysts generally assume that use of medical services, including nursing homes, is strongly influenced by the availability of government financing. One might therefore theorize that higher use rates of long-term care institutions in some countries relative to others may be associated with more

generous government financing in the countries with the higher use rates. Such a hypothesis would be in line with the widespread belief here in the United States that most other advanced industrial countries finance long-term care under their national health insurance programs. This would imply that, in other countries, long-term care is considered to be part of a broad entitlement to health care and that cost-sharing requirements are similar to what they are for hospital and physician care. It was found in the present study, however, that most other countries do not cover long-term care under national health insurance. Moreover, those that do offer it, impose either very significant limitations on coverage and/or cost-sharing requirements that are more sizable than those required for acute care services.

Government funding for institutional long-term care in about one-half the countries surveyed is provided on a welfare basis rather than on an insured entitlement basis. This means that, as in the United States, elderly persons who are not receiving cash assistance must first use up all their private income and assets paying for institutional long-term care before they become eligible for government funding. In a majority of the remaining countries, private payments, including payments by individuals using their social security pensions, remain a major source of financing for institutional care, but government funding is not contingent on all private resources being exhausted. For example, in Canada, elderly persons must contribute their social security pensions toward the cost of care, but they are not required to contribute other income or assets. In the Scandinavian countries, elderly residents of long-term care facilities are required to contribute their social security pensions plus a percentage (ranging from 60 to 80 percent) of all other income toward their care, but they are not required to liquidate or exhaust their assets. In France, the medical component (on the average 14 percent and, at maximum, 50 percent of long-term care facility costs) is funded through national health insurance, but elderly individuals are responsible for paying the nonmedical or room-and-board component of care. If elderly individuals cannot afford to pay privately for room and board in a long-term care facility, they must apply for welfare assistance.

Institutionalization rates tend to be lower in countries with less generous (i.e., means-tested) government financing; however, this is far from a simple relationship. For example, The Netherlands has the highest overall rate of institutionalization of all the countries studied. Yet the rate of use of the "AWBZ" homes (the equivalent of U.S. skilled nursing facilities), which are covered under national health insurance with low cost-sharing, is only 3 percent; whereas the use rate for less medicalized facilities, where residents must pay privately until they have exhausted their resources, is 8 percent. Further exploration suggests that the relationship between financing and institutionalization rates is strongly mediated by institutional bed supply. Indeed, it seems likely that controls or lack of controls on the bed-to-population ratio has more impact on variations in institutional use rates than the eligibility, coverage, or cost-sharing rules associated with government financing of institutional care.

Availability of government-funded noninstitutional long-term care is highly variable and much more difficult to measure than institutional bed supply. As is the

Medicare home health benefit, home nursing is typically covered by national health insurance programs with little or no patient cost sharing required. On the other hand, use rates of home nursing services vary greatly, ranging from 30-40 home nursing service users per 1,000 elderly in the United States, Israel, and Sweden to 164 users per 1,000 elderly in The Netherlands. Home-delivered nursing is a relatively recent phenomenon in France, having only been included in national health insurance coverage since 1981. Home nursing is also a relatively new benefit in the FRG; and, in Japan, coverage of home nursing under national health insurance is still under discussion. Just as in the United States, however, professional home nursing care in most European countries appears to be primarily a short-term service used mainly by persons recovering from an acute illness that required hospitalization.

In virtually all countries, there seems to be resistance to covering nonmedical long-term care services under the rubric of health programs. New Zealand, where all types of home-care services are frequently authorized by and coordinated out of hospital-based geriatric assessment units and funding is provided by local hospital boards, is a partial exception to this rule, although, even here, hospital-board funding for the nonmedically oriented services is less uniform and is more likely to be allocated on the basis of financial need. In addition, a number of Canadian provinces make available a range of noninstitutional long-term care services through their health insurance programs.

In most European countries, however, nonmedical home- and community-based long-term care services are generally characterized as social services, and they are administered locally, though they are likely to be paid for by a combination of central and local government financing. Such funding appears to be most generous in the Scandinavian countries and Britain. Although eligibility for these services is not means-tested in Scandinavia, income-related copayments are required. Sliding-scale cost sharing is also required from home-help clients in France, where close to 5 percent of all elderly living in the community receive such care. In Britain, publicly funded home help is targeted primarily toward the low-income elderly who have heavy disabilities and live alone.

HOME-CARE ALTERNATIVES

The question of whether publicly financed home care does or can provide alternatives to institutionalization is a complicated one, but, on balance, this analysis suggests that reported policy initiatives to promote noninstitutional alternatives to institutional long-term care have had only very limited success. There is some evidence, primarily from Sweden and the other Scandinavian countries, that home delivered services, especially those provided in sheltered housing environments (e.g., service-flats) can be used to reduce use rates of old-fashioned nonmedical homes for the aged. Only in the case of Britain has there been a historic association between an emphasis on funding home help and comparatively low institutionalization rates. Here again, however, the evidence suggests that it was primarily political decisions to limit the

availability of bed supply that kept institutional use rates low more than the elderly and their families choosing to use institutions less because home- and community-based alternatives were available. For many years, both the growth in National Health Service geriatric beds and the local authority home residential beds failed to keep pace with population growth and aging. The private nursing home building boom of the 1980's in Britain and the extension of social security means-tested financing to cover the costs of care in private nursing homes indicate, however, that demand can be artificially restrained only so far. Although Britain (at 4-5 percent) still has one of the lowest levels of elderly institutional use among the Western industrialized countries, the British case may well represent the limits of effective, adequate substitution of home- and community-based care for institutional care (Hobman, 1981; Larder, Day, and Klein, 1986).

