



Centre for
**Health Service Economics
& Organisation**

**A critical review of international practice
on assessment and eligibility in adult
social care: Lessons for England**
Summary Final Report

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Report No. 5

First published in August 2013, revised October 2013, by:
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Acknowledgements:

The research team are grateful to the Department of Health for funding this study and to the members of the Advisory Group and participants in a workshop held in May 2013 for all their valuable help and advice. They especially appreciate the advice and comments which Caroline Glendinning generously provided. They would also like to thank Anna Howe, Sally Keeling, Blanche Le Bihan and Hildegard Theobald for providing advice and information on arrangements in their countries. This report represents the views of the authors alone and not of the Department or the Advisory Group.

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1. Introduction

The Government declared in its White Paper *Caring for our Future* that “the current system of locally determined eligibility [for long-term care] is confusing and unfair for many” (HMG 2012). It committed to develop and test options for a potential new assessment and eligibility framework for England. To inform work on the development of the new assessment and eligibility framework the Department of Health commissioned a study by the Centre for Health Service Economics and Organisation (CHSEO), University of Oxford, to review international experience on assessment and eligibility for publicly funded care and support. This report sets out the findings of this study.

The aims of the study are to:

- discuss and formulate objectives for an adult social care eligibility framework for England;
- describe the way in which eligibility for supported social care is determined in a number of OECD countries, i.e. their key features and an account of how the process operates;
- evaluate comparator frameworks with regard to the objectives identified in the first stage;
- develop, based on the above analysis, options for improving the English eligibility and assessment framework.

Within these overall aims, the study focused on the following five key research questions:

- What are the objectives and roles of assessment and eligibility frameworks?
- What assessment instruments, algorithms and criteria are used to determine eligibility for publicly funded care and levels of care to be funded?
- How do assessment and eligibility frameworks treat unpaid carers, in terms of their eligibility for support and the eligibility of the person for whom they provide care?
- Which assessment and eligibility processes are determined on a nationally standard basis and which are determined locally?
- How is economic and political sustainability of assessment and eligibility criteria pursued?

The study explored the evidence on how these issues are addressed in practice in England and five other countries, through consideration of literature and consultation with experts. It also considered the advantages and disadvantages of the different approaches in terms of the promotion of different objectives, in particular different dimensions of efficiency and equity. The study was conducted during the period May 2012 to June 2013.

The study discusses the objectives of assessment and eligibility frameworks, in particular the promotion of efficiency and equity. It examines the frameworks of six countries in the context of these objectives. This study offered a unique opportunity to use the examples of the frameworks adopted in other countries to identify and consider the principles underpinning assessment and eligibility and to draw lessons for reform of the framework in England.

2. Background

Long-term care presents various challenges and opportunities common to almost all developed countries. Ageing populations and changing socio-cultural norms will increase demand for care services as the 'baby-boom' generation reaches retirement-age and mortality rates continue to fall over the coming years. Provision of formal care services is under pressure from a combination of tightening public sector budgets due to the financial crisis and difficulty recruiting and retaining sufficient numbers of dedicated and skilled staff. Provision of informal care is under pressure from changes in the ability of adult children to provide care for their parents due to rising female employment and greater geographical dispersion of families. At the same time, expectations concerning availability of high quality of care are expected to rise as the relatively affluent baby boom cohorts reach later old age.

One of the responses local authorities in England have taken to handle the combination of rising demand for care and support but constrained resources is to tighten their eligibility criteria for access to publicly funded adult social care. Unlike some other European countries such as France and Germany, England does not have a nationally uniform assessment and eligibility framework for adult social care. Each local authority can determine its assessment process and eligibility threshold within national guidance on *Prioritising Need in the Context of Putting People First* (HMG 2010), using the decision framework set out in the earlier *Fair Access to Care Services (FACS)* guidance (HMG 2003).

While developed countries face similar challenges, they have taken different approaches to identifying and supporting those with long-term care needs. This variability of responses to similar questions provides an opportunity to study whether approaches adopted by other countries could provide lessons for England. It is important to recognise that the variability reflects, at least in part, different cultural traditions of different countries (Glendinning and Moran 2009). Yet, so long as the difference in context between countries is accounted for, comparative studies can provide valuable insight for the development of policy and practice.

The study focuses on five countries, in addition to England. They are Australia, France, Germany, the Netherlands and New Zealand. These countries cover a spectrum of experience in terms of the degree of national consistency and local discretion within their frameworks. Most of them have considered or implemented reforms in recent years.

It is important to recognise that the definitions and roles of long-term care and of assessment and eligibility differ between countries. The study follows the Organisation for Economic Co-operation and Development's (OECD) definition that long-term care comprises 'a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are dependent for an extended period of time on help with basic activities of daily living...' (OECD, 2011).

While recognising that assessment may perform a wider function, the study focuses on its role as the gateway to publicly funded long-term care. Assessment and eligibility are treated as defining: the *criteria* under which a given individual is deemed eligible for publicly funded support for long-term care, and for how much support the individual is eligible, and the *processes* involved in selecting from the general population those who receive this support and determining for how much support each person is eligible.

It is also important to recognise that reforms to the assessment and eligibility framework in England need to be consistent with wider developments in adult social care policy and practice and wider changes in social policy. The former include increased emphasis on prevention and re-ablement and on personalisation, the introduction of a capped cost funding system in 2016 and reinforced rights for carers (subject to the passage of the Care

Bill 2013). The latter include reforms to the NHS and to social security disability benefits and measures to improve integration between health and social care.

3. Objectives of assessment and eligibility frameworks

Clarity about the aims and objectives of assessment and eligibility frameworks is clearly essential to enable proposals for reform to be developed in a coherent and robust manner. A wide range of aims for reform to assessment and eligibility processes and criteria can be justified from various economic, political and philosophical standpoints. The different potential aims have interdependencies and tensions between them. Although in theory it would be possible to prioritise one objective, in practice combinations of objectives and processes should be considered.

Equity is clearly an important objective in view of the concern in England about variable practice in assessment and eligibility across the country. It has many dimensions, including not only geographical equity but also equity between different age groups, user groups, diagnoses, ethnic groups and so on. Equity is generally regarded as encompassing both horizontal equity – the equal treatment of people who are equal in a relevant respect – and vertical equity – the unequal treatment of people who are unequal in a relevant respect.

These definitions of horizontal and vertical equity raise two questions: what deems individuals ‘equal’ or ‘unequal’ and what is meant by ‘treatment’ in this context. Perhaps the most familiar answer to the first question is that people should be deemed equal or at least similar if they have similar ‘needs’ for care and support; but this leads to questions about what constitutes ‘need’ in this context. The second question raises interesting issues about whether the aim should be fair access to care, fair inputs in terms of care packages or fair final outcomes for users and carers.

Another important objective is efficiency. It is concerned with maximising the *total* well-being in a society given limited resources. Various objectives for reform to assessment and eligibility processes and criteria can be defended from an efficiency viewpoint. To mitigate informational problems, for example, the assessment and eligibility framework should be clear and transparent. Transparency may help to reduce the costs of assessment, including by reducing the need for input from skilled professional assessors, and the costs of resolving disputes. The framework should also be sustainable and perceived as such, since uncertainty over aspects of the social care system makes it difficult for people to plan in an efficient way.

It is important to recognise the distinction between process objectives and those related to the distribution of resources through eligibility criteria. Ensuring that assessment and eligibility processes are streamlined promotes productive efficiency. The processes should be undertaken at the lowest cost consistent with achieving their purpose, but this cost minimisation should be subject to achieving the purpose of the assessment and eligibility framework. Ensuring that eligibility criteria are effective in targeting the optimal mix of services to those with the greatest capacity to benefit from them is relevant for promoting wider efficiency objectives.

Appraisal of assessment and eligibility frameworks in other countries and proposals for reform of the English framework need to make normative judgements about what aspects of equity and efficiency should be pursued. This report does not seek to make such judgements, which are for policymakers to determine. Instead we use the equity and efficiency objectives to frame our analysis of different assessment and eligibility processes and criteria.

4. Assessment and eligibility frameworks in six countries

Following a scoping review of assessment and eligibility frameworks in 15 developed countries, we selected six for more detailed study. We chose these countries to cover a range of circumstances in terms of:

- European and non-European, since the UK has close links other EU countries but also similarities with several Commonwealth countries;
- Social insurance and tax-funded systems, since there is a link between financing systems, financial control and determination of eligibility criteria;
- Nationally uniform and locally determined assessment and eligibility frameworks, since this distinction lies at the core of the current policy concern in England.

These considerations led us to select for more detailed study the following five countries, in addition to England:

- Australia: a Commonwealth country with a tax-based system, a localised assessment and eligibility framework and planned reforms;
- France: an EU country with a tax-based system and a national assessment and eligibility framework but local flexibility;
- Germany: an EU country with a social insurance system, a uniform national assessment and eligibility framework and discussion about possible reforms;
- Netherlands: an EU country with a social insurance system, a uniform national assessment and eligibility framework and severe cost pressures;
- New Zealand: a Commonwealth country with a tax-based system, a nationally mandated assessment instrument but local flexibility on eligibility criteria, and recent reforms.

