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

OVERVIEW OF LONG TERM CARE IN FIVE NATIONS:

AUSTRALIA, CANADA, THE NETHERLANDS, NORWAY, AND THE UNITED STATES

RESEARCH FROM THE INTERNATIONAL COLLABORATIVE EFFORT ON AGING

September 1995

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OVERVIEW OF LONG TERM CARE IN FIVE NATIONS: Australia, Canada, the Netherlands, Norway, and the United States

Joan F. Van Nostrand, D.P.A., U.S. Department of Health and Human Services
Anna L. Howe, Ph.D., LaTrobe University
Betty Havens, D.Litt., University of Manitoba
David Bray, Ph.D., Queen's University
Wim J.A. van den Heuvel, Ph.D., University of Groningen
Tor Inge Romoren, MD, MA, Norwegian Research Council for Applied Social Science
Robert Clark, D.P.A., U.S. Department of Health and Human Services

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INTRODUCTION[1]

Background

The International Collaborative Effort on Measuring the Health and Health Care of the Aging (abbreviated the ICE on Aging) was launched in late 1988. Its sponsor was the National Center for Health Statistics, part of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. The purpose of the ICE on Aging is to support international experts in conducting research to improve the measurement of health and health care of the aging in addressing issues of concern among nations facing the challenges of an aging population. The international emphasis of the research is intended to permit the exchange of multiple perspectives, approaches, and insights. The ICE on Aging was launched with an international symposium in which multiple proposals for comparative research were developed in the areas of health care and health status.[2] Long term Care (LTC) was selected as a research topic because the growth of the older population forecasts an increasing need for such care. Papers concerning LTC at the international symposium focused on issues in measuring outcomes of nursing home care[3,4] and on descriptions of national systems of LTC.[5,6]

The research project of the ICE on Aging chosen to focus on health care was measuring the outcomes of nursing home care.[7] This research has as its goals:

- improving the measurement of outcomes and characteristics of frail older persons in nursing homes
- strengthening the comparability of such data among collaborating countries
- disseminating the results of the research to encourage its international application

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[1] Written by Joan F. Van Nostrand, D.P.A., National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

[2] National Center for Health Statistics. The 1988 International Symposium on Aging. Vital Health Stat 5(6). 1991.

[3] Van Nostrand, J.F. LTC in the US: Issues in Measuring Nursing Home Outcomes. IN National Center for Health Statistics. The 1988 International Symposium on Aging. Vital Health Stat 5(6). 1991.

[4] Kane, R.A. Measuring Outcomes of Institutional LTC, the Problem of Both the Dependent and Independent Variables. IN National Center for Health Statistics. The 1988 International Symposium on Aging. Vital Health Stat 5(6). 1991.

[5] Havens, B. Outcomes of Community and Institutional LTC. IN National Center for Health Statistics. The 1988 International Symposium on Aging. Vital Health Stat 5(6). 1991.

[6] Howe, A.L. Research on Institutional LTC in Australia. IN National Center for Health Statistics. The 1988 International Symposium on Aging. Vital Health Stat 5(6). 1991.

[7] Van Nostrand, J.F. International Collaboration in Measuring Outcomes of Nursing Home Case. IN National Center for Health Statistics. The 1988 International Symposium on Aging. Vital Health Stat 5(6). 1991.

Strengthening measurement and understanding of nursing home outcomes in an international context can lead to greater understanding of approaches to improve outcomes. A team of experts in LTC from five nations was assembled. Each member had knowledge about and access to existing national data sets o nursing home care and its outcomes. Researchers were from Australia, Canada, the Netherlands, Norway and the United States (US).

Purpose

After discussions about the possible approaches for conducting the international analysis, the research team concluded that the initial step in analysis should be to establish the context of the research on outcomes of nursing home care. The purpose of this report is to describe the context of nursing homes and their outcomes in each of the five nations under study. As such, the report provides a background for understanding the structural and cultural context within which LTC is provided. The goal of preparing this report was to ensure that comparisons made in subsequent research on nursing home outcomes would have a valid basis.

The context for research on nursing home outcomes in each nation is described by several types of variables:

- variables about the system of LTC services, such as kinds and mix of LTC services, utilization and payment of nursing home care, and links to acute care and home care systems
- variables about the culture, such as demography, resources allocation to LTC, and role of the family
- variables about the service levels and populations served in nursing homes.

The descriptions about the service levels and populations served in nursing homes were important for identifying which types of nursing homes should be grouped for appropriate comparisons across countries. The year 1985 serves as a focal point for this analysis because, when the research was initiated, it was the only year for which data were available in all five nations. Of course, in each of the nations, the LTC system has evolved considerably since then and continues to do so. However, a comparative analysis of the 1985 data highlighted some surprising similarities.[8] The most surprising was the finding that the percent of persons aged 65 and older who were in nursing hones was very similar among the five nations. In four of the five countries (Australia, Canada, Norway, and the US), 4 to 5 percent of the elderly were in nursing homes providing the highest levels of care. The Netherlands was the exception: only 3 percent were in such nursing homes. A major reason for the lower rate is the higher percent of elderly who reside in supportive housing in the Netherlands.

[8] Van Nostrand, J.F., Clark, R.F., and Romoren, T.I. Nursing Home Care in Five Nations. Ageing International. XX(2). 1993. [http://aspe.hhs.gov/daltcp/reports/nh5nates.htm]

After much analysis of this contextual data, the research teams concluded that comparisons should concentrate on the highest level of nursing home care provided in each nation.[9] The major reason for this conclusion was that the goals, care provided, and resident characteristics in this group of LTC institutions were the most comparable across the five nations.

A detailed analysis of nursing home outcomes in five nations is now underway. A basic question of the analysis is: What can be learned from other nations to improve the outcomes of nursing home care? The chapters in this report provide a context for addressing this question.

[9] National Center for Health Statistics. The 1991 International Symposium on Aging. Vital Health Stat 5(7). 1993.

I. INTERNATIONAL COMPARISONS OF LONG TERM CARE--AUSTRALIA[10]

History and Evolution of Long Term Care

Federal government support for nursing home care began in Australia in 1963, and four phases have been distinguished in subsequent growth.[11] These phases have been defined by major shifts in policy directions, with consequences for the rate of growth of nursing home bed provision and changes in patterns of utilization. As the baseline year for the comparison with other national studies, 1985 is particularly appropriate for Australia as it marks the commencement of a major reform strategy in aged care. Australia has a federal system of government akin to that of the USA and Canada; the terms Commonwealth and Federal Government are used interchangeably. There are six States and two Territories, but for convenience these are all referred to collectively as States. A major factor of the federal system that has shaped the development of long term care over the last thirty years is that while the Federal government has virtually full responsibility for planning and financing residential care, responsibility for community care is cost-shared between the Commonwealth and the States.

Another important feature of the context of residential care in Australia is the high rate of home ownership among the aged. At the 1986 census, some 72% of the population aged 65 years and over were home owners (or purchasers). Some 7% were renters in the private sector, 5% were tenants in public housing, and another 5% had other tenure arrangements. The relatively low proportion of the aged population living in public housing reflects a much stronger policy emphasis on measures to foster home ownership in the early post war years in Australia than on the provision of public housing.

The distribution of the total population aged 65 years and over by living arrangements is summarized in Table I-A. Almost 84% were living independently in the community. The 6% receiving assistance with home help or community nursing are concentrated in the very old age groups, and so account for only a small percentage of the total population aged 65 years and over. While only some 8% of the total population aged 65 years and over is aged 85 years and over, the profile of clients of the Home and community Care Program shows that 23% of frail aged clients (aged 65 years and over) were in this advanced age group.

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[10] Written by Anna L. Howe, Ph.D., School of Health System Sciences, LaTrobe University Carlton Campus, Australia.

[11] Howe AL. Nursing home care policy: From laissez-faire to restructuring, in Kendig H, McCallum J, eds. Grey policy: Australian policies for an ageing society. Sydney: Allen and Unwin, 150-9. 1990.

Some 10% were living in non-private dwellings, which include nursing homes (4.4%), hostels (2.4%) and other forms of sheltered accommodation and congregate housing (3.2%). The next level of care to nursing home care in Australia is provided in hostels, which provide congregate living and personal and social care, but not continuous nursing care. All hostels recognized for Federal funding were provided by the voluntary non-profit sector until 1991. As of mid 1985, the maximum subsidy attracted for hostel care was about 25% of the lowest level of benefit paid for nursing home care, and there were then half as many hostel beds as nursing home beds. A major policy concern since 1985 has been to change the balance between nursing home and hostel care. The measures taken to this end and their outcomes are major themes in current policy development.

TABLE I-A: Living Arrangements of Population Aged 65 Years and Over, 1986

	Percent Distribution
Living in the Community	
Independent	83.8
Assistance with home help and/or domicilary nursing[1]	6.2
Sheltered accomidation[2]	3.2
Residential care	6.8
Hostel	2.4
Nursing home	4.4

1. Non-private dwelling other than hostels or nursing homes.
2. Estimated on basis of 1988 survey of aging and disability conducted by the Australian Bureau of Statistics.

The level of support provided in other kinds of sheltered accommodation varies widely, from minimal support in boarding houses to care equivalent to hostels. Provisions were introduced in 1991 to enable residents in private sector facilities providing equivalent care to hostels to receive hostel care subsidies, subject to approval of the facility on the basis of defined outcome standards.

Acute hospitals are not regarded as providing long term care for the aged. Rates of admission to acute hospital care increase over the older age range from 316 per 1000 at age 60-64 years to 531 per 1000 at age 85 years and over, and average length of stay increases from 7 to 16.5 days. While some individuals do have protracted stays in acute care, they are exceptional, with the great majority of those requiring long term care being discharged to nursing homes after relatively short stays in acute hospitals.

A final note on the general context of residential aged care is that very little long term care is now provided in psychiatric hospitals or mental institutions. The decline in these facilities over the last 25 to 30 years parallels the growth of nursing homes over that time. In New South Wales, for example, the number of long stay beds in psychiatric hospitals fell from about 12,700 in 1959 to only 2,680 in 1985; nursing home provision increased from 10,000 in 1965 to 30,130 in 1985. Similar declines occurred in other States, and by the mid 1980s, the national ratio was about 15 nursing home beds for every long term care bed in psychiatric facilities.

The growth of nursing home care in Australia can be summarized on the basis of the four main policy phases and the years for which data are given in Table I-B have been selected to mark the turning points of these phases.

TABLE I-B: Growth of Nursing Homes, by Sector of Provision 1963 to 1990						
Year	Sector				Percent Increase Per Year	Beds/1000 65 yrs +
	Private For Profit	Voluntary Non-profit	Public	Total		
1964	18,322[1]		10,353	28,685		29.4
1972	38,244[1]		13,042	51,286	9.8	45.9
1977	31,993	11,439	13,080	56,512	2.0	44.4
1981	37,740	15,414	14,758	67,912	5.0	46.9
1985	41,750	18,706	14,746	71,503[2]	2.7	45.3
1990	42,166	17,483	12,966	72,615	0.3	38.1
Percent Distribution						
1964	63.9[1]		36.1	100.0		
1972	74.6[2]		25.4	100.0		
1977	56.6	20.3	23.1	100.0		
1981	55.6	22.7	21.7	100.0		
1985	56.0	25.1	19.8	100.0		
1990	58.0	24.1	17.9	100.0		

1. The private for profit sector and the voluntary not for profit sector came under the same Commonwealth funding arrangements until 1974. The voluntary sector then came under separate arrangements until all funding arrangements were restructured and unified in 1987.
2. In 1985, there were 3699 beds in nursing home beds catering mainly for younger disabled people which were subsequently transferred to the Disability Services Act; these beds have been subtracted here for comparability with subsequent aged nursing home bed provision.

From 1963 to 1972

The payment of Commonwealth benefits for nursing home care began in 1963. Prior to that date, long term care for chronically ill aged people was provided in a variety of public and private hospital facilities, in convalescent and rest homes, and as already noted, in long term psychiatric hospitals. At that time, the Pensioner Medical Service (PMS) provided public hospital care for those receiving the Age Pension and who met a means test for the PMS; just over 40% of the population of pensionable age (60 for women and 65 for men) were eligible for the PMS. Those who were not eligible could only receive Commonwealth benefits for hospital care in private hospitals only if they also belonged to a private health insurance fund.

These funding arrangements were proving increasingly unsatisfactory for long term care on at least four grounds. First, those who did not take out private insurance, or could not afford to, but who did not qualify for the PMS, were faced with increasing costs for prolonged stays in hospital. Second, the private health funds imposed numerous conditions, such as maximum payments and maximum periods of payment, which effectively excluded long term cover even for insured patients; those who could not afford the full cost of continuing hospital care were discharged to a variety of convalescent and rest homes that were not recognized for health insurance purposes.

While offering care at lower cost that hospitals, a third set of problems arose from the mounting costs and variable standards of care for those needing prolonged care. Finally, public hospitals were caring for increasing numbers of chronically ill pensioners who could be more appropriately cared for in other forms of accommodation.

To remedy these problems, the Commonwealth introduced Nursing Home Benefits which were paid irrespective of the individual's pension status or their participation in private health insurance. The benefits were paid to patients in facilities that were specifically approved as Nursing Homes. As well as long stay wards of public hospitals, many small private hospitals which essentially provided long term care switched from hospital funding to the new provisions and these also extended to some of the convalescent facilities which were not previously recognized. There was thus considerable variety in staffing and other aspects of the facilities initially approved to receive Nursing Home Benefits, and as approval was left to State Governments, there was further variation from State to State.

Having introduced Nursing Home Benefits, the Commonwealth took little other part in policy development. Reflecting this non-interventionist role, the period from 1963 to 1972 has been described as period of *laissez faire policy*, during which the Commonwealth did little more than pay benefits for residents in approved nursing homes. Approval of homes depended on Commonwealth acceptance of facilities which met State requirements. States also defined staffing levels and over time, considerable divergences developed between the states in the level of bed provision, staffing, fees and benefits. There were no controls over the growth or distribution of facilities, nor over admissions or the level of fee that could be charged above the benefit. By the late 1960s, concerns about standards of care and the overall operation of nursing home care were becoming widespread.

The result of this laissez faire policy approach was a rapid growth in provision, averaging almost 10% p.a. to 1972. Many existing facilities that had been small convalescent hospitals in the private and voluntary sectors were initially approved for benefit purposes, as were long stay wards in public hospitals. Almost as many new beds again were established over the next eight years. The growth of private and voluntary sector provision contrasted with the stagnation of provision by State governments, with the public sector declining from 36* of provision in 1964 to about 25% in 1972.

From 1972 to 1981

Commonwealth policy in this phase had three main concerns: to control the rapid growth of provision and expenditure of the preceding years, to gain some control over admissions, and to address the interstate variations in fees and benefit levels that had emerged. Several regulatory measures were introduced to control growth of beds, admissions and fees in this period of policy by regulation. These measures were largely administrative and did not achieve their intended outcomes, with fluctuations in growth over this time rather being due to other factors.

Thus, while the level of growth of provision fell substantially between 1972 and 1977 compared to the earlier period, this outcome was not so much due to the success of the regulatory measures introduced but to the virtual cessation of approvals of new nursing homes during the three years of the Labour Government from 1972 to 1975, and the effect carried over the next few years. With the change of government in late 1975, approvals a higher rate of approval of new development resumed, and this growth became evident from 1977 as homes came into operation. The scale of this rapid growth, combined with the collapse in 1981 of private health insurance coverage of insured nursing home patients which had applied from 1978, attracted considerable policy interest. Concurrently with the instigation of an inquiry by the Commonwealth Auditor General, a more concerted effort was made to limit growth from 1981.

One key measure that was introduced in 1974 was the differentiation of funding arrangements for the voluntary non-profit sector from those applying to the private for profit sector. This step was initially intended to assist in controlling expenditure by breaking the nexus between fees charged and benefits reimbursed, but at the same time allow for higher funding to preserve the standard of care that was seen to be offered by the voluntary homes. However, the new deficit financing arrangements lacked strong cost controls, and when combined with capital subsidies available to the voluntary sector, the outcome was a more rapid expansion in provision and payments to the voluntary sector than to the private sector.

The late 1970s and early 1980s saw a return to a higher rate of growth, but the impact on the Commonwealth budget was blunted by moves that required private health insurance funds to pay nursing home benefits for patients who had private insurance. These arrangements could not however be sustained and the return of full funding to the Commonwealth in 1981, compounded by escalation in costs due to rapid growth in provision, brought increased policy attention to long term care. The neglect of community care was equally apparent; a major factor inhibiting development was identified as cost-sharing arrangements between the Federal and State Governments.

From 1981 to 1985

This period saw a number of major inquiries into long term care in Australia. The level of concern is indicated by the bodies involved, which included the Commonwealth Auditor General, the House of Representatives Standing Committee on Expenditure and a Senate Select Committee.

The House of Representatives Inquiry reported in late 1982 and provided the basis of policies adopted by the incoming Labour Government in 1983. Implementation of these policies began in the 1984-85 budget and was consolidated in the report of the Nursing Homes and Hostels Review which was undertaken by the then Department of Community Services to provide a response to the issues raised by the Senate Select

Committee. That report provides a baseline account of the Australian residential care system as it was in 1985.[12]

A major program of restructuring residential care was commenced from early 1986, based on the following four principles:

- Aged and disabled people should as far as possible be supported in their own homes, in their own communities.
- Aged and disabled people should be supported in residential services only where other support systems are not appropriate to their needs.
- Services should be provided in an atmosphere and using processes which promote as far as is possible rehabilitation and restoration of function. The manner in which services are provided should develop and enhance personal freedom and independent functioning.
- Services should be based on a recognition that for many people, discharge to a less supported residential service or to a community based support service will be a possible and desirable outcome.

1986 to the Present

The major reforms in nursing home care implemented over the last five years have focused on five main areas:

– planning processes for development of residential care to control growth of nursing homes and to foster hostel provision;
– the introduction of pre-admission assessment by multidisciplinary Geriatric Assessment Teams;
– the development and application of a five category system of funding of nursing home care, related to resident dependency;
– attention to special needs in long term care, including provision for dementia care, particularly in hostels, and the needs of particular groups such as the ethnic aged and older Aboriginal people; and
– the specification of outcome standards and implementation of monitoring procedures.

A major expansion and enhancement of community care has accompanied the restructuring of residential care, and the reform strategy reached its mid point in 1990-91, with overall goals expected to be achieved by 1995-96. Progress with the strategy and outcomes of the measures introduced to date have been assessed in a mid-Term

[12] Department of Community Services. Nursing homes and hostels review. Canberra: Australian Government Publishing Service. 1986.

Review of the Aged Care Reform Strategy, and many of the analyses presented below are drawn from this Review.[13]

Overview of the Current System and Recent Trends

Demography

Australia is experiencing rapid aging of its population over the decade from the mid 1980s to the mid 1990s. The population aged 65 years and over is estimated to increase by 31% from 1986 to 1996, and the 80 years and over population by 56%. Thereafter, the increase in the population aged 65 years and over falls to 17% from 1996 to 2006. The three main factors contributing to the present rapid aging are: the large birth cohorts of the decade after the World War I; the influx of young adults who migrated to Australia in the years after World War II and who are now reaching old age, making the aged population increasingly diverse as well as increasing its size; and improvements in mortality at older ages.

The effects of changes in birth rates, mortality and immigration are taken into account in the population projections prepared by the Australian Bureau of Statistics with four sets of projections being prepared using different assumptions.[14] The Series D projections are accepted as representing the most likely future, hence Series D figures are cited here. The assumptions in the Series D projections are:

- Mortality to decline to 1996 according to short term rates of mortality decline, and from 1996 to 2031 according to long term rates of mortality decline.

- Fertility to decline to from 1989 rate to 1.66 children per woman in 1998, and remain constant thereafter.

- Overseas immigration at 125,000 annually to 1993/94, then declining linearly to 80,000 per year by 1998/99 and maintained at that level thereafter.

Notwithstanding the rapid increase in the aged population, Australia is relatively young by international standards. In 1990, some lit of the population was aged 65 years and this will reach 12% in 2001. Further figures in Table I-C show that dependency ratios remain relatively stable for some time. The baby boom in Australia was later and longer than in North America, and this generation will boost the workforce ages groups until well after the turn of the century. Declines in the birthrate and hence fewer young dependents offset the increase in old dependents, so there is very little change in overall dependency ratios.

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[13] Department of Health, Housing and Community Services. Aged care reform strategy, Mid-Term review, Report. Canberra: Australian Government Publishing Service. 1991.

[14] Australian Bureau of Statistics. Projections of the Populations of Australia. States and Territories, 1989 to 2031. Australian Government Publishing Service. 1990.

The age structure within the aged population is affected by the more rapid increases in the older cohorts than in the younger cohorts. The proportion of the population aged 65 years and over that is aged 85 years and over increases from under 8% in 1990 to almost 11% in 2001. It is this rapid increase in the old old cohorts that has greatest implications for aged care services.

Life expectancies at older ages have increased in Australia in recent years. In 1971, life expectancy at age 60 was 15.5 years for men and 19.8 years for women; in 1986, these figures were 18.1 and 22.2 years respectively. Life expectancy at birth in 1986 reached 73 years for men and 79 years for women.

TABLE I-C: Demographic Data, Population Aged 65 Years and Over: Australia, 1986 to 2031

Year	Census	Projections			
	1986	**1990**	**2001**	**2021**	**2031**
Number in Thousands					
Total population	15,600	17,100	19,500	22,300	23,300
65 years of age and over	1,647	1,906	2,392	4,000	5,064
85 years of age and over	127	150	262	451	631
Percent					
65 years of age and over	10.6	11.1	12.3	17.9	21.7
Age 15-64	66.2	67.0	68.0	65.7	62.7
Age 0-14	23.2	21.9	19.7	16.4	15.6
Percent 65 and over population aged 85 and over	7.7	7.8	10.9	11.3	12.5

Provision

In 1985, the total of 71,500 beds gave a ratio of 44.4 beds per 1000 aged 65 years and over. This total is nett of some 3,700 beds in homes that catered for younger disabled people, which in line with reforms in disability programs following on from the International Year of the Disabled Person in 1981, were transferred out of the aged care program.

In recognition of the advanced age of nursing home residents, some two thirds of whom are over 80 years of age, age 70 was adopted for planning purposes in 1986. The ratio of provision on this basis was 67.2 beds per 1000. Together with hostel provision of some 33 places per 1000 aged 70 years and over, total residential care was 100 places per 1000. There was however considerable variation in nursing home provision between the States, the ratio varying from 53 per 1000 in Victoria to 74 per 1000 in New South Wales, Western Australia and Tasmania.

The distribution between sectors of provision in 1985 was 47% of beds in private-for-profit homes, 33% in voluntary nonprofit homes and 20% in public homes operated by State governments. The three sectors of provision vary in many aspects of their structure and functioning. In terms of size for example, State Government homes tend to be the largest; 65% of public beds were in homes of 100 beds or more. Many private

homes fall in the 30 to 60 bed range; 75% of private beds were in homes with 80 or fewer beds and only 20% in homes of 100 or more beds. Some 65% of beds in voluntary sector homes are in homes of 80 or fewer beds, but some 20% are in homes of 100 beds or more; voluntary sector homes also often operate in conjunction with other levels of care, particularly hostels. The sectoral pattern of provision has remained stable for the last five years, with a marginal decline in the public sector. All sectors are covered by Commonwealth funding, as described below.

Planning

Nursing home care in Australia is planned as a national program, administered by the Commonwealth Department of Health, Housing and Community Services. A central element in program planning is the needs-based planning process that controls the growth and distribution of facilities and the approval of provider organizations. Limited planning processes were introduced in 1972, but have since been elaborated and extended to hostel provision as well as nursing homes.

The principal means for controlling overall growth of nursing homes, and for changing the balance between nursing home and hostel provision, has been the establishment of planning ratios to guide residential care development over the next 20 years. The ratios were set to achieve 40 nursing home beds and 60 hostel places per 1000 aged 70 years and over by around 2006, effectively reversing the balance existing in 1985. The figure of 40 nursing home beds was determined on the basis of the number of residents who were receiving the “extensive care” benefit. It was considered that the dependency of those who were receiving the "ordinary care" benefit did not warrant the level of care available in a nursing home and that such individuals would in future be cared for in hostels or in the community, as an expanded range and level of community services became available under the Home and Community Care Program.

The ratios are applied at a regional level and hence have a considerable impact on the distribution of facilities. The needs-based planning processes which incorporate the ratios are along the lines of Certificate of Need approaches and take account of a range of population characteristics and the availability of other services. These planning processes are central to the objectives of the reform strategy that are concerned to overcome the marked variations in provision between regions and between States which existed in 1985. As most regions had more than 40 nursing home beds per 1000 aged 70 years and over in 1985, the main factor bringing about change has been the growth of the aged population. There have been only marginal additions to bed provision, and these have been concentrated in areas of very low provision. It is estimated that only some 6000 new nursing home beds will be required from 1986 to 2006 to bring all areas up to the planning ratio. In contrast, there was considerable scope for expansion of hostel provision; further, largely due to the absence of any previous planning controls on hostel provision, regional variations were even more marked than for nursing home provision and new provision was to be distributed to overcome these variations. The outcome of these planning processes has been a decrease in the ratio of nursing home provision and an increase in hostel provision, in

line with the objective of changing the balance between these forms of residential care. The actual ratios for 1985 and at mid 1991 are set out in Table I-D, together with the ratios projected for 1991 and 1996 made in Nursing Homes and Hostels Review; those projections were made with the objective of achieving ratios of 40 nursing home beds and 60 hostel places per 1000 aged 70 years and over, over a period of 20 years.

The nursing home ratio has fallen by 10 beds per 1000 aged 70 years and over. The actual ratio of 56.8 in 1991 was below the projected ratio of 59.2, due to a combination of greater than expected growth of the aged population, especially the population aged 80 years and over, and a relatively low level of provider interest in further nursing home development. In line with these trends, the ratio projected for 1996 should be easily reached, and may be even lower.

Hostel provision has grown more slowly than expected, largely due to the lag between approval, development and opening of hostels. The ratio of 36.5 in 1991 was below the projected ratio, but if the level of growth reached in 1991 is sustained, the ratio should come closer to reaching the future planning targets. The extent of change in the balance between nursing homes and hostels is seen in there being 1.6 nursing home beds for every hostel place in 1991 compared to 2 to 1 in 1985.

Variation in provision between the States and between regions has also been reduced. Whereas 41 regions had more than 60 nursing home beds per 1000 aged 70 years and over in 1984, only 24 had such high provision in 1990. Only three regions had less than 40 nursing home beds per 1000 aged 70 years and over in 1991.

TABLE I-D: Residential Care Provision Ratios, 1985 and 1990 Places Per 1000 Aged 70 Years and Over

	Year	Total	Hostels	Nursing Homes
Actual	1985	100.0	32.8	67.2
	1991	93.3	36.5	56.8
Projected	1991	100.0	40.8	59.2
	1996	100.0	47.4	52.6

Funding

In the past, substantial capital has been provided to the voluntary sector for the development of nursing homes under Commonwealth programs. In line with growth controls, only limited capital funding is now provided, and is targeted to special needs groups, such as the ethnic aged and Aboriginals, who face difficulties raising their own funds.

In 1985, different arrangements for Commonwealth recurrent funding applied to each sector of provision, and a differential of about 30% had emerged between sectors. There were also differentials between the States as Commonwealth funding then based on staffing levels set by the States. The Commonwealth related benefits to the concept of a standard fee, defined as the resident contribution of 87.5% of the Age Pension plus rental assistance. Benefits were set for each State to ensure that the standard fee

covered the actual fees charged for 70% of beds in non-government homes, with the aim of ensuring access for residents whose only income was the Age Pension and rental assistance.

With benefits effectively making up the difference between the standard fee and fees charged, homes frequently sought to increased their fees and hence increase the benefits. In an effort to control these pressures, the Commonwealth moved to make approval of fee increases and justification of expenditure a condition of receiving benefits. While bringing some control over escalating costs, continuing problems arose from the widening gap between benefits and fees in the 30% of homes which were outside the standard fee arrangements. The substantial inequities that these differences represented were a major factor prompting reform of funding arrangements.

A single set of new recurrent funding arrangements covering all sectors has been introduced from 1987. All private and voluntary sector homes are now funded under these arrangements. The new arrangements comprise a Standard Aggregated Module (SAM) that covers infrastructure costs and a Care Aggregated Module (CAM) that covers costs of nursing and personal care. SAM is paid at a standard rate and hence gives incentives to contain these costs, while CAM is paid according to resident dependency and care provided, and hence creates incentives to admit more highly dependent residents. Funding under CAM relates to standard hours for nursing and personal care staff, set for the five categories of resident dependency determined on the basis of the Resident Classification Instrument.

Changes in funding of government homes is being negotiated between the Federal and State governments to bring these homes under the CAM/SAM funding arrangements. State Governments are currently responsible for funding the ancillary services that operate in conjunction with State homes, such as slow stream rehabilitation and respite care units, and which are not provided on the same scale in other homes under CAM/SAM. These services give government homes a somewhat different function vis-a-vis private for profit and voluntary homes.

The fee paid by residents has been standardized in all but a very small number of beds in "exempt" homes. As of July 1, 1991, no resident is required to pay more than 87.5% of the Age Pension plus rent assistance; the standard resident contribution amounted to $US 120 per week in mid 1991. The resident contribution covers about 25% of the total average weekly cost of nursing home care. Residents who receive only part pensions because their income exceeds the limit of the income test applied for the Age Pension must make up the difference between their part pension and the 87.5% amount. However, 80% of all residents are full pensioners, and only 6% have sufficient income to exclude them from receiving any pension. As the Age Pension is a Commonwealth social security benefit, the Commonwealth effectively meets a very large share of the total cost of nursing home care.

