
D International experience

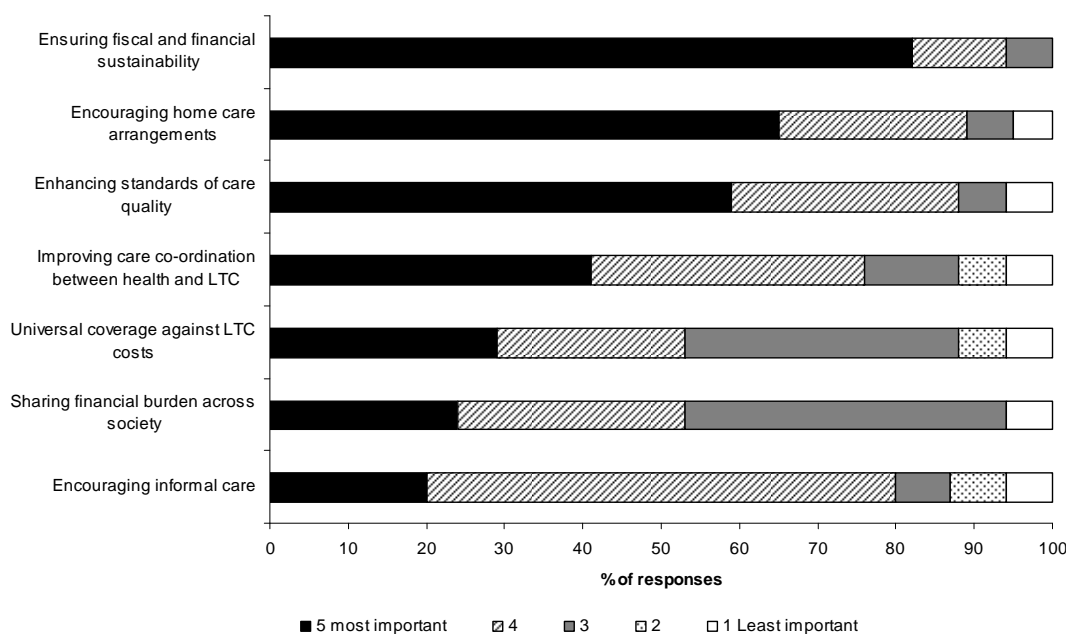
Key points

- Population ageing is a worldwide phenomenon and governments around the world are tackling issues about how to best deliver and fund aged care services.
- Aged care systems, usually referred to as long-term care (LTC) systems, can be classified into three broad categories — universal, mixed and safety-net systems.
 - Each system varies in terms of eligibility, assessment processes, and the care and support services available to eligible recipients.
- Recent reforms to LTC systems have centred around increasing consumer choice, exploring options for securing a workforce of adequate size with appropriate skills and improving the evidence base for developing better policies and programs.
- There are practical limits to simply transferring a potentially attractive aspect of one country's LTC system to another. Even so, knowledge about how other countries are approaching LTC and the issues arising in the process can provide useful insights and help inform policy development.

Australia is not alone in facing the challenges associated with an ageing population. Indeed, population ageing in other countries has prompted many of the same debates as those taking place in Australia including about how to best deliver and fund care for older people. Ensuring the fiscal and financial sustainability of LTC systems, encouraging home care arrangements, enhancing standards of care quality and improving care coordination between health and LTC systems are some of the main policy priorities across countries (figure D.1).

This appendix explores the international experiences of LTC systems, with a focus on member countries of the Organisation for Economic Co-operation and Development (OECD). It is not intended to provide a comprehensive analysis of any one country's system nor an extensive comparison of the various systems, but rather to describe particular aspects of LTC systems that may provide useful insights for policy in Australia. The main differences in LTC systems in areas such as funding, levels of benefits and service provision are set out, as well as recent developments across OECD countries, focusing on consumer directed care, workforce reform and research and evaluation.

Figure D.1 Policy priorities for long-term care systems
2009-2010 OECD questionnaire^a



^a Includes responses from 23 OECD countries. Four countries identified other policies and reforms beyond those listed above, including improving functional needs assessments and international cooperation.

Data source: OECD (2010a).

D.1 Population ageing

Population ageing is a global phenomenon. Declining fertility and mortality rates and increased life expectancy have led to a common trend of ageing populations in OECD and other developed nations, as well as across most developing nations. In 1950, less than 1 per cent of the global population was aged over 80 years. By 2050, this share is expected to be around 4 per cent. And most of the increase is expected for the OECD countries where, by 2050, almost 10 per cent of their populations will be aged 80 years and over (Colombo et al. 2011; OECD 2010c).