These five countries provide an interesting range of systems, and of current or planned reforms. A summary comparison of the six long-term care funding systems is at Table 1 and further information about each country's system is summarised in the Boxes 1 to 6.

5. Objectives and functions of assessment and eligibility frameworks

The assessment and eligibility frameworks in our sample of countries differ in their objectives and their functions. Frameworks which confer eligibility to a clearly defined benefit appear to be concerned with fair inputs. This group includes Germany, where those in a given care level are eligible for set benefits. The French system, with funding ceilings for each eligibility category, could also be thought to value fair inputs. Conversely, English eligibility guidance is clear that “within the same council area people with similar levels of needs should expect to achieve similar quality of outcomes, although the type of support they choose to receive may differ depending on individual circumstances” (HM Government, 2010).

The frameworks adopted by the different countries also differ in their functions, as might be expected given differences in their objectives. While assessment and eligibility processes and criteria act as a gateway to long-term support in all countries, they also perform other functions in some cases, such as acting as a pathway to reablement or to care planning. This diversity means that careful consideration needs to be exercised when transferring lessons from other countries' frameworks, if those other countries' frameworks do not have

the same function. A summary comparison of the six assessment and eligibility processes and criteria is at Table 2.

The frameworks we have analysed appear to lie on a spectrum in the breadth of their function. The German framework represents one end of this spectrum. Assessments and eligibility criteria for social long-term care insurance there consist primarily of the frequency and duration for which support is required to perform personal care and domestic care tasks. This assessment is used only to assign each person to one of the four eligibility categories, and does not collect the detailed information required for care planning. An intermediate position appears to have been assumed by the Netherlands, where the independent Centre for Care Assessment (CIZ) is responsible for comprehensive assessments which are used to make eligibility and resource allocation decisions; but, once eligibility has been determined, care planning and case management services are provided locally.

At the other end of the spectrum are the Australian, New Zealand and current English frameworks. The core objective of assessments for community-based care packages in Australia is “to comprehensively assess the needs of frail older people and facilitate access to available care services appropriate to their care”. Recent reforms in New Zealand also illustrate the broad role that assessment plays there: since June 2012, Needs Assessment Services Coordination agencies (NASCs) have been required to use the comprehensive RAI-Home Care (RAI-HC) tool.

The breadth of assessment and eligibility processes and criteria has important implications for the cost-effectiveness of the wider long-term care system, as a more holistic assessment may support prevention, may facilitate the integration and personalisation of care packages and may provide data for a wide range of research. The current English framework appears, at least in principle, to support this broader function of assessment and eligibility.

The Department of Health’s recent consultation paper (DH 2013) on the reformed system for England stresses in respect of assessments that ‘rather than acting primarily as a gateway to the adult receiving care and support, the future system will place more emphasis on supporting people to identify their needs, understand the options available to them, plan for meeting care and support needs and reduce or delay needs where possible’. It also indicates that ‘the assessment will build on greater access to information and advice to help people identify types of care and support can prevent them from needing care, or help them to regain and maintain their independence’.

6. Eligibility criteria

A range of factors are considered in eligibility decisions across the countries we have studied. Countries differ in their use of age as a discriminating factor. Australia and New Zealand run separate services for older and younger people, although there is no specific minimum age for access to aged care services in Australia. The cash benefit in France is only available for those aged 60 or older. England has a separate long-term care system for children. In Germany and the Netherlands, however, all citizens are covered under social insurance for long-term care.

Countries also differ in how directly they consider diagnostic equity. The Germany eligibility criteria take account of functional disability in terms of ability to conduct activities of daily living (ADLs) but do not take proper account of cognitive impairment. This has long been recognised as a major shortcoming but, despite protracted debates, as yet major reforms have still to be agreed. The French *Autonomie Gérontologie Groupes Iso-Ressources*

(AGGIR) criteria, however, do take separate account of cognitive impairment as well as functional disability.

The issue of geographical consistency is also explicitly addressed under some frameworks. For instance, the use of the AGGIR tool in France aims for an objective assessment which “should not vary by region or by the evaluator” (Dupourque, 2012). Similarly, the use of countrywide instruments and procedures in Germany was motivated by fairness considerations (Theobald, 2011).

7. Instruments and algorithms

This section concerns the use of standardised instruments for assessments and of algorithms that translate a given level of need into a given level of resource. Oxford Dictionaries defines an ‘instrument’ as “a tool or implement, especially one for precision work” and an ‘algorithm’ as “a process or set of rules to be followed in calculations or other problem-solving operations” (OUP, 2013). In the present context, we are particularly interested in tools which improve the precision of assessments for adult long-term care, and the sets of rules used to make eligibility and resource allocation decisions. We discuss them separately since it is possible to have a standard assessment instrument without a standard algorithm but they raise similar issues.

The most important motivation for the use of standard assessment instruments and algorithms in the countries we have studied appears to be the pursuit of fairness through standardisation. Collecting the same set of information and using consistent rules across clients can help to identify ‘similar’ people and to ‘treat’ them appropriately in terms of inputs, access or outcomes.

The six countries may be split into two groups in terms of their approach to assessment tools. Staff in France, Germany and New Zealand use a nationally mandated instrument during long-term care assessments, whilst assessment teams in Australia and local authorities in England are free to choose locally what information to collect in assessments, and which instruments (if any) to use. Further details about the instruments used in France, Germany and New Zealand are at Annex A.

The tools used in the first group vary in line with the different aims of assessment in different countries. Assessments in Germany, for example, which act solely to determine eligibility for long-term care and the appropriate level of benefit, collect a limited set of information relating to the frequency and duration of support required in performing core activities of daily living and instrumental activities of daily living. Assessors use the *Zeittabel* or ‘time table’, which provides an indication of the amount of time required for different components of the activities of daily living. Whilst this increases the objectivity of the assessment to some extent, assessors are still able to deviate from the *Zeittabel*’s indicative timescales where necessary. We have not found any truly objective instruments.

While care packages in France are based on a broad range of information about the client’s needs, social environment and preferences, eligibility decisions are based on the person’s ability to perform a narrower set of tasks. These tasks are set out in the nationally mandated AGGIR instrument which collects information relating to ten ‘discriminant’ variables (including washing, dressing, eating etc.) and seven ‘illustrative’ variables (cooking, housekeeping etc.). The assessment tool has been criticised for a lack of granularity and its focus on somatic needs, but does appear to achieve some degree of objectivity and inter-rater validity.

The information collected during assessments is translated into eligibility and resource allocation decisions using rules, which vary in their complexity, breadth and objectivity. It is important to note, however, that because eligibility criteria are implemented in different ways, the relationship between the criteria set out in guidance and legislation and the criteria used in practice may vary between and within countries. For instance, there is significant evidence that central government guidelines used in England are interpreted differently by assessment staff across the country (SCIE, forthcoming; Fernandez and Snell, 2012; Commission on Funding of Care and Support, 2011). Similarly, a concern about Aged Care Assessment Teams (ACATs) in Australia is the considerable variation in their patterns of recommendations for care plans that cannot be explained by variations in local population needs or supply of residential care places or other services. Conversely, de Meijer et al (2011) find that the factors included in Dutch eligibility criteria are very strong predictors of individual long-term care expenditures.

The assessment and eligibility framework in England appears to allow considerable scope for local interpretation and professional judgement. While SCIE found that 'the FACS banding system remains the basis for assessment and eligibility decision-making across all authorities' (SCIE, 2013), the FACS guidance leaves scope for local interpretation and professional judgement. All the local authorities which participated in the SCIE study reported use of assessment tools, but hardly any reported use of toolkits in respect of eligibility decisions. One or two used the FACS framework itself as the toolkit for eligibility, one used information from the SCIE website to support decisions on eligibility, and one had been pro-active in developing a toolkit to support decision-making (SCIE, 2013).

Conversely, many local authorities have developed more formal rules for sharing resources between eligible clients. Building on the Resource Allocation Systems (RAS) designed by *In Control*, the Association of Directors of Adult Social Services (ADASS) issued a Common Resource Allocation Framework in 2009 (revised in 2010). This guidance aims to support local authorities in developing equitable, transparent, sustainable and appropriate mechanisms to share their scarce resources between eligible clients.

The most objective rules used for eligibility and resource allocation decisions appear to be those used for social long-term care insurance in Germany. Although the algorithm is not complex or mathematical, decisions are clearly based on simple, formalised rules. The four eligibility (and resource allocation) categories are clearly defined in terms of the frequency and duration for which support in ADLs and IADLs is required.

