

Editorial

Long-Term Care in Five Countries*

As the world ages demographically, the health and health care of our elderly population are increasing social and research concerns. In 1988, in response to these considerations, a unique and challenging project was inaugurated: The International Collaborative Effort on Measuring the Health and Health Care of the Aging – ICE on Aging. Its sponsor was the National Center for Health Statistics, now part of the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

The purpose of ICE on Aging is three-fold: (a) to conduct collaborative international research that will strengthen our understanding of the health of older persons, (b) to improve the measurement and international comparability of health data on aging populations, and (c) to develop and maintain international networks of researchers focussing on the health of older persons.

ICE on Aging was launched in 1988 with an international symposium (National Center for Health Statistics, 1991), in which proposals for comparative research on health and aging were developed. The symposium highlighted the need for research in six areas: (a) cardiovascular and cancer statistics, (b) health promotion and disease prevention, (c) functional disabilities, (d) common chronic disease, (e) vitality, and (f) long-term care (LTC). Following the symposium, six researchers from Australia, Canada, The Netherlands, Norway, and the United States combined their research efforts and their data bases to address one of these issues: the problems facing LTC in an aging world. The baseline for this collaborative project was set at 1985, the last year for which comparable data were then available in all five countries.

There were many similarities among the elderly populations of the five countries. The proportion of elderly people (65 +) in Norway was 16 per cent; in the other four countries the range was 11–13 per cent. Life expectancy at birth was 78 to 80 years for women and 72 to 74 years for men. At age 65, the variability for life expectancy across countries was a year or less: 18.5 years for women and 14.5 for men. In the 85 + group, the cohort at greatest risk for needing LTC, life expectancy was 5.7 years for females and 4.8 for males. In all five countries, the 85 + group comprised 8–10 per cent of the 65 + population and was increasing rapidly (Van Nostrand, Clark, & Romøren, 1993).

A second comparability issue concerned the LTC facilities present in each of the five countries. If the project were to focus on LTC, it was clear that what each of the researchers called *nursing homes* must meet certain standards of equivalency. Thus it was decided that the analysis would focus on the highest levels of nursing home care provided in each country: a minimum of nursing care, assistance with personal care activities, and room and

board (Van Nostrand et al., 1993).

But the analyses presented in this journal issue¹ go far beyond these fundamental similarities into such diverse areas as service delivery and quality of care, psycho-geriatrics, finance, and data collection policies. Even within countries there are many perspectives and great diversity. Examining the situation in the United States, for instance, the emphasis on nursing home care, as analysed by Van Nostrand (1996, this issue) is tempered by the growth and potential of an alternative that has yet to be fully realized in any country: home and community care for the elderly (Clark, 1996, this issue).

It is also instructive to note that all of these countries have witnessed far-ranging changes to their health care systems since 1985, when the baseline data were collected for this project. The two major health policy issues of concern in long-term care policy making are essentially issues of balance. The first challenge is to find a balance between institutional care and home care, as the population ages and family structures change. Balancing decentralization and centralization is the second challenge. As Romøren (1996, this issue) states: "The cost of decentralization is weakening national policies and creating greater geographical differences within each country" (p. 71).

Havens and Bray (1996, this issue) speak to the same challenges and fiscal constraints that have become the driving force in health reform policies across Canada. As a result, administrative consolidation and program integration have been replaced by decentralization of services and funding into smaller regions. The increases that were anticipated in community services have been exceptionally modest, but the reductions in all forms of institutional care have been more dramatic than expected.

In the context of system changes in Australia and the Netherlands, Howe (1996, this issue) and van den Heuvel (1996, this issue) identified similar policies to restrain the growth of nursing homes and other long-term care facilities while expanding the community care sector in both countries. In Australia, the role of hostels was dramatically adjusted in the face of changes in nursing homes and community care. The Netherlands, however, has placed greater emphasis on community care as the alternative of choice. Van Nostrand (1996, this issue), in referring to LTC policy in the United States, has identified a bias toward institutional care. In referring to Clark's (1996, this issue) companion work, however, Van Nostrand also suggests that a major shift in LTC delivery may be occurring, as evidenced by a recent growth in home-health and community-based care.

Finally, van den Heuvel (1996, this issue, p. 57) reminds us that ultimately the "solution depends on the cultural philosophy of the country and its attitude toward the elderly" population. At the same time Romøren (1996, this issue) notes that "In the long run, the legitimacy of the system depends on the impression among the users ... and in the last instance, on the majority of the electorate holding the same view" (p. 71).

Clark (1996, this issue) highlights another important policy and planning

issue, by reminding us that LTC data bases have increased markedly over the past decade. However, as most of the authors discussed, we are still lacking longitudinal data that are needed to ascertain cause and effect and to describe the transitions experienced by older persons in health, functional capacity, longevity, service use, or payment sources. Such data are critical to address change, project future needs, and document outcomes.

This view is repeated in virtually every article in this special issue. For instance, Howe notes that in recent years in Australia, both quantitative and qualitative data bases have been used to measure outcomes of care. She suggests that the data base improvement has been one of their major accomplishments in aged care. The current information systems enable them to review, analyse, refine, and adjust policies and programs. She continues, and we all concur, that the ICE on Aging project provides us with the unique opportunity to exchange information and to gain from the experiences of other countries. Further, addressing the issues of data comparability has laid the foundation for further comparative research.

Additional comparative analyses are proceeding and will form the basis of presentations by the authors at the International Collaborative Effort on Aging international symposium in the autumn of 1996. This special issue of the *Canadian Journal on Aging/La Revue canadienne du vieillissement* provides the ICE on Aging LTC collaborators with the opportunity to share these data and measurement issues with a much larger audience of colleagues. Hopefully, these efforts will lead to expanding the foundation for comparative research to additional jurisdictions, as health care, including long-term care, continues to change and evolve around the world and over time. The United Nations *International Year of Older Persons* in 1999 may well provide the next stimulus for this research expansion, just as the rapid increase in the numbers of the oldest-old into the 21st century provides the stimulus for program and policy development in all forms of long-term care.

Notes

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- 1 Anyone wanting more comprehensive data on the long-term care issues discussed in any of these papers can receive detailed tables by contacting the individual authors.

References

- Clark, R.F. (1996). Home and community-based care: The U.S. example. *Canadian Journal on Aging*, 15(suppl. 1), 91-102.

- Havens, B., & Bray, D. (1996). International comparisons of long-term care: Canada, with specific reference to Manitoba. *Canadian Journal on Aging*, 15(suppl. 1), 31-45.
- Howe, A.L. (1996). International comparisons of long-term care: Australia. *Canadian Journal on Aging*, 15(suppl. 1), 13-30.
- National Center for Health Statistics. (1991). Proceedings of the 1988 international symposium on data on aging. *Vital Health Statistics*, 5(6), 1-265.
- Romøren, T.I. (1996). International comparisons of long-time care: Norway and the Scandinavian solution. *Canadian Journal on Aging*, 15(suppl. 1), 59-72.
- van den Heuvel, W.J.A. (1996). Long-term nursing home care in The Netherlands. *Canadian Journal on Aging*, 15(suppl. 1), 46-58.
- Van Nostrand, J.F., Clark, R.F., & Romøren, T.I. (1993, June). Nursing home care in five nations. *Ageing International*, 20(2), 1-5.
- Van Nostrand, J.F. (1996). The focus of long-term care in the United States: Nursing home care, *Canadian Journal on Aging*, 15(suppl. 1), 73-90.

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