A small number of homes have been granted "exempt" status in regard to the standard fee setting procedures and resident contribution. These homes are not

however exempt from other Commonwealth regulations, including outcome standards. Exempt homes may charge additional fees for services not covered under CAM and SAM, and the rate of Commonwealth benefit paid is reduced in proportion to the additional fees charged. Exempt homes account for only 1% of beds at present, with provision for up to 6% of beds to be granted exempt status. The present funding arrangements for nursing home care need to be set in the context of universal health insurance, also called Medicare in Australia, that covers medical and hospital services, and the Pharmaceutical Benefits Scheme that covers prescription drugs. Medicare reimburses medical services on the basis of a schedule of standard fees, and provides access to public hospital care free of charge. Private health insurance is available only for hospital care and gives access to both public and private hospitals for patients seeking private patient status which gives them choice of medical practitioner.

Care Services

All nursing homes in Australia are expected to provide the same kinds of care and funding is allocated on the basis of overall resident dependency. Staffing requirements are specified only in regard to the presence of a registered nurse on duty at all times. The total hours provided and mix of staff generated by CAM are notional only, and the Director of Nursing has considerable flexibility in deploying staff resources. In determining the notional hours, allowance is made for one hour of Director of Nursing time per resident per week, with the remaining hours distributed 32.5% to registered nurses, 59.5% to enrolled nurses or nurse assistants, and 8% for therapy.

Differences in the range and level of services are apparent in relation to size of facility and whether or not the nursing home operates in conjunction with other types of residential care, notably hostel care. Public sector homes especially offer more medical input and active rehabilitation rather than maintenance programs. These services in State nursing homes are funded by State Governments, usually as part of hospital budgets.

Some homes develop a particular emphasis in their services through specialization and resident selection. Three examples illustrate. First, some homes cater for special needs groups, such as ethnic groups or Aboriginals and Torres Strait Islanders; most of these homes are operated by relevant community organizations. Care practices are modified to recognize the culture of residents, with employment of staff of the same linguistic and cultural background being a critical factor. Some mainstream homes are moving to cater for ethnic communities in their locality by having a "cluster" of residents from a common background and making appropriate provision in care services.

Second, some homes have developed special psychogeriatric units. There are only a very small number of such units to date, and there is no special recognition in funding. These units are mainly for dementia care, and in the public sector, services may be provided in conjunction with State psychiatric services. Third, and again on a

very limited scale so far, some homes specialize in palliative care, often in conjunction with community services.

The type of therapy provided in nursing homes is appropriately described as maintenance therapy in comparison to post-acute rehabilitation, which in Australia is provided in a variety of hospital settings in Australia. Geriatric units in the public hospital system are major providers of slow stream rehabilitation for elderly patients, often following on from more intensive therapy. The therapy staff hours in nursing homes cover physiotherapy, occupational therapy, diversional therapy, hydrotherapy and podiatry. Some homes also offer programs of music therapy and programs for dementia sufferers including reality orientation and validation therapy. The expansion of these therapies is being promoted through education and training initiatives.

Outcome Standards

The Federal Government exercises on-going control over nursing home care through setting and monitoring outcome standards. While taking account of individual resident records and well-being, these outcomes are facility based and assessed for the home rather than for each resident. The 31 outcome standards cover seven areas: health care, social independence, freedom of choice, homelike environment, privacy and dignity, variety of experience and safety. The outcome standards are monitored by Standards Monitoring Teams that visit each home at least once every two years, and where shortcomings are found, recommendations are made for remedial action. Sanctions can be imposed by way of suspending payment of benefits for new residents, effectively precluding admissions to fill vacancies, and hence incurring a loss of income, but still maintaining funding for remaining residents. The Federal Government also operates complaints units and advocacy services as part of a User Rights strategy which includes a Charter of Residents' Rights and Responsibilities, a formal Agreement between the operator and resident, and community visitors schemes.

State government involvement in the administration of nursing homes is limited to registration and licensing, some standards monitoring and the application of guardianship legislation as required by individual residents. There is considerable variation in each of these areas from State to State. States have control over registration and licensing of nursing homes, these provisions generally being consistent with other health facilities under State control. These provisions cover the registration of the licensee and principal administrator as "fit and proper persons", and the construction and maintenance of buildings. State Governments and Local Governments also have control over landuse planning and so can affect the exact location and design of a nursing home.

It is in their approaches to setting and monitoring of care standards that the States vary most widely, and also vary from the Federal approach. State approaches generally focus on inputs while the Federal standards are outcome oriented. In moving towards more outcome oriented approaches, some States have integrated the Federal standards with their own and carry out joint monitoring. Other States have "left the

running" in the area of standards to the Federal Government and could be said to be in the process of vacating this area.

As a result of this uneven development of State standards, and varying approaches to complaints, sanctions and appeals, there is some scope for tension and conflict. Problems arise less from overlap and duplication of specific regulations than from the consequences of their interpretation in terms of outcome standards; for example, the federal system accepts State regulation in areas such as fire and safety provisions and urban planning, but a facility that met all the State requirements in these areas could fall short of providing an environment that was judged homelike according to the Federal outcome standards.

Monitoring and Data Sets on Nursing Home Care

The development of information systems has been a major adjunct to improved planning and program monitoring over the last five years. Administrative systems now generate large scale routine data sets on many characteristics of nursing home residents and their use of nursing home care. An annual statistical overview is published covering details of admissions, current residents and separations; these data can be also be analyzed by admission cohort. These data cover demographic characteristics, dependency and utilization of nursing home care in terms of length of stay and mode of separation, and are available by sector of provision and by State. The Geriatric Assessment Program is also closely monitored, with evaluation units established in each State for this purpose. Nursing homes were covered in the 1981 and 1988 surveys of disability conducted by the Australian Bureau of Statistics. Results of these surveys enable comparisons to be made between the population of residential care facilities and those living in the community, but are less useful for detailed analysis of the resident population. The measures of disability and handicap used in the surveys followed WHO conventions and are not sufficiently fine grained for describing the residential care population in any depth.

A range of other research studies have been conducted in nursing homes. The 1990 edition of the Ageing Research Directory[15] detailed studies of nursing practice, resident characteristics, provision and use of residential care services, and standards and quality of care. Many of these studies involved only small samples or case studies of selected groups of residents or particular services and so have only limited generalisability to the total residential care system. An important issues for future research is to develop methodologies and analytic techniques that will combine the use of the large scale data sets now becoming available and other data collections, and apply them to modelling various aspects of the long term care system.

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[15] Office for the Aged, Commonwealth Department of Community Services and Health. Ageing Research Directory, 1990. Canberra: Australian Government Publishing Service. 1990.

Assessment

Assessment for nursing home care in Australia occurs in two stages. Eligibility for admission is first determined by a Geriatric Assessment Team, and once admitted, each resident's care needs are assessed by the Director of Nursing.

Pre-admission Assessment

The Geriatric Assessment Program implemented since the mid 1980s provides multi-disciplinary assessment prior to admission and Geriatric Assessment Teams (GATs) have authority to approve nursing home admission. GATs now operate in all but some remote regions; the regions not served account for only 4% of the total population aged 70 years and over. The process of delegation of approval for admission to residential care is proceeding so that pre-admission assessment will be mandatory by 1992.

The assessment program is jointly funded by the Federal and State governments, and most GATs operate through State hospitals or other State health services. Geriatric assessment services were operating in some States prior to Federal funding, but their role was limited to assessing patients who were seeking admission to State nursing homes. Now, as well as being "gatekeepers" for all nursing home and hostel admissions, GATs refer clients to a wide range of services, in particular having access to rehabilitation and other medical services in the hospitals with which they are associated.

The GAT program is closely monitored, and national data for the period July to December 1989 showed that only some 24% of all clients referred to GATs were recommended for nursing home care, 36% were recommended for community care, and just on 10% were recommended for hostel care. An intermediate outcome of a recommendation for rehabilitation was made for 14% of clients and another 16% had other recommendations made (including no change in present care arrangements), or withdrew or died before completion of the assessment. Recommendations for nursing home care were strongly associated with the client's being in an acute hospital at the time of assessment; a client who was assessed in an acute hospital was about twice as likely to have a recommendation made for nursing home care as was a client who was living in the community at the time of assessment. A number of follow-up studies now underway as part of the program monitoring are showing a high degree of correspondence between the recommendations made by GATs and actual client outcomes. On the basis of the longest established GATs, it is expected that around 10% of the population aged 70 years and over will be seen annually when GATs are fully operational.

Classification of Resident Care Needs

The second stage of assessment occurs after admission and is carried out by the Director of Nursing, using a standardized schedule, the Resident Classification

Instrument (RCI). The initial RCI introduced in mid 1988 covered 11 areas of resident care: need for assistance in transfer, ambulation, toileting, bathing, dressing, and eating, continence of urine and faeces, prevention of pressure areas, specialized nursing procedures and behavior. Different weightings attach to each of the 11 items, the behavior item having the highest weight; this item serves as a surrogate indicator of dementia.

An overall service need rating (OSN) is also made on a six point scale. The OSN serves as an independent variable to which scores on the 11 individual items and the total RCI score can be compared. The OSN has also been used to check variations in RCI scoring between homes.

In trials carried out in developing the RCI, the 11 items were found to explain 71% of the variance in resident care need as measured by the OSN. The RCI has also gained wide acceptance in the field. In accord with an undertaking given when it was introduced, the RCI was reviewed in late 1990. The report of the CAM Review[16] canvassed a number of aspects of the RCI that had been found to be problematic and proposed revisions to some items of the RCI and in administration. The adequacy of the behavior item as an indicator of care needs associated with dementia and other behavioral problems was especially criticized. A trial of a revised RCI has been conducted and pending the outcome of analysis, a revised instrument will be implemented in 1992.

The RCI is the basis of the five level classification of resident dependency which replaced the two-tier system of "ordinary" and "extensive" nursing care. The hours of nursing and personal care and benefits paid for each RCI level are detailed in Table I-E. The amounts of benefit shown are national averages, as while payments are based on the standard hours shown for each RCI level, actual payments take account of differences in wage rates between the States.

TABLE I-E: Hours of Nursing and Personal Care and Funding, by Dependency Category, 1991

Resident Classification Instrument (RCI)	Nursing and Personal Care Hours Per Resident Per Week	Average Benifit[1] $ US Per Week[2]
1	27.0	537
2	23.5	464
3	19.5	394
4	13.0	298
5	9.0	234

1. Excluded resident contribution of $US 120 per week.
2. Calculated on $US = $Aust 1.25 in mid 1991.

It is pertinent to note here that increases in subsidies for hostel care over the last five years have substantially reduced the gap between funding of hostels and nursing

[16] CAM Review Steering Committee, Department of Community Services and Health. CAM Review Report to the Minister for Aged, Family and Health Services. Canberra: Australian Government Publishing Service. 1990.

home care. In mid 1985, the highest level of hostel funding was equivalent to only 25% of the lowest level of nursing home benefit then paid (based on figures for New South Wales). As of mid 1991, the highest level of hostel subsidy amounted to 62% of the lowest nursing home benefit.

Resident Characterisitcs and Use of Nursing Homes

Information presented here on the characteristics of nursing home residents and their use of nursing homes is taken from material compiled for the third edition of Nursing Homes for the Aged -- A Statistical Overview. These data cover admissions to and separations from nursing homes from 1 July 1989 to 30 June 1990; data on residents are for those who were in nursing homes on June 30, 1990. Age 70 is used to define the base population for planning of residential care, data are compiled accordingly.

Demographic and Social Characteristics

Age, sex and marital status--of the 70,987 residents in nursing homes at June 30 1990, 73W were women. New admissions have a somewhat age distribution than residents. of those newly admitted in the year to June 1990, 14% were aged under 70 years, 30% were aged between 70 and 80 years, and 56% were aged 80 years and over; for residents, the proportions were 19%, 24% and 64% respectively. Full details of age and sex are given in Table I-F. Some 53% of residents were widowed and only 25% were married; the proportion widowed varied from 27% for men to 62% for women.

TABLE I-F: Age and Sex of Nursing Home Residents, 1990

Age Group	Total	Males	Females
Number			
Total	70,987	19,368	51,619
Under 70	7,968	4,011	3,957
70-74	5,920	2,418	3,502
75-79	11,565	3,858	7,707
80-84	15,626	4,036	11,589
85-89	15,784	3,107	12,677
90 years and over	14,125	1,938	12,187
Percent			
Total	100.0	100.0	100.0
Under 70	11.1	20.6	7.5
70-74	8.3	12.4	6.7
75-79	16.2	19.9	14.9
80-84	22.0	20.8	22.4
85-89	22.2	16.0	24.9
90 years and over	19.8	9.8	23.4

Living arrangements prior to admission--Living arrangements prior to admission can be described in terms of the individual's accommodation and with whom they were living or family composition. In terms of accommodation, 69% had lived in independent housing in the community, including some 7% who were living in self contained units in

aged persons, housing projects. Another 24% were in hostels and the remaining 7% in other forms of sheltered accommodation, mostly boarding houses.

There is great variety in family composition prior to admission. One third of residents had been living alone prior, 19% with their spouse only and some 22% had lived with various family members: only 3% involved spouse and other family, 14% involved children and 5% involved other relatives, mostly siblings. The remaining 25% lived with others than family. This last group largely corresponds with those living in hostels and other forms of sheltered accommodation, only a small proportion of whom would live with spouses or siblings.

Ethnicity--The great majority of residents (77%) were born in Australia and another 12% were born in the UK or Ireland. The diversity of the overseas born population is seen in the 7% of residents with European birthplaces coming from more than 30 different countries.

Prior hospitalization--Some 63% of all residents had been admitted to the nursing home from an acute hospital, with hospital admissions being slightly more common for men (67%) than for women (61%). A higher proportion of residents in government homes (70%) had been admitted from acute hospitals than had residents in private homes (65%) or voluntary homes (55%). These differences reflect different functions of government homes, and lead to different outcomes.

Dependency Profile

The dependency profile of residents can be described in terms of the proportions requiring care for ADLs and other areas, and by the distribution of overall dependency as measured by the RCI. The ADL and other items in the RCI are each scored at four levels of need for personal assistance: independent / no assistance; supervision only; some personal assistance / moderate or intermittent care / and full assistance / constant care. The proportion of residents requiring at least some personal assistance (scored in the higher two of the four responses on these RCI items) is set out in Table I-G.

Resident dependency is summarized in the distribution between RCI categories. Category 1, the highest dependency group, accounted for 6.6% of residents and Category 5, the lowest dependency group, for 11.1%. The full distribution is given in Table I-G.

TABLE I-G: Resident Dependency, 1990	
Proportion of Residents Requiring Persona Assistance	
RCI Item	Percent Requiring Personal Assistance
Needs personal assistance in:	
Transfers	75.9
Ambulation	69.4
Toilet	80.1
Bath/Shower	96.7
Dressing	93.7
Bathing	49.5
Moderate to high care need:	
Incontinent: Urine	59.5
Incontinent: Feces	26.0
Pressure Care	67.5
Specialized nursing	25.4
Behavior	61.1

Distribution of RCI Scores					
RCI Item	RCI Category -- Percent of Residents				
	Low 5	4	3	2	High 1
Needs personal assistance in:					
Transfers	9	51	89	99	100
Ambulation	6	39	81	96	100
Toilet	8	60	96	99	100
Bath/Shower	74	98	100	100	100
Dressing	53	95	100	100	100
Bathing	1	11	51	85	97
Moderate to high care need:					
Incontinent: Urine	7	28	69	87	90
Incontinent: Feces	1	5	23	46	69
Pressure Care	2	29	81	98	100
Specialized nursing	6	14	19	38	76
Behavior	20	49	53	88	100
Total	100	100	100	100	100
Percent in category	6.6	26.3	36.0	20.0	11.1

NOTE: RCI is Resident classification instrument.

Length of Stay and Separations

The length of stay of residents who left nursing homes contrasts markedly from that of those who were still resident. Details in Table I-H show that 47% of all discharges (live and dead) occurred within stays of six months or less and 27% were after stays of two years or more. For residents, 17% had stays of up to six months and 50% had stays of two years or more.

Average length of stay of all discharges was 93 weeks, varying from 63 weeks in government homes to 91 weeks in voluntary homes and 112 weeks in private for profit homes. Overall, 69% of discharges were deaths, but this proportion varied from 44% for public sector homes to 72% for voluntary homes and 82% for private for profit homes.

TABLE I-H: Length of Stay of Discharges and Residents, 1990		
Length of Stay	**Discharges**	**Residents**
Number		
Total	38,876	70,987
Less or equal to 4 weeks	9,862	2,873
5-13 weeks	6,434	4,225
13-26 weeks	3,236	5,162
27-52 weeks	3,712	10,425
1-2 years	4,448	12,917
2-3 years	3,063	9,463
3-5 years	3,668	11,543
More than 5 years	4,453	14,379
Percent		
Total	100.0	100.0
Less or equal to 4 weeks	25.3	4.0
5-13 weeks	16.5	5.9
13-26 weeks	8.3	7.2
27-52 weeks	9.5	14.6
1-2 years	11.4	18.1
2-3 years	7.8	13.3
3-5 years	9.4	16.2
More than 5 years	11.3	20.1

Patterns of length of stay and mode of discharge varied between sectors, reflecting their different functions. Differences in admissions from acute hospitals have been noted above. Government homes especially have shorter stays and more live discharges, in part reflecting their function as transits between acute care and long term care in a voluntary or private nursing home. Length of stay and discharges in voluntary homes reflect associations with other levels of care.

Investigation of outcomes of long term care will involve more detailed analysis of these patterns and also relationships to resident dependency. Further, the nursing home population now comprises three cohorts: residents admitted prior to the introduction of assessment and the RCI, those admitted over the period these measures were being introduced, and those admitted with both measures fully in place. As the two former groups exit, the nursing home population and patterns of use of nursing home care can be expected to change considerably and cohort analysis will be useful for both monitoring changes and modelling future trends.

Access

Several measures of access to nursing home care are available, and figures given in Table I-I for 1988 and 1990 show changes in access over this time. Access is most simply measured by the ratio of provision to population. More complex measures are given by turnover and an index of accessibility. Annual turnover, the number of residents admitted to the available beds in a year, commonly used as a measure of efficiency in other areas of health care and can usefully be applied in long term care.

Another measure of access is the index of accessibility,[17] that relates admissions to the aged population from which admissions are drawn.

Access as measured by provision showed little change between 1988 and 1990. The number of beds increased by only 0.7% and the ratio of provision per 1000 aged 70 years and over decreased by 5%. The other measures of access show more pronounced changes. There were 35,713 admissions aged 70 years and over in the year to June 30, 1990, an increase of 28% over the number in 1988. The index of accessibility expresses the rate of admission from the population and so takes account of population growth; this index increased from 23.8 to 28.8. Third, the annual turnover rate for 1989-90 was 55.7%; this rate is an increase of 24% on turnover for 1988.

TABLE I-I: Access to Nursing Home Care, 1980 and 1990

	1980	1990	Percent Change
Population 70 years and over (in thousands)	1175.1	1241.6	5.6
Number of Beds	72116	72615	0.7
Ratio of provision/1000 70+	61.4	58.5	-5.0
Number of admissions 70+	27909	35713	28.0
Turnover (adm/beds)	44.8	55.7	24.3
Index of access (adm/pop 70+)	23.8	28.8	21.0

The differences between these measures of access and provision demonstrate the need to have appropriate measures of outcomes. Changes in the various measures will provide different perspectives on outcomes of nursing home care as they reflect the impacts of assessment, changes in resident dependency and consequent reductions in length of stay. The use of different measures also has a number of implications for assessing the impact of expanded community care on access to nursing home care. In particular, simple measures of admission may be inadequate where the outcome of community care has been to delay admission and to reduce eventual length of stay; the effect of increased turnover and increased access may be that there are more rather than fewer admissions, an apparently contradictory outcome unless length of stay is taken into account.

Policy Issues

Current policy issues in nursing home care in Australia fall into two broad, but related, groups: the role of nursing home care in the overall aged care system and developments within the nursing home system to enhance its capacity to perform this role effectively. The immediate future will see a continuation of the reforms implemented as part of the Aged Care Reform Strategy over the last five years, and further changes in outcomes of long term residential care can be expected. Monitoring

[17] Howe, AL, Phillips C, Preston GAN. Analysing access to nursing home care. Soc Sci Med 23(12): 1267-77. 1986.

of these outcomes will provide important indicators of the effectiveness of different policy measures.

The Place of Nursing Home Care in the Balance of Care

The clearest indicator of the changing role of nursing homes vis-a-vis other modes of aged care is seen in trends in Commonwealth expenditure. Data in Table I-J show the substantial shift from residential care to community care that have been achieved from 1985-86 to 1990-91, and within residential care, the shift from nursing home to hostel care. The increase in total expenditure, 28% in real terms, compares to an increase of 16% in the population aged 70 years and over and 25% in the population aged 80 years and over for the five year period.

TABLE I-J: Commonwealth Expenditure on Aged Care, 1985-86 and 1990-91

Program Area	1985-86	1990-91	Percent Increase
Dollars in Millions			
Total	1764.2	2257.5	28.0
Residential care			
NH benefits	1429.9	1556.0	8.8
Hostel subsidies	84.1	232.5	176.5
Users rights and training	---	2.6	[1]
Total recurrent	1513.4	1791.1	18.3
Capital	65.8	129.5	96.8
Home and Community[2]	142.8	278.9	95.3
Domestic Nursing Care Benefit	36.0	33.0	-8.3
Geriatric assessment	5.6	25.7	355.4
Percent Distribution			
Total	100.0	100.0	
Residential care			
NH benefits	81.0	68.9	
Hostel subsidies	4.8	10.3	
Users rights and training	[1]	0.1	
Total recurrent	85.8	79.3	
Capital	3.7	5.7	
Home and Community[2]	8.1	12.4	
Domestic Nursing Care Benefit	2.0	1.5	
Geriatric assessment	0.3	1.1	

NOTE: Figures are all in 1991 dollars.

1. Expenditure in 1985-86 is too small for calculating meaningful percentage increase to 1990-91.
2. HACC expenditure includes services for the younger disabled, estimated at about 25 percent of total program expenditure.

The shift between nursing home and hostel care is seen in the relative rates of expenditure increase and the proportions of total expenditure going to each over the last five years. The increase in expenditure on nursing home care has been contained to just on 9%, and nursing home benefits accounted for 69% of total expenditure in 1990-91 compared to 81% five years previously. In contrast, the increase for hostel care was 177%, the result of increased hostel provision, increases in subsidy levels and

increases in the proportion of residents receiving care subsidies. The policy attention given to hostel care is evident in the expenditure on special services in hostels, including dementia care, which increased from less than $ 1m in 1985-86 to almost $ 43m five years later. The share of all expenditure going to hostels more than doubled, from just under 5% to just over 10%.

The very high growth of expenditure on Geriatric Assessment reflects the small base amount in 1985-86 and rapid expansion to achieve national coverage by 1990-91. Commonwealth expenditure on the Home and Community Care Program almost doubled, and this increase is extended by the matching expenditure of State Governments. In 1990-91, HACC accounted for 12% of Commonwealth expenditure; when combined Commonwealth and State expenditure on HACC is considered, HACC accounted for 21% of all government expenditure on aged care.

Policy for the remainder of the Aged Care Reform Strategy is being developed in a framework of the balance of care that will see continued restraint on the growth of nursing home care and the expansion of community care, especially support to carers. The role of hostels in the overall balance of care will be adjusted as expanded community care services, including the development of strategies such as case management, enable more dependent individuals to be supported in the community.

Outcomes of Nursing Home Care

Within nursing home care, policy is now focused on two main areas. First, assessment and revisions to the Resident Classification Instrument are aimed at targeting nursing home care for the most dependent individuals and ensuring that care services are allocated according to relative need. Further changes can be anticipated in the dependency profile of residents, and in patterns of utilization in terms of sources of admission, length of stay and mode of separation. Analysis of data from the RCI and other routine data on use of nursing homes have already contributed to policy development, and further applications will be required to monitoring continuing change. Changes in the resident dependency profile are expected in line with trends in demographic change and prevalence of handicap, the declining ratio of bed provision and other factors such as the proportion of admissions from acute hospitals.

Modelling of the effects of these factors is in progress and the implementation of the revised RCI in early 1992 will be closely monitored against predicted outcomes. Further, given the changing composition of the nursing home population in terms of past admission cohorts, cohort analysis has considerable potential in modelling likely future outcomes when combined with demographic data and information on changes in use of hostel care and community care.

The second focus of policy attention is improving standards of care, and as a means to this outcome, developing training for nursing home staff. The standards monitoring processes are generating data bases that will provide a rich source of information on outcomes, especially when combined with data on resident profiles and

utilization patterns. The implications of increasing resident dependency, and possibly higher turnover, raise a number of questions for outcome standards and how outcomes can most appropriately be measured for a severely impaired resident population.

The need to address staff skills as a means to improving standards has been addressed by the Commonwealth with the establishment of the Training and Resource Centre for Residential Aged Care (TARCRAC) in 1990. This unit has been set up in the Queensland University of Technology and is developing training packages for nursing and personal care staff that are closely linked to the defined outcome standards. The Commonwealth has also commissioned a major study of the relationship between staffing mix and quality of care in nursing homes and sponsored a number of in-service training activities.

The nursing home workforce in Australia is divided into two main groups on the basis of level of training. Directors of Nursing and a proportion of other staff are registered nurses and professionally qualified therapists, and courses offering specialist training in gerontological nursing and aged care more generally have expanded considerably in recent years. The balance of the workforce comprises varying proportions of State Enrolled Nurses and nursing assistants or aides, with basic training varying depending on State requirements and the training opportunities available. A recent study in the State of Victoria[18] found that about 45% of the nursing workforce are registered nurses and 55% have other levels of training.

That study was concerned with the effects of high staff turnover on quality of care. It was found that only 6% of the total nursing staff worked full time, and that turnover was 84% and 66% for the two years of the study, with turnover being lower for registered nurses. The study was carried out over 1985-87, towards the end of several years of industrial action in the nursing profession in Australia and several aspects of the work environment of nursing homes were identified in which improvements might be made to increase staff satisfaction and retention, with benefits for resident care. Many of the findings of the Victorian study can be taken as typical of other States at the time. Monitoring of the impact of the training initiatives being implemented through TARCRAC and other educational activities will provide further information on outcomes of long term care and of the significance of staff skills to these outcomes.

The next few years can be expected to see the increasing applications of statistical and other data bases in monitoring outcomes of long term care in Australia. Both quantitative and qualitative data will be required to give a full account of outcomes for individual residents and for the nursing home system as a whole. The project for which this paper has been prepared, outcomes of Nursing Home Care, a part of the International Collaborating Effort on Aging sponsored by the National Centre for Health Statistics, provides a unique opportunity for Australia to gain from the exchange of information on the experience of other countries in these endeavors.

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[18] Phillips C, Carter M. Quantifying discontent in the nursing profession: A study of staff mobility in Victorian nursing homes. Aust Health Rev 11(4): 247-56. 1988.

II. INTERNATIONAL COMPARISONS OF LONG TERM CARE--CANADA[19]

The Canadian Context of Long Term Care

Historical Perspective

From Confederation in 1867, and reconfirmed with the patriated Canadian Constitution in 1984, health care has been identified as the responsibility of the provinces, except those "special" groups such as the military, Native Canadians, and quarantine centers which were assigned to the Government of Canada. Voluntary agencies, both religious and fraternal as well as charitable, became involved with community and institutional health care during the nineteenth century. By the turn of the present century, some health services were being provided by industries and local municipalities. Following the Depression and World War II, the federal government began to stimulate medical training and acute care through training grants for physicians and grants to construct hospitals. In 1957 hospital care became universally insured and in 1968 this was expanded to include physician services. In 1977 block funding provided more control to the provinces but was set into an already heavily "medicalized" system. By the 1970's, universally-insured hospital and medical services had provided all Canadians with access to these services when sick and eliminated pauperization consequent to illness.[20,21]

Long term care, initially also mainly institutional, was either heavily medicalized or based on means tested eligibility in order for the provinces to secure some portions of the funding from the federal government. Community-based long term care has received very limited federal funding and its existence is less universal and uniform across the country than other forms of health care.

In the early 1970's, the organization and delivery of health care was reappraised. The most serious problems were fragmentation, waste, and inefficiency. One result of this reappraisal was a series of provincial initiatives in the field of community care. As a consequence, between 1974 and 1982, almost every province developed some community-based home care services. Over a longer span from 1972 to 1989, all but one province introduced some insured long term care capacity within nursing homes.

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[19] Written by Betty Havens, D.Litt., University of Manitoba, Department of Community Health Sciences, Winnipeg, Manitoba, and David Bray, Ph.D., Queen's University, Kingston, Ontario. Comments in this section are those of the authors and do not represent the opinions of Manitoba Health, Queen's University, or Statistics Canada. The authors acknowledge the assistance of Madelyn Hall throughout this project.

[20] Berdes, C. **Warmer in Winter**. Report to World Health Organization Fellow Program. Chicago, IL: Northwestern University, 1987.

[21] Chappell. N.L. **Long-Term Care in Canada**. In E. Rathbone-McCuan and B. Havens, eds., North American Elders: United States and Canadian Perspectives. Westport, CT: Greenwood Press, 1988.