Shortcomings in the German rules have nevertheless been identified. Despite the high degree of objectivity "huge regional differences" in eligibility decisions, which cannot be explained by epidemiological and demographic factors, remain (Büscher, Wingenfeld and Schaeffer, 2011). Moreover, the focus on somatic limitations and the use of duration of support required as a discriminating factor have been criticised for biasing eligibility decisions against those with cognitive impairments. Finally, the restrictive eligibility threshold in the algorithm lacks public support (Zok (2011) in Theobald (2011)).

The scoring system designed as part of the new assessment system (NBA) in Germany aims to overcome these shortcomings. This algorithm takes into account a much broader range of factors, and weights them in terms of their impact on the person's dependency on nursing care rather than duration. The weighting process delivers a score between 0 and 100, which in turn places a given client into one of five degrees of dependency (eligibility categories). Weights and thresholds are based on empirical evidence and clinical insight. As with the NBA, the French AGGIR eligibility and resource allocation algorithm uses weights and grouping to differentiate clients in terms of their somatic and cognitive characteristics. This tool translates the 17 categorical answers from the AGGIR assessment into one of 13 ranks, using a rather complex weighting procedure. In turn, these ranks are translated into

the six GIR categories, each of which has an associated funding ceiling (set at zero (i.e. ineligible) for GIR5 and GIR6).

Other algorithms can be used to support care planning, monitor quality, facilitate reimbursement and screen for eligibility. The interRAI assessment system includes 'applications' to perform all of these functions. Care planning is supported through Clinical Assessment Protocols (CAPs), which use answers to a subset of questions to flag certain risks and opportunities to the assessor. Each protocol has associated clinical instructions, which support the care manager in designing appropriate solutions and may ultimately reduce the proportion of clients relying on on-going support. Resource allocation and reimbursement are supported through the RUG case-mix algorithms. These algorithms use information collected in interRAI assessments to group clients in terms of their expected resource use. The RUG-III and RUG-III/HC have been extensively tested with broadly positive findings.

The Method for Assigning Priority Levels (MAPLe) tool, developed and extensively tested by researchers in Canada (see Hirdes, Poss and Curtin-Telegdi (2008)), is relevant in this context. MAPLe translates answers from 44 items in the interRAI-HC/interRAI-LTCF assessment forms into one of five categories: low, mild, moderate, high, very high. The algorithm was designed to support care managers in prioritising clients on the basis of their needs, regardless of the care setting.

The extent to which the objective of fairness is achieved through use of instruments and algorithms is determined by two key attributes. First, the comprehensiveness of an assessment tool, or the volume and detail of the information collected during assessment, determines the accuracy with which two people can be defined as similar or different in a relevant respect. Similarly, an algorithm which takes account of a range of factors can differentiate clients in more complex ways.

Second, the degree of 'objectivity' of the information collected in an assessment determines the consistency with which two clients are defined as similar or dissimilar. By degree of 'objectivity' we mean the extent to which there is scope for an individual assessor's opinion or preference to influence the outcome of an assessment or eligibility decision. If the same person was assessed by local authorities across the country, a more objective framework would be expected to deliver less variation in the level and composition of the care package.

There are, however, costs associated with expanding the scope of assessment and making decisions more objective. A more comprehensive assessment is likely to require more time to complete, which may be stressful for the client/carer and mean that the assessor must reprioritise other work. To minimise costs whilst achieving other objectives, an efficient assessment tool would collect no more information than is necessary to make eligibility and resource allocation decisions and to facilitate care planning where applicable. In practice, this may mean developing a range of processes for different clients, different settings and/or different stages in the assessment and eligibility pathway.

There may also be a tension between objectivity and comprehensiveness. For example, using numerical scales to describe complex, human characteristics may make it difficult to distinguish between people with different levels of need, different preferences, different outcomes and different degrees of access. This could in turn prevent efficient and fair eligibility decisions and resource allocation. Over-simplification may also mean that the information collected during assessment is inappropriate for care planning.

Finally, complex algorithms may also be confusing for staff and reduce transparency for the service user and the public. This may make it difficult for people to account for the

assessment and eligibility framework when planning for care costs, and may lead to more appeals against eligibility decisions, both of which may impede efficiency.

Policymakers will want to consider thoroughly which attributes of assessment instruments and care planning, eligibility and resource allocation algorithms most closely meet their objectives. If the tools and rules currently used in England are considered inadequate, a detailed and comprehensive exploration of the specific instruments and algorithms used overseas should be considered before new bespoke instruments or tools are developed or recommended.

8. Informal care

The majority of care for older people in all countries is provided by unpaid, informal carers. Across the OECD, more than one in ten adults aged over 50 years provides (usually unpaid) help with personal care to people with functional limitations (OECD 2011, page 86). The role of unpaid carers raises a number of questions in the context of assessment and eligibility. The study has concentrated on two key issues. First, what are the criteria for carers' eligibility for carer support services and are they similar to the eligibility criteria for disabled people for care and support? Second, do the eligibility criteria and resource allocation decisions take account of input from unpaid carers such that those with carers receive less care or lower cash payments than those without unpaid carers?

England appears to be the only country among the six in this study which is giving unpaid carers a clear entitlement to an assessment of their own needs in their own right, where appropriate independently of the assessment of the person for whom they provide care. The other countries link eligibility for carer support with eligibility for support of the person needing care. Australia for example requires that carers' needs should be included in the client assessment where appropriate. The assessment should consider among other factors: the availability of alternative informal support; the availability and use of carer/client services; the carer's condition; other demands on the carer; the number of people being cared for; the relationship between carer and client; and the carer's financial status.

Setting eligibility criteria for carer support raises similar efficiency and equity issues as setting eligibility criteria for services for people needing care. It does however raise some additional issues. In particular there is the difficult question about achieving the most efficient and equitable balance between support for carers and support for those needing care. Whether greater overall welfare could be achieved by a marginal shift of resources from services for frail older people to carer support (or vice versa) is an empirical question. Whether such a shift would improve equity is however a normative question, which depends in part on the relative weights attached to the welfare of carers and care recipients.

The question of whether eligibility and resource allocation criteria take account of informal care inputs is a crucial issue with profound implications for the equity and efficiency of the care system, for incentives to provide unpaid care and for costs. The issue has been described in terms of whether the eligibility framework is 'carer-blind', where the availability of informal care does not affect eligibility and resource allocation decisions, or 'carer-sighted', where it does.

The German long-term care social insurance system does not take direct account of unpaid care when determining eligibility for benefits. People in receipt of intense informal care have exactly the same entitlement in principle to benefits as those with no informal care. The German system gives beneficiaries a choice between cash or services (or a combination) where the cash benefit is worth only slightly more than half the value of the care package.

The purpose is to enable those with informal care to receive cash to pay their carers. Since the cash benefit is so much lower than the value of the care package it could be argued that the system is not fully carer-blind in practice. It should be noted, however, that carers of those opting to receive cash benefits are automatically entitled to four weeks' respite plus payment of pensions and sickness insurance contributions but carers of those opting for care packages have no such automatic entitlement.

The Dutch eligibility framework distinguishes between the 'usual care' provided by others living in the same house as the client, and support provided by other family members, friends and neighbours living elsewhere. Publicly funded AWBZ (Exceptional Medical Expenses Act) support should not replace 'usual care', which includes all domestic tasks and personal care for the first three months of a client's support needs, unless there is a risk of burnout for the carer. The eligibility framework is also 'sighted' with regards to other informal support, where it is voluntarily provided and received.

In France, the availability of informal care does not influence into which of the six *Groupes Iso-Ressources* (GIR) a client falls. These categories define the maximum amount of funding for which the client is eligible. However, the availability of unpaid support from the client's family and social network is considered in determining the size and content of the care plan, subject to the funding ceiling for the GIR category.

Whether a carer-blind system is more efficient at maximising societal welfare than a carer-sighted system is ultimately an empirical question. Moreover, if the system is carer-blind there is a further empirical question about how much smaller care packages should be for those with unpaid carers in comparison with packages for those without carers. Whether it is equitable to operate a carer-blind system is by contrast a normative question. If emphasis is placed on achieving similar outcomes for all people needing care, a carer-sighted system may seem the more equitable. If greater emphasis is placed on achieving equality of access to similar care packages, however, a carer-blind system may seem more equitable.

9. National and local responsibilities

The degree of national uniformity or variation in assessment and eligibility frameworks is the central issue being considered in the English context, with the *Caring for Our Future White Paper* (HMG 2012) committing to introduce a national minimum eligibility threshold. It is therefore especially important to consider which agencies in other countries are responsible for assessments, for eligibility criteria and for allocations, and whether these functions are determined, managed and conducted nationally or locally.

An important, if not the most important, rationale for national uniformity in assessment and eligibility criteria is promotion of geographical equity. The English system, with its variability in eligibility criteria across local authorities, has been described as a 'post-code lottery'. A national system seems more likely to ensure that people with similar needs receive similar assessments and either similar levels of resources or resources that achieve similar outcomes across the country. There may be a risk, however, that by limiting local flexibility to take account of local factors national uniformity restricts the ability to match resources to needs. In that event it could militate against efficiency.

