Turning the ‘problem’ into the solution:

Hopes, trends and contradictions in home care policies for ageing populations

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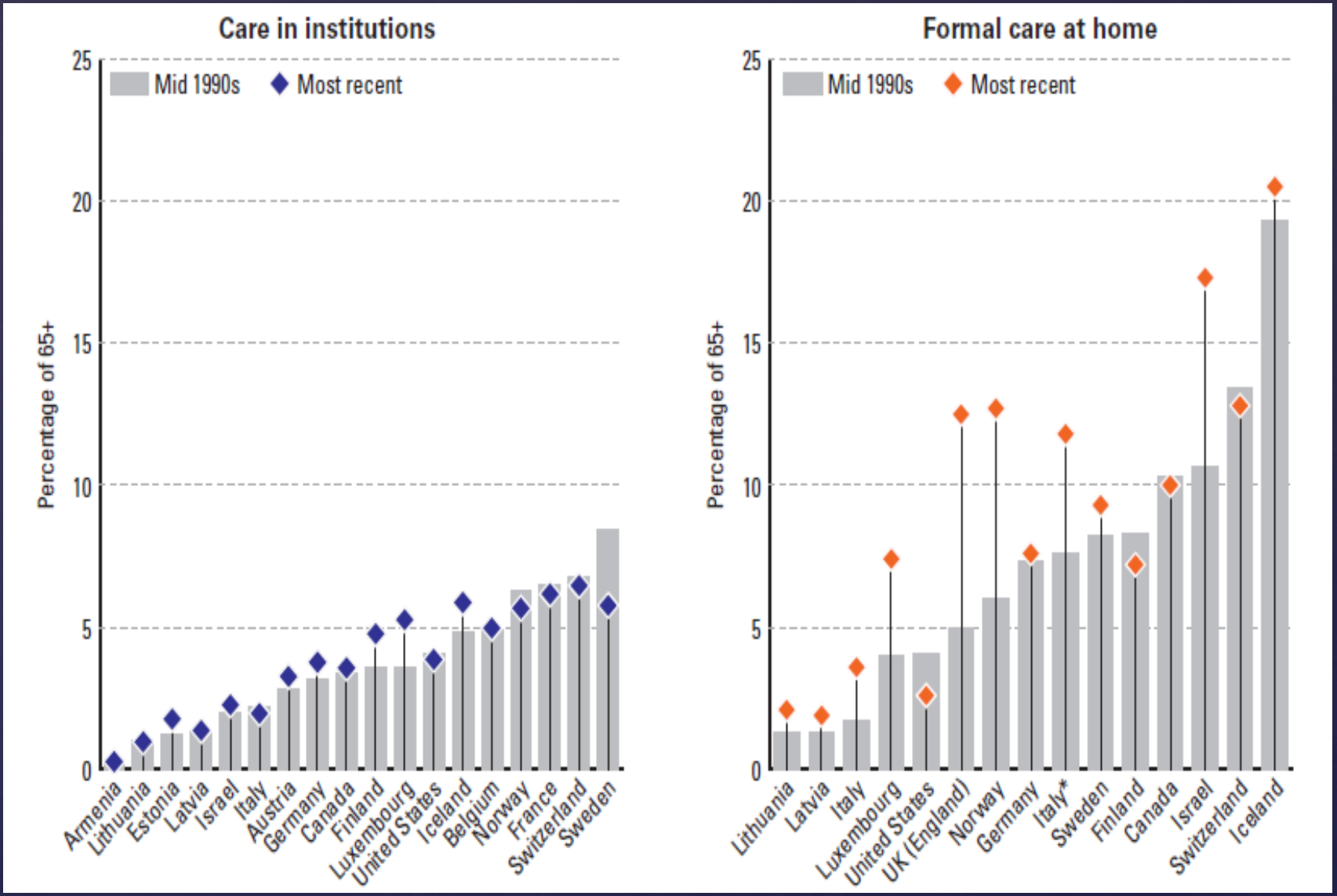
LIVINDHOME project

