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LONG-TERM CARE IN THE USA: LESSONS FOR NEW ZEALAND?

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http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/spj32/32-long-term-care-in-the-usa-lessons-for-new-zealand-pages17-31.html

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While the United States and New Zealand may not share much in common, the problem of ensuring adequate long-term care for a growing elderly population is one area of overlap. Despite the disparity in per-capita health care spending between the two nations (the U.S. spends considerably more), they face similar challenges: growing numbers of older people requiring long-term care services, a declining long-term care workforce, and funding pressures. Both nations also share a desire to provide high-quality, affordable care to older people, preferably in their homes or communities, rather than in residential settings.

In "Long-Term Care in the USA: Lessons for New Zealand?" (*Social Policy Journal of New Zealand*, Nov. 2007), Mark Booth of the New Zealand Ministry of Health and Vincent Mor of Brown University examined U.S. efforts to improve outcomes for elderly residents in long-term care facilities, and found valuable lessons for New Zealand. Booth, a former Commonwealth Fund Harkness Fellow, together with his colleague explored two initiatives: managed long-term care that helps highly vulnerable elders remain in their own homes; and "cash and counseling," an approach that allows consumers to select the care most appropriate to their own needs. "Initial analysis suggests that satisfaction and outcomes improve under these schemes," the researchers say. "Such initiatives use different incentives to balance the need for high-quality care with affordability at both an individual and societal level."

While the two approaches have been slow to catch on in the U.S.—only about 2 percent of long-term care recipients are in managed care, for example—they offer promising alternatives to the increasingly costly system that all too often delivers care of inferior quality.

For their study, Booth and Mor specifically focused on the Program of All-Inclusive Care for the Elderly (PACE). This community-based program, based in San Francisco, provides a comprehensive package of services to elderly people, allowing most to live in their own homes. PACE providers are paid a capitated rate to provide a range of services—including adult day care, therapy, medical care, social services, and prescription drugs—to take care of patients' complex needs.

"Evaluations of PACE providers have been positive," write the researchers. Although evidence of cost savings is mixed, the program is associated with significant reductions in hospital visits and nursing home stays, higher levels of satisfaction with care, improved health, and lower mortality rates.

The second approach, cash–and-counseling, allows clients to control the funding of their own long-term care services. The care recipient, often with the assistance from a family caregiver, determines the packages of services most appropriate for his or her needs. In addition to greater satisfaction and, sometimes, improved outcomes, this approach also provides an incentive for consumers to seek out less costly options.

Cash-and-counseling started as a Medicaid waiver scheme in three states (Arkansas, New Jersey, and Florida) in the late 1990s. While it has been shown to increase personal care costs, these can be offset by reduced nursing care costs; in Arkansas, such costs decreased by 18 percent. Moreover, evaluations indicate the program greatly improves satisfaction, reduces unmet needs, and increases quality of life.

"The integration models provide an interesting comparison for New Zealand as primary health care changes are further developed," the researchers conclude.