Home and Community Care in Australia, Canada, the United Kingdom and the United States:

A Comparison of Social Service Financing

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1. Introduction

This study presents descriptions of the financing and organization of public home and community care systems in four countries, namely Australia, Canada, the United Kingdom and the United States. Information used for this study was gathered from the vast amount of freely available materials in the World Wide Web. It is hoped that the findings of the study will serve as background information that can facilitate our understanding of overseas experiences and trends in home and community care financing.

1.1 Home and Community-Based Care in Hong Kong

Aging population has been a concern for Hong Kong and many developed countries in recent years. Many countries are just starting to look seriously at their health care and long- term care systems, in light of the expected heavy loads on the systems. With increasing fiscal pressures facing governments, traditional systems that emphasize institutional care has become unaffordable. Governments are looking for alternatives and many have turned to home and community-based care.

Home and community-based care are expected to serve three functions: to substitute for services provided by hospitals and long-term care facilities; to allow clients to remain in their community rather than moving to a more costly setting; and to invest in client service and monitoring at additional short-run but lower long-run costs.

In Hong Kong, public home and community-based care are mainly provided by the Social Welfare Department through its various community support services for the elderly in Hong Kong. Services are mostly delivered by non-governmental social service organizations with funding from the Department. Programs operated include Day Care Centers for the Elderly, Home Help Services, Integrated Home Care Service, and Enhanced Home and Community Care Services.

1.2 This Report

The main purpose of the study is to survey overseas practices in home and community care financing that are of reference value to Hong Kong. In particular, through collecting, reviewing and organizing relevant materials freely available in the World Wide Web, this study attempts to:

- Describe essential features in the financing and organization of the public home and community care systems in four countries: Australia, Canada, the United Kingdom and the United States; and
- Compare similarities and differences among the four countries.

Section 2 describes methodology of data collection and framework for organization of information. In section 3, essential features of the public programs offered in the four countries are outlined and compared. More detailed information regarding individual countries under study is presented in Section 4.

2. Methodology

2.1 Definition

Generally, home and community care can be described as a diverse range of services enabling service recipients, who are incapacitated in whole or in part, to remain living in their own home and community. Home and community care services comprise both medical and support services provided in the home and community setting.

However, specific services included in each public home and community care system vary from country to country; or even from jurisdiction to jurisdiction within the same country. We shall specify for each public home and community care in this study what range of services are covered.

Also, for the purpose of this study, only public system offering tangible services are examined. Programs handing out cash benefits or tax relief that might be used to pay for home and community care are excluded; e.g. old age or disability allowances.

2.2 Data Collection Method

This study involved reviewing freely available World Wide Web resources pertaining to the financing and organization of home and community care in Australia, Canada, the United Kingdom and the United States. To search for materials relevant to our study, we adopted a search strategy as follows:

Step 1. Visit websites of relevant national and federal government departments.
Step 2. Search the websites for information.
Step 3. Follow external links provided in the websites.
Step 4. Repeat Steps 2-3.
Step 5: Search WWW for keywords “home care” and “community care”.

For Step 1, the four starting points chosen are:

Australia:	Department of Health and Aging (www.health.gov.au)
Canada:	Health Canada (www.hc-sc.gc.ca)
The UK:	Department of Health (www.doh.gov.uk)
The US:	Department of Health and Human Services (www.hhs.gov)

The types of online and downloadable documents gathered include guidelines, fact sheets, newsletters, policy / position papers, working papers, reports and manuals.

2.3 Framework

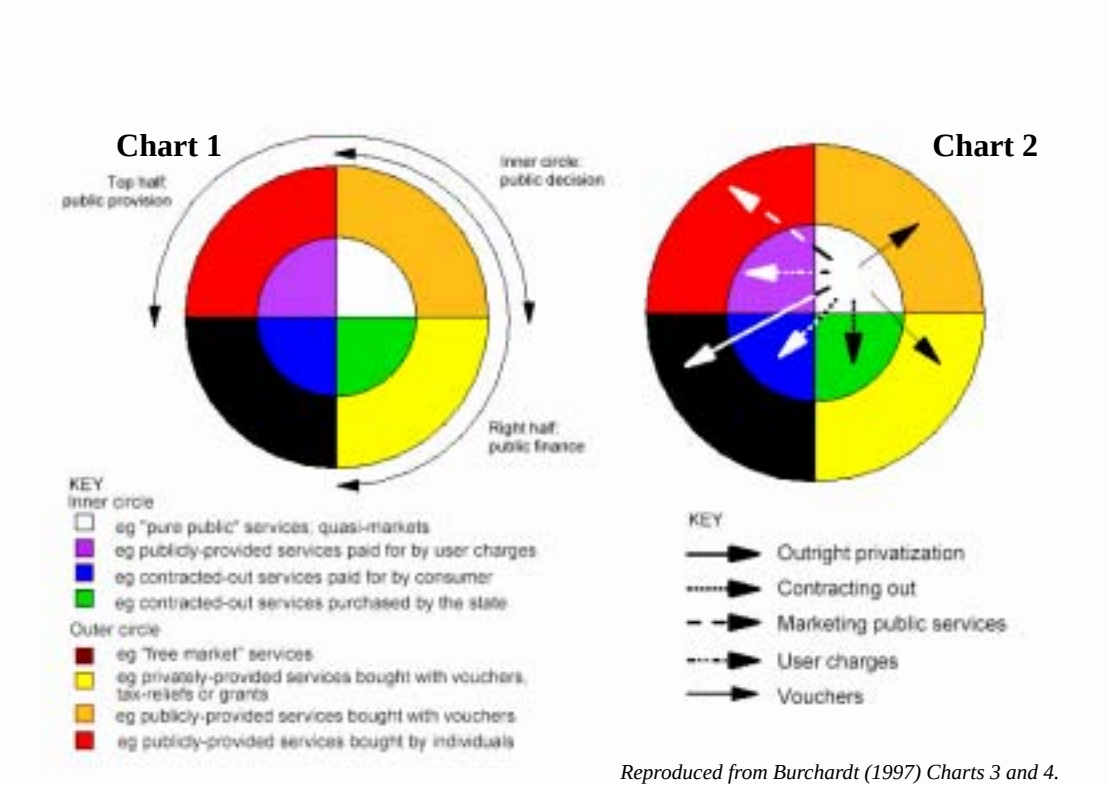
To help in reviewing and organizing the vast amount of materials gathered from our WWW search, we have developed a list of essential features in a public home and community care system that are of interest to us from the perspectives of finance and organization. The basic framework is derived from Burchardt (1997) Wheels of Welfare and supplemented by Lyons (1995) models of funding relationship between governments and private (non-profit and for-profit) organizations.

2.3.1 Burchardt's Wheels of Welfare

Burchardt (1997) identified three dimensions of welfare services, namely finance (who pays), provision (who provides) and decision (who decides) and proposed a typology of welfare services to help in examining the changing patterns of the welfare services provision in the United Kingdoms.

Making a distinction between public and private along the three dimensions leads to 'Wheels of Welfare' with eight sectors as shown in **Chart 1**. A move from the top right quadrant of the inner circle, i.e. 'pure public' services, to other sectors (**as in Chart 2**) indicates some degree of privatization, which could take the form of outright privatization, contracting out, marketing public services, user charges and vouchers.

Burchardt's Wheels of Welfare



Reproduced from Burchardt (1997) Charts 3 and 4.