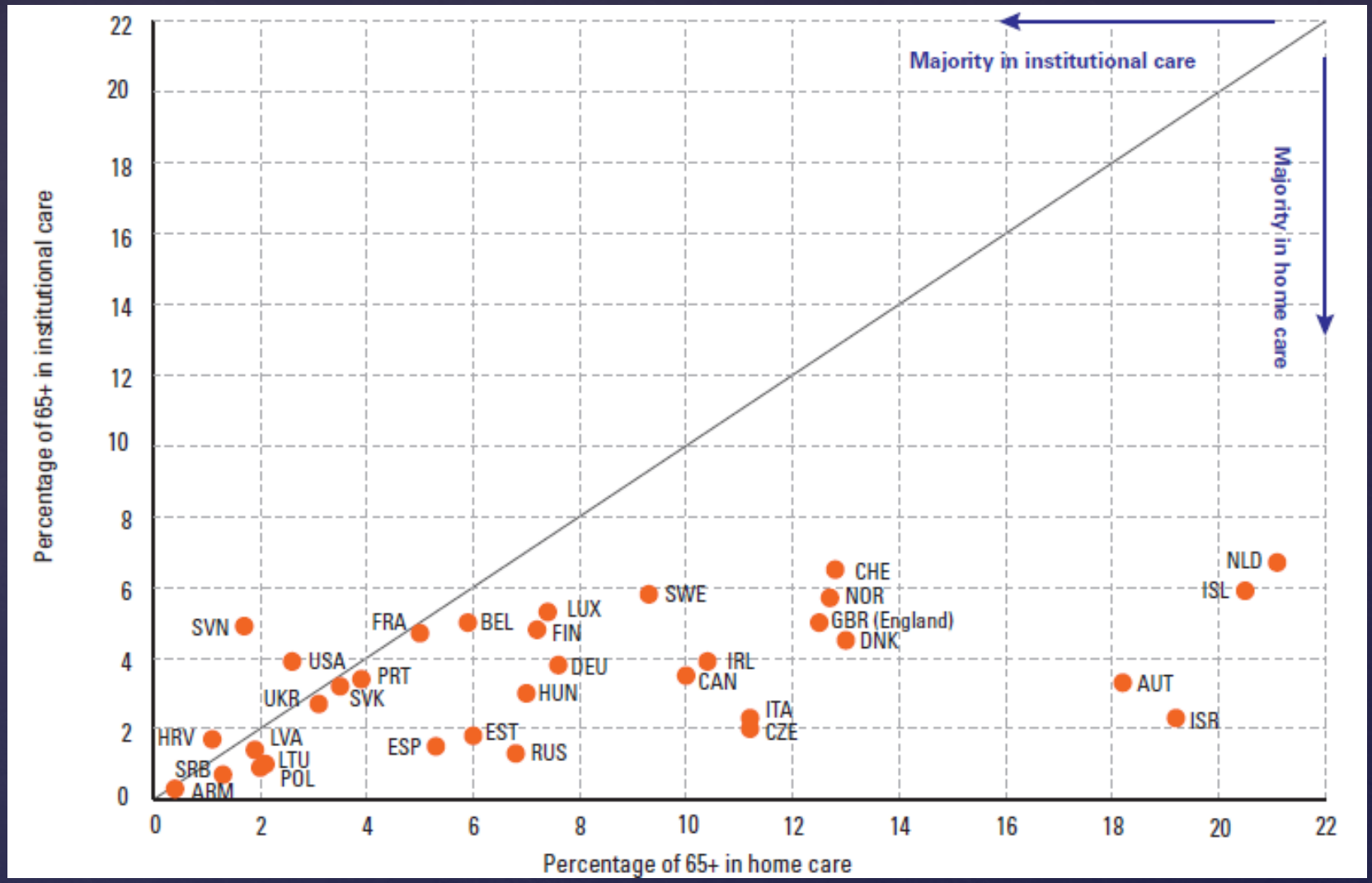
- Comparative study of reforms in home care services in nine European countries (Denmark, Sweden, Norway, Finland, Germany, Austria, England, Ireland, Italy): PI Tine Rostgaard
- Papers from the study (plus Netherlands and France) published in a special issue of the journal *Health and Social Care in the Community*
- Rodrigues et al. (2012) *Facts and figures on healthy ageing and long-term care in Europe and North America* (online)

Common pressures on long-term care systems

- Population ageing
- Public expenditure constraints
- Aspiration to increase labour market participation
- Changing attitudes to the welfare state
- Care workforce issues
- Cost of hospital, nursing home care for older adults who ‘only’ need low-moderate level of home care