The eligibility frameworks considered in this study lie on a spectrum in their degree of national standardisation. Germany and Netherlands are at one end of the spectrum with national assessment organisations and standardised tools, criteria and resource allocation mechanisms; then comes France with a standardised assessment and nationally consistent eligibility criteria; then follows New Zealand with a nationally standardised assessment

instrument. England and Australia allow the greatest degree of local flexibility, subject to national guidance. A summary table showing the responsibilities and uniformity of assessment and eligibility frameworks is at Table 3.

In Australia assessments are conducted by Aged Care Assessment Teams (ACATs) which perform a comprehensive assessment and determine each person's eligibility for publicly subsidised care. They are independent of federal and state government. They decide, for those assessed as requiring intense care, for which community-based care package or level of residential care the person is eligible. They operate within national guidelines about the assessment process and issues to be addressed in assessments, but there are currently no nationally mandated standard assessment instruments or uniform set of eligibility criteria or algorithms. Total public expenditure on care is however determined by federal government, which sets the numbers of each type of package to be publicly subsidised. If more people are assessed as requiring care than available funding, they need to join waiting lists, which act as a cost control mechanism. This system means that assessments are independent and eligibility criteria are not nationally uniform, but within each type of care package there is national consistency of care intensity and total public expenditure on care is cash limited.

District Health Boards (DHBs) in New Zealand fund Needs Assessment Services Coordination agencies (NASCs), which are responsible for needs assessments for their local areas. They operate the needs assessment and service coordination process on behalf of the relevant DHB. Anyone who wishes to receive disability support services funded by a DHB must be needs assessed by the NASC. Since July 2012 all NASCs use the *interRAI* instruments to conduct assessments. There is not just a nationally uniform assessment process but also a nationally standard assessment instrument in New Zealand. This means that the New Zealand system has a high degree of national consistency in terms of use of the same standard assessment tool across the country but does not have a nationally uniform algorithm for determining the care package for those assessed as eligible for publicly funded care.

Assessments in Germany and the Netherlands are performed by national organisations, independent of any budgetary considerations. The German Medical Board for the Sickness Insurance Funds, an official independent consultancy, assesses the needs of people covered under the social long-term care insurance. Such national standardisation has reduced regional inequalities. Assessment and eligibility for AWBZ care in the Netherlands was originally the responsibility of care providers, but the needs assessment subsequently became the responsibility first of regional organisations and then of a single national organisation (*Centrum Indicatiestelling Zorg (CIZ)*) in 2005. The move to the CIZ aimed to provide further consistency across the country, to improve transparency and to promote cost-efficiency. Assessment and eligibility processes for the cash APA in France are the responsibility of local *conseil general*. However, all councils must use the AGGIR tool to support eligibility and resource allocation decisions.

Greater national uniformity in assessment should mean that where people live has less impact on their assessed eligibility for publicly funded care or on the level of care funding they receive – but only if local authorities are mandated and funded to provide this level of care. More specifically people with similar needs living in different areas are more likely to be assessed as having similar needs and treated in a similar manner. This would apply whether the equity objective is equity of inputs, access or outcomes. Whilst national uniformity is more likely to promote equity, this is not guaranteed, since interpretation of national eligibility criteria could still vary between areas especially if there are cultural differences across the country.

Greater national uniformity of processes might also lead to greater efficiency in terms of somewhat less expenditure on assessments and care management. Staff who move

between areas will not require training in a different assessment process. Users and carers who move between areas may not require a new assessment. Uniform processes would permit use of standard IT systems to record the outcomes of assessments and care management. Whether such efficiencies are substantial however seems uncertain.

A broader issue on efficiency is whether greater national uniformity might lead to less satisfactory targeting of resources to those who have the greatest capacity to benefit. Needs and preferences may vary between different areas. Patterns of supply of care services may also vary between areas, reflecting local differences in relative prices as well as differences in preferences. Local systems would allow local decision-makers discretion to take account of such variation.

There seems to be a trade-off between efficiency and equity objectives when deciding whether assessment processes, eligibility criteria and allocations should be determined on a nationally uniform basis or on the basis of local discretion. Geographical equity is promoted, albeit not guaranteed, by greater national uniformity, but greater national uniformity risks impacting on the cost-effective matching of resources to needs especially if preferences vary across the country.

The experience of other countries suggests that there is a range of possibilities rather than a dichotomous choice between national uniformity and localism. For example, there could be, as in France, national criteria and a nationally mandated instrument to determine eligibility for publicly funded care but a degree of local discretion to determine the level of the cash payment. Similarly, there could be, as in New Zealand, a nationally mandated instrument for use in assessments but considerable local discretion to determine through care management the level and composition of the care package.

10. Political and financial sustainability

The sustainability of long-term care systems across the OECD will be tested over coming decades, as population ageing and high public expectations increase demand, whilst slow economic growth constrains the public sector's ability to expand supply, at least in the short-term. Assessment and eligibility policy is no exception: it raises issues of both financial and political sustainability.

Unsustainability is inefficient because it makes planning for the future difficult and past plans inaccurate. This means, for example, that people entering the care system under a more strict eligibility threshold than expected may not have saved enough to cover the services they now have to pay for. Frequent reforms may lead households to lose faith and over-prepare through savings, which would be inefficient. Alternatively, and more likely, frequent reforms may lead them to decide that it is not worth planning for the future since it is so uncertain. Unsustainability is also inefficient because it creates transition costs, which may include the preparation of new central government guidance, retraining for staff, client and carer time to understand the new system and perhaps new information technology. Whilst there may also be benefits to reform, such transition costs mean that policymakers should aim to 'get it right first time'.

Unsustainability may also be unfair. Fairness requires that similar people are treated similarly, and different people are treated appropriately differently. If we believe people are similar regardless of when in their lifetime they develop care needs and regardless of their generation, then changes to the assessment and eligibility framework over time could lead to inequity.

Financial sustainability may be achieved by building budget controls into the assessment and eligibility framework, by minimising the associated process costs required to achieve other objectives or by adjusting algorithms (for example by changing the amount of resource per point on a scale of needs). The assessment and eligibility framework influences the level and growth rate of long-term care expenditure in two separate ways: first, under a given funding system, the assessment and eligibility framework determines the number of clients who are eligible to receive public funding, and the amount of funding that each eligible client receives; and second, the direct cost of carrying out assessment, eligibility and care management processes can be a significant part of total long-term care expenditure.

It is important to recognise the potential tension between minimising the direct monetary cost of assessment and eligibility processes in the short-term and the impact on the cost-effectiveness of public services in the long-term. For instance, investing more resources in a high quality, multidisciplinary initial assessment for clients with complex needs could lead to less appeals, better outcomes and to lower on-going care packages in the long-run. Moreover, comprehensive, standardised assessment could provide a wealth of information for commissioners, regulators, researchers and policymakers, and for clients to hold the sector to account.

For a given funding system, it is the *combination* of a range of levers that drives the growth of long-term care expenditure. This can be seen by comparing the German and Dutch long-term care social insurance schemes. Whilst both systems are based on clear, centralised assessment and eligibility guidelines implemented by independent assessment organisations, this standardisation is combined with a generous, open-ended care entitlement in the Netherlands but an entitlement to *fixed* cash or in-kind benefits in Germany. Interestingly, the German long-term care scheme was designed in this way in an explicit attempt to avoid the cost-expansion seen in the Netherlands, although as discussed below the rising gap between costs of care and benefits in Germany raises issues of long-term sustainability.

There is the opportunity for reforms to the assessment and eligibility framework to reduce duplication across long-term care and other public services. For example, the introduction of the interRAI suite of tools in New Zealand ensures that only one assessment is required for health and long-term care services. On-going reform in Australia also aims to reduce fragmentation across health and social care. In the English context, there may be scope for efficiencies by integrating assessments for health and social care. Integration with assessments for social security disability benefits might also provide scope for efficiencies but raises wider issues since social security unlike health and social care is determined on a UK basis and is not a function devolved to individual countries of the UK.

Reforms to the long-term care system should also be politically sustainable. This means that any changes should be supported to a sufficient extent by key stakeholders, and that they should be compatible with future long-term care policy and other relevant reforms. Gaining stakeholder support may be achieved by employing a consultative and deliberative approach. However, the slow pace of reform processes underway in Germany and Australia may provide lessons for policymakers in England.

A second element of political sustainability is that to maintain the support of key stakeholders, long-term care policies should be capable of adapting to changing need drivers. A challenge to the sustainability of the German system is the rising gap between the costs of care and the social insurance benefit rates which are set by the federal government and have most of the time been held constant in nominal terms. A further issue is that the German assessment and eligibility framework arguably biases decisions against those with cognitive impairments. As the proportion of the population aged over 85 grows, pressure

may mount to adjust the way in which the system shares resources between people with somatic and cognitive impairments.