This process has led some provinces to a common assessment process being used across all sectors of long term care.[22,23] The assessment is designed to establish types and amount of care required and the last step in the process is to determine the most appropriate location for that care. If the location decision is made first, it begins inappropriately to drive the whole system. What one needs to know is not whether the individual is eligible for nursing home care, but whether the individual needs a level of care equivalent to nursing home care, regardless of its source. Then one can look at the various potential sites at which this care can be provided and make the location decisions.[24,25,26]

In summary, health services are publicly insured in Canada. Each of the ten provinces retains autonomy in the delivery of health care and in developing health programs. The Government of Canada establishes certain minimum standards of health service provision as the basis for the federal share in funding health programs, but each province develops its own programs and may supplement the requisite core standards as is appropriate to its own jurisdiction.

Current Status

As in virtually all western jurisdictions, Manitoba and in Canada are attempting to restrict the use of more costly acute care personnel and facilities in favor of less costly long term care facilities and community care programs. In 1974 the capital planning goal for personal care home (or nursing home) beds in Manitoba was established as ninety per thousand population aged seventy and over. By 1986 this ratio had been realized. Since then construction has deliberately not kept pace with the growth in the older population. Based on a 1988 reassessment by the Extended Treatment Bed Review Committee of the use of long term care beds, the 1974 ratio was revised to 140 beds per thousand population aged eighty and over. This revised ratio, in part, reflects the change in orientation to support greater use of community-based care and, in part, the changing nature of personal care home residents. In 1973, the average age at entry to personal care homes was 68.9 years of age; by 198i the average age at entry was 84.3 years of age, and the average age has continued to increase.[27,28]

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[22] Shapiro, E. **Multidisciplinary Health Assessment of the Elderly in Manitoba, Canada**. Paper presented at International Work Group Meeting on Multidisciplinary Health Assessment of the Elderly. Goteborg, May, 1987.

[23] Havens, B. **Assessment for Care: the Manitoba Model**. Provider 1987; 13:26-29.

[24] Havens, B. **Boundary Crossing: An Organizational Challenge for Community-Based Long-Term Services Agencies**. In A.O. Pelham and W.F. Clarke, eds., Managing Home Care for the Elderly: Lessons from Community-Based Agencies. New York: Springer Publishing Co., 1986a:77-98.

[25] Havens, B. **Statements of Betty Havens**, Provincial Gerontologist, Manitoba, Canada. In Select Committee on Aging, House of Representatives. Continuing Care: International Prototypes for America's Aged. Washington, D.C.: U.S. Government Printing Office, 1985a:17-22, 81-188. (Comm. Pub. No. 99-523).

[26] Havens, B. **A Long-Term Care System: A Canadian Perspective**. In R.L. Kane, ed., The Feasibility of a Long-Term Care System: Lessons from Canada. Tampa, FL: University of South Florida, 1985b):19-27.

[27] Havens, B. **Manitoba Model of Continuing Care**. Paper presented at National Conference of State Legislatures Annual Meeting. New Orleans, August, 1986b.

In a milieu of fiscal responsibility and economic constraint, responsiveness to changing client needs will have to be accomplished through redirection of existing resources. As such, it will become more essential to assure adequate program staffing and to maintain direct service staffing flexibility. If the Manitoba Continuing Care Program has learned one thing through experience, it is that there are no savings realized by curtailing program staffing. Unrealistically large caseloads inhibit prompt assessment, slow down case reviews, mitigate against appropriate and timely reassessments, and preclude innovative solutions. They incur either client dependence through delays in withdrawing unneeded services or increased costs by employing easy solutions. This often means providing more costly services that are integral to the program even if personnel are overskilled for requisite tasks. Program staffing patterns must be adequate to this impending challenge or the more costly decision to institutionalize will prevail.[29]

The full continuum of health and social services includes not only informal care, support services, home care, adult day care, respite care, nursing home care, chronic and rehabilitative institutional care, day hospitals, acute care, and care from physicians and other health professionals; but also, the broad spectrum of social services including pensions (or other income security measures), affordable housing, special interest groups, senior centers, older adult centers, senior educational programs, and all the age-integrated social programs. The most effective program models have easy access to any and all of these components, enabling solutions to be developed with the client and his or her support system, and to be changed or modified as required.[30]

Policy Issues, Changes and Expected Outcomes

As noted earlier, the long term care bed to population ratio has been reduced; however, the question is whether the new ratio is the most appropriate. Should further reductions be introduced and if so what community resource should be in place to accommodate these reductions? Alternatively, should the ratio be increased to accommodate other system reductions such as acute care bed closures?

The assessment for home care and for placement in personal care homes has been conducted by the Continuing Care Program in Manitoba since 1974 from a community perspective. However, the administration of the nursing home program was housed within the institutional and insured sector of the Ministry with hospital and physician services until mid 1991. As such, long term care was not fully integrated. Similarly, until 1991, support services to seniors was administratively separate from

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[28] Shapiro, E. **Patterns and Predictors of Home Care Use of the Elderly When Need is the Sole Basis for Admission**. Home Health Care Services Quarterly 1986; 7:29-44.

[29] Havens, B. **Boundary Crossing: An Organizational Challenge for Community-Based Long-Term Services Agencies**. In A.O. Pelham and W.F. Clarke, eds., Managing Home Care for the Elderly: Lessons from Community-Based Agencies. New York: Springer Publishing Co., 1986a:77-98.

[30] Interagency Committee for Support Services to Seniors **Policy Paper on Support Services to Seniors**. Winnipeg, MB: Manitoba Health, 1983, and Revised 1985.

both the nursing home and home care programs, producing further lack of integration. Policy and program development can be only partially successful without administrative integration. Therefore, the 1991 administrative reorganization consolidated policy and program development, service delivery responsibility, and fiscal management across all the components of long term care and support services. With its separation from the more medicalized aspects of the Ministry, this fruition of a twenty-year integrative process assures the dominance of a social model in long term care. Of related interest is the inclusion of chronic hospital care and long term rehabilitation programs within the Continuing care Programs Division, hence demedicalizing these components as well.[31,32,33,34,35,36]

There are continuing concerns on the one hand about the degree of fiscal accountability by the community-based programs which still operate with manual information systems. On the other hand, there are concerns about maintaining the quality of care with an increasing aging population, bed reductions, staffing freezes, and the necessity to constrain costs of all government programs.

There is still limited agreement as to how one can ensure appropriate program planning and policy implementation when positive changes in one sector may create problems, even though unintentional, in another sector. For example, NFA (Not for Admission) cataract surgery has reduced the use of acute surgical beds. Hospitals see this change as positive due to reduced surgical waiting lists, even though hospital costs escalate as a result of more total surgical use. However, this NFA procedure has created greater demands for home nursing services post-surgically, which is an add-on cost to the community care sector and ultimately to the Ministry.

The long term care system continues to be challenged by the need to increase both the number of persons served and the units of service delivered without sacrificing the quality of care. Can further efficiencies be found to generate more funds for support services, adult day care and respite care, as opposed to supporting capital construction, additional beds, and home nursing?

Given the changing nature of personal care home residents and home care clients referred to previously, i.e., they are older, sicker, and more likely to be

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[31] Berdes, C. **Warmer in Winter**. Report to World Health Organization Fellow Program. Chicago, IL: Northwestern University, 1987.

[32] Chappell. N.L. **Long-Term Care in Canada**. In E. Rathbone-McCuan and B. Havens, eds., North American Elders: United States and Canadian Perspectives. Westport, CT: Greenwood Press, 1988.

[33] Shapiro, E. **Multidisciplinary Health Assessment of the Elderly in Manitoba, Canada**. Paper presented at International Work Group Meeting on Multidisciplinary Health Assessment of the Elderly. Goteborg, May, 1987.

[34] Havens, B. **Manitoba Model of Continuing Care**. Paper presented at National Conference of State Legislatures Annual Meeting. New Orleans, August, 1986b.

[35] Shapiro, E. **Patterns and Predictors of Home Care Use of the Elderly When Need is the Sole Basis for Admission**. Home Health Care Services Quarterly 1986; 7:29-44.

[36] Interagency Committee for Support Services to Seniors **Policy Paper on Support Services to Seniors**. Winnipeg, MB: Manitoba Health, 1983, and Revised 1985.

experiencing some form of cognitive impairment, can staffing ratios and mixes of staff be altered to meet these changing needs? If so, can these changes be accommodated within existing budgets?

Continued increases in the use of community care is the most widely expected policy outcome. Ever increasing reductions in acute, chronic, and long term care beds as reflected in the bed to population ratios is another commonly expected outcome of current policies and of fiscal constraint.

Relevant Demography

In 1986, 2.7 million Canadians and 0.1 million Manitobans were sixty-five years of age or older. They represented 10.7% of all Canadians and 12.1% of all Manitobans. By 1991, the most recent decennial census year, the proportion of elderly persons in Canada and Manitoba increased to 11.6% and 13.0% respectively. The rate of increase was greater in Canada than in Manitoba, as can be seen in Table II-A. Manitoba was already older than Canada as a whole.

TABLE II-A: Elderly Population, Canada and Manitoba 1981-1991			
Age Group	**1981**	**1986**	**1991**
Canada			
Total	24,343,180	25,309,330	27,296,855
65 years and over	2,360,975	2,697,580	3,169,970
65 - 74 years	1,477,745	1,650,090	1,895,070
75 - 84 years	689,445	819,730	991,565
85 years and over	193,785	227,760	283,335
Percent total population 65 years of age and over	9.7	10.7	11.6
Manitoba			
Total	1,026,245	1,115,585	1,133,117
65 years and over	121,820	134,989	147,372
65 - 74 years	74,035	79,862	83,262
75 - 84 years	36,275	42,287	48,927
85 years and over	11,510	12,840	15,183
Percent total population 65 years of age and over	11.9	12.1	13.0
SOURCES: Statistics Canada, Census of Canada: 1981, 1986, 1991 Manitoba Health Services Commission, Annual Reports: 1986, 1991			

Almost sixty-percent of the Canadian and Manitoban elderly population are the young old; those sixty-five to seventy-four years of age. By contrast, the oldest old, i.e., those eighty-five years of age and over, constituted 9% of the Canadian and 10% of the Manitoban elderly population. While the oldest-old represent a very small portion (1%) of the total population and a relatively small proportion of the elderly population, they represent the fastest growing group in these populations. From 1981 to 1991, the total population of Canada and Manitoba grew by only 12% and 10% respectively, while those aged sixty-five and older in Canada grew by 34% and the oldest-old (eighty-five years and older) grew by almost 50%; During this time in Manitoba, those sixty-five and

older grew more slowly at 21% and the oldest-old increased by 32% as a result of Manitoba being older demographically than Canada at the beginning of the decade.

The total dependency ratios in Canada and in Manitoba have decreased markedly over the past thirty years. This decrease, as can be seen in Table II-B, is the result of substantial decreases in the youth dependency ratios from 72.7 in 1961 to 39.0 by 1991 for Canada, and in Manitoba, from 69.8 to 43.6. During this time the aged dependency ratios increased only slightly; i.e., by 4.3 for all of Canada and by 4.6 in Manitoba. The slightly higher aged dependency in Manitoba coupled with its less marked decrease in youth dependency is further evidence of its older demographic structure in comparison to Canada as a whole.

TABLE II-B: Dependents Per One Hundred Persons Age 18-64, Canada and Manitoba, 1961-1991

Age Group	1961	1971	1981	1986	1991
Canada					
Total	87.0	77.8	60.6	58.6	57.6
65 years and over	14.3	14.4	15.6	19.3	18.6
0 - 17 years	72.7	63.4	45.0	39.3	39.0
Manitoba					
Total	86.7	80.8	68.5	64.8	65.1
65 years and over	16.9	17.5	20.0	19.9	21.5
0 - 17 years	69.8	63.3	48.5	44.9	43.6

SOURCES: Manitoba Health Services Commission, Annual Reports: 1985-86, 1990-91 Statistics Canada, Census of Canada: 1961, 1971, 1981 Statistics Canada, Population Projections: 1984-2006, 1989-2011.

Projecting the populations of Canada and Manitoba into the early decades of the twenty-first century shows continued growth in the elderly cohorts. This growth is much greater for Canada than Manitoba based on the current higher percentage of elderly Manitobans as compared to Canada. In the case of Manitoba, projections are available only to 2011, which is just as the "baby boom" is beginning to reach age sixty-five. Their impact can be expected to be more noticeable from 2011 to 2031. The patterns in the shorter Manitoba projections demonstrate a modest rate of growth in the total older population (9.2%) and the youngest cohort of that population (9.1%), a slight decrease in the 75-84 year old cohort (-2.6%), and the greatest growth in the oldest cohort (43.7%). The impact of the "baby depression" from 1926 to 1945 is the obvious origin of these slow growth patterns as the elderly cohorts throughout these projection periods include essentially the small birth cohorts for the two decades prior to and during World War II. The impact of the "baby depression" is not as obvious in the longer projection periods of the Canadian projections. However, the impact of the "baby boom" cohorts reaching age sixty-five is also less dramatic in Canada than in the US and many other jurisdictions. The total population is only expected to grow by 8.4% but the elderly population is expected to grow by 97.8% by 2031. Within this overall growth, the youngest cohort (65-74 years) should grow by 62.8%, the middle cohort should double, and the greatest growth (113.7%) is expected among the oldest old. By 2031 the sixty-five and older population is projected to be almost one quarter of the total Canadian population.

TABLE II-C: Population Projections Canada 2001-2031 and Manitoba 2001-2011			
Canada -- Age Group	**2001**	**2021**	**2031**
Total	28,867,100	31,225,500	31,281,100
65 years and over	3,934,000	6,379,800	7,781,800
65 - 74 years	2,113,300	3,654,800	4,067,900
75 - 84 years	1,342,800	1,900,800	2,692,500
85 years and over	477,900	824,200	1,021,400
Percent 65 years of age and over	13.6	20.4	24.9
Percent 65 years of age and over in 2031	50.6	82.0	100.0
Manitoba -- Age Group	**2001**	**2005**	**2011**
Total	1,097,400	1,186,600	1,215,700
65 years and over	166,800	169,600	182,100
65 - 74 years	84,600	82,400	92,300
75 - 84 years	60,900	60,000	59.300
85 years and over	21,300	27,200	30,600
Percent 65 years of age and over	15.2	14.3	15.0
Percent 65 years of age and over in 2011	91.6	93.1	100.0
SOURCES: Statisitcs Canada, Canada Population Projections: 1984-2006, 1989-2011.			

Characteristics of Canadian Long Term Care Facilities

Administrative Criteria

The Government of Canada establishes certain minimum standards of health services as the basis on which the federal share in funding health programs is allocated to the provinces. Because these are minimum standards, each province may develop its own programs supplementing these standards with services appropriate to its own jurisdiction. As a result of this arrangement, all but one province provided some facility-based long term care through the various provincial insured health services legislation by 1989, and most provinces also insure or directly fund some community-based long term care (i.e., home care).[37,38]

As with all facility-based care, licensing of long term care facilities is the responsibility of the provinces. All facilities which are covered by the insured services legislation must be licensed to provide care in order to receive funds from the provinces. Those facilities which do not receive funding as insured service care providers may

[37] Berdes, C. **Warmer in Winter**. Report to World Health Organization Fellow Program. Chicago, IL: Northwestern University, 1987.

[38] Chappell. N.L. **Long-Term Care in Canada**. In E. Rathbone-McCuan and B. Havens, eds., North American Elders: United States and Canadian Perspectives. Westport, CT: Greenwood Press, 1988.

require a license to operate a business, but such licenses are not the responsibility of the Ministers of Health.[39,40,41]

As a result of the great degree of provincial autonomy, the terminology used by long term care facilities across Canada varies considerably. In the majority of provinces the facilities are licensed as nursing homes, but other terms include homes for the aged, auxiliary hospitals, lodges, and personal care homes. For example, Manitoba uses the term personal care homes to include all those facilities which would have been certified in the US as skilled nursing facilities (SNF's) and intermediate care facilities (ICF's) where they are known as nursing homes.[42]

Based on the insured services legislation, each province has the authority not only to license nursing homes but also to monitor their compliance with the care standards. While the minimum standards are established by the federal government, the enforceable standards do vary considerably across the provinces, as does the rigor with which they are monitored and enforced.

For example, in Manitoba, each personal care home is monitored annually and the staffing ratio is established based on the aggregate levels of care required by the residents. These ratios are the key factor in determining the allocation of funds to the facilities. Departmental staff will also respond to complaints about care in any facility at any time throughout the year, therefore some facilities may be monitored more than once during the year. The personal care home administrators may also request a review of the care levels of the residents during the year if they believe that the aggregate level of care has increased sufficiently to warrant changes in the staffing ratios and hence in their budget allocation.

The variability across Canada is even greater among the noninsured facilities. These residences generally will require licenses which deal with compliance to fire safety, public health (i.e., food and sanitation), and tax standards, but do not address standards of care. The terms by which these residences are known are even more varied than those of the insured facilities. Some are known as adult foster homes (generally restricted to three or less residents), hostels, board and care homes, care homes, lodges, quest homes, homes for the aged, sheltered housing, and even occasionally as convalescent homes, chronic care homes, and (other than in Manitoba) personal care homes. Despite their names, these residences provide virtually no care beyond meals and minimal supervision. In 1986, there were 6,274 non-certified

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[39] Chappell. N.L. **Long-Term Care in Canada**. In E. Rathbone-McCuan and B. Havens, eds., North American Elders: United States and Canadian Perspectives. Westport, CT: Greenwood Press, 1988.

[40] Havens, B. **Boundary Crossing: An Organizational Challenge for Community-Based Long-Term Services Agencies**. In A.O. Pelham and W.F. Clarke, eds., Managing Home Care for the Elderly: Lessons from Community-Based Agencies. New York: Springer Publishing Co., 1986a:77-98.

[41] Havens, B. **Manitoba Model of Continuing Care**. Paper presented at National Conference of State Legislatures Annual Meeting. New Orleans, August, 1986b.

[42] Chappell. N.L. **Long-Term Care in Canada**. In E. Rathbone-McCuan and B. Havens, eds., North American Elders: United States and Canadian Perspectives. Westport, CT: Greenwood Press, 1988.

facilities, or 7.8% of all residential care facilities in Canada. Most of these facilities tend to be relatively small but the total number of residents is not known as the data on occupancy are derived from voluntary reporting to Statistics Canada. In Manitoba in 1986, there were thirteen such facilities providing services to 297 residents, or about 3% of all those persons in any form of long term residential facility.

As noted earlier, all long term care in Canada was historically provided by the voluntary sector until the early 1900's. Gradually some local municipalities became involved as did some industries. The mix of public, voluntary and proprietary ownership varied from province to province. The vast majority of non-certified residential facilities across Canada, however, are proprietary; in Manitoba, all of the non-certified facilities are proprietary. In the case of insured facilities licensed to provide care in 1986, 45.3% of long term care facilities and 36.6% of the beds in Canada were proprietary, and these percentages had increased slightly to 45.9% and 38.4% respectively by 1991. During the same period in Manitoba, the percentage of personal care homes which were proprietary decreased from 17.7% to 14.4%, and the proportion of beds also decreased from 29.7% to 27.6% between 1986 and 1991.

Functional Criteria

As noted in the previous section, the variability in long term care across Canada, as a result of the high degree of provincial autonomy coupled with the lack of specific Canadian national legislation, means that there is no single set of service standards for nursing homes in Canada. However, each province, either through legislation, regulation, or policy has service standards. The Standards of Service for Manitoba in 1991 are presented in Table II-D primarily for comparison with the US Standards and as background to the remainder of this section.

TABLE II-D: Standards of Service, Manitoba Personal Care Homes, 1991

Services	**Personal Care Homes Levels I-IV**
Physician services	Under a physician's care, with facility responsible for ensuring emergency for ensuring emergency coverage is available
Nursing services	24-nursing; approved for Level 1 only facilities
Drugs/Medications	Administered by physician or registered/licensed nurse (self-administration in approved cases)
Specialized rehabilitation	Provided by qualified therapist on a consulting basis
Social services	Provided by qualified worker in facilities of 60+ beds or residents are referred to social services agencies
Patient activities program	Provided by designated staff under direction of trained individual
Hospital transfer	All Manitobans have insured access to hospital care
Discharge planning	Where identified as a possibility, is planned with resident, family and community home care staff

SOURCE: Manitoba Health, Long Term Care Branch, 1991a

It is possible, however, to identify the major services provided in nursing homes across Canada based on the reported annual number of hours worked by staff, which can be converted to equivalent full-time persons employed per service category. In the Canadian data, the comparison of certified and non-certified facilities highlights the

paucity of professional staff, including nurses, in non-certified homes. A similar distinction is obvious in the Manitoba data for Level 1 only facilities, although the under-representation of Registered Nurses is not as marked as in the non-certified facilities. It should be recalled that all the Manitoba personal care homes are licensed or certified, but the Level I only personal care homes are somewhat similar to the national and US non-certified facilities, and are therefore presented separately in Table II-E to enable comparisons to be made with the national data.

TABLE II-E: Services Offered in Facilities for the Aged, Canada and Manitoba, 1991

Services Offered in Canada Facilities for the Aged			
Type of Service	**Certified Facilities**	**Non-Certified Facilities**	**Total**
Registered nurses	5,578	29	5,607
Nursing assistants	4,759	3	4,763
Physiotherapists	62	---	62
Other therapists	136	---	136
Activity/Recreational Staff	1,583	8	1,590
Other care staff	19,228	71	19,299
Administration	2,946	30	2,976
Dietary	7,661	59	7,721
Other	8,046	93	8,139
Services Offered in Manitoba Personal Care Homes (Certified Nursing Homes)			
Type of Service	**Level of Personal Care Home**		**Total**
	Level I Only	**II - IV**	
Registered nurses	39	813	852
Nursing assistants	57	3,483	3,540
Physio/Other Therapists	---	14	14
Activity/Recreational Staff	9	223	231
Other care staff	---	27	27
Administration	8	267	275
Dietary	45	801	846
Social services	1	31	32
Other	53	949	1,002

SOURCES: Statistics Canada, 1991 (Residential Care Database), Manitoba Health, Long Term Care Branch, 1991a

Because nursing home care is almost exclusively an insured service across Canada, assessment for admission is based on the need for care in a nursing home. These assessments are based on medical conditions to some extent, but concentrate on the applicant's functional capacity. Each province maintains its own assessment instrument. These instruments vary in detail, but are quite similar in broad categories. There have been numerous efforts to establish a single assessment instrument across Canada, but to date these efforts have been unsuccessful. Although the provinces

share information with one another, no direct comparisons based on these assessments are possible.[43,44,45]

In Manitoba, British Columbia, Quebec, and New Brunswick, the same assessment is undertaken with persons applying for long term care in the community (i.e., home care) or in the institutional sector. In addition to the functional capacity and medical conditions, virtually all provincial assessments include mental status as well as social and cultural components in the total assessment process. Each applicant is fully assessed for placement whether he or she is in an acute care hospital or in the community at the time of application for admission. Changes in, at least, functional capacity and mental status are reassessed as part of the annual monitoring process.[46,47,48]

Table II-F shows that in 1988 (the only year for which data are available) almost all long term care residents required the assistance of another person to function. The measures used for these aggregate data were the Activities of Daily Living (ADL's). Again, it is obvious that the non-certified homes were providing a lighter level of care. They were providing assistance with ADL's, although seldom to the degree that professional supervision was required. The opposite distribution exists in the certified facilities where almost three-quarters of the residents required assistance to be provided under professional supervision.

TABLE II-F: Percent of Residents Who Need the Help of Another Person by Type of Care Provided by Facility for Canada, 1988

	Certified Facilities	Non-Certified Facilities
Total residents	136,309	11,544
Room and bed Only	0.5%	69.6%
With guidance counseling	0.1%	2.4%
With custodial care	1.1%	20.2%
Decreased physical and/or mental faculties	24.8%	5.7%
Requires some care under Professional supervision	50.9%	1.8%
Requires medium care under professional supervision	21.8%	0.4%
Requires most care under professional supervision	0.9%	---
SOURCE: Statistics Canada, 1991 (Residential Care Database)		

[43] Chappell. N.L. **Long-Term Care in Canada**. In E. Rathbone-McCuan and B. Havens, eds., North American Elders: United States and Canadian Perspectives. Westport, CT: Greenwood Press, 1988.

[44] Shapiro, E. **Multidisciplinary Health Assessment of the Elderly in Manitoba, Canada**. Paper presented at International Work Group Meeting on Multidisciplinary Health Assessment of the Elderly. Goteborg, May, 1987.

[45] Havens, B. **Assessment for Care: the Manitoba Model**. Provider 1987; 13:26-29.

[46] Havens, B. **Statements of Betty Havens**, Provincial Gerontologist, Manitoba, Canada. In Select Committee on Aging, House of Representatives. Continuing Care: International Prototypes for America's Aged. Washington, D.C.: U.S. Government Printing Office, 1985a:17-22, 81-188. (Comm. Pub. No. 99-523).

[47] Havens, B. **A Long-Term Care System: A Canadian Perspective**. In R.L. Kane, ed., The Feasibility of a Long-Term Care System: Lessons from Canada. Tampa, FL: University of South Florida, 1985b):19-27.

[48] Havens, B. **Manitoba Model of Continuing Care**. Paper presented at National Conference of State Legislatures Annual Meeting. New Orleans, August, 1986b.

Other useful comparisons can be drawn from data which demonstrate the distribution of persons with disabilities in community households versus institutions by age cohorts. Table II-G shows that at all ages sixty-five and over, more disabled persons live in the community than in institutions. However, among those aged 65 to 74 almost all disabled persons are living in the community; but for those aged 85 and over, just over one-half of those persons with disabilities are able to remain in the community. There was very little change in this distribution between 1986 and 1991.

TABLE II-G: Persons with Disabilities in Canada, 1986 and 1991

Age Group	Total		Households		Institutions	
	1986	1991	1986	1991	1986	1991
Number						
65 - 74 years	604,095	732,715	586,585	698,830	35,510	33,885
75 - 84 years	450,825	507,835	356,875	424,800	93,950	83,035
65 and Over	177,075	208,325	101,455	112,325	75,620	96,000
85 and Over	1,231,995	1,448,875	1,026,915	1,235,955	205,080	212,920
Percent						
65 - 74 years			94.1	95.4	5.9	4.6
75 - 84 years			81.0	83.6	19.0	16.4
65 and Over			57.3	53.9	42.7	46.1
85 and Over			84.0	85.3	16.0	14.7

SOURCES: Statistics Canada, Profile of Persons with Disabilities: 1991 and 1993

The mental functioning of residents is another major concern in long term care facilities. No data were available for Canada as a whole; however, relevant diagnostic data were available for Manitoba in both 1986 and 1991. Table II-H presents the total number of beds designated for use by, and the residents with, mental disorders. There was a moderate increase in residents with mental disorders from 1986 at 27.6% of all residents, to 1991 at 30.1%. Because a resident may have more than one relevant diagnosis, the total of diagnoses is greater than the number of residents with disorders. The change in the percent of residents with multiple diagnoses increased by less than one percent between 1986 and 1991. While both the percent of residents with diagnoses of dementia and other mental disorders remained virtually constant during this period, the percent diagnosed with depression increased markedly (20.7% to 28.9%, or a 39.6% increase), and those-diagnosed as psychotic decreased at about half that rate (19.2%).

The most relevant aspect of mental disorders to the care of residents is the existence of behavioral manifestations. From the Manitoba monitoring data available for 1986, 10.8% of residents evidenced sufficient behavior problems to require additional close supervision; that is, more supervision than is the basis for the usual staff ratios. It should be noted that with this behavioral measure, not all of the residents with a psychiatric diagnosis necessarily require more than the average care and supervision. In fact, about forty percent of the diagnosed residents require this additional close supervision. The monitoring data for i991 indicated 10.5% of residents and 34.9% of those with the relevant diagnoses sustained behavioral problems.

TABLE II-H: Manitoba Institutionalized Residents, Age 65 and Over, with Mental Disabilities		
1986		
Total Institutional Beds		8,244
Total Residents with Mental Disorders, All Institutions		2,275
Percent of all Residents		27.6
Diagnosis Type and Description	**Residents**	
	Number	**Percent**
Dementia	677	29.8
Psychoses	982	43.2
Depression	472	20.7
Other	442	19.4
Total diagnoses	2,573	113.1
1991		
Total Institutional Beds		8,291
Total Residents with Mental Disorders, All Institutions		2,499
Percent of all Residents		30.1
Diagnosis Type and Description	**Residents**	
	Number	**Percent**
Dementia	755	30.2
Psychoses	872	34.9
Depression	721	28.9
Other	499	20.0
Total diagnoses	2,847	114.0

SOURCES: Manitoba Health Services Commission, Personal Care Home Annual Statistics, 1986, 1991
NOTE: The total of residents and beds includes individuals with diagnoses of mental retardation and/or physiological conditions arising from mental disabilities. These two diagnoses, however, have been excluded from the breakdown of diagnoses by type, with follows.

Because of the small size of most non-certified facilities and the voluntary nature of the reporting of staffing patterns from these facilities, the employment numbers are too small to be reported reliably. Therefore, Table II-I identifies only the full-time equivalent employees per one hundred beds in certified facilities for Canada and Manitoba by occupation. As would be expected, the majority of full-time equivalent staff are nurses, with Registered Nurses far outnumbered by Nursing Assistants. The other major categories, in Manitoba and across Canada, are what are usually referred to as support staff; i.e., administration, dietary, and assorted others, as opposed to the other patient service staff such as therapists and activity staff. There is also very little variation within occupations or in total between Manitoba (total 68.3) and Canada (total 67.1). It may be useful to refer again to Table II-D, as the differential distribution in Registered Nurses is likely a result of the differences in standards relative to nursing services. These data pertain to 1988, the only year for which complete and comparable data are available.