As an illustration, in Hong Kong, if a family receive services from an Integrated Home Care Services Team of a non-governmental social service organization, then this mode of service provision can be classified as part public and part private finance (the Social Welfare Department funding the non-governmental social service organization, but the family also paying fees or charges with the level being based on a sliding scale with reference to the family income), private provision (the non-governmental social service organization) and public decision (the ability of the family to decide on the choice of publicly funded providers and the level of publicly funded services are limited by the government's control over the supply of such services).

On the other hand, if a family hires a foreign domestic helper to assist with the activities of daily living of an elderly member, then this mode of service provision can be classified as private finance (the family's), private provision (the foreign domestic helper) and private decision (the family's); .

2.3.2 Lyons's Funding Arrangement Models

Lyons (1995, as cited in Dollery, Wallis & Crase, 2002) suggested that six different models to describe the different funding relationships between the governments and the non-profit organizations in Australia. The six models are:

Government as a Philanthropist Model: The government acts as a wealthy individual and gives financial support to private organizations (usually non-profit) for worthy causes. The level of funding support is on a case-by-case basis. Usually, it is with little planning on the part of the government and requires little formal reporting on the part of the recipient organizations.

Submission Model: The government decides on which types of services it wants to appropriate funds, and then invites private organizations (usually non-profit) to submit proposals for grants to provide those services. The level of funding support is on a case-by-case basis. Accountability requirements are more demanding than in the philanthropist model, but the recipient organizations still retain considerable discretion over the manner in which their services are delivered.

Planning Model: The government determines in detail the nature, the location and the quality of services required after extensive consultation with various peak organizations, and then invites private organizations (usually non-profit) to express interest in providing the prescribed services. The level of funding support is based on some defined units of output. Comprehensive reporting on finance and profile of clients served are required to ensure more accountability.

Competitive Tendering Model: The government specifies in detail the nature, the location, the quality, and the price of services that it wants to purchase, and invites private organizations, both non-profit and for-profit, to tender for service provision. Tender winners (as providers) will enter into formal written contracts with the government (as purchaser) for a fixed period, after which new expressions of interest are called for.

Quasi-voucher Model: The government agrees to reimburse approved or licensed service providers, both non-profit and for-profit, with a predetermined amount for specified services rendered to certain categories of people who meet specific criteria. Under this arrangement, approved service providers compete with each other for consumers that are indirectly subsidized by the government.

Individualized or Consumer-focused Funding: The government gives eligible persons who meet specific criteria a set sum of money to buy a set of specified services from their choice of service providers, both non-profit and for-profit. The consumers essentially decide for themselves what and how the services are delivered.

In recent years, the predominant models practised in Hong Kong have been the submission model and the planning model. However, the government has experimented with the competitive tendering; (e.g. awarding service contract for residential care homes for the elders through an tender open for both non-profit and private operators). The government is also exploring the feasibility of developing a Fee Assistance Scheme (i.e. similar to the Individualized or Consumer-focused Funding model) for residential care services for frail elders.

2.3.3 Essential Features of Interest

Information is reviewed and organized with reference to Burchandt's Wheel of Welfare and Lyon's models of government financial support to answer the following questions for each country:

- What are the major public home and community care programs?
- Who are covered?
  - Functional eligibility
  - Financial eligibility
- What pays
  - Funding structure
  - Nature of funding sources
  - User fees
- Who provides?
  - Public sector's roles
  - Type of providers
  - Government-provider funding relationship
- Who decides?
  - Client-directed programs

3. Comparisons of Countries

3.1 Some Statistics for Comparison

Data on home and community care expenditures are hard to come by. To get a sense of how the four countries compares in terms of public / private of expenditure and coverage, OECD data on long-term care and social expenditure were obtained (See **Table 1**).

Table 1: Some Long Term Care and Social Expenditure Statistics of Australia, Canada, the United Kingdom and the United States [Sources: OECD[1]]

		Australia	Canada	United Kingdom	United States
Spending on long term care[2] (1992-5)					
Total spending as a % of GDP		0.90	1.08	1.30	1.32
Public spending as a % of GDP		0.73	0.76	1.00	0.70
Public spending as a % of LTC spending		81	70	77	53
Elderly people receiving long term care (1995)					
% of persons aged 65 and over cared for in institutions		6.8	7.5	5.1	5.7
% of persons aged 65 and over receiving formal help at home		11.7	17.0	5.5	16.0
Projection of publicly financed long-term care share of GDP					
Home help	Latest	0.15 (1996)	0.21 (1995)	0.36 (1992)	0.24 (1994)
	2020	0.23	0.36	0.37	0.25
Institutions	Latest	0.66 (1996)	0.50 (1995)	0.69 (1992)	0.42 (1994)
	2020	0.76	0.57	0.86	0.36
Total	Latest	0.81 (1996)	0.71 (1995)	1.05 (1992)	0.66 (1994)
	2020	0.99	0.93	1.22	0.61
Public Social Expenditure (1998)					
Services for the elderly and disabled persons[3] as a % of GDP		0.76	N.A.	0.81	0.05

[1] Long-term care statistics and projections are from OECD (1999) *Labor market and social policy occasional papers no 38*, Paris: OECD, and public social expenditure statistics from OECD's Social Expenditure Database (SOCX) 1980-1996.

[2] Long-term care spending refers to the care needed to help older persons leading an independent life, at home or in an institution. It excludes informal help. Home care includes all home care services, such as district nurses services, excluding medical visits. Institutional spending includes all the costs related to care and lodging, such as help for all self-care activities, but excluding medical costs. Public costs include all costs incurred by public institutions, municipalities, sickness funds or old age funds.

[3] Expenditure on services for the elderly and disabled persons encompasses services such as day-care and rehabilitation services, home help services and other benefits in kind. It also includes expenditure on the provision of residential care in an institution (e.g., the cost of operating homes for the elderly).

Among the four countries in this study, between 1992-5, total long-term care spending ranged from a high of 1.32% of GDP in the United States to a low of 0.9% in Australia. Australia, Canada and the United Kingdom relied quite heavily on the public sector to provide funding for the system, all with over 70% of spending coming from public funds.[4]

The United Kingdom had the highest level of public spending at 1% of GDP between 1992-5. In fact, the United Kingdom also spent the most public funds in providing social services to the elderly and the disabled, with 0.81% of GDP in 1998.

By contrast, the private sector, through out-of-pocket expenses and insurance payments, played a significant role in the American system. There was an almost 50/50 split between public and private spending in long-term care between 1992-5. In 1998, public funds expended on provision of social services for the elderly and the disabled was a meager 0.05% of GDP[5].

In the areas of institutional care and home care, Canada's long care system seemed to have reached more elderly persons than the other countries'. Seven and a half percent of elderly persons received institutional care in 1995, compared to 6.8 in Australia, 5.7 in the United States and 5.1 in the United Kingdoms.

As for home care, 17% of elderly persons in Canada received formal home help in 1995, compared to 16% in the United States, 11.7% in Australia and only 5.5% in the United Kingdom.

In its 1999 study of long-term care programs of its member states, OECD projected that public spending on home help (as a % of GDP) should grow in all four countries (OECD 1999). The fastest growth should occur in Australia and Canada, while growth rates of the United Kingdom and the United States should be much more modest. Among the four countries, only the United Kingdom was expected to have the share of home help services in the public spending on long-term care shrink when compared to the share of institutional services.

3.2 Comparison of Essential Features

Table 2 lists the essential features of the public home and community care systems in Australia, Canada, the United Kingdom and the United States side-by-side for comparison.

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[4] For reference, in 1994/95, about 4.4% of Hong Kong's public health expenditure went to extended care services; i.e. about 0.1% of the GDP.

[5] For reference, in 1998/99, spending on services for the elderly and the disabled was about 0.3% of the GDP.