Finally, policymakers should note that financial and political sustainability may not always be mutually compatible. For example, cost containment was one of the key drivers behind delegating responsibility for low-intensity care services to local municipalities in the Netherlands in 2007. This reform, however, combined the responsibility for assessment and resource allocation decisions for these services with a financial incentive to restrict eligibility, as any underspend of central government transfers are retained in local budgets. Whilst the size and number of low intensity care packages appears to have been maintained, the move resulted in lower hourly tariffs, leading to financial problems for providers, lower wages for care workers and consequently lower quality for clients. In this case, therefore, the pursuit of cost containment may have led to politically unsustainable pressures on wages and care quality in the long run.

11. Summary and conclusions

Different countries have taken different approaches to identifying and supporting those with long-term care needs. This variability of responses to similar questions provides an opportunity to study whether approaches adopted by other countries could provide useful lessons for England. It is of course important to recognise that the variability reflects, at least in part, different cultural traditions and values of different countries. Yet, so long as the difference in context between countries is accounted for, comparative studies can provide valuable insight for the development of policy and practice.

The objectives of assessment processes and eligibility frameworks vary between countries and within England between local authorities. It is essential to consider the objectives to be pursued before seeking to appraise different systems or develop new systems. There is a range of different efficiency and equity objectives that policymakers might want to pursue. Different countries seem to have made different decisions about which objectives to prioritise. Trade-offs between objectives, which seem inevitable, must involve value judgements. For example, in the case of informal care, a carer-sighted system, other factors equal, concentrates limited resources on those with greater needs but may reduce the incentive for carers to continue providing care. We have drawn attention to such issues, but we have not made those value judgements which are for policy-makers to consider.

After decisions have been made on core objectives, there are a range of specific issues to be resolved: the role and scope of assessments; assessment processes; assessment instruments; eligibility criteria and thresholds; processes for determining eligibility; resource allocation systems; care management; appeals and reviews. There is a decision to be made for each of these about whether they should be nationally standardised or determined locally in accordance with local priorities. It is the combination of decisions on all of these that determines how far the system promotes efficiency and equity objectives.

The eligibility frameworks considered in this study lie on a spectrum in their degree of national standardisation. The social insurance schemes in Germany and Netherlands are at one end of the spectrum with national assessment organisations and standardised tools, criteria and resource allocation mechanisms; then comes France with a standardised assessment and nationally consistent eligibility criteria; then follows New Zealand with a nationally standardised assessment instrument. England and Australia allow the greatest degree of local flexibility, subject to national guidance.

There seems to be a trade-off between efficiency and equity objectives when deciding whether assessment processes, eligibility criteria and allocations should be determined on a nationally uniform basis or on the basis of local discretion. Geographical equity is promoted, albeit not guaranteed, by greater national uniformity, but greater national uniformity risks impacting on the cost-effective matching of resources to preferences especially if these vary across the country.

We have not found in the literature any taxonomy of assessment and eligibility frameworks or any recent comparative appraisal of different frameworks. We believe that our study is innovative in this respect. The six frameworks we have studied can be divided into three broad models in terms of their balance between national standardisation and local discretion. The key characteristics of the three models are:

Model I. Local discretion on assessment process, assessment instrument, eligibility criteria and resource allocation process, subject only to general national guidance.

Model II. National standardisation of assessment instrument and possibly assessment process but local discretion on eligibility criteria and resource allocation.

Model III. National standardisation of assessment process, assessment instrument, eligibility criteria and resource allocation, with little local discretion.

These three models are described in more detail in Table 4.

The final aim of this study was to develop options for improving the English assessment and eligibility framework, drawing lessons for England from the experience of other developed countries. England, along with Australia, currently operates model I and will still operate a form of model I when a national minimum eligibility threshold is introduced. The key question now is whether England should move from model I to a form of model II or model III.

For England to move to a form of model III would not only involve considerable transitional costs but also require major changes which do not seem to be contemplated in the context of the current reforms. It would mean that local authorities would no longer be able to take account of local preferences in determining their eligibility criteria and would no longer be able to control their expenditure on adult social care. They would effectively become an agent of national government in respect of the adult social care assessment and eligibility system.

England could more readily move to a form of model II as New Zealand has done. Use of a standard assessment instrument and greater standardisation of assessment processes would seem consistent with an objective of promoting greater geographical equity and facilitating portability of assessments between areas. It would fit well with the concept of a national minimum eligibility threshold: it could be argued that a national minimum could more readily be introduced if there was a standard assessment instrument. It would also seem to fit well with the reform of the social care funding system from April 2016, when local authorities will need to assess far more people under the system of care accounts to monitor service users' progress toward the new cap on care costs. A standard assessment instrument would also facilitate the collection of data on social care users on a scale that has not so far been seen in England. It would inevitably involve some transition costs in adopting the standard instrument and would reduce local authorities' freedom to choose whatever assessment instrument they felt best suited the circumstances of their local communities.

In conclusion, the experience of other countries suggests that, within this schema of three models, there is a range of possibilities rather than a dichotomous choice between national uniformity and localism. There could be, as in France, national criteria and a nationally

mandated instrument but a degree of local discretion to determine the level of the cash payment. Or, there could be, as in New Zealand, a nationally mandated instrument but considerable local discretion to determine through care management the level and composition of the care package. Policy-makers in England may want to pay particular attention to consideration of these approaches.

12. References

Büscher, A., Wingenfeld, K., & Schaeffer, D. (2011) *Determining eligibility for long-term care - lessons from Germany. International Journal of Integrated Care* (11)

Commission on Funding of Care and Support (2011) *Fairer Care Funding*. London.

de Meijer, C., Koopmanschap, M., d'Uva, T. B., & Van Doorslaer, E. K. (2011) *Determinants of long-term care spending: Age, time to death or disability? Journal of Health Economics*, 30(2), 425-438.

Department of Health (2013) *Caring for our future: Consultation on reforming what and how people pay for their care and support*, July 2013

Dupourque, E (2012) *AGGIR the work of grids, Long-term Care News* 32

European Commission Directorate-General for Economic and Financial Affairs (2012) *The 2012 Ageing Report: Economic and budgetary projections for the EU27 Member States (2010- 2060)*, European Union

Fernandez, J.-L., & Snell, T. (2012) *Survey of Fair Access to Care Services (FACS) assessment criteria among local authorities in England*. PSSRU.

Glendinning, C. and Moran, N. (2009). *Reforming long-term care: Recent lessons from other countries*. York: Social Policy Research Unit, University of York

Hirdes, J. P., Poss, J. W., & Curtin-Telegdi, N. (2008). *The Method for Assigning Priority Levels (MAPLe): A new decision-support system for allocating home care resources. BMC Medicine*, 6(9)

HMG (2003) *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*. London.

HMG (2010) *Prioritising Need in the Context of Putting People First*

HMG (2012) *Caring for our future: reforming care and support*. London: HM Government

OECD (2011) *Help Wanted? Providing and Paying for Long-Term Care*. Paris: OECD. www.oecd.org/health/longtermcare/helpwanted

OUP (2013) *Oxford Dictionaries*, available at www.oxforddictionaries.com

Social Care Institute for Excellence (forthcoming) *SCIE Assessment and eligibility study for Department of Health*. London: Social Care Institute for Excellence.

Theobald, H (2011). *Long-term care insurance in Germany: Assessments, benefits, care arrangements and funding*. Stockholm: Institute for Future Studies

Box 1: Long-term Care in Australia

Administrative Structure: Federal country comprising six states and two territories.

Population Structure: 22.6 million people. The proportion of the population aged 65 or over is expected to increase from 13.7% in 2010 to 22.2% in 2050 and the proportion aged 80 and over from 3.8% in 2010 to 8.1% in 2050.

Funding Long-term Care: Formal care services are largely tax financed, with user co-payments. As a result of population ageing, Australian Government expenditure on aged care is projected to increase from 0.8 per cent of GDP in 2009-10 to 1.8 per cent of GDP by 2049-50. The Government currently pays the same level of subsidy for each home care package type regardless of a care recipient's income. By contrast, the fees that people pay for residential care are means tested to offset the cost of care and accommodation.

Management and Organisation: The federal government has primary responsibility for aged care. This includes developing the policy and legislative framework, oversight of capacity planning, subsidising residential and community care packages, and ensuring quality through regulation. Total public expenditure on care is also determined by federal government, which sets the numbers of each type of package to be publicly subsidised. Long-term support in Australia is delivered through a number of programmes. More intensive care is funded through nationally administered Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH), EACH Dementia services and residential care. Subject to the passage of the relevant legislation, a new Home Care Packages Program will replace CACP, EACH and EACH Dementia services from 1st July 2013. Since July 2012, the federal government has also been responsible for the Commonwealth Home and Community Care (HACC) program, which provides social care and nursing and allied health care.

