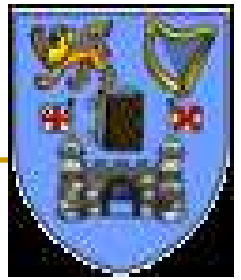
Social
Policy and
Ageing
Research
Centre



'Trends in Community Care'

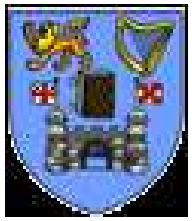
Dr Virpi Timonen
Social Policy and Ageing Research Centre (SPARC)
Trinity College Dublin, Ireland

NSW HACC and Community Care Conference
Sydney Convention and Exhibition Centre

14 May 2007

Social Policy and Ageing Research Centre

Cautionary notes…



- Difficulty of identifying global trends
- …But some countries do have significant commonalities
- Background mostly in HOME care services for OLDER people
- Cases: Ireland, Finland, Denmark, Germany, England, United States (California)

Social Policy and Ageing Research Centre

What are the most readily identifiable commonalities?

- HACC – universal aspiration
- The search for an appropriate balance between Government (Public) and Individual (Private) responsibility for the costs of caring
- The search for an appropriate balance between Formal (paid, 'professional') and Informal (family-provided) care
- The search for appropriate forms and extent of regulation
- Attempts to resolve workforce issues (supply of labour, remuneration, social rights, training, career development)
- Extension of 'consumer power'

Social Policy and Ageing Research Centre

Key questions

- **Who gets (publicly funded) care?**
- **Who provides care?**
  - Role of formal vs. informal providers
- **Who pays?**
  - Extent of Government funding
  - Cost control mechanisms
- **How is care provided?**
  - Regulatory framework
  - Workforce issues
- **What is the role of the service user?**
  - 'Consumer/client power'

Social Policy and Ageing Research Centre

Who gets (publicly funded) care?

Criteria	Denmark	Germany	California (US)
Needs	Holistic needs assessment	Functional ability (I/ADL)	Functional ability (ADL)
Income	None	None	Strict
Family availability	Some consideration to presence of a healthy spouse (domestic work)	Not taken into account	Taken into account in domestic work
Other key features	Preventative visits 2 x year to all aged 75+		

Social Policy and Ageing Research Centre

Who provides?

- The role of **formal** (public, private, voluntary) vs. **informal** providers
- Common trend within **formal**:
- Move away from public provision and towards 'contracting out' to private (and to a lesser extent, non-profit) providers
- England 1992-2005: independent providers' (profit and non-profit) share of services provided increased from only 2 % to approx. 75 % (Glendinning 2007)
- Germany: traditional privileges of non-profit organisations abolished in 1994 - -proliferation of private providers
- Denmark 2003: 'greater choice of provider' legislation

Social Policy and Ageing Research Centre

Shifts in formal vs. informal harder to measure

…but quantity (if not necessarily % share) of formal care giving increasing rapidly in most developed countries

…many countries eager to reward/encourage informal care (arguably largely due to concerns about higher *direct public* expenditure associated with formal care)

…consequent blurring of formal/informal boundary

Social Policy and Ageing Research Centre

Encouraging / rewarding informal care

- Funding can be channelled to family carers AND is extensively used: Germany, United States
- Funding can be channelled to family carers BUT is not extensively taken up: Denmark, Finland, UK
- Funding CANNOT be channelled to family carers: Ireland

Social Policy and Ageing Research Centre

Reconciling and co-ordinating informal and formal care

- Questionable whether this has been 'properly' accomplished anywhere!
- Some countries offer short-term benefits to 'worker-carers' but take-up (and benefits) tend to be low
- This is indicative of the difficulty of reconciling employment and care, and binary thinking around the roles of worker and carer

Social Policy and Ageing Research Centre

Who pays?