Table 2: Financing and Organization of Public Home and Community Care Programs in Australia, Canada, the UK and the US

	Australia	Canada	United Kingdom	United States
Major national home and community care program?	● Yes. ● Home and Community Care (HACC) program.	● No. ● Provincial programs.	● No. ● Home health care by National Health Service (NHS). ● Social care under personal social services programs by local authorities.	● No. ● Medically oriented home care by federal Medicare. ● Personal care by joint federal-state Medicaid. ● A state can have many Medicaid-funded programs and state-funds only programs, each covering different services.
Who are covered?				
Functional eligibility	● Needs assessment required. ● Persons of any age having difficulty in performing every day tasks without help because of a disability.	● Needs assessment required. ● Persons of any age. ● Criteria vary from province to province.	● Needs assessment required ● Persons of any age with disabilities as defined in the Chronically Sick and Disabled Persons (CSDP) Act 1970. ● It is up to local authorities to set criteria for other population groups.	● Needs assessment required. ● Medicare: the elderly (aged 65 and over) and the disabled. ● Medicaid: criteria vary from state to state and from program to program.
Financial eligibility	● No.	● Means-tested in some provinces. ● Criteria vary from province to province.	● No.	● Medicaid: means-tested. ● Criteria vary from state to state and from program to program.
Who pays?				
Funding structure	● Joint contribution from Commonwealth (60%) and State/Territory governments to the program (35%); the rest (5%) from local government and user fees. ● Commonwealth funds to	● Provincial/Territorial governments fund their programs with their own revenues and federal block transfers (Canada Health and Social Transfer, CHST) for health and social	● Central government responsible for funding NHS services. ● Local authorities fund their personal social services programs with their own revenues (32%), block	● Federal government responsible for funding Medicare. ● States fund their programs with Medicaid funds (Federal and State governments matching

	Australia	Canada	United Kingdom	United States
	states and territories according to outputs to be provided in the regions.	services. ● CHST to provinces/ territories according to a population-based formula.	transfers from Central government (63%) and user fees and other charges (5%). ● Grants to local authorities according to a spending needs based formula.	payments), or federal block transfers (Title XX Social Services Block Grant, SSBG) for social services and their own revenues. ● Federal share of Medicaid funds according to formulas based on states' per capita income. ● Allocation of Title XX SSBG to states according to a population based formula.
Nature of funding sources	● Public sector funding mainly from general revenues of governments.	● Federal: general revenues. ● Provincial: general revenues and in some provinces, premiums collected through provincial health insurance plans.	● Public sector funding mainly from general revenues.	● Federal government funds Medicare (a social insurance program) with payroll tax deductions and premiums collected. ● Federal government funds Medicaid and Title XX SSBG with general revenues ● State governments fund Medicaid and state-funded programs with general revenues.
User fees	● Yes. ● Fees set by providers based on client's ability to pay, compensation payments covering the services and amount of services needed.	● No if professional services. Some provinces set services limits beyond which charges apply. ● Yes if non-professional services in most provinces, with provinces setting fees based on means assessment.	● No for NHS services. ● Fees set by local authorities based mainly on client's means, and with spend down amount set for individuals with income over limit.	● Medicare: yes, rates set by Federal government. ● Medicaid and state-funded programs: yes, rates set by State governments, and spend down amount set for individuals with income over limit.

Who provides?				
Public sector's roles	● Commonwealth: policy development and planning, funding and regulation. ● States/Territories: policy development and planning, funding, administration and quality assurance.	● Federal: funding and regulation (health). ● Provinces/Territories: policy development and planning, funding, administration, regulation and quality assurance.	● Central: policy development and planning, funding, administration, regulation and quality assurance (NHS); policy development, funding and setting standards (personal social services) ● Local: policy planning, funding, administration and quality assurance (personal social services).	● Federal: legislation, funding, administration, and quality assurance (Medicare); legislation and funding (Medicaid). ● States: policy development and planning, funding, administration, regulation and quality assurance (Medicaid and state-funded programs).
Type of providers	● Purchaser / Provider split ● Mix of public and private providers; all must be incorporated.	● Purchaser / Provider split in some provinces, e.g. Ontario. ● Mix of public and private providers; degree of mix decided by provinces and varies among provinces. ● Usually professional services by public providers (not competitive) and non-professional services by private providers (competitive).	● Purchaser / Provider split ● Mix of public and private providers competing with each other.	● Purchaser / Provider split ● Mainly private providers. ● Medicare/Medicaid certified.
Government-provider funding relationship	● Closer to planning model. ● If new services, funds are usually allocated through invited or advertised submissions of providers. ● Allocation of recurrent and growth funds to existing services is usually through	● Most provinces follow planning model. But Ontario's system is closer to the competitive tendering model. ● Most private providers are selected through invited or advertised submission	● Some local authorities follows competitive tendering model. Others are closer to planning model. ● Best value approach with providers selected through selective tendering. ● Fixed term contracts,	● Closer to quasi-voucher model. ● Medicare / Medicaid certified providers get reimbursements from the governments for services rendered to qualified clients on a fee-for service basis.

	direct allocation to existing providers. ● Fixed term contracts and service agreements specify amount of measurable outputs for funding received, with unit costs pre-determined by individual States and Territories.	process. ● For example, in Ontario, a Request for Proposal (RPF) process, essentially an advertised submission process, was introduced in 1997. ● Fixed term contracts with rates negotiated on a provider-by-provider basis.	mainly fee for service for for-profit providers but block for nonprofit providers ● Rates are usually negotiated on a provider-by-provider basis.	● Reimbursement rates are pre-determined by individual States and depend on funding sources.
Who decides?				
Client-directed program	● None under HACC. ● Community Options Packages (COP) that are based on the brokerage model. ● Some programs available for people with disabilities under Commonwealth/ State Disability Agreement (CSDA)..	● Seven provinces and one territory have self-managed care programs. ● Available to mainly adults with disabilities with assessed needs, but not to the elderly. ● Purchase of non-professional services only, mainly home support services. ● Cannot hire immediate family members.	● Over 80% of local authorities have introduced such schemes. ● Available to both disabled adults and the elderly with assessed needs. ● Direct payments can be used to meet any services that are assessed as needing, except NHS services, local authority's services and permanent residential care. ● Can hire relatives but not spouses and those living in the same household.	● About half of the states have programs of varying size that adopt the client-directed approach. ● Available to persons needing assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). ● Services covered are primarily assistance with ADLs and IADLs. ● Can hire relatives but not spouses.

Sources: [Australia] Department of Health and Ageing website: www.health.gov.au, government guidelines by Department of Health and Aging (2002) and Australian Institute of Health & Welfare (2001)..
[Canada] Health Canada's website: www.hc-sc.gc.ca.
[United Kingdom] Department of Health website: www.doh.gov.uk, NHS website: www.nhs.uk, and various brochures published by Age Concern (2002a, 2002b, 2002c, 2002d and 2002e).
[United States] Department of Health and Human Services website: www.hhs.gov, and papers by Clark (1996), Coleman (2001), Tilly & Wiener (2001), Tilly, Wiener & Cuellar (2000), Wiener & Stevenson (1998) and Wiener, Tilly & Alecxih (2002).
[Others] Occasional papers by OECD (1998 and 1999).

National Programs: Australia is the only one among the four countries being examined that has a national home and community care program, namely Home and Community Care (HACC) program. In the UK, the Central government has a responsibility to provide professional home health care services nationally through the National Health Service (NHS), but has left the local authorities to design their own systems for delivery of personal social services. In the US, home health services are covered nationally by the Federal government's Medicare program. State governments however have discretion over the design of their own programs for other home and community-based services, either with Medicaid funding or state funding only. In Canada, the provincial and the territorial governments have total control over the design of the whole systems for their jurisdictions.