The rates at which populations are ageing, however, varies across countries (figure D.2). Compared with many other OECD countries, Australia has a relatively young population and is not experiencing population ageing as quickly as many others. As Colombo et al. noted:

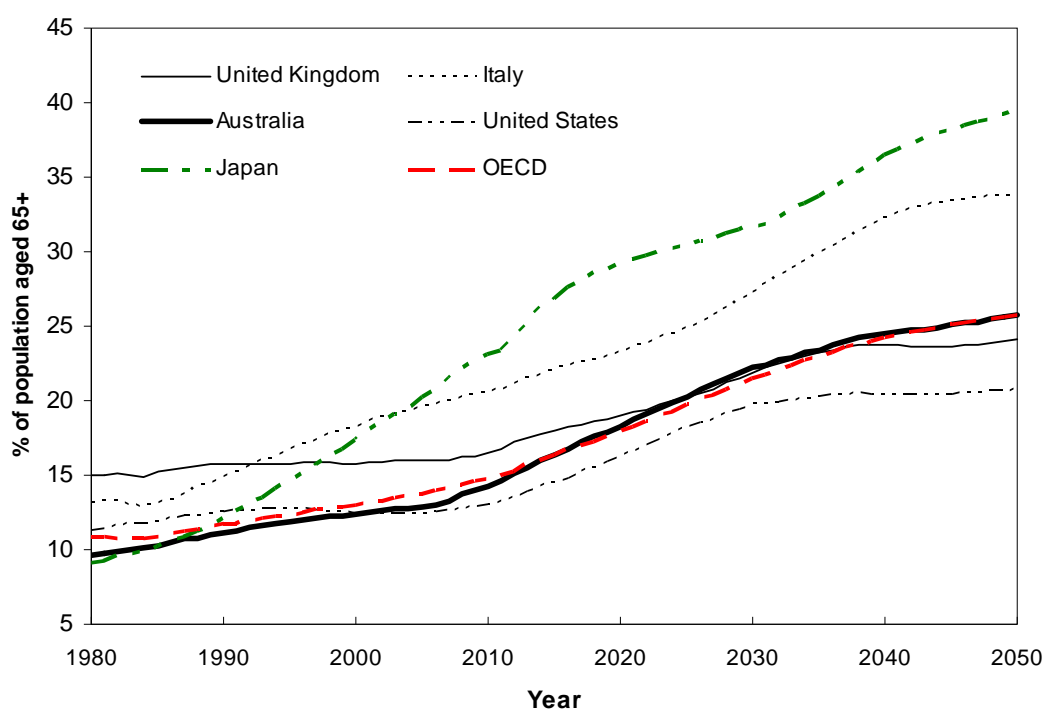
In Japan, but also in Germany, Korea and Italy, the projected shares of those aged 80 years and over will be the highest: around 15%. South Korea stands out as it will experience the largest absolute change in its share of the very old people, increasing from about 2% in 2010 to about 15% in 2050. For some countries the increase will be more gradual and reach relatively lower levels. These include Australia, Iceland,

Ireland, Luxembourg, Norway and Sweden, where the share of the oldest old is expected to increase by less than 5 percentage points between 2010 and 2050, and reach levels under 9%. (2011, p. 62)

Japan has the oldest population in the world with around 23 per cent of its population currently aged 65 years and over. Projections suggest that by 2050 this will increase to almost 40 per cent of the total population. In Europe, Italy has the oldest population and is expected to have more than 33 per cent of its population over the age of 65 by 2050 (OECD 2009a). By comparison, Australia is predicted to have slightly over 25 per cent of its population aged 65 years or above by 2050 (OECD 2009a).

Figure D.2 Ageing populations — selected OECD countries

Percentage of country population aged 65 years and over: 1980–2050



Data source: OECD (2009a).

D.2 Overview: long-term care systems

Aged care systems are usually referred to as LTC systems. And, while the majority of LTC system users across the OECD are older people — around 80 per cent of recipients of home care and around 90 per cent of those in institutional care are aged

65 years and over — LTC systems can also cover people with disabilities and in younger age groups. For example:

- Japan's LTC system covers people aged 65 years and over and 40–64 year olds with disabilities associated with ageing
- the German LTC scheme covers all those with approved needs, regardless of age
- France's LTC system covers residents aged 60 years and over (OECD 2010a).

While broad comparisons are possible, given the differing definitions of LTC systems and extent of coverage caution should be exercised when making comparisons across countries in terms of expenditure, usage and other indicators.