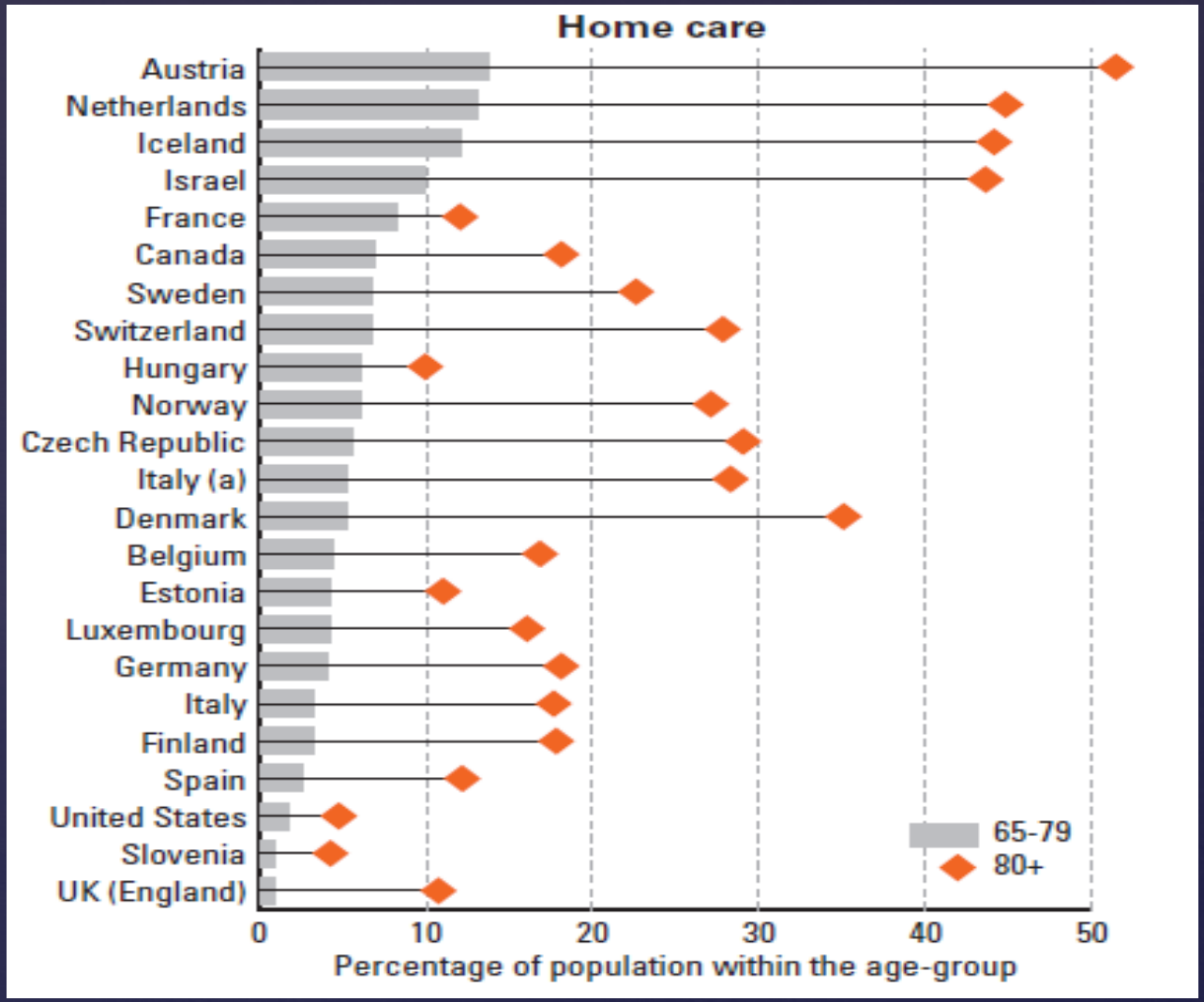
Change over time in percentage of people receiving care in institutions and at home