In Canada in 1986 there were 212,566 beds in certified long term care facilities and 44,327 beds in non-certified facilities for a total of 95.2 beds per thousand population aged sixty-five and over. At the same time there were a total of 231,435 residents, or 85.7 residents per thousand population aged sixty-five and over. In comparing these ratios with those of other countries, it is important to recall that long

term care facilities in Canada include not only nursing homes but also homes for the aged, chronic hospitals, long term rehabilitation centers, psychiatric centers, and an assortment of other service centers providing long term residential care. If the Canadian data are disaggregated to approximate only certified nursing home residents as defined in the US, the ratio becomes 63.1 residents per thousand population aged sixty-five and over.

TABLE II-I: Full-Time Equivalent Employees per One Hundred Beds by Occupation, Canada and Manitoba, 1988

Occupation	Canada	Manitoba
Total	67.1	68.3
Registered nurses	7.4	10.0
Nurses assistants[1]	31.7	30.8
Physiotherapists	0.1	*
Other therapists	0.2	NA
Activity/Recreational Staff	2.1	*
Administration	4.9	2.9
Dietary	10.1	10.7
Social services	NA	1.3
Other	10.6	12.6

SOURCES: Statistics Canada, 1991 (Residential Care Database), Manitoba Health, Long Term Care Branch, 1991a.

1. Includes social workers for Canada data.

NA = Category not applicable

* = Figure does not meet standard of reliability or precision.

In the case of Manitoba, the latter ratio in 1986 was 66.4 residents per thousand population aged sixty-five and over and decreased to 61.0 per thousand population by 1991. The occupancy of personal care homes in Manitoba is approximately 99% and therefore the ratio of beds to the population is less than one per thousand more than the ratio of residents.

It is also helpful to note that the ratio of residents to population varies substantially according to the ages of the residents. For example, the Canadian ratio of residents per thousand population aged sixty-five and over was 85.7; however, the ratio for residents aged 65 to 74 was only 31.1 per thousand, while the ratio for residents aged 75 and over was 172.0 per thousand.

Access to nursing home care is not just a matter of beds per thousand population, it also relates to admission and discharges, or the flow of residents through the long term care system. Admission and separation data are not available for Canada, but the Manitoba data in Table II-J are instructive in several ways. First, because these data are available according to the levels of care, the differential admissions and separations by level and the resulting net change is striking, a fact which is masked in the summary statistics at the bottom of the table. The other important feature illustrates the effect of policy and program decisions to decrease admissions at lower levels, especially level one, as more supportive services have become available in the community between 1986 and 1991. There is also indirect

evidence that the home care program continues to provide care at all levels in the community. Finally, there is ample evidence that Manitoba personal care homes are residents, homes, as opposed to being facilities which are used for post-hospital and rehabilitative care until the patient is able to return to the community, as is common practice in the US.

TABLE II-J: Manitoba Admission/Separation Summary by Level of Care, 1986 and 1991			
		1985/86	**1990/91**
Level 1	Admissions	242	25
	Community Discharges	11	---
	Deaths	88	17
	Total Separation	99	17
	Net Change	143	8
Level 2	Admissions	879	533
	Community Discharges	27	6
	Deaths	494	209
	Total Separation	521	215
	Net Change	358	318
Level 3	Admissions	503	372
	Community Discharges	11	7
	Deaths	553	344
	Total Separation	564	351
	Net Change	-61	21
Level 4	Admissions	108	94
	Community Discharges	1	3
	Deaths	640	412
	Total Separation	641	415
	Net Change	-533	-321
All Levels	Total Admissions	1,732	1,024
	Total Community Discharges	50	16
	Total Deaths	1,775	982
	Total Separations	1,825	998
	Total Net Change	-93	26
SOURCE: Manitoba Health, Long Term Care Branch, Special Runs, 1991b			

In the Canadian health care system, as noted earlier, virtually all long term care is part of the publicly funded or insured benefit system, however, the non-certified residences are totally private pay in most provinces. Most provinces do require nursing home residents to pay some portion of the "hotel" costs of living in a care facility. These payments are generally based on the minimum (i.e., public) pension income available to the elderly population and not on the actual “hotel” costs. The goal of most provinces is to ensure that every resident retains approximately one hundred dollars per month for discretionary spending even if they are receiving only the minimum pension. Of course, those persons with larger incomes will have more discretionary income and, in some provinces, they may decide to pay a premium for a preferred room or enter a totally private pay facility, or may purchase additional services not provided in the insured benefits.

Therefore, the costs of long term care in Canada are costs to the health system; i.e., government expenditures. This can be seen in Table II-K. In both 1985 and 1989

the level of public expenditures (the first four rows in Table II-K) provided over 63% of the total sources of funds to nursing homes. The second largest source of funds was co-insurance and self-pay (i.e., "hotel" cost contributions) at approximately 30% as described above.

TABLE II-K: Nursing Homes Expenditures and Source of Funds, Canada, 1985 and 1989		
Source	**1985**	**1989**
Dollars (in millions)		
Total	3,037	3,823
Health insurance	1,460	1,824
Social assistance	343	441
Other Provincial	22	23
Municipal	100	150
Other agencies	40	87
Co-insured, self pay	947	1,124
Other	127	174
Percent		
Total	100.0	100.0
Health insurance	48.0	47.7
Social assistance	11.3	11.5
Other Provincial	0.7	0.6
Municipal	3.3	3.9
Other agencies	1.3	2.3
Co-insured, self pay	31.2	29.4
Other	4.2	4.5
SOURCES: Statistics Canada, Special Runs 1991 (based on Health Reports, Supplement #18), Statistics Canada, Residential Care Facilities for the Aged.		

In Table II-L, the costs of nursing home care is shown in the context of all health care expenditures for Canada, but in the context of long term care expenditures for Manitoba. In 1985, nursing home care in Canada accounted for 8.5% of all personal health care costs, while in 1990 this had dropped to 7.6% of total expenditures. This occurred in spite of a one billion dollar increase in expenditures, or a 33% rate of increase, between 1985 and 1990. The total expenditures increased to $52.9 billion, an increase of 49.9% during this same period. Despite a 66.7% increase in expenditure to $500 million in 1990, home health care represented only nine-tenths of one percent of all health care costs. Based on the Manitoba data, 80.4% of all long term care costs were expended in personal care homes in 1986. This proportion had dropped to 77.3% by 1991, but the $282 million expenditure represented a 43.1% dollar increase from 1986. Unlike the national situation, home care increased by 68% from $25 million to $51 million from 1986 to 1991, and the related percent of all long term care expenditures also increased from 10.2% to 14.0% during this time. Long term care costs represented about one-fifth of all Manitoba health care expenditures in 1991.

TABLE II-L: Expenditures for Health Care by Type of Care for Selected Years for Canada and Manitoba (Dollars in millions)					
Canada		**All Personal Health Care**	**Hospital Care**	**Nursing Home Care**	**Home Health Care**
1981	CDN$	23,100	11,000	2,400	200
	US$	20,000	9,500	2,100	170
1985	CDN$	35,330	16,200	3,000	300
	US$	30,600	14,000	2,600	260
1987	CDN$	42,100	18,800	3,400	400
	US$	36,500	16,300	2,900	350
1990	CDN$	52,900	26,500	4,000	500
	US$	45,900	23,000	3,400	430
Manitoba		**Personal Care Homes**	**Home Health Care**	**Extended Treatment Hospitals**	
1981/82	CDN$	130	14	14	
	US$	112	12	13	
1985/86	CDN$	197	25	23	
	US$	171	22	20	
1987/88	CDN$	213	36	28	
	US$	185	31	24	
1989/90	CDN$	258	42	30	
	US$	224	37	26	
1990/91	CDN$	282	51	32	
	US$	245	44	28	

SOURCES: Manitoba Health, Long Term Care Branch, 1991a. Manitoba Health, Home Care Branch, 1991. Supply and Services Canada, National Health Expenditures, 1975-87, #H21-99, 1989. Statistics Canada, Special Runs, 1991 (based on Health Reports, Supplement #18). Statistics Canada, Residential Care Facilities for the Aged, 1991.

(NB: US$ = CDN$ x 0.867)

Conclusion

Policies, funding and services in long term care will continue to evolve and change over time. Having better, more complete and comprehensive data, and data which will be appropriate to producing accurate comparisons over time and are comparable across nations, will enable policy-makers and care providers to make better informed decisions. It is also useful to compare across jurisdictions within the same country which is often as difficult as cross-national comparisons. As further efficiencies and increased effectiveness is being demanded by consumers and funders alike, this project has demonstrated that common terminology or agreed upon definitions are essential and to some extent possible. Further work is required in meeting the challenges ahead for long term care and all health care as an aging world meets the twenty-first century.

III. LONG TERM NURSING HOME CARE IN THE NETHERLANDS[49]

Introduction

This paper describes the institutional arrangements for long-term care in the Netherlands. Its emphasis is on nursing homes since these institutions were the most important till the mid-eighties in taking care of the elderly who needed long-term care. The paper contains two parts.

In the first part a short overview of the Dutch health care system and some statistical data of the Netherlands are presented. After a short historical background most data concentrate on the year 1985 for reasons of international comparison.

The description of the health care system in the Netherlands is given to understand the place and function of the institutional long-term care facilities. Especially, data are presented about the arrangements for the elderly and the demographic development, since most institutional long-term care facilities have the elderly as clients.

In the second part of the paper the type of care, the characteristics of patients, the functioning of the long-term care system (nursing homes) and the outcomes are dealt with. In presenting the data on nursing homes a differentiation is made between 'somatic' and 'psycho-somatic' institutions because they represent different kinds of patients, staffing and outcomes.

Historical Background

Long-term care has developed slowly as a professional, formal care provision after the Second World War. The initiative for 'nursing-home care' was taken by 'private organizations', which were structured along religious, humanitarian principles ('pillarisation'). They were expanding their care for the poor, sick and disabled 'group members' to include care for the elderly.

Two types of institutions were founded: homes for the elderly, which were primarily housing arrangements for the (poor) elderly, and nursing homes, which were medical facilities for disabled persons who did not need hospital care, but extensive nursing. Money came from private organizations and churches. The state (government did not have a specific task in this field. The management and control, financing and

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[49] Written by Wim J.A. van den Weuvel, Ph.D., Department of Health Sciences and Department of Sociology, University of Groningen, the Netherlands.

boarding were left to the private organizations. The only task of the state was to inspect the quality of care.

In the fifties the ‘private organizations’ started to ask for support in financing the nursing homes. As a result the costs of stay for sickfund patients (an employee's health care insurance, income related) were reimbursed for a limited period. Long stay and privately insured patients had to pay the costs themselves or were dependent on charity. While the quality of care improved the stay in nursing homes became more expensive.

In the sixties the ideology of the ‘providing state’ started to take over the major role of the ‘private initiative’. In the field of health care policy the role of the state was increasing as being responsible not only for the quality of health care, but also for the number and accessibility of facilities.

Nursing Homes

In 1968 long-term care in nursing homes came under the Exceptional Medical Expenses Act (AWBZ), i.e. the stay in nursing homes was completely reimbursed when the nursing home was recognized as a qualified nursing home. So, the stay was without costs for the patient, the quality of care was ensured and nursing homes (private, non-profit organizations) could invest in new facilities with the costs being reimbursed. It was not until the eighties that nursing home patients had to make an own financial contribution to their stay related to their income/financial situation.

Homes for the Elderly

For those elderly people who wanted to live in a home for the elderly, but could not afford it financially the General Assistance Law (ABW) reimbursed their costs of stay to the home for the elderly. In the early seventies it was concluded that this arrangement resulted in a disproportionately large burden in the costs of the ABW.

In the policy memorandum ‘Nota Bejaardenbeleid’ in 1975 it was announced that the number of homes for the elderly had to be limited and should be related to the number of people of 65 years and over (the so-called 7% norm). In the beginning of the eighties it was concluded that this norm was not applied successfully, so in 1985 the provinces were instructed to plan the number of homes for the elderly according to the ‘norm’, which was now related to the number of persons of 75 years and over. The provinces were given budgets to realize this plan. It should be completed by 2001.

In 1977 each municipality had to assess the need for admission to a home for the elderly. A special committee, the so-called ‘indication committee’, was set up to make these assessments. Till 1985, however, homes for the elderly (private, non-profit organizations), were free to admit elderly persons regardless of the outcome of the assessment. This changed in 1985; then homes for the elderly were only allowed to admit those elderly persons with a 'positive, assessment.

The Growth in Institutional Long-Term Care

In the beginning (unintentionally) stimulated by state policy, later despite limiting, policy measures the increase in the number of nursing home beds and places in homes for the elderly has been impressive (as have been the costs). In table III-A this increase is demonstrated.

TABLE III-A: The Number of Nursing Homes and Homes for the Elderly and the Available Bed or Places from 1965 to 1985							
	1965	**1968**	**1971**	**1974**	**1977**	**1980**	**1985**
Nursing homes	131	167	239	293	301	326	328
Beds	10,581	16,656	28,737	38,740	42,555	46,343	49,252
Homes for the Elderly	1,528	1,863	1,865	1,730	1,633	1,547	1,575
Places	78,188	103,928	112,877	129,987	145,997	144,798	148,738
Persons 65 years of age and over (in thousands)	1,159	1,248	1,340	1,435	1,523	1,615	1,729
Percentage 65 and over	9.6	9.9	10.2	10.7	11.0	11.5	11.9

The number of nursing homes (NH) more than doubled between 1965 and 1974 and has since shown a more modest growth. However, in 1985 the number of beds in NH's was 5 times higher than in 1965, whereas the percentage of elderly people in the population increased from 9.6 to 11.9 during the same period.

The growth of places in homes for the elderly (HE) is less spectacular; it almost doubled over these 20 years. After 1977 the number of places decreased relatively. Table III-A also shows the scaling up of both institutions.

The Care Delivery System in the Netherlands

Care for the elderly and especially long-term care are closely related to the organization of the health care and welfare system in the Netherlands. So a short overview is needed of the relevant institutions, number of facilities and beds, and costs in health care. Subsequently, some specific data will be presented related to the care for the elderly.

A Description of the Health Service System

The Dutch health care system is a complex one. It can be characterized as a combination of elaborate government regulation and private delivery of health care services.[50] Government regulations include health insurance covering specific health risks/services (Exceptional Medical Expenses Act), planning (e.g. intramural health care facilities are regulated by the Hospital Facilities Act) and prices, which are uniform throughout the country, but are composed and approved by an autonomous body: the Central Council for Health Care Charges (COTG).

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[50] Van den Heuvel, W.J.A. Developments in Dutch health care policy: the ideology of market mechanism, Cahiers de sociologie et de démographie médicales, 30 (1990), 329-403.

The private delivery of services includes independent, entrepreneurial doctors, private non-profit hospital and nursing home organizations, profit and non-profit health insurance companies, non-profit district nursing organizations, entrepreneurial physiotherapists etc.. General practitioners, dentists, pharmacists, physiotherapists and medical specialists are independent workers (entrepreneurs) running their own 'store'. Most GP's, dentists and pharmacists work alone. Medical specialists and physiotherapists are mostly working in partnerships, renting beds and equipment from hospitals. Hospitals, nursing homes, homes for the elderly and other institutions are in general private, non-profit enterprises. Nurses are employed by hospitals or by district nursing organizations; the same goes for home helpers and social workers.

Till the end of the eighties health service delivery was structured in 'echelons', ranking from preventive care to long-term care, from non-institutional to institutional care, from simplicity to complexity. The idea of 'echelons' was developed in the beginning of the seventies. Each echelon was expected to fulfill specific tasks. Patients were to be referred to other echelons if these were better qualified to solve the problem. It was believed that this structure of health care would improve planning and control, and that in this way the system would be used more rationally. The 'echelons' comprise:

Public health--Including preventive activities such as vaccination, screening and health promotion, but also food inspection, hygiene etc. These services are carried out by regional or municipal (health) authorities. The services are offered to the whole population and financed from tax revenues (government).

Primary health care--In this echelon activities are patient-oriented and for the most part directly focussed on care, though they may also include prevention. Core disciplines in this echelon are: general practice, district nursing and home care. However, social work organizations, homes for the elderly, practices of physiotherapists and community service centers are also part of this echelon. In general, access to these services is free, although in some cases an assessment of the need for care is required. A financial contribution for some of these specific services was demanded from the patient. The services of district nursing and home help services are compensated by the Exceptional medical Expenses Act (AWBZ), an insurance scheme for the whole population financed from public means.

Secondary health care--Activities here are concentrated on specialized patient care. This specialized care may include outpatient and in-patient services. Theoretically access is only possible through referral by the general practitioner. This echelon includes (mental) hospitals, medical specialists and ambulatory services. The services are financed by health insurance funds (sickfunds or private health insurance companies).

Tertiary Health care--This includes nursing homes and long-term health care facilities. These institutions and services are sometimes considered as belonging to the

second echelon, or even in a position between the first and second echelon. However, it should be understood that there is no hierarchical order of hospitals and nursing homes. General practitioners may refer patients directly to a nursing home. These services are compensated by the Exceptional Medical Expenses Act (AWBZ).

The numbers of main health care facilities (divided over these echelons) are presented below. As far as possible the numbers relate to 1000 inhabitants; the year on which the data are based is also mentioned.

TABLE III-B: Main Health Care Facilities in 'Echelons' in a Specific (year), Related to 1000 Inhabitants or 1000 65+ (when possible)	
Public Health	
Number of public health services (1987)	62
Number of school health services (1987)	78
Number of ambulance services (1987)	222
Centers for infants (per 1000 living births; 1985)	9.7
Public health physicians (per 1000; 1988)	0.15
Primary Health Care	
Pharmacies (1988)	2,133
Home help services (cases of assistance; 1985)	218,909
Homes for the elderly (places per 1000 65+; 1987)	79.5
Number of health centuries (1988)	147
General practitioners (per 1000; 1988)	0.43
Dentists (per 1000; 1988)	0.50
Pharmacies (per 1000; 1988)	0.14
Secondary Care	
Number of ambulatory mental health care institutions (1987)	87
Number of thrombosis services (1987)	70
Number of blood banks (1987)	22
Specialists (per 1000; 1987)	0.81
Hospital beds (per 1000; 1987)	4.6
Hospital admission rate (per 1000; 1987)	104.1
Average duration of stay in hospital in days (1987)	12.1
Mental hospital beds (per 1000; 1987)	1.7
Tertiary Health Care	
Nursing home beds (per 1000 65+; 1987)	3.4
Part-time treatment in nursing homes (places; 1987)	2,803
Institutions for the mentally deficient (per 1000; 1987)	2.1
Institutions for the sensorily handicapped (per 1000; 1987)	0.1

Costs and financing--The cost of health care as a percentage of the gross national product at market prices was 8.2% in 1980 and 8.5% in 1987. The cost per head of the population was 1949 guilders in 1980 and 2491 guilders in 1987. The total health care costs amounted to 36,537 million guilders in 1987. The intramural care accounted for 57.2%, extramural care for 37.1%.

TABLE III-C: Costs and Financing Health Care in 1987	
Public health	6.5
Primary health care (excluding homes for the aged, district nursing and home help services)	13.9
Secondary health care	54.3
Tertiary health care	19.9
Administration policy	5.4

As far as the health care system is financed through patient insurances there are four different ways.

1. Some general and exceptional medical expenses are financed by the Exceptional Medical Expenses Act (AWBZ). On the one hand this includes, for example, district nursing and on the other hand it covers expensive long-term care like nursing homes and psychiatric hospital care. The scheme is financed from compulsory employers, and employees, income-related premiums. The act covers the whole population. In 1987 the costs were 9.9 billion Dutch guilders.

2. Employees below a certain income level (compulsory) and other lower income groups are (compulsory) insured by Health Insurance Funds (Sickfunds), private non-profit (social) insurance companies. The money is provided by compulsory employers, and employees, premiums, which are mainly income-related. General practitioners receive an annually fixed amount for each patient registered in their practice. Care is provided free. For secondary care, annually fixed fees for services are paid by the Sickfunds to medical specialists and hospitals. These health insurance funds cover about two third of the population. In 1987 the costs amounted to 15.9 billion Dutch guilders.

3. Higher income groups are insured by private (profit) health insurance companies. In general, the privately insured patient will pay a fee to the general practitioner. Other care is reimbursed by the insurance companies (fixed national rates). Insurance by private companies covers about 30% of the population. The total cost in 1987 amounted to 7.4 billion Dutch guilders.

4. Insurance for persons in the public services is statutory for civil servants employed by provincial and municipal authorities. The premium is mainly income-related. Arrangements vary, but are very similar to those of private insurance companies. About 6% of the population is insured in this way. In 1987 the total cost was 1.4 billion Dutch guilders.

The annual rates are negotiated between medical care professionals and insurance companies/sickfunds and must be approved by the COTG (see above) whose members are appointed by the Government, employers, and employees, organizations, insurance companies and organizations of health care professionals. Premiums are adjusted to these rates. Another council (Sickfund Council, ZFR) decides which activities (diagnostic procedures, types of treatment, drugs etc.) are covered by health insurance; they do not fix prices, which is the task of the COTG. A third body

(National Hospital Facilities Board) advises on (the planning of) the number of hospitals/nursing homes and the number of beds. Provincial Health Councils should make regional health plans (regionalisation and decentralization), but prove to be less influential.

The National Council for Public Health (composed of members from all relevant national associations and of independent experts) advises the Government on all issues concerning health (care) policy. The Health Council is a council which advises the Government on the 'state of the art' of specific medical developments (e.g. on liver transplantation, breast cancer screening).

Data on Facilities and Costs of Care for the Elderly

While we are concentrating on long-term and institutional care, it should be kept in mind that the majority of elderly persons live independently, as can be seen from the overview.[51] In 1982 about 13% of elderly people were in institutions. These data are cross-sectional. The proportion of those ever experiencing a stay in a home for the elderly or a nursing home is substantially higher, ±35%.[52]

TABLE III-D: Housing Conditions and Care for Those Aged 65 and Over in the Netherlands, 1982

	Percent
Living independently	57.5
Living with help (outside of institutions)	29.5
With home help	10.5
With district nurse	1.5
With home help and district nurse	2.5
Living in sheltered housing	15.0
With no care	8.0
With care	7.0
Living in institutions	13.0
Homes for the elderly	9.0
Nursing homes	3.0
Hospital	1.0
SOURCES: CBS 1984; Van den heuvel 1989.	

By sheltered housing (Table III-D) is meant adapted housing for the elderly. This may include architectural (no stairs etc.) and service (alarm, services nearby etc.) adaptation. Most of these sheltered houses are especially designed for the elderly. By (formal) care for elderly living independently at home or in sheltered houses is meant care by home help or community nurse.

Table III-D shows the balance of expenditure on costs of care for the elderly between institutional and community services. In the calculation of these costs a correction was made for the proportion of users younger than 65 years. Spending is

[51] Van den Heuvel, W.J.A., The use of care facilities by psychogeriatric patients, Nieuw Toutenburg, paper, 1988.

[52] Van der Zanden, G.H.J.M. Levensloop en instituutsopname: de versluierende werking van het percentage, TG&G 13 (1982): 139-46.

unevenly distributed over community and institutional care. Large budgets are spent on institutional facilities. These are almost four times higher than the total budget spent on community care. The ratio of community care: institutional care did not change between 1975 and 1985.

Within community care, district nursing and community mental-health care (including a special section for elderly people) have received relatively larger budgets, while there has been a decrease in expenditure for general practitioners. Within institutional care there has been a relative increase in the nursing-home budget (psycho-geriatric nursing homes), while less is now spent on mental hospitals. The proportion spent on other services, including home help, has remained unchanged. The relatively high spending on institutional care operates as an incentive for policy-makers to stimulate and explore possibilities of substitution.

TABLE III-E: Expenditure of Community and Institutional Care for the Elderly in Millions of Guilders (fl.), 1975 and 1985

	1975	1985
Number		
Total	12,690	25,498
Community care	2,200	25,498
Home-help service	841	1,544
District nursing	288	748
Community mental-health care	182	642
General practitioners	889	1,470
Institutional care	10,490	21,094
General hospital	5,584	11,108[1]
Mental hospital	1,082	2,014
Nursing home	1,627	2,556
Old people's home	2,197	4,416
Percent		
Total	100.0	100.0
Community care	17.3	17.2
Home-help service	6.6	6.0
District nursing	2.3	2.9
Community mental-health care	1.4	2.5
General practitioners	7.0	5.7
Institutional care	82.7	82.8
General hospital	44.0	43.5
Mental hospital	8.5	7.8
Nursing home	12.8	13.9
Old people's home	17.3	17.3

SOURCES: FOGM 1987; CBS 1976

1. All age groups; +/- 40% of the costs are due to patients 65 years of age and over.

Table III-F shows the supply of service relative to the number of older people in 1975 and 1985. In the Netherlands institutional services have a relatively large capacity. In addition, many hospital facilities are available for all age groups. If we compare institutional services over a period of 10 years, a decrease in capacity

(expressed as standardized data) is visible, with the exception of psycho-geriatric nursing homes.

TABLE III-F: Developments in the Availability in Institutional and Community Care for the Elderly in the Netherlands, 1975 to 1985		
	1975	**1985**
Institutional Care		
Old people's homes (places/100 of 86+ years)	9.44	8.05
Psycho-geriatric nursing homes (beds/100 of 65+ years)	0.80	1.27
General (non-psychiatric)		
Nursing homes (bed/100 of 65+ years)	1.78	1.61
General hospitals (bed/total population)	4.47	3.79
Mental hospitals (beds/total population)	1.76	1.68
Community Care		
Community mental health care for the elderly (per 1000 65+ years)	---	0.17
District nursing per (per/1000 of 65+ years)	2.69	3.65
Home-help service (per/1000 ofd 65+ years)	21.35	20.72
General practitioners 1000 of 65+ years	3.11	3.46

Demographic Developments

Demographic Data of 1985

On 1 January 1985 the Netherlands had 14,453 million inhabitants. The number of inhabitants of 65 years and over was 1,729,746.; i.e. 11.9% of the total population.

The division among the older age groups and gender is presented in table III-G. The table also shows the percentages of marital status and gender. The number of females exceeds the number of males in old age, especially among the old-old.

TABLE III-G: Age Groups (65 and over) and Marital Status (proportionally) by Gender in 1985			
Age Group	**Male**	**Female**	**Total**
		Number	
Total	695,611	1,034,135	1,729,746
65-69 years	240,593	293,276	533,869
70-74 years	197,716	272,999	470,715
75-79 years	134,292	220,162	354,454
80-84 years	76,654	146,146	222,800
85 years and over	46,356	101,552	147,908
		Percent Distribution	
Marital status	6.1	10.3	
Single	74.9	38.4	
Married	16.3	47.8	
Divorced	2.7	3.5	

Of men of 85 years and older 2.6% is married; 0.8% of women of 85 years and older is married. The proportion of people of 85 years and over is 8.5% of the 65 years and over.

The dependency ratio is defined as the number of persons of 0-19 and 65 years and older divided by the number of persons between 20 and 64 years x 100%. The dependency ratio in 1985 is 67.2%.

The life expectancy at birth in 1986/1987 was 73.6 years for men and 80.2 years for women. The life expectancies at the age of 65 and 80 are presented below: Life expectancy in 1986/1987 for men and women at age 0, 65 and 80 is presented in Table III-H.[53] The 'overaging' of women above men is shown at all age levels.

TABLE III-H: Life Expectancy by Gender at Ages 0, 65 and 80		
Age	**Male**	**Female**
0	73.6	80.2
65	14.3	19.1
80	6.3	8.5

Projections of the population in the Netherlands The projections of the future population composition, as shown in Table III-I, are based on a study by the Netherlands Central Bureau of Statistics.[54] The figures presented are the so-called 'medium variant'. Due to uncertainties concerning fertility, mortality, external migration and (re)marriages and divorce CBS calculates a low, medium and high variant.

TABLE III-I: Projections 2000, 2010, 2020 and 2030 by Age Groups (65-79 and 80 years and over) and Gender (x 1000) (Number in thousands)

Year	Male		Female		Total	Percent
	65-79	80>	65-79	80>		
2000	722	152	929	366	2,169	13.8
2010	832	186	996	433	2,447	15.1
2020	1,091	211	1,303	458	3,066	18.8
2030	1,221	289	1,482	593	3,585	22.3

The figures show the continuous process of the aging of the population and particularly the increase in the number of very old persons. The numbers of the age group of 90 years and older are respectively (x 1000): 17 and 62; 19 and 73; 23 and 86; 26 and 90.

As to mortality it is expected that the negative influences (like socioeconomic differences, environmental factors etc.) will not outweigh the positive influences (like medical technology, nutrition, hygiene etc.). Life expectancy at birth will continue to increase from 73.6 in 1986/1987 to 75 years in 2010 for men, and from 80.2 (1986/1987) to 81.5 (2010) for women.

[53] Vademecum Gezondheid, CBS, SDU, Den Haag, 1989.

[54] Bevolkingsprognose voor Nederland 1988-2050, CBS, SDU, Den Haag, 1989.

Characteristics of Nursing Homes and Their Patients

In the seventies several studies were carried out on the characteristics of the nursing home population, their adaptation to institutional life, their contacts with the 'outside' world and the quality of their lives and of the care. These studies are based on small-scale samples including 2 to 6 nursing homes.