Each country's LTC system is unique and generally is the result of a complex interaction of history, culture, and institutional legacies. However, some common elements are apparent across OECD countries — particularly in terms of coverage and funding arrangements. The OECD has identified three broad categories of LTC systems:

- *Universal*: where the majority of the population is entitled to publicly funded LTC, with little need for private contributions. These include tax-based (such as Denmark, Sweden and Scotland) and insurance model systems (notably Germany, Japan and the Netherlands). With a focus on need, rather than ability to pay, these systems generally enjoy widespread public support.
- *Mixed or progressive*: where there is some degree of universality, but also means-tested and/or income-related LTC benefits. Under such systems, a significant share of the LTC cost can be borne by users. Countries that fall in this category include Austria, France and Australia.
- *Safety net*: where there is minimal state intervention in LTC with public support directed to those that lack the financial resources to pay for services. The United Kingdom (UK) and the United States (US) are included in this category. While effective in limiting public spending, inequities and unmet need in these systems may leave people vulnerable to catastrophic spending on care.¹

Within these broad categories, there are differences across countries in many aspects of individual LTC systems, including expenditure levels, funding arrangements, eligibility and assessment processes, and the available benefits and delivery of care and support services (OECD 2010a).

¹ The UK recently announced a National Care Service which supports universal entitlement and protection from catastrophic costs of care. Commencing in 2014, anyone staying in residential care for more than two years would receive fully subsidised care after the second year.

Expenditure on LTC

The extent of coverage and generosity of a LTC system as well as the availability and reliance on informal care affect a country's total expenditure on LTC and the mix between public and private contributions.

Total expenditure on LTC across OECD countries averages around 1.5 per cent of GDP (figure D.3). Sweden and the Netherlands spend 3.6 and 3.5 per cent of GDP on LTC respectively (the highest among OECD countries). By contrast, Korea — which has only recently implemented a social insurance scheme — spends around 0.3 per cent of GDP on LTC. Australia's total expenditure on LTC (around 1 per cent of GDP) is slightly lower than the OECD average and is on par with spending in the US (Colombo et al. 2011; OECD 2010a).

The mix of public and private expenditure on LTC also varies across OECD countries, but most LTC expenditure is public (figure D.3). While countries with a more targeted means-tested system have a higher proportion of expenditure from private sources (for example, around 40 per cent of expenditure is sourced from private funding in the US), more universal LTC systems rely less on private expenditure (Sweden and the Netherlands). In Australia, private expenditure is estimated to be around one fifth of total LTC expenditure (Colombo et al. 2011; OECD 2010a).

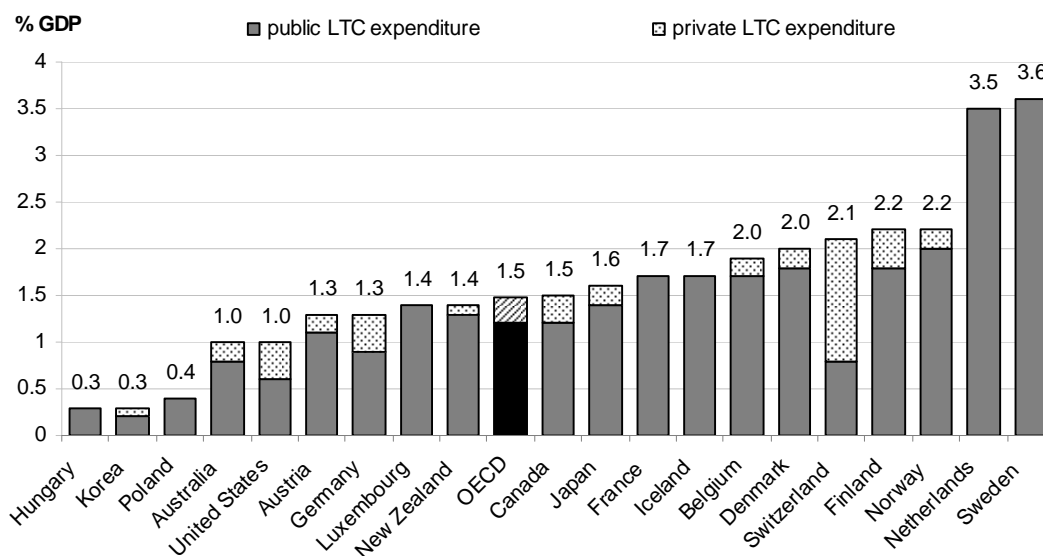
Although there are differences across countries, more than half of public expenditure on LTC in OECD countries is directed towards providing care in an institutional setting. This ranges from more than 80 per cent in Canada to just over 50 per cent in Germany (OECD 2005b). Germany's cash benefit option, which has proven popular and is of a lower monetary value than in-kind benefits, may partly explain the lower reliance on public spending for institutional care in that country (Gibson and Redfoot 2007). For Australia, around 65 per cent of public expenditure on LTC is spent on providing institutional care for older people, which is around the OECD average.