Most countries that have expanded or are in the process of expanding either services in the home or such halfway services as day hospitals claim to be doing so in order to reduce institutionalization rates. The data suggest--albeit in most cases more by inference than by direct measures--that home- and community-based services complement, rather than substitute for, institutional-level care. Thus, greater availability of public funding for noninstitutional services is not systematically associated with lower cross-national use rates of institutional care. Indeed, use rates of these noninstitutional services tend to be especially high in those countries that also have above-average institutional use rates (e.g., Sweden, The Netherlands). It is therefore inferred that the populations typically served by home-care programs tend to be more moderately disabled than those in institutions, and most such clients are probably not at imminent risk of institutionalization. The association between above-average institutional use rates and more generous funding for home-care services probably means that both are indicative of a greater political will to spend government funds on long-term care generally.

There appear to be a number of reasons for the limited success of home- and community-based care as a true alternative to institutionalization. Two factors that stand out as being potentially amenable to policy change are the insufficiency of the services offered and the lack of coordination among providers and payers of medical versus social services.

In general, the types and amounts of home-care services currently being offered better serve the needs of the mild-to-moderately disabled than they do the needs of persons imminently at risk of institutionalization. Everywhere, these are almost exclusively oriented toward providing either professional nursing care (injections, dressings, etc.) or a few hours per week of assistance with instrumental activities of daily living (homemaker or chore services). The kinds of intensive (i.e., 20 hours or more per week, including nights if needed) nonprofessional nursing or personal care required by persons with severe impairments in ability to perform activities of daily living (bathing, dressing, toileting, eating) are typically not widely available in any of the countries surveyed, including those generally thought of as providing comparatively generous financing for home-care services. In part, this is because European countries

are no more willing than the United States to spend more per person, per day on noninstitutional care than on institutional care. (Comité Européen de Santé, 1985). Recently, some of the Scandinavian countries have become conscious of the limitations of existing services, and they have tried to increase their usefulness to the severely disabled by offering some night and weekend coverage, albeit still on a limited basis.

Inadequate coordination of the different types of services provided or financed by medical versus social services agencies or by different levels of government (national, regional, and local) was cited as a problem by most countries replying to the ISSA questionnaire. Although New Zealand, Denmark, and a few of the Canadian provinces have made greater progress toward integrated long-term care delivery systems than other countries, fragmentation of long-term care services organization and financing is a perceived problem in virtually all countries.

SUMMARY

Use rates of institutional long-term care among the elderly in advanced industrial countries vary almost threefold. The United States (along with Japan, Britain, and the FRG) has one of the lowest use rates for institutional long-term care among industrialized countries, whereas Sweden and The Netherlands have the highest use rates.

Cross-national variation in use rates of nonmedical institutions is greater than that of medically oriented facilities. Population characteristics--that is, older, more female elderly populations--account for only part of the higher institutionalization rates in some countries. Although institutionalization rates are generally lower in countries where public financing for institutional long-term care is available only on a means-tested basis, it appears that the relationship between government financing and institutional use rates is mediated by bed-supply policy. Tight bed supply controls can curb the use of long-term care facilities generously financed by nation insurance, and use rates of more generously supplied facilities are much higher even where public financing is means-tested. Generous public financing for home care is more often associated with countries also having above-average institutionalization rates--suggesting that both are related to greater political willingness to spend public monies on long-term care services across the board.

The lack of a systematic association between generous home-care financing and below-average institutional use indicates that policy initiatives aiming at reducing institutional use through increased public funding of home care services have not been particularly successful. There is some evidence, however, from the Scandinavian countries, that it is possible to use home care in combination with sheltered housing to reduce the use rates of nonmedical institutions, particularly where use rates of such facilities have been especially high.

The following two countervailing evolutionary trends are observable:

- Increased medicalization of the institutional long-term care sector, particularly in countries that historically had relatively few freestanding medically oriented facilities and most medically oriented long-term care was provided in hospital or mental hospital settings.
- A move to phase out nonmedically oriented institutions in favor of sheltered housing (elderly service flats).