Assessment and Eligibility Processes: Assessments are conducted by multi-disciplinary Aged Care Assessment Teams (ACATs), which perform a comprehensive assessment and determine each person's eligibility for publicly subsidised care. Assessment of care needs by an ACAT is required for admission to residential care and for access to community care packages (including CACP and EACH packages), but not for access to HACC services. ACATs are funded by but independent of federal and state government and are usually based in public hospitals. They can approve access to a range of services. They decide, for those assessed as requiring care beyond the HACC, to which type/level of community-based care package or level of residential care the person is eligible.

Eligibility and Resource Allocation Criteria: Older people can arrange an assessment themselves by contacting a local ACAT or they may be referred. The ACAT generally visits the person, consults their doctor and completes an Aged Care Client Record (ACCR). There are currently however no nationally mandated standard assessment instruments or uniform set of eligibility criteria or algorithms. There is considerable variation between ACATs in their eligibility decisions. Income is not a criterion for eligibility. Approval by an ACAT does not guarantee access to care: if more people are assessed as requiring care than available funding, they need to join waiting lists, which controls costs.

Assessment and Eligibility Policy: The Government announced in July 2012 a ten year programme of reform to Australia's aged care system. Major reforms include: expansion of the number of publicly funded care packages; development of the Home Support Program which will encompass the HACC program; and development of a more standardised approach to assessment. The reasons for these reforms include achievement of greater national consistency and integration with other public services.

Box 2: Long-term care in England

Administrative Structure: One of the four constituent countries of the United Kingdom, comprising 152 local authorities with social services responsibilities.

Population Structure: 53 million people. 16.5% of England's population is aged 65 or over and 4.6% is aged 80 or over, but by 2050 24.1% is projected to be aged 65 or over and 10.3% aged 80 or over.

Funding Long-term Care: Health services and social services are funded largely through general taxation; for social services this comprises a combination of unhypothecated grants from central government tax revenues and local tax revenues. The UK spent 2.0% of its GDP in 2010 on publicly funded long-term care services and is projected to spend 2.7% of GDP on them in 2060. While health care is free at point of use, social care is subject to a means test. People with assets above £23,250 (usually including the value of their home, for residential care) are ineligible for publicly funded care. Those who are eligible are required to contribute to their care costs from their income above set thresholds. A life-time cap of £72,000 on care costs and a higher capital limit for residential care are to be introduced from 2016.

Management and Organisation: Central government are responsible for overall policy, legislation and guidance on adult social care. Local authorities (152 upper tier authorities) are responsible for assessing needs and arranging care for their populations. They decide their budgets for social services in the light of local priorities. They contract with independent sector providers and fund care packages or direct cash payments for those who meet their local eligibility criteria.

Assessment and Eligibility Processes: People can refer themselves or be referred to their local authority social services department for an assessment. The assessment is conducted by social services staff, with the involvement of health service staff in some cases. The assessment determines whether the person meets the local eligibility criteria for publicly funded care and, if so, the level of care package or direct (cash) payment. A care manager arranges the care if the person prefers that to a direct payment.

Eligibility and Resource Allocation Criteria: To be eligible for publicly funded care the person must have a local authority needs assessment to determine whether they meet the local eligibility criteria and a financial assessment to check if they meet the conditions of the means test. Local authorities generally follow the approach of the national Fair Access to Care Services guidance in setting their local eligibility criteria. Most provide care for those with critical or substantial needs, a few limit eligibility to critical needs, and some meet moderate needs. The interpretation of these FACS categories however varies between areas and even within areas.

Assessment and Eligibility Policy: The government has decided, following comments from stakeholders and the independent Commission on Funding of Care and Support, to set a minimum standard national eligibility criterion and to develop and test options for a potential new assessment and eligibility framework for England.

Box 3: Long-term Care in France

Administrative Structure: Unitary country of 22 regions and 96 départements

Population Structure: 65.4m people. The proportion of people aged 65 (80) and over is estimated to increase from 16.7% (5.3%) in 2010 to 26.2% (10.5%) by 2050.

Funding Long-term Care: Publicly financed long-term care for older people (aged 60 and over) in France has been primarily provided through *l'allocation personnalisée d'autonomie* (APA, or 'personal allowance for autonomy') since 2002. In practice, however, the long-term care system is a combination of a core scheme (APA), social health insurance, private health and long-term care insurance, other peripheral public measures such as tax exemptions and pensions, and the contribution of informal care. Public funding for long-term care is drawn from central and local taxation, and means-tested social health insurance contributions. Public long-term care expenditure in France is projected to increase from 2.2% to 4.3% of GDP between 2010 and 2060. Despite the introduction of the APA, informal care continues to be the main support system for those with long-term care needs.

Management and Organisation: Long-term care is administered at the département-level. Central government and social health insurance also play an important role in organising and funding care. In collaboration with central government, département authorities are responsible for defining long-term care policy (including most assessment and eligibility processes and criteria), planning and coordinating service provision and financing a significant part of the APA. Département authorities are also responsible for accreditation of providers and approving pricing policies for institutional and home care services, and fix the price of personal care in institutional settings and the hotel component in nursing homes.

Assessment and Eligibility Processes: APA applications are filed with the local council. The council's socio-medical team visits the applicant to perform a need assessment. This assessment is based on the *Autonomie Gérontologie Groupes Iso-Ressources* (AGGIR) assessment tool and eligibility algorithm, which aims to be as objective and consistent as possible. To complete the AGGIR assessment, the assessor answers A (The individual cannot complete, needs assistance, or must have someone else to do the activity) to C (The individual completes alone, spontaneously, habitually, totally and correctly) for each of seventeen need items, covering ADLs, IADLs and cognition. As they form the basis for subsequent care-planning, assessments can be quite detailed. The AGGIR aims to be as objective as possible.

Eligibility and Resource Allocation Criteria: All people aged 60 and over may apply for the APA. AGGIR assessments are translated into one of six eligibility categories called *Groupes Iso-Ressources* (GIR1-GIR6), using a complex algorithm. Each category has an associated funding ceiling to ensure access to the same services across the country. Those in GIR5 and GIR6 are not eligible for the APA. The precise amount and type of care that a client receives is determined through a process of care planning in collaboration with the client, their family and any relevant medical professionals. Care plans are based on the client's social environment, living conditions, technical aids, physical location and the availability of medical and care services. Means-tested co-payments are charged to eligible clients.

Assessment and Eligibility Policy: The main limitation of the AGGIR tool is that it may bias eligibility decisions in favour of those with functional limitations, because the algorithm does not attribute sufficient weight to psychological and cognitive impairments. No reform process appears to be underway.

Box 4: Long-term Care in Germany

Administrative Structure: Federal Republic composed of 16 states (*Länder*)

Population Structure: 81.7m people. Proportion of people aged 65 (80) and over is estimated to increase from 20.6% (5.1%) in 2010 to 33.1% (14.7%) by 2050.

Funding Long-term Care: The majority of long-term care funding is provided through a social long-term care insurance (SLTCI) programme, covering around 90% of the population, although those with very high incomes are able to opt into private insurance. SLTCI beneficiaries may choose between in-kind benefits, lower cash allowances or a combination of the two. However, as SLTCI benefits are not comprehensive, most clients rely on informal support, private resources and other social policy programmes to meet their care needs. SLTCI expenditure in 2009 amounted to EUR20.33bn (0.86% GDP). Total public expenditure on long-term care in Germany has been projected to rise from 1.4% to 3.1% of GDP between 2010 and 2060.

Management and Organisation: Each health insurance fund has an affiliated long-term care insurance fund. In 2007, there were some 200 self-administrating SLTCI funds and around 40 private LTCI funds. The funds perform legally mandated tasks (capacity planning, monitoring service provision and organising the care system) but are organisationally and financially independent. The Medical Advisory Service is responsible for quality control through audits and inspections. Assessments for clients covered by the social LTCI are performed by the Medical Board of the sickness insurances (MDK), an official independent consultancy jointly financed by the health insurance funds and SLTCI funds. Medicproof, a private company, assesses needs for those covered under the mandatory private LTCI.

Assessment and Eligibility Processes: Assessments for LTCI are based on detailed federal guidelines, and are concerned with the frequency and duration of support required in performing core activities of daily living and housekeeping. Assessors use the *Zeittabel* (time table), which provides an indication of the amount of time required for different components of the ADLs. This information is insufficient for care planning, and is used to assign a given person to one of the four eligibility categories. Since 2002, there has also been a separate benefit for people with dementia, and a separate assessment exists for this benefit.

Eligibility and Resource Allocation Criteria: Statutory, capped SLTCI benefits and a nationally consistent entitlement aim to provide a compromise between universalism and cost containment. The national definition of 'dependency on nursing care' states that "a person is considered to be eligible for long-term care benefits if she or he is unable to perform regular activities of daily living in the areas of personal hygiene, nutrition, mobility and domestic care due to physical or mental illness/disability for at least six months". Federal legislation sets out four eligibility categories, defined by the frequency and duration for which support is required for ADLs and IADLs. Each category has associated cash and in-kind benefits, and the client can choose which is most suitable to meet their needs. Notably, the framework is – in principle – carer-blind.