However, nationally based data are available through a national registration system on numbers and characteristics (like age, ADL, living situation, diagnoses) of patients at admission and at discharge per year. Besides the numbers and characteristics are 'measured' on a specific date in each year. 83% of all nursing homes are supplying these data to the national registration system (SIVIS).[55]

Administrative Criteria

As mentioned above, since 1967 nursing homes are financed by the Exceptional medical Expenses Act (AWBZ) (nationally based; premiums are paid by % of salaries). As shown in table III-A this financing system allowed for a strong growth in the number of nursing homes. After permission to build a nursing home (based on norms and criteria about size, staff etc.) all costs are in fact reimbursed by the 'bed price'. The allowance to build or renovate a nursing home (and getting financed by the AWBZ) is a weak way of certification.

As indicated before, all nursing homes are organized on a non-profit base; most of them are private foundations as are homes for the elderly.

Until recently patients admitted to a nursing home did not need to spend any of their own money (in contrast with the homes for the elderly). Since 1990, however, a contribution in the costs of staying in a nursing home is required. This contribution is income-related.

The central government puts forward criteria for the number of beds, staff, equipment, capacity etc. The planning of nursing homes is a task of the provinces.

In 1990 the 'bed norms' were reviewed. Now the norm is based on 0.08% of the total population + 5% of all people aged 75 years and over in the province. At least 2.9% (as part of the 5%) is reserved for psychogeriatric patients. (In the 'big cities' a slightly different norm is used; i.e. 6% and 3.5% psychogeriatry).

Numbers and Functional Criteria

In the Netherlands in 1985 there were 328 nursing homes. The total number of beds (including 1 October beds) was 49,252; that is 3.4 beds per 1000 inhabitants and 28 per 1000 persons of 65 years and older. As mentioned before there is no formal

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[55] Sivis jaarboek 1985.

assessment procedure for admission. However, the government intends to develop a common assessment system for nursing homes and homes for the elderly (see below).

The so-called ‘1 October beds’ are located in homes for the elderly; their total is 808; their number is decreasing and the special rule is ended in 1991. Without the ‘1 October beds’ the average number of beds was 48,863 in 1985. The occupancy rate was 97.9%. The division among ‘type’ of nursing home is as presented in table III-J.

TABLE III-J: Types of Nursing Homes by Number of Beds in 1985		
Somatic	15,197	97.1
Psychogeriatric	11,706	98.3
Combined		98.4
Somatic	11,902	
Psychogeriatric	10,058	

The average age on admission (institutionalized) is 75.2 for male and 78.1 for female patients. Patients admitted to psychogeriatric nursing homes are older (77.8 and 79.8) than patients admitted to somatic nursing homes (74.3 and 77.6). Patients admitted to day care are on average younger: 72.3 for men and 75.1 for women.

The following items are used to indicate the level of activities of daily living:

- washing upper part
- washing under part
- dressing
- toilet (w.c.)
- eating

Based on the 5 ADL-items an index is constructed with a range from 0 to 5. The items are scored as: 0 = no assistance, 1 = assistance needed (based on a subscore: partly-completely needed).

The average ADL-index on admission was 3.9 for institutionalized patients and 3.6 for day care patients.

In 1985 27,778 patients were newly admitted to a nursing home; 20,829 (75%) somatic patients and 6,949 (25%) psychogeriatric patients. (4,695 patients newly admitted in day care; 62.6 somatic and 37.4 psychogeriatric). As shown in table III-K most patients admitted in 1985 had been in hospital before admission; this is especially the case for patients who are admitted to somatic nursing homes. About 25% of the newly admitted patients was living at home. Almost 1 out of every 5 psychogeriatric patients came from a home for the elderly.

TABLE III-K: Place Where Patients Stayed Before Admission (somatic/psychogeriatric); New Admissions, 1985			
	Total	Somatic	Psychogeriatric
Other nursing home	2.7	1.8	6.3
Home for the elderly	8.8	6.6	19.0
Hospital	59.5	64.2	33.3
Psychiatric hospital	2.0		
At home	25.2	24.3	30.7
Other	1.7		

In 1985 27,441 patients left the nursing homes; 12,156 were discharged (doubles excluded) and 15,285 died. These figures also include patients under 65 years. For patients of 65 and over the figures are presented in table III-L. The somatic nursing home was left by 18,117 patients aged 65 and over, the psychogeriatric by 6,022 patients.

TABLE III-L: Numbers of Deceased and Discharged Patients by Age and Type of Nursing Home						
Age	Type of Nursing Home					
	Total		Somatic		Psychogeriatric	
	Dead	Alive	Dead	Alive	Dead	Alive
Age 65 and over	15,916	9,027	8,069	8,012	4,847	1,015
Age 65-74	1,884	2,520	1,448	2,330	436	190
Age 75-84	5,756	4,516	3,620	3,983	2,136	533
Age 85 and over	5,276	1,991	3,001	1,699	2,275	292

In somatic nursing homes more than 8,000 older patients leave the home alive vs. about 1000 patients in psychogeriatric nursing homes (50% vs. 17%).

Table III-M presents the places patients went. About a quarter left the nursing home to return to their own home; however, most of these patients came from a somatic nursing home. Almost 80% of psychogeriatric nursing home patients die in the nursing home.

TABLE III-M: Deceased and Discharged Patients by Type of Patient and Place After Discharge			
	Total	Somatic	Psychogeriatric
Other nursing home	3.1	2.4	5.1
Home for the elderly	8.6	10.9	1.5
Hospital	7.2	7.7	5.6
Home	23.1	28.8	5.8
Home plus day care	3.5	3.8	2.6
Other	0.1	0.1	0.1
Deceased	54.4	46.3	79.2

Personnel and Costs

In 1985 67,899 persons were employed in nursing homes. The average number of occupied workplaces was 52,321. The composition of the staff is as follows in Table III-N:

TABLE III-N: Composition of Staff in Nursing Homes, 1985	
Administrative	12,775
Nurses (skilled/in training)	33,024
(Para)medical assistance	4,000
Medical staff and scientists	541
Trainees, other	1,981

One physician is available for 93 beds

The total costs were 3.556 billion Dutch guilders in 1985. The average price per bed is 72,200 Dutch guilders per year.

Characteristics of Homes for the Elderly and Their Inhabitants

Administrative Criteria

As was explained in the 'historical background', in 1977 the government set criteria (norm) for the number of places in homes for the elderly: 7% of all persons aged 65 years and over. By that time the percentage of elderly people living in a home for the elderly was higher. Together with this norm it was 'compulsory' that the needs of older persons who wished to be admitted to homes for the elderly, should be assessed by a specific committee (which must at least include a physician and a social worker). In each region a so-called indication committee, was set up. The homes for the elderly were expected not to admit elderly persons without an indication'. At the same time, however, until 1985 they were free to choose among the elderly who were seen by the committee (with or without 'indication').

Numbers and Functional Criteria

By the end of 1985 the maximum capacity in homes for the aged was 149,000 'places'; 92% of this maximum was used. So, the total number of older people living in a home for the elderly by the end of 1985 was 137,527 (of which 136,238 were 65 and over). The majority of residents are women (74%).[56]

Of all people of 65 years and over 7.7% lived in homes for the aged; nearly 5% of the men and 9.5% of the women 65 years and over. In 1985 23,861 persons entered a home for the elderly; 24,775 residents left. Newly admitted residents came mostly from home or hospital.

The number of persons of 65 years and over staying in a home for the aged on 31 December 1985 and their 'validity' are presented in table III-O.

[56] Statistiek van de bejaardenoorden 1985, CBS, SDU, Den Haag, 1989.

TABLE III-O: Invalidity by Gender in Homes for the Elderly, 1985			
	Male	**Female**	**Total**
Number			
Total	35,000	101,200	136,200
Percent			
(Practically) continuous bedfast	2.8	3.0	2.9
Not bedfast but completely disabled (infirm), i.e. need assistance with the following 4 activities: dressing, washing, eating and toilet	16.3	19.0	18.3
Not bedfast but partially disabled, i.e. need assistance in 1 to 3 activities of the four mentioned activities	34.6	38.0	37.1
Not physically disabled (no assistance of the 4 activities)	46.4	40.1	47.1
SOURCE: Statistiek van de Bejaardenoorden, CBS, 1989 (Statistics of homes for the aged).			

Outcomes

The majority of residents leaving the home for the elderly in 1985 (24,775) were deceased (79%; 19,477 persons). Of those residents who left the homes for the elderly alive (5,298) 14% went back to their own home (or family), 19% went to another home for the elderly, 62% was admitted to a nursing home and 5% into a psychiatric hospital.

Personnel and Costs

Altogether about 74,000 people were employed in homes for the aged. In full-time equivalent (fte) the number of employees was 52,649 in 1985; 54% is nursing and caring personnel; 46% is not.

The total expenditure was 4.416 billion Dutch guilders. The residents contributed 1,800,000.-, whereas 2,200,000.- were government subsidies (General Assistance Law).

In the Dutch welfare system the cost of living in a home for the elderly (on average 3,000 guilders a month in 1990 for persons living alone and 4,500 for couples) are paid to the institutions by the municipal authorities under the State Pension Act (AOW) and supplemented by the provincial authorities or by the elderly persons themselves, if their capital exceeds 48,000 guilders (1990) or if they own substantial property like e.g. houses.[57] People in a home for the elderly receive a monthly allowance under the General Assistance Act (ABW) (268 guilders per month for those living alone, 464 for couples in 1990). Moreover, people can request additional financial support in case of an emergency or special problems. The vast majority of those living in homes for the elderly were (and are) supported by the General Assistance Act.

[57] Statistisch vademecum ouderen 1990, CBS, SDU, Den Haag, 1990.

Developments Since 1985

As explained before the emphasis in this paper is on the situation as it was around 1985.

Since then, however, the ideas on the organization of health care and the role of institutional care as well as financing long-term care have been discussed extensively.

Innovations in care were proposed and are being introduced gradually. The most important ones are mentioned briefly: - in 1987 a committee (the so-called Dekker committee) published a restructuring of the health care system. This plan was followed by a policy memorandum in 1989, in which the basic ideas on restructuring put forward by the Dekker committee were worked out.

I.e. the health care system should be seen as a market system with three parties: the 'health-insurance-companies' (responsible for offering care packages to their clients and negotiating with care-providers and professionals on the content and price of the services), the 'care-providers' or 'professionals' (who have to offer their services in clearly defined functions) and 'clients' (who are entitled to care and must be accepted by the insurer they choose).

All services are covered under one law which specifies the basic services to be included and the premiums to be paid by the clients. These premiums are income-related and serve as a financial basis (through a qualified budget system) for insurance companies. In addition, each client has to pay a nominal premium and has the possibility of taking an own risk, on services not in the basic insurance.

- Community long-term care (replacing nursing home care, enabling a shorter stay in the hospital and preventing admission to homes for the elderly) is strongly promoted by experiments and so-called substitution projects. As a result of these policy intentions the cooperation between home help services and community nursing services is intensified and has resulted in one new organization of community care (excluding the general physician).

- Besides the cooperation between homes for the elderly and nursing homes is stimulated. It is proposed that they develop (maybe together with the community care organization) a common assessment system and use the same financial rules for clients, contributions to the costs of their stay (income-related).

Results of evaluation research on these innovations are available. It is expected that in 1992 and 1993 a more unified system will be realized.

IV. INTERNATIONAL COMPARISONS OF LONG TERM CARE: NORWAY AND THE SCANDINAVIAN SOLUTIONS[58]

Introduction

This part is primarily about Norway. To broaden the perspective, however, the two other Scandinavian countries -- Denmark and Sweden -- to some extent will be taken into consideration. The organization, financing and functioning of the health and social services is **basically** similar in these three countries. The system has been called "The Scandinavian Model of Welfare".[59]

There are also interesting differences of course, -- not least in goals, structure, level and current development of services in long term care. Broadly speaking, the Norwegian LTC system places itself somewhere in between the quite radical Danish and more traditional Swedish solutions. On the other hand, there are how strong tendencies of convergence between the LTC systems of the three countries.[60] So in the following analysis, Norway with its 4,2 million people is representing a median case in Scandinavia between Sweden (8,5 millions) and Denmark (5,1 millions).

In the presentation I will comment briefly on issues where Norway deviates **markedly** from one or both of its neighbours. A short, systematic summary of comparisons between the three LTC systems is given in the final section titled ‘A final note on Denmark and Sweden.’

The Basic Political-Administrative Context of the LTC System

In order to understand the development and current state of the LTC system in Norway and Scandinavia, one has to be aware of some basic characteristics of the political-administrative apparatus in which it is embedded.

The LTC-system is part of a comparatively large **public sector**. Approximately only 15% of the volume of Norwegian LTC services for the elderly has been provided by voluntary (i.e. religious and humanitarian) organizations in the 1980s.[61] The voluntary sector, however, is part of public health care plans and almost completely financed through public sources. A private (profit) sector is almost non-existent due to lack of a market for this kind of service provision.

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[58] Written by Tor Inge Romøren, MD, MA, The Norwegian Research Council for Applied Social Science.

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[60] Aldreomsorg i Norden -- kostnader kvalitet, styrning. Statskontoret, Rapport 1987:34, Stockholm 1988.

[61] Daatland SO, Ressurser of ressursbruk i eldresektoren. Norsk Gerontologisk Institutt, Rapport 5-1990, Oslo 1990.

This orientation towards public welfare solutions have long historical traditions. It can be traced back to late middle ages ("legdeordningen"), was renewed through the revised Poor Law legislation at the turn of this century and got a modern form through the development of the public welfare programmes after the second the world war.[62] These programmes were built up under the leadership of continuous social democratic governments up to 1965 -- supported in all basic issues by the other major political parties.

The public sector in Norway is **mostly** tax-financed with indirect taxes (e.g. value added tax) being the dominating single source of income to the public economy. Almost half the national product is redistributed to the citizens through the public sector. Of this, about half goes to funding the health and welfare services including a national pension system and other kinds of social security. The elderly are without any comparison the largest consumer group of the public sector expenditure, with a total consumption equal to 9 billion USD -- or 13 000 USD per person 65+ -- in 1985. Of this, 45% was services (including hospital services) and the rest pension expenditures.[63]

The public sector is managed through **three levels of government**, with separate political and administrative bodies and separate tax-income: national, county and local (municipal) level. The social security system is run nationally, the hospital system by the counties, and primary health and social care -- including all kinds of community and institutional LTC -- at the local level. There are 19 counties with a population of 220000 inhabitants on average, and 450 municipalities with a mean of 9000 per unit. The range of the municipalities is large, however, from 500 to 500000 people, with a median of only 4000 people.

The result of this administrative structure is a comparatively **decentralized** LTC system with **small units** in the hands of local authorities responsible to small -- and often scattered -- populations. For instance, the average size of a nursing home was 42 beds in 1990.[64]

National government is sharing the cost of services given on county and municipal level. The total amount of resources transferred from national to county and municipal level counts for 30-50% of total budgets on these levels. From 1980 the sharing has gradually shifted from a fixed part varying from 25-75% of the different services to **block grants** given from national government to the lower levels of administration based on criteria of "need" -- in practice mostly population criteria.

From 1986 these block grants have been given to counties and municipalities as **one net sum** to cover the national grant to **all** kinds of public services (education, roads, health etc.) to the lower levels of administration. In this process the Danes have

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[62] Seip AL, Om velferdsstatens framvekst. Universitetsforlaget, Oslo 1981.

[63] Romøren TI, Helse of velferd. Cappelen, Oslo 1988.

[64] Søbye E, Institusjoner for eldre 1989. Statistisk sentralbyrå, Rapporter 90/22, Oslo 1990.

been the earliest and most radical, while the Swedes -- due to a more centralized and bureaucratic tradition -- are still in the early stages. County or Municipal Councils in Norway now independently decide how resources should be divided between the kind of services they have the responsibility for giving. To illustrate the current situation, it can be mentioned that at municipal level about 49% of total budgets have been spent on health and social services the last years, 26% on primary schools.[65]

Demographic Data

Norway has had a rapid growth of its total population of elderly in the period 1955-1990. The number almost exactly doubled, from 347800 to 690900. From now on, it will diminish a little, as seen from Table IV-A. This is due to small birth cohorts in the period of economic depression and war-time (1925-45). The "baby-boom" with large birth cohorts from the period 1945-70 will lead to a rapid rise again of the total population of elderly after 2010.

The number of the oldest old (85+) -- most likely in need of LTC -- show another pattern. It will continue to grow until about 2005, representing large birth cohorts in the decades between the turn of the century and the economic depression. Then the number diminishes for a couple of decades and rise again -- reflecting depression and war with the following baby-boom as described above.

TABLE IV-A: Demographic Data, Population Aged 65 Years and Over, Norway 1985-2030

	Registered[1]		Projections		
	1985	**1990**	**2000**	**2020**	**2030**
Number in Thousands					
Total	4,153	4,233	4,420	4,653	4,731
65 years of age and over	653	691	674	815	931
85 years of age and over	56	65	85	88	100
Percent					
Aged 65 years and over	15.7	16.2	15.1	17.7	19.7
Aged 20-64	56.2	57.3	59.2	58.6	56.9
Aged 0-19	28.1	26.5	25.7	23.7	23.4
Percent of 65 and over population aged 85 and over	8.6	9.5	12.6	10.8	10.8
Total dependency ratio	78.0	74.5	69.6	69.9	76.9

SOURCE: Befolkningsstatistikk 1985 Hefte III, Central Bureau of Statistics, Olso 1987 and Norges offisielle statistikk, NOS B 983, Alternativ KM1, Central Bureau of Statistics, Olso 1991.

1. According to the Central Population Register.

The overall dependency ratio (defined as the number of population 0-19 **and** 65+ divided by the number 20-64 x 100) was 78,0 in 1985. It is now diminishing and is not expected to reach today's level before in 40 years. It can be seen from the table that the proportion of elderly counts for most of these differences over time.

[65] St.meld.nr.36 (1989-90) -- Røynsler med lova om helsetenesta i kommunane. Sosialdepartementet, Oslo 1990.

The life expectancy in Norway was 72,6 years for men and 79,4 years for women in 1985. It is now 73,3 years for men and 79,9 years for women. It is expected to rise to 75,0 and 81,6 years respectively in the year 2010.

The demographic data shown here differs a little between the Scandinavian countries. Denmark has a little bit younger population, Sweden an older one compared to Norway. In spite of this different starting points the patterns of further development as seen form population projections are quite similar.[66]

Evolution of Long Term Care in Norway

The evolution of modern Norwegian LTC services is described here using a time frame covering shifting trends in national policies. These policies have been highly incremental. And when new goals have been set, they have been fairly global. This is also the case with policy measures. By and large, the repertoire of measures mostly has consisted of shifting general administrative and/or financial frameworks for the provision of services. A more detailed analysis of these processes is given by the author elsewhere.[67]

In the following analysis, data from two sources are used. There are, first, simple administrative data gathered on a national base and edited by the Central Bureau of Statistics since 1970. Recently, these data have been refined, combined with other national statistics and tabulated in a time series form by the Norwegian Institute of Gerontology.[68] Second, there are data from improved routine data collection in long term institutional care, also made by the Central Bureau of Statistics, since 1990.[69]

LTC services for the elderly in Norway have two parts

- Institutions:
  - Nursing homes
  - Homes for the aged
- Community care:
  - Sheltered housing
  - Home help
  - Home nursing

Community care includes medical services, but they are both provided to and used by the general population, and therefore not included here.

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[66] Aldreomsorg i Norden -- kostnader kvalitet, styrning. Statskontoret, Rapport 1987:34, Stockholm 1988.

[67] Romøren TI, Ut av sykehjemmet. Magistergradsavhandling i sosiologi, Institutt for sosiologi, Universitetet i Oslo, Oslo 1984.

[68] Daatland SO, Ressurser of ressursbruk i eldresektoren. Norsk Gerontologisk Institutt, Rapport 5-1990, Oslo 1990.

[69] Søbye E, Institusjoner for eldre 1989. Statistisk sentralbyrå, Rapporter 90/22, Oslo 1990.

Traditionally, nursing homes have functionally and legally been classified as medical institutions, mostly coming under health authorities. Homes for the aged have been social institutions, offering a common household with 24 hour staffing for people not able to live in their own homes, but not in need of continuous medical or nursing services. However, in many communities the two sorts of institutions are combined in one building.

1955-1970: Doubling of Institutions, Establishing a Structure

When public discussions over a LTC policy in a modern sense started -- around 1955 -- there were LTC institutions for the elderly in almost every municipality, which also owned and ran 70% of them. A limited community care existed at that time, too, with religious and other voluntary organizations responsible for this activity.

As a consequence of pressure group activity,[70] central government authorities were involved in setting standards for both the quality and the quantity of LTC institutions at the end of the 1950s. Regulations to be followed by the local authorities were adopted. Central government also adopted financial incentives to expand the institutional LTC sector in the municipalities rapidly. A ratio of provision of 7 nursing home beds per 100 70+ (in many European countries called "the seven per cent rule") was set up as a goal in this period. At the end of the 1960s central government also launched programmes to be carried out by local authorities to establish more comprehensive community care for the elderly, based on home help, home nursing services and sheltered housing.

TABLE IV-B: Growth of Institutional Long Term Care in Norway 1955-1988

Year	Nursing Homes	Homes for the Aged	Total	Percent Increase Per Year
Number of Beds				
1955	n.a.	n.a.	17,576	
1970	13,480	18,085	31,565	5.3
1975	19,465	15,617	35,082	2.2
1980	26,709	14,042	40,751	3.2
1985	29,532	16,072	45,607	2.4
1988	30,485	16,976	47,461	1.3
Beds Per 1000 Persons 65 Years of Age and Over				
1955	#	#	51	
1970	27	36	63	
1975	36	28	64	
1980	44	23	67	
1985	45	24	69	
1988	44	24	68	

SOURCE: Daatland SO, Ressurser og ressursbruk i eldresektoren. NGI Rapport 5-1990 and Vital statistics and migration statistics. Central Bureau of Statistics.

[70] De gamles helsekomite: Gamle -- of pleiehjem i Norge. Norske gerontologiske skrifter nr.2 1956, Oslo 1956.

As a result of these national policy initiatives, a number of new LTC institutions were built. The number of beds almost doubled before 1970 (Table IV-B), and the ratio of provision for both types of institutions rose from a total of 51 to 63 per 1000 65+. The basic structure of the main components in the care for the elderly (including community care) was laid down. The voluntary sector was far outnumbered by the public sector, because all growth in services from now on took place here.

1970-1980: Centralizing, Medicalizing, Expanding

As a result of major changes in the **hospital** sector in the late sixties,[71] the administrative and financial structure of institutional LTC also changed. In 1970, the responsibility for running **nursing homes** was moved to the county level. Nursing homes were to be run together with the hospital sector. In this sense, parts of the institutional LTC system were obviously centralized and "medicalized" in this period.

Political authorities made these changes hoping to solve both problems of quality and of funding a planned major expansion of the nursing home sector.[72] Public funds for institutional health care were still quite abundant at that time, larger and less in a squeeze than scarce municipal budgets.

The homes for the aged, together with all community care were left to the municipalities. With the exception of the homes for the aged, 50 to 75% of the cost for the different services was covered by central government grants at that time.

The LTC system changed considerably through these years. As seen from Table IV-B, the number of beds in the homes for the aged fell, while the number of nursing home beds doubled. The net result was expansion of institutional LTC, with a changed balance: from 0,75 to 1,9 nursing home beds per bed in the homes for the aged. A new -- and stable -- level of provision of institutional LTC was reached: 44-45 nursing home beds and 23-24 beds in homes for the aged per 1000 65+. This level has persisted until now.

There was also a considerable expansion of community services, as indicated by the figures in Table IV-C.

In a period of ten years then, the LTC services changed from a system dominated by locally run homes for the aged to a system on a higher level of provision, based on a medically oriented nursing home sector run on a county level, and newly developed home care services run by the municipalities, supplemented by a diminishing volume of homes for the aged.

[71] Ot.prp.nr.36 (1967-68) -- Om lov om sykehus m.v. Sosialdepartementet, Oslo 1968.

[72] Ot.prp.nr.36 (1967-68) -- Om lov om sykehus m.v. Sosialdepartementet, Oslo 1968.

TABLE IV-C: An Overview of Growth of Community Care in Norway			
Year	**Sheltered Housing Per 1000 65+**	**Home Help Users Per 1000 65+**	**Home Nursing Patients Treated Per 1000 65+**
1958	9	---	---
1965	---	130	55
1975	28	203	---
1980	35	---	110
1985	40	221	---
1988	37	205	150
SOURCE: Daatland, SO, Ressurser og ressursbruk i eldresektoren. NGI Rapport 5-1990 and Vital statistics and migration statistics, Central Bureau of statistics.			

1980-1990: Resource Constraints, Reorganization and Rethinking Service Ideologies

Since the end of the 1970s, the volume of services closely kept pace with a less rapid aging of the population. Hence, the level of provision of the total LTC services has been almost stable. The only exception is the home nursing service which central government continued to stimulate by reimbursing 75% of the costs until-1984.

In this period, Norway -- as well as Sweden and Denmark -- experienced constraints in public expenditure which lead to a search for more cost-effective solutions in the whole public sector, as well as in health and social services, including LTC.

In the 1980s, health and social services have been reorganized according to the principles of decentralization and of primary care in the community as a base for all other services.[73] The division of labour and financial relations between levels of government in this reorganized system of welfare has been explained in the introduction of this paper.

The process of reorganization was not completed for the LTC sector until 1988, when the responsibility for running nursing homes were transferred back to the municipalities. From that time, local authorities have had the total responsibility for **all** LTC services in the country: nursing homes, homes for the aged, sheltered housing, home help, home nursing etc. -- partly financed by general block grants from central government and partly by local taxation.

It is proposed that this administrative and financial framework establishes the right incentives for the local authorities to run services with a maximum of flexibility and effectivity. In this process, elements of the care for the elderly in Denmark have been taken as a model for renewing the ideology of the Norwegian LTC system: these include less emphasis on a medical orientation, more emphasis on the residential aspects of LTC, shifting the balance of resource allocation heavily towards community care.[74]

[73] NOU 1979:28 -- Helse -- of sosialtjenesten i kommunene. Sosialdepartementet, Oslo 1979. NOU 1982:10 -- Spesialistene i helsetjenesten, pleiehjemmene m.v. Sosialdepartementet, Oslo 1982.

[74] St.meld.nr.68 (1984-85) -- Sykehjemmene i en desentralisert helse-of sosialtjeneste. Sosialdepartementet, Oslo 1985.

As these reforms have been prepared and set into action during the 1980s the development of the LTC sector in the period can be summarized in the following way:

- a diminishing growth of resources is more and more channeled to community care
- nursing homes are being used in new and different ways, with more of their capacity transferred to rehabilitation, respite care, terminal care and to the care of patients with dementia
- at an organizational and practical level nursing homes are integrated with the community care
- service flats (sheltered housing with the possibility of community care day and night) partly seem to become an inheritor of nursing homes in the LTC system
- community care is increasingly based on 24 hour services, more professionalized and distributed according to stricter priority of needs.[75]

A striking feature is the remarkable increase of discharges from nursing homes. This point is taken up further in section F of this paper.

Main Changes in Institutional LTC Characteristics Over Time

During the whole period from 1955 to 1990, more than the structure, volume, administrative arrangements and ideology of the LTC sector have changed. Comparable surveys from 1953, 1966 and 1990 also show changes in aspects of the quality of care. For instance, the proportion of single rooms expanded and staffing increased dramatically. The use of LTC institutions also changed, indicated by the age structure of the institutional LTC population. Figures illustrating some of these changes are summarised in Table IV-D.

TABLE IV-D: Changes in Institutional LTC Characteristics Over Time

Age of Residents	1953	1966	1990
Less than 70 years	21%	13%	4%
70-79 years	79%	33%	23%
80-89 years	---	45%	52%
90 years and over	---	9%	21%
Percentage single rooms	47	60	75
Full time staff per bed	0.24	0.36	0.90
Cost per bed per year (NOK, 1989)	n.a.	187,000	254,000

SOURCE: Søbye E, Institusjoner for eldre 1989. Rapporter 90/22. Central Bureau of Statistics of Norway.

[75] Romøren TI, Kommunehelsetjenestens fem første år. I St.meld.nr.36 (1989-90), Sosialdepartementet, Oslo 1990.

The Current Care System: Facilities and Costs

As a result of the evolution described above, the place of residence of the population of elderly people in Norway in the middle of the 1980s was as described in Table IV-E.

TABLE IV-E: Place of Residence of Population Per 100, 1985		
	65 Years of Age and Over	**80 Years of Age and Over**
Total	100.0	100.0
Nursing homes	4.5	14.1
Homes for the aged	2.3	8.3
Psych. nursing homes	0.3	1.1
Sum institutions	7.1	23.5
Sheltered housing	3.5	7.5
Ordinary homes	89.4	69.0
SOURCE: Daatland, SO, Ressurser of ressursbruk i eldresektoren. NGI Rapport 5-1990 and Vital statistics and migration statistics. Central Bureau of Statistics.		

7,1% of people 65+ lived in institutions, 3,5% in sheltered housing, and the rest (89,4%) in ordinary homes. Figures for community care services utilization are given in Table IV-F.

TABLE IV-F: Use of Personal Community Care Per 1000, Noninstitutionalized 1985		
	65 Years of Age and Over	**80 Years of Age and Over**
Home help (end of year)	169	456
Home nursing		
End of year	68	172
During the year	131	351
SOURCE: Daatland, SO, Ressurser of ressursbruk i eldresektoren. NGI Rapport 5-1990.		