Because of the decentralization approach adopted in Canada, the UK and the US, there exist wide intra-country variations in the systems of those countries. People from the same country are expected to face varying eligibility of, cost, quality and access issues to home and community care services. By contrast, the Australian system, with a closer collaboration between the Commonwealth government and State and Territory governments, is more consistent across the nation.

3.2.1 Who's Covered

Financial Eligibility: In Australia, many provinces of Canada and the UK, HACC services, home support services and personal social services respectively are not means-tested to determine eligibility. Clients are however subject to financial assessment to determine how much user fees they are expected to contribute. People with high income or compensatory benefits are required to pay the full cost of the services rendered. In the US, many state-funded programs and all Medicaid-funded programs are reserved for low-income clients through means-testing. Also, in some provinces of Canada where home support services are provided with user fees, clients are means-tested to ensure that services go to those of low income or without other care options.

3.2.2 Who Pays

Funding Structure: In all four countries, home and community care services are essentially financed by general revenues of the governments. National governments are usually the largest funders of the systems. In Australia and the UK, national governments contribute about 60% of the home and community care funding. In Canada and the United States, matching transfers from the national governments, like the Canada Health and Social Transfer (CHST) in Canada and Medicaid in the US, are the major sources of funding for home and community care services.

User Fees: Charging of user fees is seen by governments in all four countries as a cost containment measure. In Canada and the UK, medical-oriented professional services are often considered as entitlements and therefore are not subject to charging user fees. But, home support services in many provinces of Canada and personal social services offered by local authorities in the UK are charged with fee level often determined with reference to the client's ability to pay. By contrast, in Australia, all

HACC services are subject to charging user fees. It is in fact the responsibility of the service providers to set their fee schedules based on the client's ability to pay. In the US, many Medicare's home health services required co-payments. Low-income clients can however apply Medicaid subsidies to settle Medicare's co-payments.

However, all countries seem to be committed to the principle that no clients should be refused services due to their inability to pay. As a matter of fact, in Australia and the UK, service providers cannot withhold services from the client who has been assessed to be needing those services, even if the client fail to pay the user fees.

3.2.3 Who Provides

Administration: Except for medical-oriented home care services in the UK and the US, the delivery of home and community care services (especially non-professional ones) is the responsibility of state/provincial/local governments in all four countries. This arrangement is seen as appropriate to allow each region to development and management a delivery structure that best meets the diverse needs of its geographic area.

Privatization: The trend of privatization to increase competition has affected all four countries. The approach often adopted is purchase/provider split through contracting out services.

In Australia, private organizations (both nonprofit and for-profit), and State and Territory Government agencies are all eligible to become HACC providers. While a significant number of HACC services are still provided by agencies set up by the local council, (for example 60% of services in Victoria are offered by local councils, 35% by primarily non-profit organizations and 5% by primarily for-profit organizations), those agencies are required to be incorporated and separated from the local councils' departments that do the purchasing.

In the UK, the NHS and Community Care Act 1990 split the role of health authorities (in charge of NHS services) and local authorities (in charge of personal social services) by changing their internal structure. This change of structure meant that local authorities are responsible for assessing the needs of the local population and then purchasing the necessary services from providers who may be their own departments or private (non-profit and for-profit) organizations. As in Australia, departments of the local authority often have to compete with private organizations for contracts. It is expected that local authorities would eventually purchase 85% of services from the private sector.

Likewise in the US, there is always a conscious effort to separate the purchasing function from the service delivery functions. This is seen as a mean to contain cost and control the amount of services provided. In most states, home support services are contracted out to the private (non-profit and for-profit) sectors or departments of local councils.

In Canada, the extent of purchaser/provider split varies from provinces to provinces. Ontario is moving toward a model where all services except assessment are contracted out. While in the other extreme, Sackatchewan, Quebec, Prince Edward Island, Yukon and Northwest Territories, all services are mainly delivered by the public sector. In between, Manitoba and Nova Scotia have some professional services and all home support services contracted out, but public employees remain the providers of other services. The remaining provinces, i.e. New Brunswick, Newfoundland, British Columbia and Alberta, have their professional services mostly delivered by public employees while home support services are contracted out.

3.2.4 Who Decides

Assessment and Case Management: Systems of all countries strive to offer a single entry point. All clients have to go through an assessment process where they will be assessed for functional eligibility, financial eligibility and needs. For the client with high or complex needs, a case/care manager is usually assigned to put together a care plan that best fits the client needs.

Client-Directed Programs: All countries have implemented client-directed programs of some sort to allow the clients more control over what and how the services are delivered. These programs usually are limited to home support services and in essence give the client a set of sum for him to hire home help.

In Australia, for the elderly, Community Options and Community Aged Care Packages are highly structured programs that are based on a brokerage model, under which funding is allocated to the client through a service broker who purchases services for the client with the money. No direct cash payments are involved. For younger people with disabilities in Australia, but not to the elderly, more varieties of programs, including direct payments, are offered under Commonwealth/State Disability Agreement (CSDA).

Likewise, in Canada, such programs are limited to younger people with disabilities, and many of them are still at the experimental stage.

The UK was the first countries to offer cash options to people with disabilities for purchase of services. It was implemented through the Independent Living Fund in the early 1980s. Since 1997, local authorities have been required to make cash options available to younger people with disabilities, and since 2000, this requirement has been extended to the elderly.

The US, like the UK, has made client-directed programs available to both the disabled and the elderly. Depending on the States, programs vary in the form of cash payments.

4. Country Summaries

4.1 Australia

4.1.1 Introduction

The Home and Community Care (HACC) program is the largest national program that specifically funds home and community care services in Australia. HACC funded services provide basic maintenance and support services to frail older people and younger people with disabilities, as well as their carers, so as to let them continue to live in their community, rather than moving into long term residential care.

Besides HACC, the Commonwealth government also funds and administers Community Aged Care Packages (CACPs) to provide home and community care services for older people, and together with State and Territory governments, contributes funding to disability support services administered by State and Territory governments under Commonwealth/State Disability Agreement.

The following sections focus on the HACC program.

4.1.2 Governments

Responsibilities: The HACC program is a joint initiative of the Commonwealth, State and Territory governments. The *National Program Guidelines for the Home and Community Care Program 2002* outlines the responsibilities of the two levels of governments as follows:

The Commonwealth, State and Territory governments are jointly responsible for:

- developing national strategic plans;
- agreeing individual service plan in each State and Territory;
- agreeing on the overall and regional budgets;
- developing and maintaining national policy documents and guidelines; and
- developing program outcome indicators.

The Commonwealth government is responsible for:

- Developing national policy initiatives; and
- identifying national trends through publication of annual statistical overviews and analyses

The State and Territory governments are responsible for:

- developing annual plans and business reports;
- developing, implementing and evaluating models of assessment;
- approving, contracting and liaising with service providers; and

- implementing mechanism to involve stakeholders in policy planning, to enable community feedback, and to handle complaints and disputes.

Funding Structure: The program is jointly funded by the Commonwealth, State and Territory governments. About 60% of the funding is from the Commonwealth government, while the State and Territory governments contribute about 35%. Local governments, non-government organizations and user fees account for the remaining 5%. In 2001-02, the Commonwealth government allocated A$565 million to the program, and the State and Territory governments A$365 million.

Fund allocation to individual regions within each State or Territory is based on the measurable program outputs to be provided in the region, including the mix, the level and the quality of services.