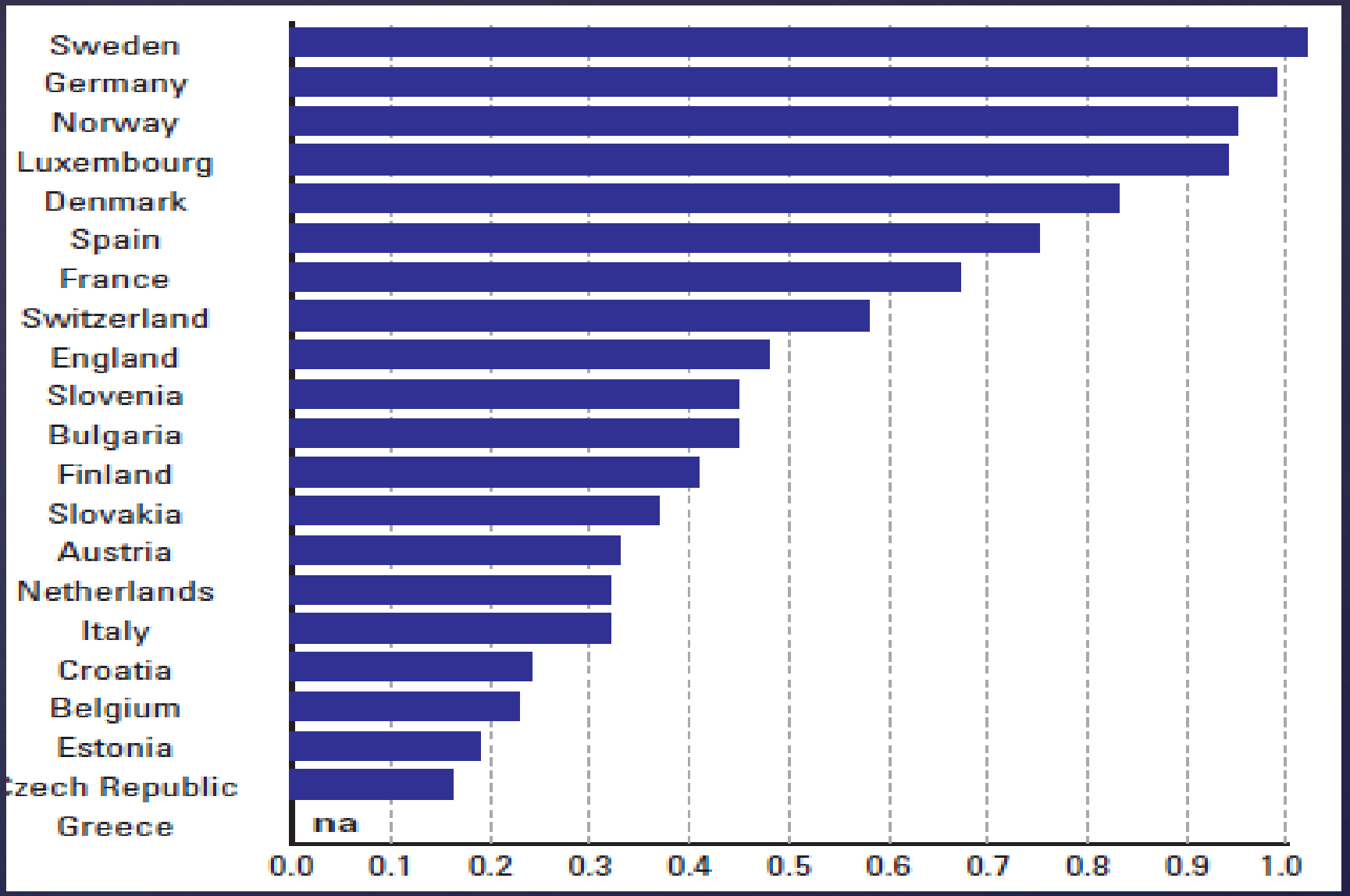
65+ receiving care benefits (cash or in-kind) in different care settings

Common pressures on home care

- Intensification as more people staying longer at home, at higher levels of need
- Ensuring adequacy and appropriateness
- Monitoring quality, preventing abuse
- Ensuring linkage with other health and social care providers in the community
- Family care-formal care interaction (the family carer increasingly likely to have some level of care needs)



% of 'younger old' and 'oldest old' receiving home care



Ratio of people formally employed in the care sector to users of formal care services