Funding arrangements

As discussed above, the funding arrangements for LTC systems include a combination of public and private funding mechanisms. While a country's LTC system can be characterised on the basis of a predominant source of funding, maintaining a sustainable system has led countries to rely increasingly on a mix of funding sources. Across the OECD, there is also evidence of on-going debate about the preferred and most effective means to fund LTC for the future (Colombo et al. 2011).

Figure D.3 Expenditure on long-term care in selected OECD countries^a

Share of GDP, 2008



^a Data for Austria, Belgium, Canada, Denmark, Hungary, Iceland, Norway, Switzerland and the United States refer to only health-related (nursing) long-term care expenditure. In other cases, expenditure relates to both health-related (nursing) and social long-term care expenditure. Data for Iceland and the US refer to only to nursing long-term care in institutions. Data for the US underestimate expenditure on fully private LTC arrangements. Data for Poland exclude infrastructure expenditure, amounting to 0.25 per cent of GDP (2007). Data for the Netherlands do not reflect user co-payments, estimated at 8 per cent of total LTC-expenditure (2007). Data for Australian and Luxembourg is for 2005 and data for Denmark and Switzerland is for 2007.

Data source: OECD Health Data (2010) in OECD (2010a).

Public funding

The main difference in public funding mechanisms for LTC is whether funding is sourced from general taxation or an hypothecated tax; that is, where the tax revenue collected is earmarked specifically for LTC. In Norway, Sweden and Denmark — three Nordic welfare states known for having relatively high tax rates — universal coverage of LTC services is fully funded from general taxation. The LTC systems of the UK, the US and Australia are also predominantly funded through general taxation. Other developed nations, such as the Netherlands, Germany, and Japan, have established universal social insurance programs with a dedicated revenue source to cover their LTC provision (often complemented by employer contributions).

Private funding

Savings

People can pay for their own LTC services through accumulated savings. While the obvious advantage of this funding option is reduced reliance on public funds, there are several disadvantages or inefficiencies from a system primarily relying on savings, including the tendency for people to save either too much or too little for their cost of care needs in the future (chapter 8).

Singapore has a unique funding system for financing its health and LTC services which includes a significant role for universal and compulsory savings schemes (box D.1). However, savings are not the only financing source for LTC, with complementary insurance schemes and user-payments also in place. Self provision for meeting care costs is the general expectation of citizens (Wong and Verbrugge 2008).

Box D.1 Singapore's compulsory saving schemes

Building on its universal and compulsory savings scheme, the Central Provident Fund (equivalent to Australia's superannuation scheme) was set up in 1950. As a compulsory savings scheme to cover hospital and medical expenses, *Medisave*, was introduced in 1984. These compulsory savings schemes, which mandate every person in the paid workforce to contribute a percentage of their wages to their personal government-managed account, were seen as the means to provide for a person in their retirement — including covering their LTC needs.

Recognising that savings schemes may be insufficient to cover all costs that may arise (particularly for those suffering from prolonged illness), a public insurance scheme, *MediShield*, and a range of private insurance vehicles, and a national endowment fund *Medifund*, for the very poor were introduced in the 1990s.

Two additional schemes with a focus on older people's needs — *ElderCare Fund* and *ElderShield* were introduced in 2000 and 2002 respectively.

- *ElderCare Fund* is a national endowment fund with interest from the fund used to finance operating subsidies to nursing homes run by Voluntary Welfare Organisations.
- *ElderShield* is a public LTC insurance scheme designed to assist those with severe disabilities (inability to perform three or more activities of daily living), and in need of long-term care, to meet their expenses. As of 2009, there were more than 850 000 *ElderShield* policy holders.

Sources: Ashton et al. (2009); Hogan (2004b).