4.1.3 Service Provision

Range of Services: The range of services covered under the HACC programs includes:

- nursing and allied health services;
- home support services such as personal care, meals, domestic assistance, and home maintenance or modification;
- client assessment, case management, referral and coordination;
- carer support, including community respite care; and
- information, training and advocacy services.

Types of Providers: Service provision essentially follows the contractual model, where all services can be contracted out. Eligible organizations include local governments, community organizations, religious or charitable bodies, State and Territory Government agencies, and private for-profit organizations. To be approved for funding, these eligible organizations have to be incorporated.

Because of the purchaser-provider split approach adopted by the Commonwealth, States and Territory government, government provision of HACC services requires a ‘government unit’ that is separated from funding and purchasing units within the same government be created.

On the whole, majority of HACC services are provided by non-profit organizations, with some State and local governments also providing services. Private for-profit companies do provide a small but significant amount of home and community care services, and most of the services are not subsidized.

Funding Arrangement with Providers: The State or Territory government is responsible for determining which service providers will provide services in the regions within its own jurisdiction. These providers are required to enter into service contracts with the State or Territory government. As a result, the details of contracting arrangements vary from State to State.

In the 1990s, a number of States attempted to reform their funding arrangement with private providers of community services (mainly non-profit organizations) by introducing compulsory competitive tendering (CCT) into the awarding of contracts for all services; e.g. Victoria and New South Wales. Although nowadays none of the State and Territory governments practice CCT anymore, the trend of shifting toward output based funding continues, with emphasis in establishing clearer service specifications and performance and accountability measures.

While not compulsory, competitive tendering is still commonly applied to new services, many State and Territory governments are more flexible. The governments are more willing to exercise discretionary power in choosing service providers through direct allocation or selective tender methods, particularly if the nature of the service requires targeting to a specific provider or group of providers.

4.1.4 Clients

Eligibility: Any person who would like to receive HACC services are required to go through an assessment process to determine if he has a demonstrated need for the services, with availability of informal care also taken into consideration. In general, HACC are for people of any age who are not able to take care of themselves on their own, and their carers.

More specifically, the *National Program Guidelines for the Home and Community Care Program 2002* lists the basic requirements for eligibility for services as follows:

- must live in the community;
- must have difficulty in performing every day tasks without help because of a disability; and
- may require admission into long term residential care without assistance from HACC services.

According to the Australian Bureau of Statistics (ABS), there are on average 240,000 people receiving one or more HACC in a month.

User Fees: HACC Clients may be asked to pay a fee for the services received. Fees charged are determined by service providers and should not exceed the actual cost of service provision. Fee policies usually take into consideration the ability of the client to pay, and are based on the person's income; and the amount of services needed by the person. If the client has compensation payments covering the costs of the services, he may be charged the full cost of the services.

All fees collected are used to fund HACC services. By supplement public funds with user fees, charging HACC clients is seen as a way to increase service provision under the HACC program.

However, no clients assessed as requiring a service can be refused a service because of inability to pay.

Assessment and Case Management: All persons requesting HACC services are assessed to:

- screen for eligibility;
- determine needs and priorities;
- determine whether referral to another service and coordination of services is appropriate; and
- arrange for montoring and reviewing service provision. :

Clients with low or less complex needs usually require only a general assessment or service specific assessment, which is done individual service providers. Clients with high and/or complex needs or require case management will go through a comprehensive assessment so as to develop an integrated package of services tailored to their needs and put in place mechanism to coordinate care across different services. Comprehensive assessments are usually done by accredited assessors or accredited HACC agency that are independent of service providers.

Client-Based Programs: The HACC program does not offer direct cash payments or vouchers to clients for purchase of services. People who are assessed to be eligible for HACC services and have high and/or complex needs that cannot be met by normal HACC services can however join the Community Option Program (COP, called Linkages in Victoria), which organizes services with an individual focus.

The COP essentially operates u nder a bkerage model where a flexible budget is allocated to the client via a case manager, who can purchase services from different providers, including those not available from HACC agencies, and put together an integrated care package tailored to the needs of the client.

As is the case with other HACC services, the client may be asked to pay a fee for the care package offered by the COP. The fees charged are negotiated between the client and the COP provider, and no one will be refused of the services because of inability to pay.

4.2 Canada

4.2.1 Introduction

There is no national home and community care program in Canada. All provincial and territorial governments have the responsibility to fund and administer home and community care services in their own jurisdiction. The federal government provides funding support through general transfer payments for health and social services.

The following sections focus mainly on common features of the provincial programs.

4.2.2 Governments

Responsibilities: The federal government provides funding for home and community care mainly through the Canada Health and Social Transfer (CHST) under the conditions set out in the Canada Health Act (CHA).

In addition to CHST, the federal government also provides direct funding to programs targeting veterans of war and aboriginal people, as well as funding initiatives relating to research and development of home care.

Provincial/territorial governments are given the jurisdictional responsibilities of providing home and community care services at their own discretion. They finance their home and community care spending with general revenues, transfers from CHST and user fees.

Besides financing, their other responsibilities include overall policy development, planning, monitoring, and setting standards for service delivery. In recent years, the regionalization process in many provinces has seen regional and local authorities given more flexibility in deciding funding and priorities for home and community care services in their region.

Funding Structure: Each province/territory has its own home and community care systems. The CHST funding provided by the federal government is on a 50-50 cost-shared basis to the provinces/territories for the provision of health and social services. The provinces/territories have full control and flexibility in determining how the funds are allocated to the different services.

This decentralization model of funding and administration has given rise to the different speeds in the development and implementation of home and community care services in the different provinces / territories, which contributes to the wide inter-provincial variations in public home and community care spending, as well as regional variations within some jurisdictions. For example, with respect to level of funding, the actual level varies from C$24 per capita in Prince Edward Island to C$124 per capita in Manitoba. (Health Canada, 2000)

Nationwide, public home care spending was approximately 3.3% of the total public health care expenditures in 1999-00. Public funding accounted for about 80% or C$ 2.5 billion of home and community care expenditures, while private funding made up the other 20% or C$ 639.5 million (Cyote, 2000).

4.2.3 Service Provision

Range of Services: Different provinces/territories have different services covered under their own home and community care systems. The range of services which are basic to all provinces'/territories' systems include:

- client assessment, case coordination and case management;
- nursing serices; and
- home support services such as personal care, homemaking, Meals-On-Wheels and respite services.

The following services are included in some provinces' system:

- social work, speech therapy and dietician services; and
- rehabilitation services and specialized nursing services.

Types of Providers: All provinces/territories provide a single point of entry to their public home and community care systems, and the single-entry functions (i.e. assessment, case management and discharge planning) are carried out by public employees or staff of publicly funded community agencies. However, the public / private mix of professional and home support service providers varies across provinces/territories. The variations can be described as follows:

- Northwest Territories, Prince Edward Island, Quebec, Saskatchewan and Yukon follow the public provider model in which essentially all professional and home support services are delivered by public employees.
- Alberta, British Columbia, New Brunswick and Newfoundland follow the public professional and private home support model in which all professional services are delivered by public employees, while home support services are contracted out to private non-profit and/or for profit agencies.
- Nova Scotia and Manitoba follow the mixed public-private model in which some professional and all home support services are contracted out.
- Ontario is moving toward the contractual model in which essentially all professional and home support services are contracted out.

Funding Arrangement with Providers: Most provinces and territories are moving away from the previous practice of historical allocations and toward awarding contracts of services on a competitive basis. In general, provinces and territories contract out services to both non-profit and for profit organization, even though non-profit organizations are usually given preferred status (e.g. Nova Scotia).