Assessment and Eligibility Policy: Since 2005, an Advisory Board to the federal government has been investigating a new definition of the long-term care entitlement and an associated assessment instrument. This process aims to redress a perceived bias towards those with somatic limitations, by developing a more holistic entitlement and assessment. The Advisory Board also considered the costs associated with reform, including the risk of cost expansion in the LTCI scheme and process costs. There is no indication of when or whether reform in this area will proceed.

Box 5: Long-term Care in the Netherlands

Administrative Structure: Unitary country composed of twelve provinces and 430 municipalities.

Population Structure: 16.7m people. Proportion of people aged 65 (80) and over is projected to increase from 15.5% (4.0%) in 2010 to 24.4% (9.8%) by 2050.

Funding Long-term Care: Publicly financed long-term care in the Netherlands is primarily provided through the AWBZ ('Exceptional Medical Expenses Act'), WMO ('Social Support Act') and further means-tested social assistance. The AWBZ has been the central pillar of the Dutch long-term care system since its introduction in 1968. It provides centrally administered social insurance for the 'uninsurable' costs associated with long-term ill health, disability and ageing at home and in care homes, and for very long hospital stays. AWBZ care is funded through relatively high employment-based contributions (12% of work-related income in 2011), taxation, and, more recently, through means-tested user co-payments. Total public expenditure on long-term care in the Netherlands has been projected to rise from 3.8% to 7.9% of GDP between 2010 and 2060.

Management and Organisation: The Dutch Ministry of Health, Welfare and Sport (VWS) sets the broad policy and legislative framework in which private providers operate. These providers are responsible for the quality of their services and their governance systems, with oversight from the Dutch Healthcare Inspectorate (IGZ). The Dutch Health Authority (NZa) plays an important regulatory and supervisory role in health and long-term care markets. The VWS also sets guidelines on assessment and eligibility for AWBZ care. An independent care assessment agency (the CIZ) then translates these guidelines into practical, objective protocols used in needs assessment. WMO services are organised by municipal councils, which have significant freedom. In most cases, service-users deemed eligible for public funding may choose between in-kind and cash benefits. In-kind services are commissioned by regional care offices.

Assessment and Eligibility Processes and criteria: Assessment and eligibility for WMO support is organised at the municipal level, and varies across the country. Assessment and eligibility for AWBZ care is the subject of detailed CIZ guidelines, and follows the 5-stage *Trechtermodel* 'Funnel Model'. Stage 1 is a holistic initial assessment, which focuses on the client's health problems, physical and cognitive limitations, social and home environment, quality of life and service-use. It is also concerned with informal support, and differentiates between the 'usual care' expected from co-habitants, parents, children and partners, and other informal support from outside the household. Step 2 translates the assessment into a 'gross need' for care, defined as the total assessed need, less those needs that can be alleviated through occupational therapy and rehabilitation, less needs that are met by usual care and needs that are met through existing non-AWBZ services. This stage also considers the risk of burnout for informal caregivers. Step 3 takes into consideration any other sources of support that can be used to meet the client's gross needs, including voluntary informal support beyond the expected 'usual care'. The remaining unmet need is defined as the client's 'net need'. Step 4 determines the most appropriate care setting to meet the person's net needs. Finally, Step 5 determines the size of an eligible client's care package. If residential care is preferred, the package is determined with reference to specific care profiles, each of which has an associated maximum funding level. For home care, packages are designed with reference to six functions (personal care, nursing care, guidance, treatment, residence and long-term psychiatric residence). The client's net needs are classified into one of up to nine categories for each function, and each category has an associated tariff.

Assessment and Eligibility Policy: The most pressing policy issue for long-term care in the Netherlands is balancing a history of universalism and generosity (and so high public expectations) with the realities of increasing unit costs and the ageing of the Dutch population. Various reform options are being considered, including further decentralising elements of the AWBZ to municipal authorities. Decentralisation aims to make care more flexible and fit more closely to individual preferences, and to contain costs by funding services through less stringent entitlements.

Box 6: Long-term Care in New Zealand

Administrative Structure: Unitary country

Population Structure: 4.4 million people. 13.0% of NZ's population is aged 65+ and 3.4% is aged 80+, but by 2050 23.3% is projected to be aged 65+ and 9.3% aged 80+.

Funding Long-term Care: Long-term care services and benefits are funded largely through general taxation. NZ spent 1.3% of its GDP in 2008 on publicly funded services related to long-term care. User charges are levied for home-based care from those with income above a threshold. Publicly funded residential care is subject to a means test of assets and incomes but the assets test is being phased out.

Management and Organisation: The Minister of Health develops policy for the health and disability sector and provides leadership. Most of the day-to-day business of the system, and around three quarters of the funding, is administered by the 20 district health boards (DHBs). DHBs plan, manage, provide and purchase health services for the populations. In 2003 responsibility for long-term care was devolved to them through annual block grants. Around 3.6% of NZ's population aged 65+ receive residential care and 11.6% receive home-based care. Different systems apply for older people and younger adults.

Assessment and Eligibility Processes: DHBs fund Needs Assessment Services Coordination agencies (NASCs) which are responsible for needs assessments for their local areas. A health professional conducts the assessment and considers what support the person requires to continue living at home if possible. The assessment determines the level of need the person has – very low, low, medium, high, or very high. The NASC also assesses what support the person's family can provide and what support the family may require to do so. The assessor discusses with the person their abilities, goals and support needs, and develops a care plan to meet them. The service co-ordinator then identifies the most appropriate services and support options to meet the assessed needs based on the care plan. All DHBs have adopted the interRAI Minimum Data Set – Home Care (MDS-HC) assessment tool. It assesses multiple key domains – including activities and instrumental activities of daily living – and has several subscales. The interRAI-HC instrument has been used for all community care assessments since June 2012, and the interRAI-LTCF tool will be mandatory for assessments in all aged residential facilities by July 2015.

Eligibility and Resource Allocation Criteria: To be eligible for publicly funded care the person must have a needs assessment to determine their needs and the level of care required to meet those needs. For residential care, the person must have high or very high needs which are indefinite and must be aged 65+ (or 50+ if unmarried without dependent children). NASCs determine, despite the use of a standard instrument, their local resource allocation criteria and may change their criteria to contain costs.

Assessment and Eligibility Policy: The New Zealand Guidelines Group published in 2003 a set of evidence-based guidelines, which recommended that NZ introduce a standardised assessment process, a national data set and a national assessment tool. The Group commissioned a comparative review of the leading assessment tools available internationally. The interRAI MDS-HC assessment was identified as the tool that would best meet the requirements for a standardised assessment process and a national data set. It was trialled in five areas and evaluated by Auckland University before national introduction.

Table 1: Long-term Care Funding Systems

LTC FUNDING SYSTEMS	ENGLAND	FRANCE	GERMANY	NETHERLANDS	AUSTRALIA	NEW ZEALAND
What is the main programme for residential care?	Supported care, in care home place contracted by the council	Cash payments toward care costs	Social insurance benefits toward care costs	Social insurance benefits	Residential care place	Residential care subsidy for contracted place
What is the main programme for home-based care?	Care package or cash direct payment	Cash payments toward care costs	Social insurance benefits in kind or cash payment	Social insurance benefits	Home and Community Care Programme; CACPs and EACH Packages	Care package
Which agency has main responsibility for funding social care?	Local government	Central and local government	Social insurance for long-term care	Social insurance for long-term care	Federal Government	District Health Boards
Main source(s) of funding for social care	General taxation	General taxation	Payroll social insurance contributions	Payroll social insurance contributions	General taxation	General taxation
Is public support for residential care means-tested	Yes	Yes	No	Yes	Yes	Yes
Is public support for home-based care means-tested	Yes	Yes	No	Yes	No	Yes

Table 2: Assessment and Eligibility Processes and Criteria

ASSESSMENT AND ELIGIBILITY PROCESSES	ENGLAND	FRANCE	GERMANY	NETHERLANDS	AUSTRALIA	NEW ZEALAND
Who conducts assessments?	Local councils	Local councils	National Body	National Body	Aged Care Assessment Teams (ACATs) and providers of HACC services	Needs Assessment Coordination Agencies
Are the assessors independent of funding agency?	No	No	No	Yes (for AWBZ scheme)	Yes	No
Which profession(s) conducts the assessment?	Social worker, sometimes multi-disciplinary	Multi-disciplinary	Mainly nurses for German Medical Board, physicians for Medicproof	?	Multi-disciplinary, usually	Health professional
Is there a nationally mandated assessment instrument?	No	Yes	Yes	Yes	No	Yes
Is there a nationally mandated eligibility or resource allocation algorithm?	No	Yes	Yes	No	No	No
Does the need assessment precede the means test?	Yes (in principle)	Yes	N/A	Yes	Yes	Yes
Does the assessment take account of informal care?	Yes	Yes	No (not directly)	Yes but only 'usual care'	Yes	Yes