Voluntary private LTC insurance

While voluntary private LTC insurance is a potential source of funding in many countries, the take-up rate is generally low. Even where the take-up of private insurance is encouraged through a range of incentives, it has generally remained a minor source of LTC funding. For example, the US has had the most extensive experience in offering voluntary private LTC insurance and related incentives (box D.2), and yet the take-up rate remains low (Gibson and Redfoot 2007). Around 5 per cent of the population aged 40 years and over in the US hold an LTC insurance policy (Colombo et al. 2011; OECD 2010c).

Box D.2 LTC Insurance Partnership Program

One initiative to improve the take up of private LTC insurance in the US has been the *Long Term Care Insurance Partnership Program*. Under the program, those who purchase LTC insurance have access to Medicaid coverage once their insurance benefits have been exhausted. A particular attraction is that their personal assets do not have to be assessed to receive coverage.

By 2005, there were around 200 000 partnership programs in force in the four states that originally began the program (California, Connecticut, Indiana and New York). The *Deficit Reduction Act of 2005* allows all states to adopt such programs. Concerns about whether the program actually reduces Medicaid spending however (one of the initial objectives) have been raised by some commentators.

Sources: Gleckman (2010); Melnyk (2005).

Similarly, voluntary private LTC insurance offered in European countries has experienced low take-up rates. In France, which has the highest rate of voluntary private insurance in Europe — but no incentives like those offered in the US — only 3 per cent of the population have private voluntary LTC insurance (Fernandez et al. 2009).

Commenting on the take-up of private LTC insurance, Colombo et al. said:

In OECD countries where private LTC insurance is sold, the market is generally small. ... private insurance arrangements play the largest role in the United States and Japan financing about 5 to 7% of total LTC expenditures; but they generally account for less than 2% of total LTC spending. (2011, p. 248)

There are a number of factors contributing to the reluctance to take-up voluntary private LTC insurance, including — affordability of insurance plans, adverse selection problems for providers, and consumer short-sightedness in considering future care needs (chapter 8).

Reverse mortgages

Reverse mortgages, also commonly known as equity release schemes (ERSs), constitute another potential funding source for older people — be it to help fund their costs of care or provide them with general cash flow in retirement (chapter 8).

With relatively high home ownership rates among older people in many countries, ERSs have become more popular in recent years and there are expectations of continued interest into the future (box D.3). For example, in the US there are nearly 25 million homeowners with no mortgage debt — more than 12.5 million of them are aged 65 years or over (Neil and Neil 2009). The tendency for older people around the world to be ‘asset rich and income poor’, has been met with growing support for financial tools which enable access to the home (usually an older person’s largest asset) as a source of funding.

However, while popularity of ERSs has increased in recent years, internationally uptake of such schemes has been relatively small as a funding instrument used by older people. According to the OECD:

... in most countries, [reverse mortgages] are still scarcely used, including because they require a relatively high degree of household financial education. Even in the United States, where the reverse mortgage market has developed rapidly in recent years, it remains very small. (2005a, p. 51)

The lack of information and perceived complexity of ERSs is a significant concern for many potential consumers. With multiple products in the market, each containing varying conditions, older people may not feel confident in finding the most appropriate product for them. Failed providers and schemes in the past have also added to consumer reluctance to use such products (Bishop and Shan 2008).

There may also be a cultural barrier preventing older people from viewing their house as capital that can be accessed. According to Reifner et al. in a survey of the European market:

It appears that elderly people see their home as the most stable and visible pillar for their consumption needs in retirement, which must therefore be completely secure, and hence debt free. If ERS could, however, be structured in such a way as to guarantee this security, so that a decline in house prices will not affect the loan and that there is no risk of repossession, the proportion of households willing to use the equity in their homes may increase. (2009, p. 65)

Box D.3 Prevalence of reverse mortgage markets

The UK:

- is considered to have a well developed reverse mortgage market worth with around 43 000 clients in 2007
- the Safe Home Income Plans body was established to protect reverse mortgage plan scheme holders and promote a code of good practice across industry.

The US:

- around 90 per cent of the reverse mortgage market is made up of one form of loan — Home Equity Conversion Mortgages (HECMs). HECMs were developed in 1989 and are facilitated through approved providers, with the Federal Government (through the Federal Housing Administration (FHA), as a sponsor and backer)
- if the sale proceeds from the home are insufficient to pay the amount owed to the lender, the FHA will pay the shortfall (an insurance premium is collected to provide this coverage)
- growth in the market has been considerable, with originations of reverse mortgages sponsored by FHA growing from less than 10 000 to over 100 000 between 2000 and 2007.