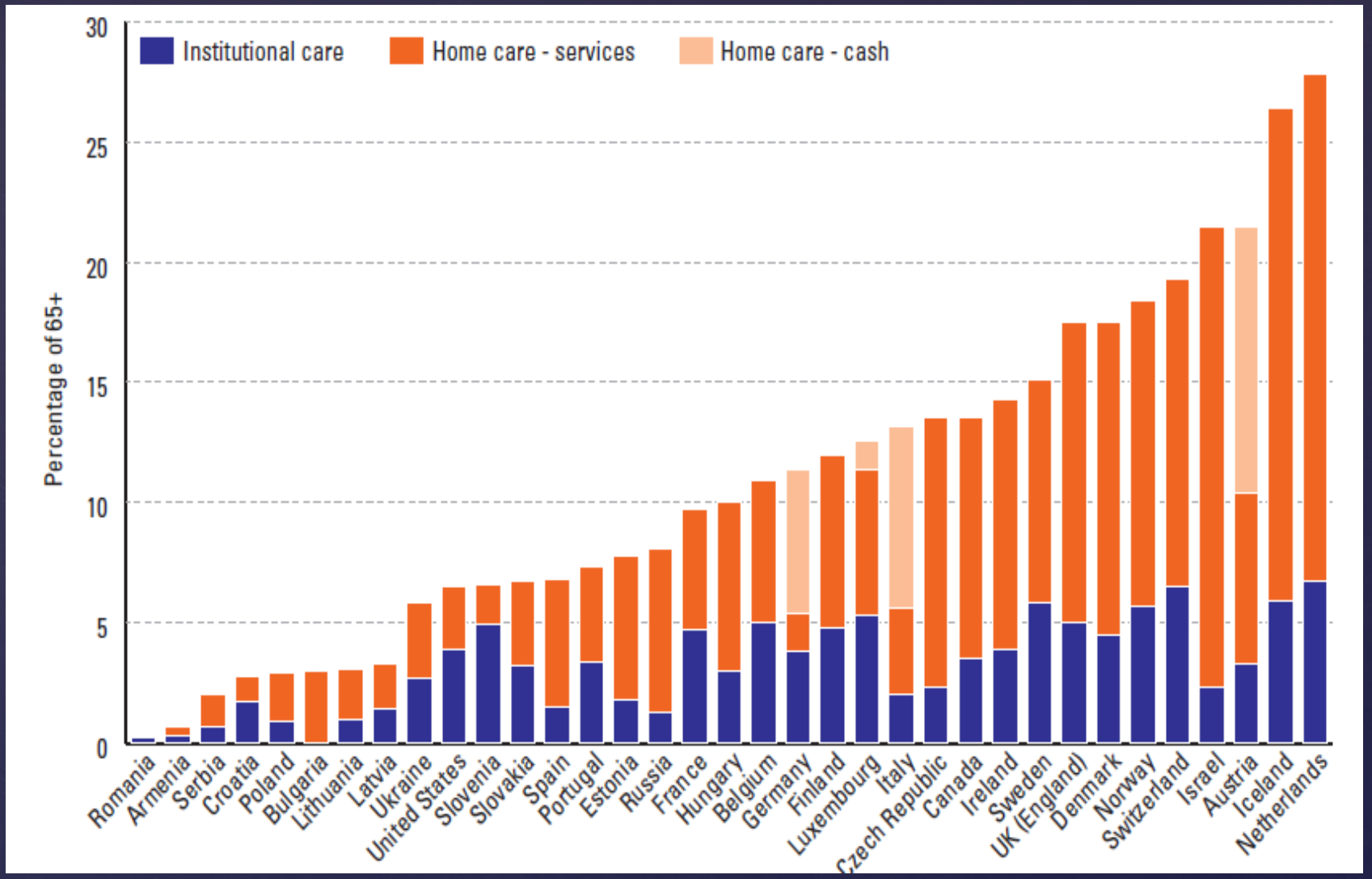
Reasons for divergence

- Historical traditions, values and structures of each country (path-dependency)
- Shifting patterns of governance in home care services, particularly the tensions between local government, central state and market modes of governance

- A corporatist policy response in Austria and Germany led to the establishment of new social rights to long-term care

- In Italy and Ireland, the role of the central state remained limited, despite considerable expansion and innovation (most notably through cash-for-care arrangements)

Family-oriented



People aged 65+ receiving care (cash or in kind) in different settings

Micro-adaptive systems

- The care gap is closed by individuals and markets – policy is primarily oriented to sustaining and maximising family care
- Social gradient, with some able to purchase care, others having to turn to their relatives and friends for 'free' inputs
- Need more proactive and preventative approaches (e.g. for when caregivers begin to struggle) – but policy makers' concern here is with possible substitution effects i.e. turning a 'free' resource into forms of care that carry a cost
- Care(giving) in these systems is (still) construed *primarily* as an individual experience

- Denmark England Finland Netherlands Norway Sweden
- Policies increasingly carefully targeted to people with 'highest needs' (typically defined as extensive ADL difficulties)
- Greater family care inputs expected in some countries (e.g. NL) and incentivised in FI
- Preventive approaches and notions of self-help / re-ablement have entered the policy language and practices in this group
- Greater use of market mechanisms, including encouragement of private providers