Table 3: Responsibilities and Uniformity of Assessment and Eligibility Frameworks

Country	Assessment	Eligibility criteria	Allocations
England	Local authorities are responsible for setting the processes for assessments and conducting assessments	Local authorities are responsible for setting local eligibility criteria within the framework of national guidance	Local authorities are responsible for determining the size of personal budgets: there are no nationally set algorithms or maximum personal budget rates
Australia	Aged Care Assessment Teams (ACATs) are responsible for setting their processes for assessments and conducting assessments	ACATs (and HACC providers for HACC) are responsible for determining locally eligibility for care criteria within the framework of broad national legislation and guidance	ACATs determine the type of package to which the user is eligible; and contracts between Government and providers determine the intensity of the care package. The numbers of packages funded are based on planning guidelines
France	Local teams are responsible for conducting assessments	Eligibility criteria are set nationally based on use of AGGIR	There is a maximum APA allocation for each AGGIR category
Germany	Local branches of the national MDK or Medicproof organisations conduct assessments	Eligibility criteria are set nationally	There is a maximum cash or care package allocation for each needs category
Netherlands	Local branches of national CIZ assess for AWBZ care. Local councils are free to determine procedures for WMO care	Eligibility criteria are set nationally for the AWBZ	Detailed national guidelines and tariffs are used to determine the size of care packages
New Zealand	Assessments are conducted by NASCs attached to District Health Boards	Eligibility criteria are set nationally, based on use of interRAI assessment instruments	NASCs determine care packages when undertaking care management for those assessed as meeting eligibility criteria

Table 4: Models for Reform

Parameter	Model I	Model II	Model III
Assessment and eligibility staff training	Local decision	National guidance	Nationally standardised
Assessment and eligibility staff-mix	Local decision	National guidance	
Assessment and eligibility responsibilities (including for carer services)	Local authority performs assessment tasks	Local authority performs assessment tasks	National (probably independent) organisation performs assessment tasks
Assessment instrument(s)	Local decision within a framework set out in central guidance	Nationally standardised instrument	Nationally standardised objective instrument
Review and appeal processes		Local decision within a framework set out in central guidance	Nationally standardised processes
Eligibility decision process			Nationally standardised numerical algorithm
Resource allocation process			
Eligibility criteria			
Eligibility threshold	Local decision subject to national minimum	Local decision subject to national minimum	Nationally standardised
Resource allocation criteria	Local decision	Local decision	
Most similar to...	England ¹	New Zealand	Germany

¹Subject to the passage of the Care Bill (2013)

Annex A: Assessment Instruments

Germany: Zeittabel

Type of Care	Activity	Time Bracket (Mins)
Personal Care	Whole body wash	20-25
	Upper body wash	8-10
	Lower body wash	12-15
	Hand/face wash	1-2
	Showering	15-20
	Bathing	20-25
	Dental hygiene	5
	Shaving	5-10
	Combing hair	1-3
	Toileting	Urinating, hygiene, cleaning
Defecation, hygiene, cleaning		3-6
Changing diaper after urinating		4
Changing diaper after defecation		7-10
Correcting clothes		2
Nutrition	Breaking down food	2-3
	Feeding	15-20
	Tube feeding, cleaning	15-20
Mobility	Getting up/going to bed	1-2
	Repositioning	2-3
	Getting dressed (whole body)	8-10
	Getting dressed (upper body)	5-6
	Getting dressed (lower body)	5-6
	Getting undressed (whole body)	4-6
	Getting undressed (upper body)	2-3
	Getting undressed (lower body)	2-3

For example, if a client required their carer to wash their entire body (20-25mins), brush their teeth (5 mins), shave (5-10mins) and comb their hair (1-3mins), they would be deemed to require 31-43 minutes of support per day.

France: Assessments using the AGGIR grid

APA applications are filed with the local council (*conseil général*), and the council's socio-medical team visits the applicant to perform a need assessment. Since 1997, this assessment has been based around the *Autonomie Gérontologie Groupes Iso-Ressources* (AGGIR) assessment tool and eligibility algorithm.

The AGGIR aims to be as objective as possible. Results should not vary by region or by assessor; however, several studies have shown that this is not entirely the case (Dupourque, 2012).

The tool collects information relating to ten 'discriminant' variables (coherence, orientation, washing, dressing, eating, hygiene, transfers, indoor movement, outdoor movement and remote communication) and seven 'illustrative' variables (management, cooking, housekeeping, transportation, purchasing, medical treatment and leisure activities). The client's ability to perform each function is graded A-C by answering four questions:

1. Can the person perform the activity spontaneously?
2. Can the person perform the activity entirely?
3. Can the person perform the activity correctly?
4. Can the person perform the activity normally?

If the answer is 'Yes' for all four questions, the client is graded A for the activity – the activity is not a problem. If the answer is 'No' to all four questions, the client is graded C for the activity – the activity cannot be completed. If the answer to some but not all of the questions is No, the client is graded B for the activity. The combination of all seventeen grades is translated into one of six *Groupes Iso-Ressources* (GIR) using a computer-based algorithm (see below). The 2008 version of the form can be accessed online at: <http://www.ibou.fr/aggir/grille.php>

Although to complete the AGGIR assessment the assessor needs only to answer A-C for each item, the subsequent care-planning process requires assessments to be quite detailed; including observation, questioning, demonstrations and consultation with other medical staff and carers where necessary.

Scope of interRAI-HC and interRAI-LTCF

	interRAI-HC	interRAI-LTCF
Background	Name, Gender, Date of birth, Provider information, Marital status, Payment source, Assessment type, Residential status, Living Arrangement	Name, Gender, Date of birth, Provider Information, Marital status, Payment source, Assessment type, Assessment date, Time since last hospital stay, Admission and history
Functional Status	IADL self-performance, ADL self-performance, Mobility, Physical activity, Improvement potential, Recent change in ADL status, Driving	ADL self-performance, Mobility, Physical activity, Improvement potential, Recent change in ADL status
Health Conditions	Falls, Balance, Cardiac or pulmonary, Psychiatric, Neurological, GI status, Sleep problems, Dyspnoea, Fatigue, Pain, Self-reported health, Alcohol and tobacco	Falls, Balance, Cardiac or pulmonary, Psychiatric, Neurological, GI status, Sleep problems, Dyspnoea, Fatigue, Pain, Self-reported health, Alcohol and tobacco
Cognition	Decision-making, Memory/Recall, Orientation, Change in mental status, Change in decision-making	Decision-making, Memory/Recall, Orientation, Change in mental status, Change in decision-making
Communication and Vision	Expression, Comprehension, Hearing, Vision	Expression, Comprehension, Hearing, Vision
Goals	Person's expressed goals of care	Person's expressed goals of care
Mood and Behaviour	Depression, anxiety and mood, Self-reported mood, Behaviour symptoms	Depression, anxiety and mood, Self-reported mood, Behaviour symptoms
Psychological Wellbeing	Relationships, Loneliness, Change in social activities, Time alone during day, Major life stressors	Relationships, Sense of involvement, Major life stressors
Continence	Bladder continence, Urinary collection device, Bowel continence, Pads or briefs	Bladder continence, Urinary collection device, Bowel continence, Pads or briefs
Disease Diagnoses	Musculoskeletal, Neurological, Cardiac or pulmonary, Psychiatric, Infections, Other	Musculoskeletal, Neurological, Cardiac or pulmonary, Psychiatric, Infections, Other
Oral and Nutritional Status	Height and weight, Nutritional issues, Mode of nutritional intake, Dental or Oral	Height and weight, Nutritional issues, Mode of nutritional intake, Parenteral or enteral intake, Dental or Oral
Skin Condition	Pressure ulcers, Ulcers, Skin problems, Skin tears or cuts, Foot problems	Pressure ulcers, Ulcers, Skin problems, Skin tears or cuts, Foot problems
Activity Pursuit		Time involved in activities, Preferences for activities, Time asleep during day
Medications	All medications (dose, unit etc.), Allergies	All medications (dose, unit etc.), Allergies
Treatments and Procedures	Prevention, Treatments received, Formal home care, Hospital use, Physician visits, Restrictive devices	Prevention, Treatments received, Therapy/Nursing services received, Hospital use, physician visits, Physician orders, Restrictive devices
Social Supports	Informal helpers, Informal helper status, Hours of informal care, Strong and supportive relationship with family	
Environmental Assessment	Home environment, Adaptations, Outside environment, Finances	
Responsibility and Directives	Legal guardian	Legal guardian, Advance directives
Discharge	Discharge potential and overall status, Discharge	Discharge potential, Discharged to, Subsequent services



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