Unfortunately, separate figures are not available for residents in sheltered housing and people living at home with formal care. Neither is it known how many home nursing clients used home help and vice versa. But altogether a maximum of 300 per 1000 non institutionalized elderly used formal community care during the year 1985. This means that more than 70% lived with no formal care of any kind. Surveys indicate that most of these individuals lived independently.[76]

As can be seen from the tables, the figures for the population 80+ are considerably higher, the utilization rates mostly being 2-3 times higher for the different services.

Cost of Services

Table IV-G shows the costs of both institutional LTC and community care during the period 1975-1988. The table clearly shows how institutional costs by far take the largest share. On the other hand, the shift in balance over time is clearly demonstrated.

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[76] Lingsom S, Gammel of sprek. Institutt for sosialforskning, Rapport 89:8, Oslo 1989.

The proportion of institutional care costs went down from about 85 to 74% of total LTC costs in the period 1975 to 1988.

TABLE IV-G: Costs of Institutional Long Term Care and Community Care 1975-88 (Mill USD deflated. 1991=100)				
Year	**All Long-Term Care Institutions**	**All Community Care**	**Total**	**Percent Institutional Care**
1975	152	27	179	84.7
1980	396	95	491	80.7
1985	1100	340	1440	76.4
1988	1814	621	2435	74.4
SOURCE: Daatland, SO, Ressurser of ressursbruk i eldresektoren. NGI Rapport 5-1990.				

The costs for the acute hospital care utilization by the part of the population 67+ have been calculated to be about the half of total LTC costs (USD 1300 per capita per year, 1989).[77] Hospital beds are far more expensive, but less used. Calculated as costs per year per bed, the figure for hospitals was equal to 80000 USD i 1989, nursing homes were equal to 40000 USD and homes for the aged 27000 USD.[78] While there is no out of pocket payment for patients in hospitals, 10% of nursing home costs are financed by this form of payment. Pensions are automatically reduced with 30% after two months of utilization of nursing home facilities. Homes for the aged have a similar payment system, but the out of pocket payment here starts from the day of admission.

Within the welfare system, however, the total costs of services are much less than the costs of the old age pension system. The pension system accounts for about twice the amount of total service expenditures per year.[79] In the long run, the costs of a national pension system are more worrying to the political authorities than the costs of services.

Characteristics of Norwegian Nursing Homes and Nursing Home Residents

Nursing homes in Norway are fairly well staffed, with full time therapists and other care staff, equivalent to 71,6 per 100 beds. The total level of staffing is 10-20% higher in Denmark and Sweden, but on the other hand, the level of qualifications and degree of specialization is higher in Norwegian nursing homes.[80] The total therapeutic staffing pattern is seen from Table IV-H, which also includes figures for Norwegian homes for the aged.

[77] Hammervold R, Jørgensen S, Regionale variasjoner i bruk av sykehus. Somatiske sykehustjenester i 1986 of de eldres bruk av aykehus/kommunehelsetjeneste. Norsk Institutt for Sykehusforskning, Rapport 5/89, Trondheim 1989.

[78] Daatland SO, Ressurser of ressursbruk i eldresektoren. Norsk Gerontologisk Institutt, Rapport 5-1990, Oslo 1990.

[79] Romøren TI, Helse of velferd. Cappelen, Oslo 1988.

[80] Aldreomsorg i Norden -- kostnader kvalitet, styrning. Statskontoret, Rapport 1987:34, Stockholm 1988.

TABLE IV-H: Staffing Pattern in Norwegian Nursing Homes and Homes for the Aged 1990		
Full Time Equivalent Employees 1 Per 100 Bed, by Occupation	**Nursing Homes**	**Homes for the Aged**
Total therapeutic	71.6	51.2
Registered nurses	18.3	9.6
Nurse assistant	38.6	26.9
Nursing personnel without formal education	8.4	1.9
Physiotherapist	1.4	0.1
Occupational therapist	0.4	n.a.
Physician	0.6	0.6
Social worker	0.1	n.a.
Other therapeutic	3.8	2.1
SOURCE: Søbye E, Institusjoner for eldre 1989. Rapporter 90/22. Central Bureau of Statistics of Norway.		

All Norwegian nursing homes offer medical services and skilled nursing services. In addition, more than 90% offer physical therapy, occupational therapy, chiropody and hairdressing, while 80% have bank and post services.[81] 96% of the homes for the aged reports to have regular medical services, 61% to offer physical therapy, 18% occupational therapy, 90% chiropody, 89% hairdressing and 78% bank and post services.

As mentioned earlier, the institutions are small, with an average of 42 beds per unit, ranging from 7 to 200 beds. Nursing homes more and more are connected to the services offered in community care -- from the late 1980s often as one administrative unit. This relationship is reflected in the proportion of admissions directly from the community, which was 72% in 1990. The rest are mainly from acute hospitals.[82]

An admission team consisting of a representative from the home nursing services, the physician (usually a general practitioner connected to the nursing home) and the director of the nursing home, and other representatives from the local health and social services make decisions for admission. Decisions are made on an ad hoc base, using no formal pre-admission assessments. The team tries to find the best total solution in each case, looking to all resources available in the local service system. The home nursing team member is reported to have the strongest influence on the final decisions. This is also judged as an advantage, as she will have the best information available concerning the total situation of the patient and of the informal care resources.[83]

Decisions not accepted by the elderly or their families can be appealed to a central government health authority representative in the area. To prevent the admission team causing bed blocking in acute hospitals, it has been proposed to have

[81] Søbye E, Institusjoner for eldre 1989. Statistisk sentralbyrå, Rapporter 90/22, Oslo 1990.

[82] Søbye E, Institusjoner for eldre 1989. Statistisk sentralbyrå, Rapporter 90/22, Oslo 1990.

[83] Ellefsen B, Forandring fryder? En analyse av prosessene rundt overføringen av sykehjemmene fra fylkeskommunalt til kommunalt nivå. Statens institutt for folkehelse -- Avdeling for helsetjenesteforskning, Rapprt nr.6-1989, Oslo 1989.

municipalities pay for patients who have finished their treatment in acute hospitals and who are waiting for transfer to a nursing home. Up to now, these problems have been considered minor and no action in this direction has been taken. Directors of nursing homes mostly report on good cooperation with acute hospitals on these and other matters.[84]

Until 1990, routine data on nursing home residents have been scarce and surveys have only been undertaken in 1953 and 1966. Therefore, in the following information from the first improved routine data collection in 1990 is used. Table IV-I shows the composition of the nursing home population by age and sex.

TABLE IV-I: Nursing Home Residents by Age and Sex, January 1990			
Age Group	**Total**	**Males**	**Females**
Number			
Total	34,617	10,402	24,215
Less than 67	1,393	731	662
67-79	8,187	3,103	5,084
80-84	8,365	2,481	5,884
85-89	9,346	2,366	6,980
90 years and over	7,326	1,721	5,605
Percent			
Total	100.0	100.0	100.0
Less than 67	4.0	7.0	2.7
67-79	23.7	29.8	21.0
80-84	24.2	23.9	24.3
85-89	27.0	22.7	28.8
90 years and over	21.2	16.5	23.1
SOURCE: Søbye E, Institusjoner for eldre 1989. Rapporter 90/22. Central Bureau of Statistics of Norway.			

Only 4% of the residents are under pensionable age (67) and almost three out of four residents are more than eighty years old.

Table IV-J shows the level of resident dependency judged by the staff in a one day census in 1990 for the whole LTC population in Norway. The figures express percentages based on staff counting the number of patients in daily need of help with one or more of the ADL items included. Although there are obvious problems of reliability in these data, they give a basic impression of dependency levels of the LTC population in Norway and the systematic difference between residents in nursing homes and homes for the aged.

[84] Ellefsen B, Forandring fryder? En analyse av prosessene rundt overføringen av sykehjemmene fra fylkeskommunalt til kommunalt nivå. Statens institutt for folkehelse -- Avdeling for helsetjenesteforskning, Rapprt nr.6-1989, Oslo 1989.

TABLE IV-J: Resident Dependency, Nursing Homes and Homes for the Aged (Percent of residents in daily need of personal help)		
	Nursing Homes	**Homes for the Aged**
Washing upper part and lower part	82.0	53.0
Dressing	76.0	47.0
Toilet	70.0	34.0
Walking outside	65.0	49.0
Walking inside	50.0	27.0
Eating	33.0	12.0
SOURCE: Søbye E, Institusjoner for eldre 1989. Rapporter 90/22. Central Bureau of Statistics of Norway.		

Nursing Home Discharges

According to improved routine statistics from the last years, the purpose of stay at admission for the total nursing home population in the middle of January 1990 was as follows:

- Rehabilitation: 8%
- Respite care: 14%
- Permanent care: 77%
- Other: 2%

Although a large majority of the residents are admitted for permanent stays permanently, a substantial proportion also have intermediate stays for rehabilitation and respite care. This proportion has increased during the years, as reflected in the numbers of discharges.

As seen from Table IV-K, there were about 70000 discharges from approximately 30000 beds in 1990. Of these, 70% were live discharges. Of the residents discharged alive in 1990, 82% went back to the community, and 12% to another institution, mainly a home for the aged or a local hospital.

TABLE IV-K: Discharges from Norwegian Nursing Homes 1974-1988				
Year	**Beds[1]**	**Discharged Total**	**Discharged Living**	**Discharged Dead**
		Number		
1974	18,854	33,120	17,713	15,407
1980	26,709	49,569	20,094	20,835
1984	28,968	60,855	41,654	19,204
1988	29,648	70,855	50,496	20,359
		Percent		
1974			53	47
1980			59	41
1984			68	32
1988			71	29
SOURCE: Ellefsen, B, Forandring fryder? SIFF -- Helsetjenesteforskning, Rapport nr.6- 1989.				

1. Only beds in nursing homes reporting on discharges are counted.

From the table it is also evident that the number of total discharges has more than doubled in the period 1974-1988 and that the proportion of live discharges increased from 53 to 71% in the same period.

These figures are both indicators of a developmental dynamic of the whole LTC system and a more conscious shift in the use of the nursing home segment, towards more rehabilitation and respite care.

As institutional LTC was developed before sufficient community services are available, admission cohorts will shift in their characteristics and length of stay over time. Residents gradually will shift from the relatively young old permanent stayers from the first phase of institutional development to the relatively old old and shorter stayers of today. In addition, more use of nursing home resources for rehabilitation and respite purposes lead to an increasing turnover rate and expanding proportion of live discharges.

A Local Area Study

As there is a lack of national data, some preliminary figures from a local area study will be presented here to illustrate some of these points about nursing home discharges in the Norwegian LTC system.

The study is being conducted by the author and is a longitudinal population study from a coastal town in southern Norway. The whole population 80+ as at January 1981, altogether 434 persons, was followed over 10 years. As of October 1991 385 were deceased. Courses of disability, health services utilization and family caregiving have been studied prospectively and retrospectively, from the first episode of permanent dependency until death. In the period 1981-1991, the level of provision for nursing homes in this town has been 15 % higher than the average for the country. In all other aspects, its LTC system is fairly representative-and typical for Norway.[85]

In this study population, 5% have died at home, 25% in the local acute hospital, 67% in the nursing home and 3% in the home for the aged. There has been a range from 0 to 6 nursing home stays before death, but more than two stays are very rare (8%).

Table IV-L shows the length of nursing home stays in this population. From the table, it can be seen that there tends to be three groups of nursing home stays: short stays for respite and rehabilitation purposes (the high proportion of live discharges after with a short length of stay), short stays for terminal care (approx. 30% discharged dead before 3 months) and long permanent stays ending with death (more than 50% discharged dead after more than one year). Further analysis has shown a **period effect** behind this pattern: corrected for age, sex, ADL-limitations etc. the probability for

[85] Romøren TI, Forløp av avhengighet, tjenesteforbruk of familieomsorg i høy alder. Arkeidsrapport nr. 3, INAS, Oslo 1991.

becoming a long permanent stayer was much larger in the 1970s than in the late 1980s.[86]

TABLE IV-L: Length of Nursing Home Stays in the Larvik Study		
Length of Stay	**Discharged Living N=129**	**Discharged Dead N=256**
< 1 month	40.0	15.9
1 - 3 months	33.3	14.4
3 - 6 months	13.2	8.0
6 - 12 months	5.5	9.5
1 - 3 years	4.4	17.6
> 3 years	3.3	35.2

For the live discharges the most frequent groups of diagnosis by admission were heart diseases, lung diseases, stroke and hip fracture, while cancer and dementia were the most frequent diagnosis at admission for patients discharged dead.

Place of residence after discharge for those discharged living was

- Home, alone: 50%
- Home, co-resident with family: 32%
- Hospital: 4%
- Another nursing home: 4%
- Home for the aged: 7%
- Sheltered housing: 3%

In the Norwegian system very few nursing home patients are **discharged** to hospitals. Also only a minority has an **intermediate** stay in hospital (not counted as a discharge) during their nursing home stay. The goal is to treat most acute major illnesses among nursing home patients satisfactorily without transferring them to hospitals or otherwise moving them unneccesarily. In this local area study, 30% of nursing home patients had an intermediate stay at a hospital some time during their total nursing home career. 85% of these patients were moved for hip fracture surgery or other major surgical conditions in need of operations. More than 90% returned to the nursing home after a short period.

A Final Note on Denmark and Sweden

Concerning **strucure**, Denmark for a long time has placed the responsibility for all LTC services -- including its institutional part -- on the local (municipal) level. State fundings were **equal** for all parts of LTC (50%) until the change into a block grant system as early as 1975. LTC institutions legally have been social institutions. Today,

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[86] Romøren TI, Forløp av avhengighet, tjenesteforbruk of familieomsorg i høy alder. Arkeidsrapport nr. 3, INAS, Oslo 1991.

Denmark has the lowest level of institutional LTC and the highest level of community LTC among the Scandinavian countries.

Until this year Sweden had a structure of LTC with many similarities to Norway in the 1970s: Nursing homes and home nurses (and in addition: geriatric wards in hospitals) were administered at on county level, and other LTC services on local level. Now the nursing homes have moved down to local (municipal) level, but still they are (as in Norway) considered medical institutions. The old system of partly state funding for services, according to **different percentages**, survives. Today, Sweden has the highest level of institutional LTC in Scandinavia. At the same time, the level of community care almost as high as in Denmark.

Altogether Sweden uses the most economic resources in services per elderly person. The amount was equal to USD 5 200 in 1985. Denmark used 10% less, Norway 20% less, at that time.

Concerning current development, Denmark is reducing its (already small) institutional LTC further. On the other hand, the level of sheltered housing with extensive community care is expanding, as in all Scandinavian countries. Sweden is moving towards a general reduction of its high service level, in combination with converting more resources into sheltered housing. In addition, there are some radical experiments with other, community care-oriented LTC-systems in Sweden, e.g. the "Huddiksvall" model.[87]

The distinct profiles of LTC in Scandinavia are now rapidly changing. Their present structure and service level are the results of administrative, financial and professional traditions from the nineteen sixties and seventies. Now they are becoming more alike as a consequence of convergence of administrative and financial structures and philosophy of care during the last years. Generally, the Danish system is considered the most successful seen both from a users perspective and in terms of economic efficiency. It has both higher quality (measured as continuity, quality of personnel, freedom of choice and access to services for users) and lower costs than the Swedish and the Norwegian system. However, data show that differences in quality and costs **within** each country may be much larger than these differences on a national level.[88]

[87] Thorslund M, Johansson L, Elderly people in Sweden: Current realities and future plans. Ageing and Society, 7, 345-355, 1987.

[88] Aldreomsorg i Norden -- kostnader kvalitet, styrning. Statskontoret, Rapport 1987:34, Stockholm 1988.

V. THE FOCUS ON LONG TERM CARE IN THE UNITED STATES: NURSING HOME CARE[89]

Introduction

This paper is an overview of long term care (LTC) in the United States (US). It concentrates on nursing home care because of the institutional emphasis of LTC in the US. It is intended as context to the research on nursing home outcomes which is part of the International Collaborative Effort on Aging.[90,91] The paper provides an overview of nursing home care in the US in relation to:

- history and evolution of LTC,
- the current LTC system, including policy concerns, and
- characteristics of certified nursing homes, including administrative and functional criteria.

It also presents demographic data on the elderly population who are at the highest risk of needing LTC.

Because the research on nursing home outcomes of the International Collaborative Effort on Aging focuses on nursing homes providing the highest level of skilled care, this overview concentrates on nursing homes certified for Medicaid and Medicare. Data on non-certified homes is provided for comparison purposes. The year 1985 serves as a focal point because, when the research was initiated, it was the only year for which data were available for all countries included in the comparative analysis.

History and Evolution of Long Term Care

Historically, most formal LTC in the US was delivered in institutions with the generic label of "nursing home." In 1954, at the time of the first survey on nursing homes, there were 9000 nursing homes in the US that provided skilled care. Eighty-six percent of them were proprietary-owned.[92] Major growth in nursing homes beds began after the passage of Medicaid and Medicare in 1965. Both pieces of legislation provided benefits for nursing home care in skilled and/or intermediate fare facilities.

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[89] Written by Joan F. Van Nostrand, D.P.A., National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Disclaimer: This chapter reflects only the views of its author and does not necessarily represent the position of the U.S. Department of Health and Human Services.

[90] National Center for Health Statistics. Proceedings of the 1988 International Symposium on Data on Aging. Vital Health Stat. 5(6). 1991.

[91] National Center for Health Statistics. Proceedings of the 1991 International Symposium on Data on Aging. Vital Health Stat. 5(7). 1993.

[92] Solon, J and Baney, A. Ownership and Size of Nursing Homes. Public Health Reports 70(May): 437-444. 1955.

Rapid growth followed in the next decade, so that by the early 1970's, there were over 1 million beds. Growth leveled off and by 1985 there were 1.6 million beds in about 19,000 nursing homes. The majority of nursing homes were proprietary-owned (70 percent) and were certified by Medicaid or Medicare (75 percent).[93]

Growth of nursing home beds kept pace with the growth of the elderly population. Since 1973-74, the number of nursing home residents per 1000 persons 65 years and older has remained at about 45. The risk that an elderly person will enter a nursing home anytime during his or her life is considerably higher than this cross sectional rate of 45 per 1000. If rates of use remain the same, a person who is 65 in 1990 has a 40-45 percent chance of using a nursing home before death.[94]

Overview of the Current LTC system

Although over 80 federal programs assist persons with LTC needs,[95] no one program offers an full array of LTC services on a systematic basis. When LTC expenditures are considered, major federal programs are Medicaid and Medicare. These programs have an institutional bias, i.e., nursing home care is the most available LTC benefit in relation to program expenditures and program qualifications for receipt of care.[96]

Medicaid and Medicare Benefits

The Medicaid program provides nursing home benefits to some, but not all, low income elderly. Generally, they must have incomes below the federally established poverty level which in 1989 was $5947 for a single elderly individual and $7503 for an elderly couple. Medicaid also has several provisions to allow states to provide LTC to other groups of elderly.[97] One optional provision allows states to cover the medically needy, who are persons who meet the non-financial standards for Medicaid but who exceed its income or resource requirements. Each state establishes its standard for defining the medically needy, so that standards differ from state to state. Some elderly may also deplete their resources on medical bills, "spend-down" to the state-established standard for the medically needy, and become eligible for Medicaid.[98] Medicaid is a

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[93] National Center for Health Statistics. The National Nursing Home Survey; 1985 Summary. Vital Health Stat. (13)97, 1989.

[94] Kemper, P. and C. Murtaugh. Lifetime Use of Nursing Home Care. New England Journal of Medicine, 32(9): 595-600. 1991.

[95] Committee on Ways and Means of U.S. House of Representatives. Overview of Entitlement Programs, Washington, D.C. U.S. GPO. 1990.

[96] Rivlin, A. and J. Wiener. Caring for the Disabled Elderly: Who Will Pay?: Washington, D.C. Bookings Institution Press. 1988.

[97] Congressional Research Service. Medicaid source book: Background data and analysis. Washington, DC: US GPO. 1993.

[98] Congressional Research Service. Medicaid source book: Background data and analysis. Washington, DC: US GPO. 1993.

joint federal-state program. There is on average a 50-50 sharing of the costs between the two levels of government. From 1965 to 1990, Medicaid had two levels of nursing care: skilled and intermediate. Skilled care was legislatively defined as services for persons who needed on a daily basis skilled nursing care or rehabilitation which as a practical matter could only be provided on an inpatient basis (Social Security Act, 1905f). Intermediate care consisted of health care services to persons who do not require skilled or hospital care, but require care above the level of room and board (Social Security Act, 1905c). Many states had developed special assessments to determine who needed skilled versus intermediate care. Care is paid for prospectively in a flat monthly rate. The states established the rates. Generally, rates were higher for skilled than for intermediate care. Medicaid is a major payor of nursing home care in the US. About half of all residents in 1985 used Medicaid as their primary source of payment.[99]

Medicare is a health insurance program for most (98 percent) persons 65 years and older. It mainly provides benefits for acute care--hospital and physician services. Elderly are eligible for Medicare benefits in nursing homes if they have had a hospital stay and have acute care needs for rehabilitation. The actual cost of care, rather then a flat rate, is paid by the federal government within established ceilings. Although nursing home care is limited to a stay of 100 days, most stays are less than a month. Nursing homes participating in Medicare were called skilled nursing homes from the 1970's to 1990. Medicare provides benefits to very few nursing home resident. About 2 percent used it as their primary source of payment in 1985.[100]

For nursing home care under both Medicare and Medicaid, the federal government sets the care standards and the states conduct the inspections of the nursing homes. Prior to 1990, the standards were more stringent for Medicare than for Medicaid. After that time, legislation made the standards identical.

Linkage to Home Care and Hospital Care

Both Medicaid and Medicare have benefits for home health care (see chapter 6), but the programs are limited. In 1989, national expenditures for nursing home care were 12 times greater than for home health care. The differential in spending was the greatest for Medicaid. In 1989, Medicaid spend nearly 7 times more on nursing home care than did Medicare.[101]

The elderly are the greatest users of acute care hospitals in the US. Hospital discharges in 1985 were 295 per 1000 population aged 65-74 and 477 per 1000 aged 75 and over. The average stay for those 65 and over was 8.7 days.[102] In the US, there

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[99] National Center for Health Statistics. The National Nursing Home Survey; 1985 Summary. Vital Health Stat. (13)97, 1989.

[100] National Center for Health Statistics. The National Nursing Home Survey; 1985 Summary. Vital Health Stat. (13)97, 1989.

[101] Health Care Financing Administration. Health Care Financing Review, 16(1): 247-299. 1994.

[102] National Center for Health Statistics. Health U.S., 1993. Hyattsville, MD. Public Health Service, 1994.

is a substantial flow between acute care hospitals and nursing homes. In 1985, 39 percent of nursing home residents were admitted from the hospital. Furthermore, of all live nursing home discharges, 49 percent were discharged to the hospital. The flow between hospitals and nursing homes has increased significantly since 1977. At that time, only 32 percent of residents were admitted from hospitals, and only 41 percent of live discharges were discharged to the hospital. The increased flow from 1977 to 1985 often is attributed to implementation of a prospective payment policy to control the cost of hospital care.[103]

Impact of Prospective Payment for Hospital Care

Legislation passed in 1983 (Tax Equity and Fiscal Responsibility Act of 1983) established a prospective payment system for Medicare coverage of inpatient hospital operating costs. Costs were based on a fixed amount, determined in advance, for each case, according to one of over 460 diagnosis related groups (DRGs) into which a case is classified. The system categorizes discharges by the DRGs which are based on: patient diagnosis, patient age, treatment procedure, discharge status and sex. Because the cost is fixed regardless of the length of stay, some have argued that hospitals have an incentive to reduced their lengths of stay by discharging patients to LTC.[104,105]

Others have argued that the reduction in length of hospital stay results in the transfer to nursing homes of residents who are sicker.[106] Data from 1985 support this view. Nursing home residents admitted from hospitals were sicker in that they were more dependent in ADL's then were their 1977 counterparts.[107] Thus, prospective payment legislation as implemented through DRG's has impacted on nursing home care by increasing not only admission rates from hospitals but also the need for skilled care and sub-acute recuperative care.

Impact of National Health Planning Policy

Growth of the number of nursing home beds began to slow in the early 1970's because of a national policy intended to control costs of health care through health planning. The National Health Planning and Resources Development Act of 1974 (Public Law 93-641) charged health planning agencies at state and sub-state levels with major new responsibilities in planning for health care delivery. One tool provided the planning agencies was the review and approval of new institutional health services and facilities through state certificate of need (CON) programs. Each state was required to

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[103] National Center for Health Statistics. Effects of the prospective payment system on nursing homes. Vital Health Stat 13(98). 1989.

[104] Guterman, S., and A. Dobson. Impact of the Medicare prospective payment system for hospitals. Health Care Financing Review. 7(3): 114. 1986.

[105] Lave, Judith. Cost containment policies in Long Term Care. Inquiry. 22(1): 7-23. 1985.

[106] Eggers, P. Prospective payment system and quality: early results and research strategy. Health Care Financing Review. Annual Supplement. 1987.

[107] National Center for Health Statistics. Nursing home utilization by current residents: United States, 1985. Vital Health Stat. 12(102). 1989.

administer a CON program to insure that only those services, facilities and organizations found to be needed were to be offered or developed in the state. A primary emphasis of review was hospital beds and nursing home beds. It was felt that once this type of bed was built, it was likely to be filled. This, in turn, put pressure on health care costs.[108] In the case of nursing home beds, in particular, it was felt that holding down the number of new beds would limit the increase in Medicaid costs, since Medicaid pays for a high proportion of the nursing home population.

With the advent of the Reagan Administration in 1981, it was felt that the health planning approach involved too much federal government regulation. Improved competition--reliance on market forces--was seen as a better approach to restrain costs. Consequently, federal government support for health planning and CON was phased out in the early 1980's. Many states, however, decided to continue with their own CON programs.[109] In part, this was often because of an increased desire to restrain growth in nursing home beds so as to lessen the demand for expanded Medicaid spending for LTC.

Policy Concerns

This section identifies some critical policy concerns in LTC: financing, impoverishment of tome elderly, quality of nursing home care, and bias toward institutional care. It concentrates on policy-making through national legislation, with an emphasis on the legislation of the 1980's.

The underlying policy concern in LTC is financing; who should pay? More specifically, what is the appropriate mix of LTC expenditures from public welfare and entitlement programs, national and state governments, private insurance, and the elderly themselves? Although these questions have been discussed and analyzed in detail,[110] no national consensus exists on the answers. During the 1980's, about 50 percent of the nation's expenditures for nursing home care were paid by Medicaid,[111] a welfare program for those poor who meet certain standards established by the national government. Other provisions allow states to provide LTC to other groups of elderly.[112] Medicaid is funded jointly be national and state governments. In 1985, the elderly paid for 44 percent of the nation's nursing home expenditures from their own resources. Other sources paid small amounts of the expenditures. Private insurance paid for nearly 3 percent. Medicare, an entitlement program covering mainly acute health care for the elderly and disabled, paid for 2 percent. About 60 percent of all government costs was paid by the national government, and the remainder was paid by state and

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[108] Van Nostrand, L.G. Capital Financing for Health Facilities, Public Health Reports, 92(6): 499-507. 1977.

[109] Simpson, J.H. State certificate of need programs: the current status. American Journal of Public Health, 75(10): 1225-1229. 1985.

[110] Rivlin, A. and J. Wiener. Caring for the Disabled Elderly: Who Will Pay?: Washington, D.C. Bookings Institution Press. 1988.

[111] Health Care Financing Administration. Health Care Financing Review, 16(1): 247-299. 1994.

[112] Congressional Research Service. Medicaid source book: Background data and analysis. Washington, DC: US GPO. 1993.

local governments.[113] Government costs for nursing home care are difficult to control because Medicaid is an entitlement program, available to all those poor who meet established standards. Because the oldest-old are the greatest users of nursing home care and their numbers are growing rapidly, the demand for nursing home care is projected to increase. If Medicaid continues to cover about 50 percent of the nation's nursing home expenditures as it has through 1993,[114] this increased demand will place even greater strains on national and state budgets.

A policy concern related to the question of financing is the impoverishment of some elderly due to the costs of a long nursing home stay. Elderly with long stays can be impoverished to such an extent that they become eligible for Medicaid. The average monthly cost of nursing home care is expensive; in 1985 it was $2,100 for Medicare residents and $1,5000 for Medicaid residents.[115] Stays can be long. About 26 percent of all nursing home discharges in 1985 had stays of 1 year or longer.[116] The expense combined with a long stay can result in catastrophic costs that wipe-out life-time savings and other assets. About 60 percent of nursing home residents on January 1, 1987 relied on Medicaid as their primary source of payment. Nearly all the rest relied on their own personal resources. As of the same date, about 11 percent of the residents met eligibility requirements for Medicaid because they had "spent-down" their assets during their stay.[117] Some argue that the figure of 11 percent of the elderly who become impoverished by catastrophic costs of nursing home care is an under-estimate. This is because the figure on asset spend-down is based on survey data which does not collect information about all previous nursing home stays of the resident. Thus, residents impoverished by a previous nursing home stay would not be classified as spending-down assets to become eligible for Medicaid.[118]

Most elderly do not have insurance for LTC. Very little private health insurance was offered for LTC, but this began changing in 1987. As of June 1990, about 1.7 million LTC insurance policies had been sold, compared to 815,000 in December 1987.[119] Some see LTC insurance as economically feasible only for middle and upper income elderly because of the cost.[120] Older persons need to be educated about their risk of needing LTC, its catastrophic costs, and the general lack of funding from Medicare or their own acute care insurance policies to cover LTC costs. Otherwise, the

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[113] Health Care Financing Administration. Health Care Financing Review, 16(1): 247-299. 1994.