Formal care oriented

- Policy is primarily oriented to enhancing supply of formal care and towards prevention; spending is at a comparatively high level
- Family care plays an important role, and may even be encouraged in more or less subtle ways, but it is not at the heart of policy efforts
- Families are not seen as the *primary* untapped care potential
- Individuals increasingly enabled / encouraged to re-learn or cope independently through enhancement of capacity to carry out all or most of the normal activities of daily living

Macro-adaptive systems

Between expansion and control

- Governments must be seen 'to do something' to protect a population group that is widely seen as both vulnerable and deserving; expand (home) care policies
- **But** governments also seek to control the costs associated with care
- Developing home care policy therefore becomes an exercise in expanding policy while controlling the costs

How on earth do you square that circle?

- Policy that seeks to ‘tick both boxes’

The“typical” trend is towards some increase in public funding, in tandem with

controlling demand/rationing provision through:

a.) increased focus on those with ‘most extensive’ needs

b.) involvement of non-State provider organisations

b.) encouragement and incentivisation of private spending

c.) family and other ‘informal’ care integration into the broader framework of long-term care

Shared responses

Focus on ‘most extensive’ needs

- Narrowing eligibility through increased targeting – typically to ‘highest needs’, especially ADL difficulties – with the corollary of increasing frailty of recipients
- In some countries, this has been combined with greater focus on efficiency (including Taylorisation of care tasks)
- Some preventative and rehabilitative approaches may be construed as devices for ‘controlling demand’ (e.g. care contracts that specify ‘outcomes’ and responsibilities)

Involvement of non-State provider organisations

- Opening up of the provider to landscape to private companies that have proliferated in many countries
- Encouraging non-profit organisations to become more ‘business-like’, and/or to take on ‘softer’ forms of care (companionship, social activities)

Encouragement and incentivisation of private spending

- Introduction of cash allowances: expenditure becomes in principle more controllable e.g. value can be 'frozen' (Germany) – but this also leads to increased need for private spending; and inequalities in access to formal care
- Degree of control over how cash allowances are used varies (very strict in France, very liberal in Italy)
- Tax allowances in some countries (e.g. Finland, Sweden, Ireland) – encourage and enable private spending

- This ranges from the incorporation of family carers as recipients of long-term care insurance funding in Germany,
- to freedom to employ migrant care workers (and indeed other 'undocumented' workers) in Italy,
- to the increasingly diverse field of care providers in England, following greater emphasis on the care users' choices and designation as 'purchasers' of their own care.

Embedding family and other 'informal' actors into the care architecture

Diversity within ‘user orientation’

{ Four different meanings of the concept

Germany

- Long-term care insurance established a social right to support for people with care needs
- The continued role of family carers has been encouraged and promoted
- Cash support for informal care or opportunities to choose between providers of formal care
- Where the insurance is used to pay for formal home care services, the amount of services received may not be sufficient to meet need, hence necessitating 'topping up' through private and family resources

Denmark

- Home care remains free at the point of use and the rights and obligations of care recipients are clearly spelled out
- Quality has been to a large extent interpreted as revolving around autonomy and choice for the care user
- A corollary of this emphasis on choice is increased competition between public and private providers
- Attempts to improve quality have in some cases led to standardisation and rigidities; this may be an inevitable consequence of maintaining universal right to extensive home care

Italy

- The ‘companion payment’, a flat-rate cash-for-care allowance, not means-tested, paid to approximately 9 % of the older population of Italy
- Lack of care planning/management
- Some payments are used inappropriately
- Migrant care workers constitute a growing proportion of the care workforce; in many cases delivering live-in, round-the-clock care
- Regional variation in direct home care provision is considerable

England

- The system is means-tested and targeting has increased
- Publicly funded home care service is increasingly residual, and the role of private funding and supply are growing
- Consumer choice now extends to individual choices to purchase home care (through direct payments and personal budgets), which may lead to a more diverse workforce as care recipients elect to hire persons whom they consider best suited
- This increase in choice may also lead to consolidation in the sector into larger provider units that can deal with the resulting increase in administration

To conclude

- Governments seek to dampen demand and draw on a wider variety of providers, especially (from the state's perspective) 'low-cost' sources of care (families, migrant workers, voluntary sector, older people themselves)
- These shared trends arise from the need to 'square the circle' of coming under pressure to improve and extend home care provision, while controlling costs
- Several contradictions and challenges arise from the shared reform logic
- These include, most importantly, inequalities in access; and uneven/unknown quality that is increasingly difficult to measure or control