The net result for the future is likely to be that the institutional long-term care sector in most countries will be more medically oriented. Overall, institutional rates may rise somewhat in countries with historically low use rates--especially where the lack of specialized, medically oriented long-term care has caused the unintended use of general hospital beds for long-term care, and this phenomenon has not been measured sufficiently well to figure in the calculation of national institutionalization rates (e.g., FRG and Britain). On the other hand, overall institutionalization rates may well drop somewhat in those countries with historically above-average use rates of nonmedical institutional facilities (Sweden, The Netherlands), even if use rates of medical facilities rise as many of the nonmedical facilities are phased out and replaced with noninstitutional sheltered housing.

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TABLE 1. Cross-National Projected Institutional Use Rates for the Elderly 65 Years of Age or Over in Medically Oriented and Nonmedically Oriented Long-Term Care Facilities: 1980

Country	Total Institutional	Medical Institutional	Nonmedical Institutional
Use rate in percent			
United States	5.7	4.5	1.2
Argentina	5.0	3.9	1.1
Australia	5.3	4.2	1.1
Belgium	5.7	4.5	1.2
Canada	5.3	4.2	1.1
Costa Rica	4.7	3.7	1.0
Denmark	5.7	4.5	1.2
France	6.1	4.8	1.3
Federal Republic of Germany	5.5	4.3	1.2
Greece	5.4	4.2	1.1
Israel	4.4	3.5	0.9
Japan	4.9	3.9	1.0
Netherlands	5.8	4.6	1.2
New Zealand	5.2	4.1	1.1
Spain	5.3	4.2	1.1
Sweden	5.7	4.5	1.2
Switzerland	5.7	4.5	1.2
Turkey	4.2	3.3	0.9

NOTES: Data are based on U.S. rates. Age- and sex-specific use rates for nonmedical long-term care facilities in the United States are not available. Our best estimate is that the ratio of elderly (65 years of age or over) residing in such facilities (which in the United States are variously termed "domiciliary care facilities," "personal care homes," and "board and care homes" or "rest homes") to elderly residents of nursing homes was 0.27. We have employed this ratio in making the projections.

TABLE 2. Cross-National Projected Institutional Use Rates for the Elderly 65 Years of Age or Over in Medically Oriented and Nonmedically Oriented Long-Term Care Facilities: 1985

Country	Total Institutional	Medical Institutional	Nonmedical Institutional
Use rate in percent			
United States	5.6	4.4	1.2
Argentina	5.2	4.1	1.1
Australia	5.5	4.2	1.3
Belgium	6.4	5.0	1.4
Canada	5.5	4.2	1.3
Costa Rica	4.8	3.8	1.0
Denmark	6.0	4.7	1.3
France	7.0	5.5	1.5
Federal Republic of Germany	6.5	5.1	1.4
Greece	5.8	4.6	1.2
Israel	5.0	3.9	1.1
Japan	5.2	4.1	1.1
Netherlands	6.0	4.7	1.3
New Zealand	5.3	4.2	1.1
Spain	5.6	4.4	1.2
Sweden	6.0	4.7	1.3
Switzerland	6.2	4.9	1.3
Turkey	4.7	3.7	1.0
NOTE: Data are based on U.S. rates.			

TABLE 3. Comparison of Projected Use Rates Versus Actual Institutional Use Rates: 1980

Countries	Total	Medical Facilities	Nonmedical Facilities	Total	Medical Facilities	Nonmedical facilities
	Projected Rate in Percent			Actual Rate in Percent		
United States	5.7	4.5	1.2	5.7	4.5	1.2
Argentina ¹ 1984	5.0	3.9	1.1	<0.1	N/A	N/A
Australia ² 1981	5.3	4.2	1.1	6.4	4.9	1.5
Belgium ³ 1981-1983	5.7	4.5	1.2	6.3	2.6	3.7
Canada ⁴	5.3	4.2	1.1	8.7	7.1	1.6
Costa Rica ⁵ 1980	4.7	3.7	1.0	1.5-2.0	N/A	1.5-2.0
Denmark ⁶	5.7	4.5	1.2	7.0	N/A	N/A
France ⁷ 1982	6.1	4.8	1.3	6.3	5.3	1.0
Federal Republic of Germany ⁸ 1980	5.5	4.3	1.2	3.6-4.5	1.2-3.6	0.9-2.4
Greece ⁹ 1982	5.4	4.2	1.1	0.5	N/A	0.5
Israel ¹⁰ 1981	4.4	3.5	0.9	4.0	1.4	2.6
Japan ¹¹ 1981	4.9	3.9	1.0	3.9	3.1	0.8
Netherlands ¹² 1982-1983	5.8	4.6	1.2	10.9	2.9	8.0
New Zealand ¹³ 1982-1983	5.2	4.1	1.1	6.3-6.7	2.4-2.8	3.9
Spain ¹⁴ 1982	5.3	4.2	1.1	2.0	N/A	2.0
Sweden ¹⁵ 1980	5.7	4.5	1.2	8.7-10.5	4.8	4.1-5.9
Switzerland ¹⁶ 1982	5.7	4.5	1.2	7.8-9.0	2.8	5.0-7.2
Turkey ¹⁷ 1984	4.2	3.3	0.9	<0.2	N/A	N/A

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NOTES: N/A is not available. ISSA is International Social Security Association.

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