For example, Ontario introduced a Request for Proposal process (RFP) in 1997, which gradually withdrew the province from direct provision of services. By 2000, except for case management, all services were open to all non-profit and for profit organizations, and these organizations competed on both price and quality.

4.2.4 Clients

Eligibility: With respect to eligibility for care, each provincial / territorial program has its own set of requirements, which are quite similar. The common requirements are:

- The client must be a resident of the province or territory where the services are provided;
- The client must have a demonstrated need based on a case manager's professional assessment;
- The needs are not met by other means, such as one's own income and assets, or help from family and friends;
- The home is safe and suitable for service delivery; and
- The client's consent is obtained

In 1996-97, the National Population Health Survey (NPHS) estimated that approximately 545,000 people aged 18 years and over received some types of publicly funded home and community care services in the past year (Health Canada, 2000). Most of these people were elderly and chronically ill.

User Fees: Public home and community care programs of all the provinces / territories offer professional services (nursing, rehabilitation and case management) at no cost to the clients.

As for home support services (personal care, homemaking, meals, respite care), seven provinces charge fees for such services. The amount is based on the ability of the client to pay. Provinces that do not charge fees may impose an income test to restrict the services to people with low income.

Both professional and home support services usually have service limits in terms of the number of hours or the dollar maximums for the services. If the limit is exceeded, the user is required to pay the full cost of the extra services.

Assessment and Case Management: All provincial and territorial home care programs have a single access point. Assessment is used to screen for eligibility and determine the care needs of the client. Informal support available to the client is a factor in the assessment process in some provinces, such as Saskatchewan and Quebec.

Most provinces and territories are developing and using standardized home care assessment mechanisms, and integrating assessment and case management to better serve the needs of clients. However, the role of the single access point is different among provinces and territories. Three models can be discerned as follows:

- referrals and admissions but no follow up;
- referrals, admission and follow up (including reassessment from time to time); and
- referrals, admission and case management (including provision of care).

Furthermore, regardless of the above three models, the range of services that can be accessed through the single access point also varies from province to province. In such provinces, specialized programs such as rehabilitation, geriatric services and specialized nursing services are accessible through the single access point.

Client-Based Programs: While the agency directed model of home and community care is still dominant in Canada, many provinces have begun to experiment with the client-based model, in which the clients are actively engaged in managing and supervising their own care. These programs are called Self-Managed Care Programs in Canada. Currently, Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland, Northwest Territories, Ontario and Quebec offer some type of self-managed care programs.

Under these programs, the eligible clients are given cash or service vouchers to do their own hiring. Working closely with their case managers, they take on the responsibilities of hiring staff, ensuring quality of care and determining tasks and frequency to provide.

These programs are currently available to only adults with disabilities and covered mostly home support services. They are not available to the elderly and do not include professional services. It is estimated that about 8,134 clients participated in self-managed care programs in 1997-98. (Dumont-Lemasson, Donovan and Wylie, 1999).

4.3 United Kingdom

4.3.1 Introduction

There is no national program specifically on home and community care in the UK. Different levels of government provide different types of publicly funded home and community care services, depending on whether the services are health services or social services. Nationally, the Central government, through the National Health Service (NHS), is responsible for administering health services, including home health services; local authorities (unitary councils, metropolitan districts, London boroughs, and county and district councils) are responsible for social services, including home support services within their own jurisdiction. Despite this division of labor, the NHS and local authorities both strive to work closely together to jointly provide integrated packages of health and social services to people in need.

England, Wales, Scotland and Northern Ireland each have their own laws governing and institutions administering health and social services within their jurisdiction. Differences exist between their systems. The following sections will focus on the public programs in England.

4.3.2 Governments

Responsibilities: Professional health care services delivered in the home and community are included in the health care services that are the responsibility of the Central government. In general, the Department of Health of the Central government funds the public health care system, offers direction and policy framework for health care, and puts into practices health care policy, and, through the NHS, provides publicly funded health services. The Department oversees the whole health care system with the following responsibilities:

- managing the overall system;
- setting service standard (through developing the National Service Framework) for different client groups, such as people with disabilities, mental health patients and the elderly.
- developing policy and managing major change in the NHS;
- regulating and inspecting the NHS; and
- intervening when problems occur in the running of the NHS at any level.

To be in a better position to reflect community needs, regional health authorities are set up to manage the NHS locally. They are charged with the responsibilities to develop strategies for local health services, monitor performance and to ensure local concerns and needs taken into consideration while the Central government sets policy priorities on health care. The NHS services, including home health services, are delivery by the different NHS trusts in the different regions.

Social care services are delivered under the personal social service program administered by each local authority in its jurisdiction. In general, social services became the responsibility of local authority with the National Assistance Act 1948. The Local Authority and Social Services Act 1970 established local authorities'

responsibility of developing and maintaining the provision of care to the vulnerable groups, namely elderly, children, mental health patients, and people with disabilities, in their jurisdiction. The NHS and Community Care Act 1990 reformed the organizational structure of the local authorities in delivering social services and their relationship with the NHS.

Under the NHS and Community Care Act 1990, local authorities are responsible for:

- Producing plans for providing community care services, after consultation with various stakeholders;
- Carrying out assessments of those persons who may be in need of community care, in conjunction with other authorities such as health or housing if necessary;
- Purchasing or contracting with independent providers (non-profit and for-profit) for services as well as providing some direct services themselves in order to secure the most cost-effective package of services that meet the needs of individual users;
- Financing, regulating and inspecting provision of social services; and
- Putting in place mechanism and procedures to hand complaints about the discharge of social services functions by the local authority.

As of April 2002, local authorities no longer need to prepare and publish Community Care Plans. The service areas covered by those plans are now incorporated into each local authority's Local Delivery Plans.

Funding Structure: Professional health care services delivered in the home and community are financed directly by the Central government with general taxation and through the NHS. Recipients of these services do not have to pay any charges at point of delivery.

Social care and other personal social services from the Social Services Departments of local authorities on the other hand are financed with Central government's funding (63%, mainly through local authority grants), local authorities' revenues (32%, through local taxation such as non-domestic rates and the council tax) and increasingly user fees and charges (fee charged depending on income of clients).

Local authority grant from the Central government is based on an estimate of the local authority's spending needs in the coming year, and elements of grants are dependent on the local authority meeting performance targets.

Overall, it was estimated that, in 2001/02, total spending on formal domiciliary care in England was £4.1 billion, of which the NHS spent £1.7 billion (40.2%), local authorities spent £2.1 billion (49.9%) and personal expenditure £0.4 billion (9.8%) (Age Concern, 2002f).

4.3.3 Service Provision

Range of Services: The NHS is responsible for arranging professional health services to meet the physical or mental health care needs of people at home or in a care home. The range of services includes:

- case assessment and management of recipients who need extensive professional health services; jointly with local authorities;
- primary health care;
- assessment involving doctors and nurses;
- rehabilitation and recovery as part of a package of NHS care;
- respite healthcare;
- community health services;
- specialist health care support;
- palliative care; and
- specialist transport services.

Local Authority Social Services Departments are responsible for arranging social services to meet the social care needs of people. These social care services fall into two categories: (1) statutory obligations, services under which local authorities must provide to people with disabilities under statutory obligations; and (2) non-obligatory provision, services of which local authorities have the power to provide to people in vulnerable groups but do not have a duty to do so.

Specifically, local authorities must provide the following home and community care services to persons with disabilities who are assessed to have demonstrated needs:

- assessment of eligibility and needs;
- case management, including securing of services from service providers;
- home help or home care;
- respite care;
- day care;
- night sitting services;
- care in a care home;
- provision of aids to help with ordinary tasks of daily living; and
- meals on wheels.