New Zealand:

- as of December 2006, the market had more than 4 500 reverse mortgages worth a total of \$NZ227 million — more than double the value of the previous year
- the average loan size is around \$NZ49 900, with many consumers opting for intermediaries to assist with acquiring loans, and a preference for lump sum — rather than income stream — payments.

Sources: Deloitte (2007); Housing and Urban Development (2010); Oliver Wyman (2008); Reifner et al. (2009).

The impact of reverse mortgage schemes on pensions and income support can be a further concern for older people. This was highlighted in the context of the US market:

The [reverse mortgage] loan proceeds are tax-free. However, it may affect your eligibility for federal or state assistance, including Medicaid, Supplemental Social Security Income (SSI) and medical benefits ... loan advances will be counted as 'liquid assets' if the money is kept in a [cheque] or savings account past the end of the calendar month in which it is received. The borrower could then lose eligibility for such public programs if his or her liquid assets are greater than those allowed by that program. (Neil and Neil 2009, p. 55)

Amid such reservations, some governments and organisations have tried to increase the attractiveness of reverse mortgages through various measures, including:

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- government-sponsored schemes: the high uptake, relative to other provider-types, of HECMs in the US indicates that the added security from the government backing may be attractive to consumers. From a lender's perspective, the government backing may encourage more entrants into the market as there is effectively a safety net to significant shortfalls that may occur.
 - pilot schemes: the Joseph Rowntree Foundation has been working with local authorities, industry and voluntary bodies and has piloted ERSs in three local authorities. The schemes are aimed at overcoming many of the concerns that consumers have (such as lack of information and minimising the impact on entitlement to income support benefits) (Terry and Gibson 2010).

User payments

The role of user payments in funding LTC services through out-of-pocket expenses and co-payments has been approached differently across countries. While safety net LTC systems place a high importance on user payments, more universal systems also see a role for co-contributions. Distinctions between different types of costs — 'hotel' costs, personal costs, care costs etc. — have also been made in order to address the question of 'who should pay' and 'what should they pay for' (box. D.4).

User payments — home care

A number of countries have fixed user co-payments for services provided in the home (including meals on wheels, home maintenance, and nursing care). For example, in Japan, there is a 10 per cent user co-payment for home services in addition to public financing through the LTC insurance scheme. In the Netherlands, the co-payment is per hour of home care, averaging 12 per cent of costs, depending on a recipient's income (Merlis 2004).

While some countries have no stated co-payment for home care, the amount of public subsidy can be designed as an implied copayment on individuals. For example, in Germany, at the level of 'substantial care dependency', the home care allowance is set to cover 33 minutes of home care a day, while the expected need is 90 minutes a day (Merlis 2004). Thus, the shortfall is an implicit co-payment on the user in using home services.

Other aged care systems, such as those in Denmark and Austria, fund home care services sufficiently to meet expected need (thus requiring no user co-payment). In the US, home care services are generally funded out-of-pocket — unless a person is eligible for means-tested Medicaid support (or some skilled nursing home costs under Medicare) (Feder, Komisar and Niefeld 2000; Karlsson et al. 2004; Merlis 2004).

Box D.4 Personal care costs — who should pay?

In recent years, there has been a public debate in the UK about the appropriate funding source for personal care.

One of the key recommendations of the 1999 UK Royal Commission on Long Term Care called for personal care to be made free of charge with nursing care, while the 'hotel' and accommodation costs continue to be means-tested:

The elements of care which relate to living costs and housing should be met from people's income and savings, subject to means testing, as now, while the special costs of what we call 'personal care' should be met by the state.

However, concerns regarding sustainability and the commensurate improvement in quality was raised by some members of the Royal Commission and the government did not adopt the recommendation. Scotland, however, introduced free nursing and personal care for the elderly in April 2002.

In the 2010 UK White Paper on national care and support, the debate has been revived as a 'Comprehensive' funding option for LTC including free personal care was recommended.

Sources: Department of Health (UK) (2009, 2010); Henwood (1999); Royal Commission on Long Term Care (1999).

User payments — institutional care

Generally users contribute a greater proportion to the cost of institutional care than home care, because certain costs associated with institutional care (such as everyday living and accommodation — which includes rent, meals, utilities, housekeeping, etc) are expected to be covered by the care recipient. For example, Germany's LTC system expects users to pay 100 per cent of these costs (and 25 per cent of the total institutional cost). Under Japan's LTC insurance scheme, charges for accommodation, food and other everyday living expenses are borne by the user in addition to the standard 10 per cent co-payment for long-term care (Merlis 2004; Tsutsui and Muramatsu 2007).