[114] Health Care Financing Administration. Health Care Financing Review, 16(1): 247-299. 1994.

[115] National Center for Health Statistics. Nursing home utilization by current residents: United States, 1985. Vital Health Stat. 12(102). 1989.

[116] National Center for Health Statistics. Discharges From Nursing Homes; 1985 Summary. Vital Health Stat., 13(103). 1990.

[117] Short, P.F., Kemper, P., Cornelius, L.J., & Walden, D.C. Public and private responsibility for financing nursing home care: The effects of Medicaid asset spend-down. The Millbank Quarterly, 70(2), 2077-298. 1992.

[118] Adams, E.R., Meiners, M.R., & Burwell, B.O. Asset spend-down in nursing homes. Medical Care: 31(1): 1-23. 1993.

[119] Health Insurance Assoc. of America. Research Bulletin, Washington, D.C. 1991.

[120] Rivlin, A. and J. Wiener. Caring for the Disabled Elderly: Who Will Pay?: Washington, D.C. Bookings Institution Press. 1988.

elderly incorrectly assume that they have LTC coverage and do not purchase LTC insurance.[121,122]

A third policy concern is the quality of nursing home care. Although legislation for Medicare and Medicaid was passed in 1965, the legal standards for nursing home participation in these programs were not developed until 1974. At issue in the delay was setting the Medicaid standard for intermediate care facilities low enough so that some of the existing homes would qualify. Setting low standards was essential to assure that the poor elderly in existing nursing homes would qualify for Medicaid benefits. Poor elderly, although eligible for Medicaid, could not receive benefits unless they were residents in a Medicaid-certified nursing home. As a consequence, the 1974 standards had limited impact on the quality of care.[123] During the early 1980's, concern over quality intensified. In 1985, Congress commissioned the Institute of Medicine to make recommendations for strengthening the government standards for nursing homes to participate in Medicare and Medicaid and, thereby, improve the quality of care. Based on their recommendations, Congress passed legislation in 1987 to improve the quality of care by (a) creating one level of nursing home care (a nursing facility) rather than the two levels of skilled and intermediate care and (b) requiring a standardized assessment and care plan to be developed and maintained for each resident. The legislation was effective in October 1990. The legislative changes are such that the quality of care is expected to improve over time.[124] The impact these changes have on quality is being assessed currently.

Another policy concern is the bias in the US towards institutional LTC. Although US policy creates a bias toward institutional LTC, the preference of the elderly and their families are for maintaining independence by receiving LTC in the home or the community. About 95 percent of elderly who needed LTC and lived in the community in 1982 indicated that they would like to stay out of a nursing home as long as possible.[125] The costs to the tax payer for institutional care are high at $35 billion in 1985 and $49 billion in 1989. In the 1981 Omnibus Budget Reconciliation Act (OBRA), section 2176 established waivers which gave states the flexibility of substituting state-funded home health care in place of nursing home care. However, approval of waiver requests was judged by some as limited.[126] In the 1987 OBRA, states were given waiver authority to provide home and community based care to persons at risk of a nursing home admission on a budget neutral basis. States were limited to an annual overall maximum

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[121] Rivlin, A. and J. Wiener. Caring for the Disabled Elderly: Who Will Pay?: Washington, D.C. Bookings Institution Press. 1988.

[122] Health Insurance Assoc. of America. Research Bulletin, Washington, D.C. 1991.

[123] Institute of Medicine. Improving the Quality of Care in Nursing Homes: Washington, D.C. National Academy Press. 1986.

[124] Estes, C. & Swan, J. The long term care crisis: Elders trapped in the no-care zone. Newbury Park, CA: Sage. 1993.

[125] Rivlin, A. and J. Wiener. Caring for the Disabled Elderly: Who Will Pay?: Washington, D.C. Bookings Institution Press. 1988.

[126] Kane, R.L. & Kane, R.A. Long term care: Principles, programs, and policies. New York: Springer. 1987.

seven percent growth rate for all LTC services.[127] During the 1980's, use of home care and associated expenditures increased by over 400 percent. Nevertheless, nursing home care still remained as the predominant mode of formal LTC in the US. In 1989, for example, national expenditures for nursing home care were 600 percent greater than for home health care.[128]

There were attempts in Congress in the late 1980's and early 1990's to mitigate the institutional bias. Various bills proposed LTC benefits as an entitlement, covered disabled persons of all ages, and emphasized home care. Congress has passed legislation which takes some modest steps in this direction. Under Medicaid amendments included in the 1990 OBRA, states may opt, as part of their Medicaid program, to offer home and community based care to functionally disabled elderly eligible for Medicaid. A more comprehensive set of recommendations for a home and community based LTC entitlement program were developed by a bipartisan Congressional Commission.[129] To date, none of the many bills introduced in Congress to mitigate the institutional bias have passed. There are two major reasons for lack of LTC legislation. One, such legislation leads to significant increases in public expenditures at a time of budget deficits and negative reaction of voters to increased taxes. Two, there is a lack of a national consensus on the underlying policy concern of LTC: what is the appropriate mix of LTC expenditures from public welfare and entitlement programs, national and state governments, private insurance, and the elderly through their own resources?

Potential Users of LTC: Demographic Data

Introduction

People who need LTC are so disabled by physical or mental conditions that they do not have the capacity for self care. Disability, regardless of the age at onset, is so severe that they need the help or supervision of another person in performing activities of daily living (ADL's). ADL's include bathing, dressing, eating, using the toilet, and transferring from bed to chair. Many of the persons who need LTC are elderly. The oldest of the old, those aged 85 and older, are at the highest risk.[130] They are also the highest users of nursing home care at 220 per 1000 elderly in 1985.[131]

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[127] Committee on Ways and Means of U.S. House of Representatives. Overview of Entitlement Programs, Washington, D.C. U.S. GPO. 1990.

[128] Health Care Financing Administration. Health Care Financing Review, 16(1): 247-299. 1994.

[129] Pepper Commission. Access to Health Care for All Americans, Washington, D.C. U.S. GPO. 1990.

[130] Estes, C. & Swan, J. The long term care crisis: Elders trapped in the no-care zone. Newbury Park, CA: Sage. 1993.

[131] National Center for Health Statistics. Nursing home utilization by current residents: United States, 1985. Vital Health Stat. 12(102). 1989.

Wiener, Hanley, Clark, and Van Nostrand[132] estimate that the elderly population who need LTC because they require the help of another person with at least one ADL was about 2.3 million persons in 1987. A higher estimate using an ADL criterion of greater disability was developed by the Pepper Commission[133] based on a micro-simulation model developed by the staff of The Brookings Institution and ICF, Incorporated.[134] In 1990 about 3.3 million elderly needed LTC because they required the help of another with three of five ADL's or required substantial supervision due to cognitive impairments or disruptive behavior.[135] These severely disabled elderly account for about 11 percent of all older persons.

This section presents demographic data about the elderly, the age group with the highest risk of needing LTC. It presents data about the distribution of the elderly in the population, support ratios, and population projections.

The Elderly Population

In 1985, there were 28.5 million persons aged 65 and older. They comprised nearly 12 percent of the resident population. In 1990, the latest year of the decennial census, the number of elderly rose to over 31.0 million and they comprised 12.5 percent of the population.[136,137,138] (See Table V-A.)

TABLE V-A: Elderly Population by Age: United States, Selected Years, 1980-90			
Age	**1980**	**1985**	**1990**
Total population	227,757	238,736	248,710
65 years and over	25,704	28,540	31,079
65-74 years	15,653	17,010	18,045
75-84 years	7,782	8,836	10,012
85 years and over	2,269	2,695	3,021
SOURCE: Bureau of the Census.			

About 60 percent of the elderly are the "young-old"--those aged 65-74 years. The "oldest-old"--those ages 85 and over--comprised nearly 10 percent of all elderly in 1990. Although the proportion of oldest-old is small in comparison to the total United States population, they are the fastest growing group. In the decade from 1980 to 1990, the total population grew by 9 percent, and the those age 65 and over grew by 21 percent. The oldest-old group, in contrast, grew by 36 percent.

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[132] Wiener, J., Hanley, R., Clark, R., & Van Nostrand, J. Measuring the activities of daily living: comparisons across national surveys. Journal of Gerontology, 45(6), S229-S237. 1990. [http://aspe.hhs.gov/daltcp/reports/meacmpes.htm]

[133] Pepper Commission. Access to Health Care for All Americans, Washington, D.C. U.S. GPO. 1990.

[134] Rivlin, A. and J. Wiener. Caring for the Disabled Elderly: Who Will Pay?: Washington, D.C. Bookings Institution Press. 1988.

[135] Pepper Commission. Access to Health Care for All Americans, Washington, D.C. U.S. GPO. 1990.

[136] Bureau of the Census, 1990, P25, No. 1045, Washington, D.C. U.S. GPO. 1990.

[137] Bureau of the Census, 1990, Series P25, No. 1057, Washington, D.C. U.S. GPO. 1990.

[138] Bureau of the Census. Series CPH-L-74. Washington, D.C. U.S. GPO.

Support Ratios

In the US, support ratios (number of elderly and children per 100 persons of working age) have changed significantly since the 1960's (Table V-B). The ratio overall support ratio of total dependents--including both children (under age 18) and elderly (65 years and over)--dropped from 82 per 100 persons 18 to 64 years old in 1960 to 62 per 100 in 1990. This drop was due to the decrease in the support ratio for children which fell from 65, to 42 per 100. The support of working age during this 30-year dependency ratio for the elderly has increased slowly but steadily from 17 to 20 per 100.

TABLE V-B: Support Ratios for Elderly and Children per 100 Persons Age 18 to 64: United States, Selected Years, 1960-1990					
	1960	**1970**	**1980**	**1985**	**1990**
Total for elderly and children	81.6	78.0	64.6	61.9	61.8
Elderly (65 years and over)	16.8	17.5	18.6	19.3	20.2
Children (Under 18 years)	64.9	60.6	46.0	42.6	41.6
SOURCE: Bureau of the Census.					

Population Projections

Projections of the population for the beginning of the 21st century forecast a major growth in the proportion of elderly.[139] While the total population is projected to increase by 27 percent between 2000 and 2030, the elderly population is projected to increase by almost 100 percent (table V-C). As a percent of the total population, the proportion of elderly is projected to increase from about 13 percent to 20 percent in 2030. The greatest growth is projected for two subgroups of the elderly--the young-old and the oldest-old. Both subgroups are projected to increase 105 percent. The increase for the young-old is due to the aging of the "baby boom" cohort. This large cohort, born in the decade after World War II, will reach age 65 around 2010-2020. Growth of the subgroup 75-84 years, although not as great, at 88 percent, will still be significant. According to these projections, the support ratio for children is estimated to remain the same in 2030 as it was in 1990: 42 per 100 working persons (data not shown). The support ratio for the elderly is estimated to rise dramatically. It is estimated to increase from-20 to 36 elderly per 100 persons of working age.

[139] Bureau of the Census. Population Projections of the United States, by Age, Sex, Race, and Hispanic Origin: 1993 to 2050, P25, No. 1104, Washington, D.C. U.S. GPO. 1993.

TABLE V-C: Projections of US Elderly Population by Age for Selected Years, 2000-2030				
Age	**2000**	**2020**	**2030**	**Percent Increase 2000 to 2030**
Total Population	276,241	325,942	349,993	26.7
65 years and over				
Number	35,322	53,384	70,175	98.7
As percent of total U.S. population	12.8	16.4	20.1	---
65-74 years	18,551	30,910	37,984	104.8
75-84 years	12,438	15,480	23,348	87.7
85 years and over	4,333	6,959	8,843	104.1
SOURCE: Bureau of the Census.				

Characteristics of Certified Nursing Homes in the US

Introduction

This section describes the characteristics of certified nursing homes in the U.S. according to administrative and functional criteria. The emphasis is on nursing homes certified for Medicaid and Medicare because the research on nursing home outcomes of the International Collaborative Effort on Aging focuses on nursing homes providing the highest level of skilled care. Data on non-certified homes is provided for comparison purposes. The source of data for this analysis is the 1985 National Nursing Home Survey (NNHS). The 1985 NNHS was a national sample survey of all nursing homes in the U.S. with 3 or more beds.[140] In addition to collecting data about the characteristics, staff, and expenditures of the facility, the 1985 NNHS also collected data from national samples of current residents and discharges. Response rates for facility, resident and discharge samples were over 95 percent. Data about residents and discharges were collected by interviewing the member of the nursing staff most familiar with care provided to that person. The nurse referred to the medical record when responding. The sampling for the 1985 NNHS was a stratified probability design. Data were weighted to produce national estimates.

Administrative Criteria

Jurisdiction, Certification, and Licensing

Jurisdiction and certification described here focus on the situation prior to the recent legislative changes implemented in late 1990. This time frame is used because it corresponds to that of the available data from the National Nursing Home Survey.

The federal government, through legislation and regulation, sets the conditions (or standards) of participation for certified nursing homes. In 1985, participating nursing homes included skilled nursing facilities (SNF's) certified under either Medicare or

[140] National Center for Health Statistics. The National Nursing Home Survey; 1985 Summary. Vital Health Stat. (13)97, 1989.

Medicaid and intermediate care facilities (ICF's) certified under Medicaid. (In late 1990, the distinction between SNF's and ICF's was dropped and all certified homes now are called nursing facilities.)

In 1985, some nursing homes could have been dually certified in that they provided both skilled and intermediate care in all parts of the facility. Others were certified as distinct part facilities in that they provided skilled care in one part of the facility and intermediate care in another, separately designated, part. Given dual certification, it is the status of the resident which determines if the bed is being used to provide skilled or intermediate care and, therefore, at what amount the home is reimbursed for providing care. The health criteria the resident must meet to be eligible for skilled care differ from that for intermediate care.

In each state, an agency uses the federally-determined conditions (or standards) of participation to inspect a nursing home to determine whether it is eligible to participate in Medicare or Medicaid as a SNF and whether it is eligible to participate in Medicaid as an ICF. The conditions of participation have standards for many areas, such as complying with federal, state and local laws; providing certain health services, meeting specific staffing levels and meeting fire safety standards.[141]

Because ICF's are conceptualized as providing a lower level of care than SNF's, the standards of participation are generally less demanding. State agencies generally conduct an annual inspection of each certified nursing home to determine if the conditions of participation are being met. In some situations, states are given the authority to waive certain standards in particular situations, e.g., waiver of 7-day registered nurse requirement in SNF1s in rural areas where there are no or few registered nurses (RN's).

The conditions of participation required that nursing homes meet the state's licensing standards. States can require licensure of non-certified nursing homes and board and care homes if they choose. Generally, non-certified nursing homes are licensed, but the standards vary considerably by state. Some states license board and care homes and others do not. Even in those states which do license, some board and care homes may not require a license. These are usually places with only 1 or 2 beds.

Ownership

Ownership of certified nursing homes is mainly proprietary. About 72 percent of the homes and 69 percent of the beds were operated in 1985 under proprietary auspices. Even a greater proportion (81 percent) of non-certified homes were proprietary.[142]

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[141] Institute of Medicine. Improving the Quality of Care in Nursing Homes: Washington, D.C. National Academy Press. 1986.

[142] National Center for Health Statistics. The National Nursing Home Survey; 1985 Summary. Vital Health Stat. (13)97, 1989.

The genesis of a high proportion of proprietary-owned nursing homes goes back to Social Security Act legislation passed in 1935. The Old Age Assistance program for the elderly, a joint federal-state public program, was established then. At that time, many elderly needing LTC lived in publicly operated poorhouses. The Act prohibited payment of funds for care of the elderly to public institutions because Congress wanted to provide better living arrangements for the elderly than the dismal poorhouses.[143] Availability of funds for proprietary-owned homes created a demand for these nursing homes and resulted in the current dominance of proprietary-owned nursing homes.

Administrative Arrangements for Certification

State agencies certify nursing homes for participation in Medicare and Medicaid and inspect them yearly to determine if they are meeting the standards. Although the conditions of participation are national, uniformity of administrative arrangements can vary from state to state for several reasons. One, the standards are generally worded and interpretations and judgement are required in applying them. In addition, the philosophy of standard enforcement varies from state to state, enforcement is strict in some states and less so in others. Three, states have the authority to waive standards under certain circumstances. Nevertheless, the standards are useful in providing a general profile of the basic characteristics of certified nursing homes.

Local Terminology

The terminology most often applied in research about nursing homes in the mid-1980's was generically "certified nursing homes." More specific terms were "skilled nursing homes" (SNF's) and "intermediate care homes" (ICF's). These terms usually are not embedded in the actual names of the nursing homes. often such facilities are called "homes for the aged." Although the actual name of the facility included the word "skilled', or "intermediate", this does indicate that the home is certified by Medicare or Medicaid. No law or policy prohibits use of these terms by any nursing home.

Non-Certified Homes

In 1985, 4,700 nursing homes were not certified under Medicare or Medicaid. These homes included 183,000 beds or 11 percent of the total. Most were small, housing less than 50 beds.[144] Although some nursing homes were not certified for Medicare or Medicaid, they were usually licensed according to the requirements of the individual states. Homes which were not certified fall into two categories: those that do not provide as intense a level of care as required for certification and those that meet certification requirements but whose operators chose not to seek certification.

There are also facilities called “board and care” homes. These places provide assisted living. Care is minimal, generally group meals and protective oversight, i.e.,

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[143] Vladeck, B. Unloving Care: New York. Basic Books. 1980.

[144] National Center for Health Statistics. The National Nursing Home Survey; 1985 Summary. Vital Health Stat. (13)97, 1989.

someone, either in the home or on-call, to handle emergencies and oversee the residents. It is unknown exactly how many such places exist. Some, but not all, are licensed by the states and many, especially those with 1 or 2 beds, go into and out of business rapidly.

Functional Criteria

Types of Care

According to the legislation prior to late 1990, SNF's provided a higher level of services than did ICF's. This was reflected in the more stringent SNF requirements for staffing (especially for nurses) and for specialized rehabilitation services--physical, speech/hearing and occupational therapy by certified therapists.

TABLE V-D: Comparison of Standards of Conditions of Participation Prior to 1990 for Nursing Homes in Medicaid and Medicare Programs by Level of Care

Standard	Skilled Nursing Facility	Intermediate Care Facility
Physician services	Admitted by physician Remain in physician's care	
Nursing services	24-hour nursing RN: 7 days/week on day shift	RN or LPN as supervisor 7 days/week on day shift
Drugs/medications	Administered by physician or licensed nurse	Administered by Physician or resident permitted to self-administer drug
Specialized rehabilitation services	By qualified therapist	Required
Social services	By qualified social worker or residents are referred to social service agencies	Required
Patient activities program	Required	Required
Hospital transfer agreement	Agreement must be in effect with hospital	Arrangement must be in effect with hospital and SNF
Discharged planning	Required	

SOURCE: Institute of Medicine.
NOTE: RN is registered nurse. LPN is licensed practical nurse.

Selected standards from the SNF conditions of participation (42CFR 405.1120-1137) and from the ICF conditions (42CFR 442.300346) are compared in Table V-D. The differences between SNF's and ICF's reflect differences in the intensity of care provided. For example, in SNF's the standard for nursing care is for round-the-clock nursing with an RN on duty for the day shift every day of the week. In ICF's, the standard is for either an RN or a licensed practical nurse (LPN) as supervisor for the day shift. In some cases, services are required in both SNF's and ICF's, but the services must be provided by specially trained, certified personnel in SNF'S. This is the case for rehabilitation and social services. In addition to required services, facilities can elect to offer other services. A list of required and elective services actually offered in certified and non-certified nursing homes is presented in Table V-E. Over 95 percent of certified facilities offer care from RN or LPN, social services, equipment or devices, administration of medications, and help with ADL's. At least 80 percent offer physical therapy and speech/hearing therapy by a certified therapist. Certified homes were twice

as likely to offer physical therapy, speech/hearing therapy and occupational therapy than were non-certified homes. However, the percent of certified homes offering help with ADL'S was similar to that for not certified homes (about 98 percent).

TABLE V-E: Percent of Nursing Homes Offering Selected Services to Residents of Medicaid and Medicare Certifications of Nursing Home: United States, 1985		
Service	**Certified**	**Not Certified**
Total nursing homes	14,500	4,700
Physician services	92.4	68.1
Services of registered or licensed nurse	95.2	51.1
Help with activities of daily living	98.6	97.8
Social services	95.2	74.8
Equipment or devices provided	95.1	66.0
Administration of medications (prescribed and non-prescribed)	94.5	85.1
Nutrition counseling	92.4	55.3
Physical therapy[1]	87.6	38.3
Speech/hearing therapy[1]	80.7	29.8
Mental health	71.0	55.3
Occupational therapy[1]	64.1	27.7
SOURCE: National Nursing Home Survey 1. From a certified therapist.		

Assessment for Nursing Home Admission

Elderly who are eligible for nursing home care under Medicare must meet the following criteria:

- need for skilled nursing care on a daily basis for an acute illness
- at least a consecutive three-day hospitalization prior to nursing home admission. The emphasis is mainly on acute care needs for recovery and rehabilitation after a hospital stay.

Assessment is done, but only as part of the discharge planning of the acute-care hospital. Prior to late 1990, a standard assessment at admission to a SNF was not required.

Elderly who were eligible for nursing home care under Medicaid fell into two categories

- SNF eligibles: individuals who required daily skilled nursing care which as a practical matter could only be provided on an inpatient basis.

- ICF eligibles: individuals who did not require the care of a hospital or SNF but required health-related care which as a practical matter could only be provided on an inpatient basis.

About half of the states have preadmission screening programs to determine if elderly who are eligible for Medicaid (i.e., meet low income criteria) are placed appropriately in a certified nursing home.[145] The purpose of the screening is to identify elderly who could be cared for in the community or at home if relevant services are available. Although the screenings are not standardized from state to state, many address the ability to perform ADL's. In 1987, legislation was passed so that all states would require screening prior to admission and for current residents to identify the mentally ill and mentally retarded who should be served in specialized mental health care facilities rather than in nursing homes. Patients with Alzheimer's Disease, however, were not included in this legislation because Alzheimer's Disease is not classified as mental illness in the International Classification of Diseases.

In late 1990, legislation became effective in which all certified nursing homes would use a standardized assessment instrument. This instrument, called the minimum data set, would be used at admission and periodically thereafter to identify changes in the condition of the resident. The data set contains several hundred items, many of them focus on functioning.

Levels of Dependency or Care

The levels of dependency of nursing home residents can be viewed in two ways:

- Programmatic: eligibility criteria for SNF or ICF care (prior to late 1990).

- Individual: the resident's functioning as measured by need for assistance of another person in performing ADLIS and by presence of behavior and emotional problems.

The programmatic levels of dependency were defined above in the section on assessment for nursing home admission. The individual levels of dependency focus on measures of functioning. The percent of residents who need the assistance of another person in performing ADL's is presented in Table V-F for certified and non-certified facilities. Certified nursing homes have a resident population that is extremely disabled in functioning; much more so than non-certified nursing homes. Over 90 percent of residents in certified homes needed help of another person with bathing, nearly 80 percent with dressing, and over 60 percent with transferring from bed to chair. Fifty percent needed help in using the toilet, and over forty percent were incontinent. Seven percent were bedfast. The percent of residents needing help was twice as high in certified facilities, than in non-certified facilities. The one exception was for the ADL going outside the facility; the percent needing help was similar for certified and non-certified homes at about 35 percent.

[145] Special Committee on Aging of the U.S. Senate. Developments in Aging, Washington, D.C. U.S. GPO. 1990.

TABLE V-F: Percent of Residents Who Need the Help of Another Person in ADL's by Medicaid and Medicare Certification of Nursing Home: United States, 1985		
	Certified	**Not Certified**
Number of residents	1,320,000	170,000
Bathing	92.1	55.5
Dressing	78.5	36.8
Eating	53.5	16.6
Bedfast	7.1	*
Transferring from bed to chair	63.7	24.8
Walking	36.5	15.8
Going outside the home	37.2	32.5
Toileting	51.2	24.0
Incontinence-bowels	41.8	16.3
Incontinence-bladder	45.0	20.3
Ostomy care	11.0	*

SOURCE: National Nursing Home Survey.

* Figure does not meet standard of reliability or precision.

Table V-G presents another measure of functioning, the percent of residents with behavior and emotional problems by certification of the nursing home. The percent of residents with emotional problems of depression, anxiety and fear were similar for certified and not certified homes. The major difference was in behavior problems of wandering, yelling, and violence. Residents in certified homes were 1.3 times more likely to display behavior problems than were those in non-certified homes.

TABLE V-G: Percent of Residents with Behavior and Emotional Problems by Medicaid and Medicare Certification of Nursing Home: United States, 1985		
Problem	**Certified**	**Not Certified**
Behavior problem	40.4	30.1
Depression	24.0	20.9
Anxiety	26.0	21.1
Fear, worry	22.7	18.8

SOURCE: National Nursing Home Survey.
NOTE: Residents could be counted more than once, depending on their behavior and emotional problems.

Staffing Pattern and Skilled Nursing Staff

Certified nursing homes had specific requirements for nursing services.[146] However, they differ according to whether the facility is a SNF or ICF. The requirements for the SNF were most stringent. A RN must be employed 7 days a week for the day tour of duty. In addition, a director of nursing who is a RN must be employed full-time. Furthermore, a charge nurse who is either a RN or LPN must be employed for each tour of duty, i.e., 24 hours a day. The requirements for the ICF were that it must employ a RN or LPN 7 days a week for the day shift.

[146] Institute of Medicine. Improving the Quality of Care in Nursing Homes: Washington, D.C. National Academy Press. 1986.

Certified nursing homes had 51 full-time equivalent (FTE) employees per 100 beds to provide direct patient care (see Table V-H). This amounts to 1 FTE employee for every two beds. Nearly 46 of the 51 FTE's per 100 beds were some types of nurses. Most of the nurses--32 FTE's per 100 beds--were nurse's aides. Few of the nurses were RN's; only 5.4 FTE's per 100 beds. Other notable FTE occupations were physical therapists (nearly 2 FTE's per 100 beds) and activities director (1 FTE per 100 beds).

TABLE V-H: Full-Time Equivalent Employees[1] Per 100 Beds by Occupation and Medicaid and Medicare Certification of Nursing Home: United States, 1985

Occupation	Certified	Not Certified
Total	51.0	31.8
Registered nurses	5.4	2.7
Licensed practical nurses	7.9	3.4
Nurse's aides	32.3	19.4
Administrator and assistant	1.3	3.8
Physician	0.1	*
Dietician	0.4	*
Medical records administrator	0.2	*
Other administrative and medical staff	1.2	*
Physical therapist	1.8	*
Activities director	1.2	1.1
Social worker	0.7	*
Other therapeutic	0.1	*

SOURCE: National Nursing Home Survey.

1. Includes only those providing direct health-related services.

* Figure does not meet standard of reliability or precision.

Non-certified homes had nearly 20 fewer FTE's per 100 beds, 32 versus 51 for certified homes. Certified homes had twice as many FTE RN's and LPN's per 100 beds. The differential was not as large for nurse's aides. Certified homes had 32 FTE's per 100 beds and non-certified had 19.

Beds and Residents Per 1000 Population

In 1985, the total number of beds in certified homes was 1.4 million.[147] The number of beds per 1000 population 65 and over was:

certified homes	50.5
non-certified homes	6.4
total	56.9

The ratio was early 8 times higher for certified than non-certified homes. The number of residents per 1000 population 65 and older was:

[147] National Center for Health Statistics. The National Nursing Home Survey; 1985 Summary. Vital Health Stat. (13)97, 1989.

certified homes	41.6
non-certified homes	4.5
total	46.1

The number of residents per 1000 population is shown by age in table V-I. The greatest users by far were the oldest-old. For certified homes, the rate of 204 per 1000 was 4 times higher for persons 85 years and over than for those aged 75-84.

TABLE V-I: Number of Nursing Home Residents Per 1000 Elderly Population by Age of Resident and Medicaid and Medicare Certification of Nursing Home: United States, 1985		
Age	**Certified**	**Not Certified**
65-74 years	10.7	0.2
75-84 years	51.7	5.8
85 years and over	203.8	17.7
SOURCE: National Nursing Home Survey.		

Cost for Nursing Home Care

Costs for nursing home care can be examined from both individual and national perspectives. From the individual perspective, the average monthly cost per resident in 1985 was about $1,500. Average monthly costs differed by the primary source of payment as follows:

Primary Source	Average Monthly Cost
Medicare	$2,141
Medicaid-skilled	$1,898
Medicaid-intermediate	$1,292

Medicaid was used by the majority of residents (56 percent) in certified homes as the primary source of payment (See Table V-J). Of all residents with Medicaid as the primary source of payment, 65 percent were receiving intermediate care. Residents qualifying for Medicaid must use their social security benefits to help defray the cost of care after allowing for the needs of a spouse at home. Monthly social security benefit payments are received by nursing homes either directly or from residents, families. After crediting a portion of the benefit to the resident's personal account for miscellaneous personal spending (newspapers, toothpaste, etc.), the remainder is applied to the resident's nursing home expense.[148]

In contrast to Medicaid, Medicare was used by very few residents, less than two percent. This is because of Medicare's restrictive eligibility criteria which emphasized nursing homes as a place for recovery and rehabilitation after an acute-hospital stay. Nearly 40 percent of residents in certified homes relied on their own income as the primary source of payment. The figure was higher in non-certified homes at 66 percent.

[148] Health Care Financing Administration. Health Care Financing Review, 12(2). 1990.