People who are older but not disabled are not entitled to the above services, but local authorities can each determine whether to provide these services to them. These are non-obligatory provisions, meaning that if there is not money, the local authority do not have to provide the services to the person even if he is assessed to have the needs for those services.

Types of Providers: The NHS and Community Care Act 1990 introduced the ‘purchaser-provider split’ and ‘a mixed economy of care’ into the delivery of health and social services. Health authorities and local authorities no longer concern themselves with direct provision of services.

Under the 'purchaser-provider split' approach, health authorities and local authorities take on responsibility for assessing local population needs, drawing up service specifications and purchasing necessary services for their clients. Internal markets have been set up with the NHS and local authorities, where the public sector competes with independent providers (both non-profit and for-profit) for contacts. In some areas, health and local authorities work together with other providers, instead of competing. It is hoped that eventually 85% of services would be purchased from independent providers, so as to achieve a 'mixed economy of care.'

Funding Arrangement with Providers: Under the NHS and Community Care Act 1990, health and local authorities increasingly use contract arrangements with independent service providers. The awarding of contracts is on a competitive basis and follows the principles of Best Value proposed by the Central government. In brief, Best Value principles place less emphasis on economy and efficiency through price competition and more on quality and effectiveness through performance target achievements.

Each authority determines the price it pays for each service and the type of contracts it enter into with its service providers. Matosevic, Knapp, Kendell, Forder, Ware and Hardy (2001) found that most contracts between local authorities and domiciliary care providers were fee-for-services with guaranteed hours. Laing and Buisson (1999) found that local authorities were more likely to use fee-for-services contracts when dealing with for-profit providers, but block contracts (i.e. payment for a pre-determined number of hours or clients whether taken up or not) when dealing with nonprofit providers.

4.3.4 Clients

Eligibility: Local authorities are required to provide social care services to people with disabilities as defined by the Chronically Sick and Disable Persons (CSDP) Act 1970 and who are in need. Under the Act, a person has the right to the services if he is assessed to have demonstrated needs and he is

- substantially and permanently handicapped;
- blind or partially sighted;
- deaf or hard of hearing;
- mentally ill; and
- mentally handicapped.

Local authorities may each set their own eligibility criteria for other groups of population, such as people aged 60 and over who are not disabled (as defined in CSDP Act 1970). And there can be different criteria for different types of service.

User Fees: NHS services are provided free to clients at point of delivery, while clients of local authorities' social care services (except as part of after-care services following hospital stay and as intermediate care to avoid admission to hospital) may have to contribute toward some of the cost of the services delivered to them, depending on their income.

It is up to each local authority to decide how much to charge each client, as long as the amount is 'reasonable' for the client to pay. Most services have flat fees, but the charges to the client will be reduced if his total income is taken below a certain level by the charges.

In general, local authorities have to make charges for residential services, and have discretionary power to charge for non-residential services. The Central government expects local authorities to recover 9% of their gross expenditure on non-residential community care by making charges to service recipients.

In many areas, local authorities set a maximum amount of care an individual will receive in their own home or in sheltered housing. The amount varies from one local authority to another, and may be in the form of the number of hours or the dollar cost.

Assessment and Case Management: Each local authority has its own assessment procedure and standards. The assessment process consists of three parts:

- finding out care needs,
- assessing client's finances; and
- determining whether to provide or arrange services; based on eligibility criteria.

Depending on the complexity of the client's needs, a comprehensive assessment may be conducted, and other authorities, such as health and housing, may take part in the assessment process.

For the client with complex needs, once a decision is made to provide and / or arrange for services, a care manager will draw up a care plan, stating what services the local authority has agreed to provide and / or arrange, and what services will be provided / arranged by other authorities (e.g. the NHS), organizations (e.g. nonprofit and / or for-profit service providers), or individuals (e.g. carers).

Client-Based Programs: The Community Care (Direct Payments) Act 1996 gives local authorities the power to offer cash benefits instead of (or as well as) providing / arranging community care services to help people remain at home. The level of direct payment is normally be no higher than the cost for the local authority to provide / arrange the services. Local authorities have the discretion not to set up a scheme for direct payments.

The national eligible criteria for a direct payment are as follows:

- 18 years old or over;
- disabled as defined by the National Assistance Act 1948;
- assessed as needing services;
- not subject to certain mental health or criminal justice legislation which carry elements of compulsion; and
- willing and able to manage a direct payment.

Direct payments must be used to organize or purchase services to meet the assessed needs of the clients. They cannot be used to pay;

- informal care by spouse or close relatives in the same household;
- services provided by the local authority;
- services provided by the NHS or housing authorities; and
- permanent residential care.

Besides Direct Payments, severely disabled people aged between 16 and 66 can apply to the Independent Living (Extension) Fund, a means-tested cash benefits, for paying care in order to remain living at home. Limited in scope, the Fund is meant to be a supplement to services provided / arranged by the local authority.

4.4 United States

4.4.1 Introduction

There is no national public home and community care program in the United States. Americans essentially have to pay for home and community care services, especially for long term care purpose, either through out of pocket expenditures or through purchasing of private insurance. Each State administers its own public program that provides services to low income and medically needy individuals in its jurisdiction.

As there are as many public home and community care systems in the United States as there are States, the following sections will mostly focus on a handful of States that have received intensive examination in recent literature; namely Wiener and Stevenson (1998) and Wiener, Tilly and Alecxih (2002). The States include Alabama, California, Colorado, Florida, Indiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Kentucky, Texas, Washington and Wisconsin.

4.4.2 Governments

Responsibilities: The Federal government assumes mostly a funding role in the provision of public home and community care services. Through Medicare and Medicaid legislations, it governs the use of federal funds in public health care. Meanwhile, in addition to sharing with the Federal government in funding health care and social services, the States are given a large degree of flexibility in the implementation of their own health care and social policy, including the design of their own system of home and community care.

States run their Medicaid programs, as well as other programs with federal funds, with conformity to the relevant federal guidelines, rules and regulations. Most States spread administrative responsibilities of their federal and state-funded programs, as well as programs with state-only funds, over multiple State agencies. These responsibilities include program administration, program design, budgeting, setting reimbursement rates, contracting, service delivery, and so on. For home-based and community-based services, many States devolve some of these responsibilities to local agencies, such as area agencies on aging, counties, area development agencies, and so on. Some States (e.g. Alabama) have local agencies handle only program administration, while other States (e.g. Wisconsin) let local agencies take on almost all responsibilities for their Medicaid waivers and State-funded programs.

Funding Structure: There is no single funding source for home and community care. Public funds come from federal, state and local levels, while private funds are from out-of-pocket expenditures and private health insurance. As regards public funding, the two major federal programs that contribute to a varying degree funding for home and community care are Medicare and Medicaid.

Medicare is a federal health insurance program with uniform eligibility and benefits structure throughout the United States. It is the largest payer of home health care, but primarily for people who require skilled nursing for acute care rather than long-term care. Persons aged 65 and above entitled to Social Security benefits and persons under age 65 entitled to disability benefits are covered.

Medicaid is the largest source of public funding for home- and community-based services. It is a federal-state matching entitlement program providing medical assistance to mostly low-income persons. Home and community care services are financed through three coverage options: home health care, personal care, and home- and community-based wavier services.

Medicaid home health services are a mandatory component of a State's Medicaid program and are for low-income persons with mainly acute care needs. Medicaid personal care services are an optional component that a State can include in its Medicaid program to finance personal care services to functionally impaired elderly persons living at home. Medicaid home- and community-based services waivers, for which a State must apply from the federal Health Care Financing Administration, allows a State to have normal Medicaid requirements waived in order to finance a more diverse set of services and persons.