Source and extent of Government funding

	Denmark	California	Germany
Source of public funding	Local and national tax revenue, using equalising mechanisms between local governments.	Local and national tax revenue, does not use significant equalising mechanisms. Emphasis on cost-control.	Employee and employer social insurance contributions. These, as well as the benefit levels, have been capped since 1994.
Extent of individual/family responsibility for costs	None.	Full responsibility for all whose incomes/assets above means-testing threshold.	Over and above LTCI payments: full responsibility (extended to family members)
Treatment of individual's savings/assets	Protected.	Must deplete to a very low level. Posthumous cost recovery	Implicit requirement to tap into assets/savings.

Social Policy and Ageing Research Centre

Cost control mechanisms

- **Common features**:
  - stricter time-monitoring, rationing of care (focus on high-dependency)
  - encouragement of informal carers; low wages for formal carers
- **US**:
  - caps on the extent to which Federal and State govts subsidise wages of care workers and the overall budget
  - encouraging private long-term care insurance and a clampdown on persons transferring their assets to access the Medicaid programme
- **Denmark**:
  - targeting of services to 'higher dependency' care recipients
  - decreases in the amount of care awarded
- **Germany**:
  - caps on value of care awarded; payments unchanged since 1994
  - encouraging 'cheaper' forms of care
  - extending co-payments by default

Social Policy and Ageing Research Centre

How is care provided?

Control and oversight

	Denmark	California	Germany
Legislation, general control and oversight	General guidelines from central govt; implementation, detailed provisions by local govt	Relatively little guidance and control from central govt	Strong guidance and control from central govt
Quality Assurance	Quality guidelines outlined by local government (vary substantially)	Providers under the agency contract mode follow strict quality/ monitoring controls. Care recipients in the independent provider mode are visited 1 x year by social worker, quality assurance heavily reliant on care recipients themselves.	Cash benefit recipients visited by a nurse every 3 or 6 months depending on level of care. Owners and managers of domiciliary agencies must develop quality assurance guidelines.

Social Policy and Ageing Research Centre

Workforce issues

- Expansion of low-wage, low-security jobs: *employment* rather than long-term care policy?
- Ambiguous attitude to training: more, but must not lead to major cost increases
- Increase in pay can stabilise workforce (California)

Social Policy and Ageing Research Centre

What is the role of the service user?

"Consumer/client power"

	Denmark	California	Germany
Service user choice	Can choose between public or private provider (number of private providers very low in some areas).	Care recipients can choose a carer from either their own informal contacts or from a formal list provided by the Public Authority.	Choice between cash-benefit and direct service delivery. Recipients who choose latter can also choose between private and non-profit provider.
Service user direction	Care recipients can instruct care worker to carry out care task other than those specified in the care plan. The care worker should oblige but can use his/her own discretion.	In the Independent Provider mode, the most common care contract, care recipient hires, fires, directs and supervises the care worker. While there is a formal care plan, care recipient can change this plan.	Consumer direction for beneficiaries who opt for the cash option is an outcome of the care relationship, less a formal mechanism. Consumer direction for care recipients who receive care via formal service providers is absent.

Social Policy and Ageing Research Centre

Conclusion I

- Common trends/patterns

1) changing role of govt: emphasis on purchaser function – introduction and strengthening of 'social markets'; cost control
2) acknowledgement of the contribution of informal caregivers
3) emerging predominance of private sector providers
4) new focus (rhetorical?) on the value of the voluntary sector
5) targeting of services to people with higher dependency needs and consequent decreased emphasis on domestic work /companionship

Social Policy and Ageing Research Centre

Conclusion II

6) increased focus on consumer power
7) exploration of new forms of provision/financing such as the use of personal budgets
8) precariousness / de-professionalisation of the care workforce
9) acknowledgment that quality monitoring will become a growing concern in coming years
10) continuing lack of information re. older persons' wishes and experiences – what constitutes quality of care; what is a good care relationship?

Social Policy and Ageing Research Centre

Conclusion III

- **Policies rooted in past and present practices/values**

…Social and economic change leads to change in policies

…But policies also shape practices/values

…Small changes can have extensive repercussions

Social
Policy and
Ageing
Research
Centre

Please see also:

Doyle, Martha and Timonen, Virpi (2008) Home Care for Ageing Populations. Cheltenham: Edward Elgar.

(Available January 2008)

Thank you!