TABLE V-J: Percent of Residents by Primary Source of Payment and Medicaid and Medicare Certification of Nursing Home: United States, 1985		
Primary Source of Payment of Care	**Certified**	**Not Certified**
Own income	38.6	65.5
Medicaid-skilled care	19.7	NA
Medicaid-intermediate care	36.7	NA
Medicare	1.5	NA
Other government	1.5	19.9
All other[1] and unknown	1.9	14.6

SOURCE: National Nursing Home Survey.

1. Includes religious organization, foundations, volunteer agencies, initial-payment plans, life-care plans, and situations where the facility assumes the cost.

NA = Category not applicable.

The previous section on policy concerns describes the process of impoverishment of some elderly due to the costs of a long nursing home stay. Elderly with long stay's can be impoverished to such an extent that they become eligible for Medicaid. The expense of nursing home care combined with a long stay can result in catastrophic costs that wipe-out life-time savings and other assets. As of January 1, 1987, about 11 percent of nursing home residents met eligibility requirements for Medicaid because they had "spent-down" their assets during their stay.[149] Some argue that this figure is an underestimate because it excludes residents impoverished by a previous nursing home stay.[150]

From a national perspective, costs for nursing home care are the fourth largest type of expenditure. In 1985, national expenditures for nursing home care amounted to $34.9 billion or 9 percent of all personal health expenditures.[151] (See Table V-K.) Between 1985 and 1989, national expenditures for nursing home care increased by 1.4 times to $48.9 billion.

TABLE V-K: National Expenditures for Health Care by Selected Types of Care: United States, 1985, 1989 (in billions)		
Type of Care	**1985**	**1989**
All personal health care	$380.5	$550.5
Hospital care	168.2	231.8
Nursing home care	34.9	48.9
Home health care	4.9	8.1

SOURCE: Health Care Financing Administration.

Government payments for nursing home care increased dramatically after the advent of Medicare and Medicaid in 1967. Government (federal, state, and local) paid

149 Short, P.F., Kemper, P., Cornelius, L.J., & Walden, D.C. Public and private responsibility for financing nursing home care: The effects of Medicaid asset spend-down. The Millbank Quarterly, 70(2), 2077-298. 1992.

150 Adams, E.R., Meiners, M.R., & Burwell, B.O. Asset spend-down in nursing homes. Medical Care: 31(1): 1-23. 1993.

151 Health Care Financing Administration. Health Care Financing Review, 16(1): 247-299. 1994.

35 percent of nursing home expenditures in 1965 in contrast to 51 percent in 1985.[152] In 1985, close to half of all expenditures were paid out of pocket. Social Security insurance was an important source of out of pocket payments. The elderly used these social security insurance payments to cover 21 percent of nursing home costs. From 1985 to 1989, there has been a small shift away from out of pocket expenditures toward government expenditures. Given that the average monthly charge for nursing home care in 1985 was $1,500 for Medicaid residents,[153] the average monthly social security benefit does not come close to covering it. As Table V-L shows, the average social security benefit in 1987 for persons 85 and older (i.e. those with greatest risk of needing nursing home care) was about $471 for retired workers and about $450 for widows.[154]

TABLE V-L: Average Monthly Social Security Benefit for Retired Workers and Widows by Age, United States, 1987		
	Retired Workers	**Widows**
Ages 62 and over[1]	$512.65	$468.94
75-79 years	537.92	477.17
80-84 years	515.36	473.97
85 years and over	470.83	450.40

SOURCE: Social Security Administration.

1. For widows, age 60 and over.

Table V-M shows the sources of funds for nursing home expenditures. In 1985, nearly 45 percent of the funds were out of pocket and 52 percent were paid by government. Private health insurance covered only about 2 percent of expenditures. Medicaid paid for 48 percent of the expenditures while Medicare paid for less than 2 percent. Between 1985 and 1989, government expenditures increased to 56 percent. Most of the increase was in the Medicare program which rose from 2 to 7 percent of expenditures. This increase was due to the passage of the Medicare Catastrophic Coverage Act, which expanded Medicare's coverage of skilled nursing facility care. It was passed in 1987 and repealed in December 1989. As a result, Medicare's share of spending decreased to 4.4 percent in 1990.[155]

[152] Health Care Financing Administration. Health Care Financing Review, 12(2). 1990.

[153] National Center for Health Statistics. Nursing home utilization by current residents: United States, 1985. Vital Health Stat. 12(102). 1989.

[154] Social Security Administration: Social Security Bulletin: Annual Statistical Supplement, 1989. Pub. No. 13-11700. Office of Research and Statistics. Social Security Administration. 1989.

[155] Health Care Financing Administration. Health Care Financing Review, 16(1): 247-299. 1994.

TABLE V-M: National Expenditures for Nursing Home Care by Source of Funds: United States, 1985, 1989		
Source	**1985**	**1989**
Total funds (billions)	$34.9	$48.9
Out of pocket payments	44.2	39.4
Private health insurance	2.4	3.0
Other private funds	1.9	1.9
Government (Total)	51.5	55.7
Federal	30.0	35.4
State and local	21.4	20.3
Medicare[1]	1.7	7.0
Medicaid[2]	47.7	46.6

SOURCE: Health Care Financing Administration.

1. Subset of federal funds.
2. Subset of Federal, state and local funds.

VI. HOME AND COMMUNITY-BASED CARE IN THE USA[156]

Introduction

Long term care refers to a wide range of medical, social and personal care services that are needed by individuals who are functionally impaired. Such impairment may result from injury, chronic illness or some other physical or mental condition. Long term care is used mainly by the disabled elderly and such non-elderly persons as the developmentally disabled or the mentally ill.

This paper focuses on the elderly, aged 65 and over, who are the primary users of long term care in the USA. It examines their use of long term care services, particularly home and community based care. It describes the kinds of data available on the functionally impaired elderly and their use of such care.

Functionally Impaired Elderly Population

The most reliable indicator of the need for long term care is the presence of functional impairment. A significant number of elderly persons have functional impairments, as measured by the Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL) or cognitive impairments. Such persons are candidates for LTC services, whether provided formally or informally.

In 1985, there were about 5.5 million functionally disabled elderly persons aged 65 and over living in' the community and an additional 1.3 million in nursing homes. Each of these figures is expected to almost double by the year 2020 to 10.1 million and 2.5 million respectively.

There were about 1.1 million of the oldest old, i.e. persons aged 85 and over, who were functionally disabled and living in the community in 1985. An additional 600, 000 lived in nursing homes. By 2020, the community-dwelling group is expected to grow 2.5 times to 2.6 million and the nursing home group similarly to 1.4 million.

These estimates rely on a broad definition of functional disability. They include persons who received active human assistance, standby assistance or used an assistive device. Obviously, a more restrictive definition (e.g. one covering only persons who received active human assistance) would lower these estimates.

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[156] Written by Robert F. Clark, D.P.A., Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Disclaimer: This chapter reflects only the views of its author and does not necessarily represent the position of the U.S. Department of Health and Human Services.

TABLE VI-A. The Functionally Disabled Population: 1985-2060 (Number in thousands)						
Year	In Community			Subtotal	In Nursing Home	Total
	1+ IADL Limitations	1-2 ADL Limitations	3-4 ADL Limitations			
Age 65+						
1985	1,965	1,826	1,673	5,466	1,310	6,776
2000	2,522	2,401	2,240	7,163	1,863	9,026
2020	3,592	3,360	3,176	10,131	2,547	12,678
2060	5,160	5,135	4,929	15,223	4,517	19,740
Age 85+						
1985	282	407	417	1,106	593	1,699
2000	465	668	692	1,826	970	2,796
2020	663	947	983	2,593	1,363	3,956
2060	1,434	2,035	2,117	5,585	2,884	8,469

SOURCE: Adapted from K. Manton, Epidemiological demographic and social correlates of disability among the elderly. The Milbank Quarterly, 67(2,1):13-58, 1989 using data from the National Long Term Care Survey.
NOTES: ADL is activities of daily living. IADL is instrumental activities of daily living.

Long Term Care: Overview

The long term care system in the USA is large and complex. It consists fundamentally of: (a) informal care; (b) home and community based care (including home health care); and (c) nursing home care.

Informal care is care provided voluntarily by one's immediate family (e.g. spouse or adult child), other relatives, friends, neighbors and community service organizations. It is estimated that about three quarters of functionally impaired elderly persons living in the community rely exclusively on such care.[157]

Home and community based care refers to formal services provided in home or community-based settings and paid for from either private or public funds. For every person in a nursing home, there are an estimated three persons with similar disabilities living in the community. To the extent that the needs of these persons are met, informal care and formal home and community based care are the means.

Nursing homes provide specialized medical, nursing and social services in an institutional setting. As discussed in Joan Van Nostrand's paper, nursing homes consume the largest fraction of long term care dollars.

There is no single funding source for long term care. From a financing perspective, the LTC system is supported by public funds, out-of-pocket expenditures, and, to a growing degree, private long term care insurance. Public funds may be federal, state or local in origin. The complexity of the system is suggested by the fact

[157] Rivlin, A.M. and Wiener J.M., with R.J. Hanley and D.A. Spence, CARING FOR THE DISABLED ELDERLY: WHO WILL PAY? Washington, DC: Brookings Institution, 1987.

that over 80 separate federal programs provide income support, housing assistance or supportive services to persons needing long term care.[158]

The five major federal programs are Medicare, Medicaid, Social Services Block Grant, Older Americans Act and Supplemental Security Income (SSI). Total long term care spending annually in the USA from all sources, public and private, is estimated at approximately $50 billion. Nursing home care consumes about 80% and home and community based care 20% of this amount.

Medicaid, a joint federal-state program, is the largest public source of funds, accounting for about 40% of all long term care spending. The remaining amount is accounted for by Medicare and other public programs, private long term care insurance and out-of pocket expenditures.

Home and Community-Based Care: Evolution and Trends

Care of the functionally disabled elderly at home is not new. The Boston Dispensary established the nation's first home care program in the 1790s. "In the late 1800s, home nursing services were organized and administered by lay persons".[159] During this period Visiting Nurse Associations emerged. Dr. E.M. Bluestone founded a hospital-based home care program at Montefiore Hospital, New York City in 1947.[160]

The passage of Medicare and Medicaid in 1965 gave impetus to the expansion of home health care in the succeeding decades.

Medicare Home Health Care

Medicare is a federal health insurance program with a uniform eligibility and benefit structure throughout the United States. The program covers most persons entitled to Social Security benefits, persons under age 65 entitled to disability benefits and some persons with end-stage renal disease. Medicare covers primarily acute rather than long term care.

Medicare benefits are provided under two parts: Part A--Hospital Insurance and Part B--Supplementary medical Insurance. Under current law, Medicare home health benefits under either part are targeted at persons recovering from an acute illness. The beneficiary must be home-bound and services must be ordered and reviewed periodically by a physician.

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[158] U.S. House of Representatives, Committee on Ways and Means, OVERVIEW OF ENTITLEMENT PROGRAMS--1990 GREEN BOOK. Washington, DC: US Government Printing Office, June 5, 1990.

[159] Spiegel, A.D. HOME HEALTH CARE. Owings Mills, MD: Rynd Communications, 1987.

[160] Spiegel, A.D. HOME HEALTH CARE. Owings Mills, MD: Rynd Communications, 1987.

TABLE VI-B: Medicare Home Health Benefit Payments					
Fiscal Year	**Medicare Home Health**			**Percent Change**	**Home Health as Percent of All Medicare**
	Part A	**Part B**	**Total**		
1985	$2,119	$53	$2,172	---	3.1
1990	3,400	73	3,473	60.0	3.2
1995 estimate	5,246	85	5,331	53.5	3.0
SOURCE: U.S. House of Representatives, Committee of Ways and Meands, Overview of Entitlement Programs--1991 Green Book. Washington, DC: U.S. Government Printing Office. **NOTE**: Figures in millions.					

Medicare expenditures were about $70 billion in FY 1985, $105 billion in FY 1990 and will be about $178 billion in FY 1995. Home health expenditures have remained at about 3% of all Medicare expenditures in recent years.

Medicaid Home and Community-Based Care

Medicaid is a federal-state matching entitlement program providing medical assistance to low income persons who are aged, blind, disabled, members of families with dependent children and certain other needy persons. Within federal guidelines, each State designs and administers its own program. There is considerable variation from State to State in persons covered, benefits included and amounts of payment for services.

Medicaid finances home and community-based care under three coverage options: (1) home health care; (2) personal care; and (3) home and community-based waiver services.

Medicaid Home Health Services

Medicaid-financed home health services are usually the same set of services as those authorized under the Medicare home health benefit and are provided by Medicare-certified home health agencies. The differences lie in the fact that Medicaid is a welfare program for low income persons regardless of age and Medicare is a social insurance program for the elderly.

While Medicare home health care is intended as acute care, Medicaid home health care can be used by patients with chronic care needs. Furthermore, these services are a mandatory part of each state's Medicaid plan (in contrast to some services which are optional) and must be provided to individuals entitled to nursing home care.[161] In Fiscal Year 1986, Medicaid payments for home health services were

[161] Congressional Research Service, MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS. A Report prepared for the Subcommittee on Health and the Environment of Committee on Energy and Commerce, U.S. Housing of Representatives. Washington, DC: U.S. Government Printing Office, 1988.

$1.35 billion (3%r of all Medicaid payments) on behalf of 593,000 beneficiaries. Of this amount, $766,000 (56.7%) was spent on behalf of the elderly.

TABLE VI-C: Medicaid Home Health Vendor Payments				
	Total	**Percent of Total**	**Aged**	**Percent of Total**
FY 1985				
All Medicaid	$37,508.0	100.0	$14,096	100.0
Home health	1,120.0	3.0	639.0	1.7
FY 1989				
All Medicaid	$54,368.6	100.0	$18,558.3	100.0
Home health	2,571.0	4.7	1,440.5	7.8
SOURCE: Health Care Financing Review: 1990 Supplement. **NOTE**: Figures in millions				

Medicaid payments for home health services for the elderly represent about 56% (1440.5/2571.0) of all Medicaid home health payments. They also amount to about two-fifths of Medicare home health payments (1440.5/3473.0).

Medicaid Personal Care Services

At their option, states may also provide personal care services as part of their Medicaid plans. As of January 1990, 30 states did so. These are semi-skilled or non-skilled services, such as assistance with bathing, dressing and toileting, that are prescribed by a physician under the recipient's plan of care and provided to functionally impaired elderly persons living at home.

In Fiscal Year 1989, about $1.2 billion was spent under Medicaid for personal care. However, about 80W of this amount was accounted for by New York and an additional 15% by five other states--Arkansas, Massachusetts, Michigan, Texas and Oklahoma.

Medicaid Home and Community-Based Care

Medicaid home and community-based care services were first authorized under Section 2176 of the Omnibus Budget Reconciliation Act (OBRA) of 1981. Such services typically include case management, personal care, homemaker and chore services, and respite care. In general, they are designed to assist elderly persons who otherwise would occupy a nursing home bed. Since such services were not covered under the regular state Medicaid plan, states had to apply for a waiver. By 1989, 36 states had done so.

In Fiscal Year 1986, Medicaid expenditures for the disabled elderly under Section 2176 were $164 million and served 78,600 elderly beneficiaries.[162]

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[162] Congressional Research Service, MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS. A Report prepared for the Subcommittee on Health and the Environment of Committee on Energy and Commerce, U.S. Housing of Representatives. Washington, DC: U.S. Government Printing Office, 1988.

OBRA 1987 established a second home and community-based waiver program under Section 1915 (d). This waiver provision exempts states from serving only persons who otherwise would be in a nursing home. In return, states agree to set an overall spending cap on their long term care expenditures. This waiver has been used by only one state, Oregon.

Under OBRA 1990, states may elect to provide home and community-based services at their option under the state Medicaid plan. However, this new provision establishes an overall spending cap for each state and for Medicaid overall. This source of funding is independent of the Medicaid section 2176 waiver program under which States may request a waiver from normal Medicaid requirements in order to provide home and community-based care.

These examples, pertaining only to home and community-based care (not nursing home care) and drawn from a single program, Medicaid, illustrate the complexity of the USA's long term care system. Even within this single public program, these are different combinations of services and multiple sources of funding for home and community-based care.

Other Sources of Home and Community-Based Care

Older Americans Act

The Older Americans Act of 1965 established a "network" on aging, consisting of a federal Administration on Aging, State Agencies on Aging and local Area Agencies on Aging. In Fiscal Year 1989 there were 670 AAAs. A variety of services is provided to the elderly under Title III, including: (a) supportive services and senior centers; (b) congregate nutrition services; (c) home-delivered meals; and (d) in-home services for the frail elderly.

Supportive services include transportation, housekeeping, telephone reassurance and friendly visiting, chore services, education, training, escort service and legal assistance. In FY 1989, approximately 7.1 million persons received such services. Ombudsman services and, for the first time in FY 1990, elder abuse prevention services are also authorized.

Over 144 million congregate meals were served to older persons and their spouses. An addition 99.6 million meals were provided to the homebound elderly.

Funding for in-home services to the frail elderly first became available in FY 1988 and over 91, 00 persons were served in FY 1989.

Services under the Older Americans Act are available to all elderly persons aged 60 and over. There is no means test, although under law there is a requirement to emphasize the needs of low income minority elderly. Over the past decade, there has

been an expansion of case management and other supportive services to the frail elderly.

TABLE VI-D: OAA Title III Funding: Fiscal Year 1991	
Total	$901,827
Supportive services	$290,818
Ombudsman/elder abuse prevention	5,367[1]
Congregate nutrition	361,083
Home-delivered meals	87,831
U.S. Department of Agriculture commodities	149,897
In-home services for frail elderly	6,831

SOURCE: U.S. Senate, Special Committee on Aging, 1990(1):361.
NOTE: Figures in thousands.

1. Includes $1 million for planned White House Conference on Aging.

Social Services Block Grant

The principal source of federal funding for state social service programs is the Social Services Block Grant (Title XX of the Social Security Act). In Fiscal Year 1989, $2.7 billion were allotted to the states. Within general statutory limits, each state can determine what services to provide, who is eligible for these services and how funds are distributed among state agencies. Social services aimed at assisting elderly persons with self-care needs may be provided.

States are not required to report the number of elderly recipients of services or expenditures on behalf of the elderly. Most states provide homemaker and chore services, as well as adult protective and emergency services for their elderly citizens.

Supplemental Security Income

The U.S. Social Security Administration administers the Supplemental Security Income (SSI) program for needy aged, blind and disabled persons. SSI benefits are financed from general revenues. As of June 1989, there were 4.5 million SSI beneficiaries, of whom about 2.0 million were aged 65 and over. In Fiscal Year 1989, total benefits paid amounted to $14.3 billion, of which $11.4 billion were federal and $2.9 billion were federally-administered state supplemental benefits.

In 1990, the regular federal SSI benefit was $386 a month for an individual and $579 for a couple. Most states supplement this amount. All but seven states provide supplements aimed at covering the additional costs of housing for the frail elderly, mentally ill, or developmentally disabled in board and care homes or similar group living arrangements.

When a person enters a hospital or nursing home, where a major part of the bill is paid by Medicaid, the SSI benefit is reduced to a personal needs allowance of $30 a month.

TABLE VI-E: SSI Recipients: Selected Years				
Year	Total	Aged Only	Blind or Total	Disabled 65 and Older
1975	4.3	2.3	2.0	0.2
1980	4.1	1.8	2.3	0.4
1985	4.1	1.5	2.6	0.5
1989	4.6	1.4	3.2	0.6
SOURCE: Social Security Administration. **NOTE**: Figures in millions.				

Home Health Care: Summary

The following table (table VI-F) summarizes spending on home health care in 1985.

Data (unpublished) from the 1984 National Long Term Care Survey indicate that 7.3% of the functionally disabled elderly living in the community used home health care services in the month prior to the survey. The rate of use rose with age with 5.1% of those aged 65-74 using home health care, 7.5% of those aged 75-84 and 11.7% of those aged 85 and over.

TABLE VI-F: Home Health Care by Payment Source (1985)		
Payment Source	Expenditures	Percent
Total	$9.1	100.0
Medicaid		
Federal	0.6	7.0
State	0.5	5.0
Medicare	2.3	25.0
VA, Older Americans Act Social Services Block Grant	0.6	7.0
State	0.5	5.0
Out-if-pocket payments	3.7	41.0
Private insurance/other	0.9	10.0
SOURCE: U.S. General Accounting Office, 1988. **NOTE**: Dollar figures in billions.		

Supportive Housing

Long term care involves housing, personal care and, where needed, skilled nursing care. Besides one's own home and the nursing home, a variety of supportive housing arrangements for the frail elderly has grown up in recent years. These include Continuing Care Retirement Communities (CCRC), board and care homes, and various forms of subsidized housing.

Continuing Care Retirement Communities

CCRCs, sometimes called life care communities, provide under contract housing, personal care, nursing care and other social and recreation services to their residents. Residents pay an entrance fee and a monthly fee for these benefits. "There are approximately 700-800 continuing care retirement communities with an estimated 230,000 residents…"[163] Median entrance fees range from $33,000 to $70,000 and median monthly fees from $700 to $1000. The average age of residents is about 75.

Board and Care Homes

Board and care homes are non-medical community-based facilities that provide protective oversight and personal care for their residents, who in the main are disabled elderly, mentally ill and developmentally disabled. While CCRC residents come from middle and upper middle income groups, board and care residents are more often low income.

Frequently, residents receive SSI checks, which they turn over to board and care owner/operators in return for services. Alternatively, e.g. when the resident is cognitively impaired, checks may be sent directly to the owner/operators who act as representative payees. While hard data are lacking, there may be as many as 50,000 to 75,000 board and care homes nationally, serving approximately one million disabled persons.

Other Supportive Housing Arrangements

At the federal level there are several programs that provide supportive housing to the frail elderly. The Department of Housing and Urban Development (HUD) administers the Section 202 program, under which subsidies are provided for the building and managing of rental housing for the elderly. The number of frail elderly in these projects has been growing, due to the phenomenon of residents "aging in place".

The low income elderly among others also may take advantage of HUD's Low Rent Public Housing Program, which includes 1.4 million units and houses 3.5 million persons. HUD's Section 8 Rental Assistance Program provides subsidies to landlords on behalf of tenants with incomes too low to afford private market housing.

The U.S. Department of Agriculture's Farmer's Home Administration (FmHA) administers several programs that benefit low income rural residents, including the elderly, under several sections of the Housing Act of 1949 as amended.

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[163] U.S. Senate, Special Committee on Aging, DEVELOPMENTAL IN AGING: 1990, VOLUME 2--APPENDICES. Washington, DC: U.S. Government Printing Office, March 22, 1991.

There are an estimated 105,000 persons aged 65 and over with a limitation in at least one ADL living in government-assisted housing[164]

A number of supportive housing programs have been initiated at the state level, such as Maryland's Sheltered Housing Program, the Massachusetts, Congregate Public Housing Program, New York's Enriched Housing Program and Oregon's Assistive Living Program.

The linkage between housing and long term care is evident as residents age in place and increasingly require more personal care and nursing services. Traditional lines of demarcation between housing and long term care are breaking down.

Besides the existing arrangements, many new models of housing with supportive services for the frail elderly are being developed and tested. These include the Supportive Services Program in Senior Housing sponsored by the Robert Wood Johnson Foundation, the National Demonstration of Congregate Housing for the Elderly in Rural Areas developed jointly by the Administration on Aging and the Farmers' Home Administration and the Life Care Home model developed at Brandeis University.

Data Sources and Data Needs

Data on the long term care system in the USA are available from several main sources: surveys, administrative data, and other data sources (inventories, state and local data systems, and demonstrations). Coverage of nursing home care is more comprehensive than coverage of home and community care, because the latter is more diffuse and the former absorbs the largest share of public funds.

Surveys

A number of national surveys yield data on the functionally disabled elderly population and their use of long term care services. Current surveys whose data are available include:

- National Long Term Care Surveys (1982, 1984, 1989)
- New Beneficiary Survey (1982, 1989)
- National Health and Nutrition Examination Survey (NHANES)
- I Epidemiologic Followup Study
- Survey of Income and Program Participation (SIPP)--Disability Module
- National Health Interview Survey--Supplement on Aging and Longitudinal Study of Aging (1984-1986)
- National Nursing Home Survey (1985)

[164] Struyk, R., Page, D.B., Newman, S., Carroll, M., Ueno, M., Cohen, B., Wright, P., PROVIDING SUPPORTIVE SERVICES TO THE FRAIL ELDERLY IN FEDERALLY ASSISTED HOUSING. Washington, DC: Urban Institute Press, June 1989.

- National Mortality Followback Survey (1986)
- National Medical Expenditure Survey--Household and Institutional Components (1987).

See Wiener, et al.[165]

The decennial Census of the U.S. population provides baseline data for the elderly as well as other population subgroups. It is supplemented annually by the Current Population Survey.

Administrative Data

Administrative records on the functionally disabled elderly are available through the Social Security Administration (SSA) and the Health Care Financing Administration (HCFA), both of which are components of the U.S. Department of Health and Human Services.

Administrative records have the advantage of being centralized and of being policy-relevant, since they cover persons who meet the program's eligibility criteria. They, of course, miss non-beneficiaries. Furthermore, because they are maintained for purposes of program administration, they often lack data about an individual's abilities, disabilities and other characteristics that do not pertain to program eligibility.

Within SSA, there are administrative data on the beneficiaries of two programs, viz., the Old Age, Survivors and Disability Insurance (OASDI) program and the Supplemental Security Income (SSI) Program.

OASDI serves persons with substantial work histories and their dependents, while SSI, as described above, targets low income persons.

HCFA maintains records on Medicare beneficiaries through its Medicare Automated Data Retrieval System (MADRS). Through cooperative arrangements with States, the agency has also developed the Medicaid Management Information System (NMIS).

SSA supplements its administrative records periodically with surveys such as the New Beneficiary Survey. In 1991, HCFA is inaugurating the Current Beneficiary Survey, which will be administered on an ongoing basis.

Other Data Sources

Data on the functionally impaired elderly can often be found by accessing specialized inventories. For example, the National Center for Health Statistics is

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[165] Wiener, J.M., Hanley, R.J., Clark, R., Van Nostrand, J.F., Measuring the Activities of Daily Living: Comparisons Across National Surveys, JOURNAL OF GERONTOLOGY: SOCIAL SCIENCES 45(6):S229-S237. [http://aspe.hhs.gov/daltcp/reports/meacmpes.htm]

conducting the 1991 National Health Provider Inventory (NHPI) , which is a comprehensive national listing of long term care providers (nursing homes, board and care homes, home health agencies and hospices) Such inventories often include data on the characteristics of their resident populations such as the frail elderly.

State and local governments maintain their own data bases. For example, Connecticut has an extensive longitudinal file on its long term care population that shows transitions from one setting to another and funding sources. Massachusetts has sponsored surveys of home and community based services for its frail elderly population.

While not nationally representative, data from federally-funded research and demonstration programs can be used to examine in depth the characteristics, service use patterns and expenditures of their participants. A prominent example is the public use files from the National Long Term Care Channeling Demonstration, which was conducted from 1981 to 1986.

Conclusion

Over the past decade, there has been significant growth in long term care data bases. Over the same period, however, there have been major shifts within the long term care system itself. "To project the need for long term care, data are required for a relatively long period on changes in the characteristics of the elderly population, their use of services, and the nature of their support system, as well as changes in the system both formal and informal".[166]

The three followup waves to the 1985 National Nursing Home Survey, the Longitudinal Study of Aging and the National Long Term Care Surveys form the core of such longitudinal survey data.

More such longitudinal data are needed to describe the transitions of the elderly from one state to another, where "state" can refer to health, functional status, longevity, service use or payment source. Such longitudinal data are vital to model the processes of change, project future needs, and document the outcomes of care.

Finally, the entire long term care system needs to be examined in terms of the degree to which it produces desirable outcomes for the frail elderly, their caregivers and the taxpayers. For the frail elderly, these outcomes include the maintenance of dignity and independence in their latter years, access to needed services and an acceptable quality of life.

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[166] Gilford, D., ed., THE AGING POPULATION IN THE TWENTY-FIRST CENTURY: STATISTICS FOR HEALTH POLICY. Washington, DC: National Academy Press, 1988.

For their caregivers, there must be an appropriate mix of formal and informal care and of public and private support. The nation's taxpayers, whose average age is rising, are not likely to quarrel with such a system.

INTERNATIONAL COLLABORATIVE EFFORT (ICE) ON AGING: OUTCOMES OF NURSING HOME CARE IN FIVE COUNTRIES

Reports Available

Home and Community-Based Care in the USA

HTML	http://aspe.hhs.gov/daltcp/reports/hcbcusa.htm
PDF	http://aspe.hhs.gov/daltcp/reports/hcbcusa.pdf

Home and Community-Based Care: The U.S. Example

HTML	http://aspe.hhs.gov/daltcp/reports/usexampl.htm
PDF	http://aspe.hhs.gov/daltcp/reports/usexampl.pdf

Long-Term Care in Five Countries

Executive Summary	.
HTML	.
PDF	.

Nursing Home Care in Five Nations

HTML	http://aspe.hhs.gov/daltcp/reports/nh5nates.htm
PDF	http://aspe.hhs.gov/daltcp/reports/nh5nates.pdf

Overview of Long-Term Care in Five Nations: Australia, Canada, the Netherlands, Norway, and the United States

HTML	http://aspe.hhs.gov/daltcp/reports/1995/5overvie.htm
PDF	http://aspe.hhs.gov/daltcp/reports/1995/5overvie.pdf

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