The reasoning behind this distinction is that older people are usually responsible for their housing and living expenses in their own home, and thus the type of housing for aged care services (whether it be the user's own home or an institutional facility) should make no difference from a user-pay perspective (Glendinning et al. 2004).

However, safety-net LTC systems in the US and the UK expect all institutional care costs to be borne by the user, unless their income/asset level reach a certain limit. This has led to a tendency for users to 'spend down' their resources in order to

qualify for public funding for institutional care (Gibson and Redfoot 2007; Hirsch 2006; Karlsson et al. 2004).

Eligibility and assessment processes

Consideration of need

The eligibility and assessment criteria in LTC systems are generally based on a person's need for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

A number of countries have established distinct care levels based on the need for assistance, usually according to the number of care hours needed and the nature of care required.

- The Austrian system has seven levels of care based on the number of hours of care a person needs each month. The levels range from Level I — at least 50 hours of care a month — through to Level VII — the highest level of assessed need of 180 or more hours of assistance per month.
- The German LTC system has three levels of care based on the level of assistance a person needs with ADLs and IADLs (box D.5).
- In France, there are four care levels: the lowest level of assessed need is needing assistance with at least three ADLs (therefore being quite strict).
- Japan has five levels of care and two levels of preventative care (Support Level 1 and Support Level 2) for those needing low level support (box D.6).

Other countries have no explicit care bands, with eligibility for benefits determined through assessments and evaluations which may follow a general guide or be more discretionary in nature. For example:

- in the US, Medicaid applicants are assessed against health and functional criteria for the type and amount of service they need
- in Sweden, there is no general assessment guideline with assessment undertaken by the evaluator (general practitioner or local authority). There are, however, commonly used tests for assessing individuals which focus on assessing functional ability. England and Denmark have similar procedures.

Assessments are usually conducted by a team of physicians, nurses or multidisciplinary teams.

Box D.5 Eligibility in Germany's LTC system

Care recipients of Germany's LTC insurance scheme are assessed based on their need for assistance with carrying out routine ADLs and IADLs. There are three levels against which people are assessed as being eligible for LTC benefits:

- *Level I:* person needs help with at least two ADLs at least once a day and one IADL more than once a week over at least a 6 month period (translating to needing at least 1.5 hours a day of care on average).
- *Level II:* person needs help with ADLs at least three times a day at different times of the day and one IADL more than once a week over at least a 6 month period (translating to needing at least 3 hours a day of care on average)
- *Level III:* person needs assistance around the clock (translating to needing at least 5 hours a day of care on average)

Under these assessment criteria, 10.5 per cent of those over 65 years of age were eligible for benefits in 2007. Germany's eligibility and assessment processes are considered relatively strict, with 30 per cent of applicants rejected in 2007.

Sources: Campbell and Ikegami (2010); Gibson and Redfoot (2007).

Box D.6 Assessment of need in Japan's LTC system

Assessment of need in Japan's LTC system is a three-stage process.

1. A person is assessed by their municipality based on a 79-item questionnaire administered by the government — covering a range of functional status areas (joint movement, movement, self care etc).
2. Responses to the questionnaire are processed through a computer algorithm which then allocates the person to the appropriate care level (five care levels and two preventative care levels).
3. Results are then reviewed by a local independent committee of physicians, care managers and academics.

Source: Campbell and Ikegami (2010).

Means testing

In addition to assessment of need, some LTC systems require assessment of an individual's financial means in order to determine access to publicly subsidised benefits. While the LTC systems in the Netherlands, Denmark, Austria and Germany offer universal coverage for those assessed as needing LTC regardless of means, several other countries apply some form of means testing to determine

access to benefits and/or subsidies and the level of user co-payment for LTC services.

- In the US, the primary LTC benefit scheme is through Medicaid and only those meeting the asset and income tests are eligible for benefits.
- In France, access to cash benefits is strictly means tested and depending on income, the level of co-payment for services in a care package can range from 0-90 per cent of the total cost.
- In Japan, insurance premiums levied on workers and retirees are means tested.
- In New Zealand, those who meet the means test are able to access a government care subsidy to cover the costs of institutional care. Recently, the means test has been liberalised amid criticisms of inequity (box D.7).

Box D.7 Changes to means testing in New Zealand

For those assessed as needing care in a residential care facility (in a rest home or hospital), the New Zealand government may provide funding through residential care subsidies depending on a number of criteria, including a means (asset and income) test.