Federal legislation demands that Medicaid's home health services and, if included in a State's plan, personal care services must be provided to any individual who meet pre-established eligibility requirements, regardless of the cost to the State. In contrast, State governments have more control over services offered under Medicaid home- and community-based services waivers.

Other sources of federal funds for home and community care services are the Older Americans Act and the Social Service Block Grant Program. The former sets up a network of federal, state and local Agencies on Aging to provide home support services to the elderly. The latter allots federal funds to the States for financing of social services, including services for the elderly and the disabled, at each State's discretion and subject to only general statutory limits.

All States rely heavily on Medicaid to finance their home- and community-based services. While the size of their programs may vary widely, all States have some programs financed under Medicaid waivers. All States also have at least a state-funded program that is designed to fill the gap in coverage of services and persons under Medicaid. Of the sixteen focal States mentioned earlier, only Indiana, Kentucky Maryland, Massachusetts, Minnesota, Washington and Wisconsin have state-funded programs play a significant role in their offering of home- and community-based services. The recent trend sees these States trying to refinance existing state-funded programs with expanded or newly implemented Medicaid home- and community-based waivers, so as to maximize federal funding and reduce the financial burden on their State budget.

All in all, Americans spent US$29.3 billion on home health care in 1998. #5.6% were from Medicare, 20.5% were out-of-pocket expenditures, 17.1% were from Medicaid, 13.7% were from private health insurance, and other sources accounted for the remaining 13% (Tilly, Goldenson, & Kasten, 2001).

4.4.3 Service Provision

Range of Services: The range of services offered varies from State to State. Medicare is a federal program and hence provides essentially a uniform range and level of home health services to clients in different States. These services include nursing, therapy and home health aide services and others.

But within Medicaid, only home health services are a mandatory component of each State plan. Many States also include adult day health care and personal care services, including such physician prescribed semi-skilled and non-skilled services as assistance with bathing, dressing and toileting, as options in their plan. In an attempt to control public expenditures, many States, such as Alabama, Indiana, Kentucky and Maryland, offer only this basic set of services, plus case management and respite services, in their State plan.

But with the flexibility that Medicaid home- and community-based services waivers and state-funded programs offer, many States, such as Michigan, Washington and Wisconsin offer a considerable wider variety of services in their State plan. These services include counseling, meals, environmental modifications, supplies and equipment, emergency response systems, and training. These States however attempt to contain costs by operating these programs as appropriated programs without entitlement to services. These allows them to imposing strict limits on the number of Medicaid waiver placements, allocating counties with fixed amounts of funds rather than fixed number of places, and put an ceiling on the average cost per client.

Types of Providers: Only Medicare/Medicaid certified home health agencies will be reimbursed for services provided to Medicare/Medicaid recipients. Certification ensures service providers to meet standards of business operations, record maintenance, personnel management, consumer responsiveness, and documentation according to Federal and State rules and regulations.

These Medicare/Medicaid certified home health agencies can be operated by either private (non-profit or for-profit) organizations or local authority, such as county nursing services or local health departments. These agencies, including county-operated agencies, may contract for services from other private non-profit and for-profit organizations or individual workers. Of the sixteen focal States, Alabama is an exception, with its Department of Public Health serves as the primary provider of home health care in the State, especially in rural areas.

Funding Arrangement with Providers: In each county, there is usually one or more certified home health agency offering different range of services for Medicare/Medicaid recipients to choose from. Reimbursement to these certified home health agencies is often on a fee-for-service basis, with Medicaid reimbursement rates being determined by individual States using different methodologies.

4.4.4 Clients

Eligibility: The three major types of public programs, namely Medicare, Medicaid and state-funded, have different eligibility requirements. Medicare is a national social insurance program and has uniform requirements across the United States. It covers most persons who are entitled to Social Security benefits, persons under the age of 65 who are entitled to disability benefits, and persons who have end-stage renal disease

Different states have different eligibility requirements for their Medicaid, Medicaid-wavier and state-funded programs. In general, Medicaid programs are limited to applicants who are assessed to have severe disabilities, usually requiring nursing home level of care and meet income and asset tests, such as Supplemental Security Income beneficiaries. Medicaid waiver and state-funded programs have more liberal functional and financial requirements. Many states link financial requirements to a percentage of the maximum monthly SSI payment, a percentage of the federal poverty level, or their medically needy income level. Some States', e.g. Indiana's and Kentucky's, state-funded programs use sliding fee scales with no assets tests. Level of subsidy is based on incomes with the federal poverty level as a yardstick.

User Fees: Some Medicare-covered services, including home health care services, require deductible or co-insurance to be paid by beneficiaries. In all States, eligible low-income persons can have Medicaid funds to cover these charges.

Federal laws allow States to charge co-payment (a set fee) or co-insurance (a set percentage of cost of service) for certain services, including home- and community-based services. Many States set co-payment rate to their services, but some services charge the beneficiary in a sliding fee-scale with lower income persons pay less.

In general, while all States are concerned about the financial burden of rising expenditures on their public programs, they do not consider fee charging as a mean to recoup part of their spending. To contain costs, they are more inclined to adopt measures to limit supply of services. The limits may be on the quantities of services provided to each beneficiary, such as the number of hours of care or the number of home visits; it may also be set dollar limits on services purchased by each beneficiary. If the beneficiary wants to receive services over the limits, he will have to finance them either out-of-pocket or through private health insurance plan.

Assessment and Case Management: To be eligible for the services offered by public programs, the applicant has to go through an assessment process to determine both functional eligibility and financial eligibility. For most programs administered by States, State or local organizations such as local agencies on aging will provide the assessment services.

After assessment, the eligible individual may be offered case management services, where a case manager is assigned, negotiate service plans with the individual, authorizes the services that the client receives, arrange for home care agencies to deliver services, monitor services and reassessed need when required. Case

management is normally restricted to Medicare-waiver programs and state-funded programs, and is not offered to recipients of Medicare home health care services and Medicaid home health care and personal care services.

In most States, assessment, case management and service provision are separated so as to avoid potential conflict of interest. It is believed that if they were combined, providers might have an incentive to over-prescribe services. Even In Alabama, where the Department of Public Health handles assessments, case management and service delivery, different independent divisions are set up to performs these different functions.

As for Medicare, it requires home health care beneficiaries to have their physician certify their needs to have care in the home and have him make out a plan for the home care.

Client-Based Programs: The traditional model of publicly funded home- and community-based services has been a case-managed and agency-operated system. While this model still dominates the delivery of home- and community-based services, client-based programs, especially those for people with disabilities, have been offered in many States through the States' Medicaid-waiver programs and state-funded programs.

The programs are primarily targeted at people who need assistance with personal care tasks such as bathing, dressing, transferring from bed to chair, eating, and going to the toilet (often referred to as activities of daily living (ADLs)) or other routine tasks for maintaining a home and taking care of personal business such as housekeeping, meal preparation, doing laundry, managing money, and making telephone calls (often referred to as instrumental activities of daily living (IADLs)).

In most States, with assistance from counseling service contracted by the States, the clients are responsible for hiring and firing their own workers to provide ADL and IADL services, while fiscal agents or contracted intermediary are designated to pay those workers. In many States, family members, except spouses, can be hired with the funds. Professional services are not usually covered by these client-based programs.

As most of these client based programs are offered within Medicaid-waiver programs and state-funded programs, they usually have financial eligibility requirements which limit the benefits to low-income individuals and a cap on the number of beneficiaries. As measures of cost containment, in many States, there are also limits on hours of care or dollar amount per beneficiaries.

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