In July 2005, the level of exempt assets in the eligibility criteria for subsidised residential care was increased significantly, particularly for single persons and, to a lesser extent, married couples in need of care. The threshold of the exemption would increase by \$NZ 10 000 each year thereafter. A change to the income test also saw the exclusion of any earned income of the spouse where the partner is in care (aligned with those in 'non-marital' couples).

The change was due largely to criticisms regarding equity, sustainability, and other anomalies found in the previous arrangement. However, the changes have been criticised for not solving the inherent problems, while placing further pressure on the sustainability of New Zealand's LTC system into the future.

Sources: Ashton and St. John (2005); Work and Income (2010).

Benefits and delivery of care and support services

While informal caring in the home by family or friends in OECD countries constitutes the vast majority of help received by older people (in line with Australia's experience), LTC systems provide a range of formal care services in both institutional and home and community settings. Within this structure, benefits from LTC systems take various forms:

- cash only

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- Austria: untied cash benefits (which range from €154.20 per month to €1655.80 per month according to the care level) which a recipient is free to spend in any way — except for residential care where, excluding a personal allowance, the cash benefit is given to a provider.
 - France: cash benefit which must be used to fund an agreed care package.
 - services only
 - Japan: benefits are services (up to a financial limit). The rationale for not offering a cash alternative is to reduce the ‘burden’ on the family, particularly daughters, in providing informal care.
 - mix of cash and services
 - Germany: choice between cash allowance for home care, formal home care services, institutional care, or a combination of cash and formal home care services. The cash allowance is not equivalent to the formal home care amount — around half the value (though it has been very popular, with 72 per cent choosing cash benefits in 2005 because of the preferred option to pay family members and informal carers).
 - US: through Medicaid, some states offer more than formal home or institutional services and also provide the option of cash payments/budgets for care.

In general, there has been a shift in policy emphasis away from institutional care towards home care services, in line with the generally accepted notion that the majority of older people want to remain in their own homes or communities. As such, many LTC systems are becoming increasingly focused on providing care and support services in the home, as well as offering greater consumer choice in, and access to, domiciliary care and support.

Preventative care and healthy ageing services

There has been a growing interest in providing preventative services in LTC systems. Japan seems to be the most developed in this regard, with recent reforms incorporating preventative care and healthy ageing into its LTC benefits scheme (box D.8).

Box D.8 Preventative care levels in Japan

A review of Japan's LTC insurance scheme was conducted in 2005 and, in response to concerns about mounting costs and the fiscal sustainability of the scheme, one of the 2006 reform measures included a re-focus of benefits towards preventative measures.

Before the 2006 reforms, the LTC insurance scheme had five care levels and one support needs level (39 per cent of eligible persons in the scheme fell under the lowest two care categories). Arising from the reforms, the care levels were restructured into five care levels and two preventative care levels (Support Level 1 and Support Level 2). The preventative care levels had lower benefit ceilings and included activities such as strength training and home modifications. This helped to contain costs, as well as meet the broader objective of healthy ageing — keeping older people independent and giving them the ability to support themselves in the community.

The reforms also included the provision of preventative measures to the broader community (including for those not covered under the LTC insurance scheme) such as rehabilitation centres, care management consultants and other support schemes.

Source: Tsutsui and Muramatsu (2007).

Regional disparities in service delivery

A common concern in many OECD countries is the regional disparities and inconsistencies in LTC service delivery. Many OECD countries place considerable responsibility for LTC service provision on local or provincial governments, which has sometimes led to discrepancies in the availability and cost of services for older people. For example:

- in the Netherlands, responsibility for social care services was shifted from the national to local governments in 2006. With local governments having greater autonomy in administering services, concerns were raised about differences — across regions — in access to services, the level of copayments and quality of care for older people
- in Norway, the municipalities are allocated block funding from the central government with LTC services and support available to older people varying from one region to the next
- in Canada, different approaches to funding across provinces have led to disparities in the types of services available to older people. Some commentators maintain that this is one of the most important problems facing the country's LTC system (AARP Public Policy Institute 2006; Chi, Mehta and Howe 2001).

D.3 Consumer-directed care

There has been an international trend towards providing greater individual choice and control to older people receiving care and support services through consumer-directed care (CDC). CDC is defined as:

... a philosophy and orientation to the delivery of home and community-based services whereby informed consumers make choices about the services they receive. (OECD 2005b, p. 51)

In Australia, CDC trials have been undertaken in recent times. Increasingly, CDC is being considered a necessary progression to a higher quality aged care system for older people (chapter 9).

Consumer-directed care can take many forms

In practice, CDC can take various forms and the extent to which it empowers the care recipient varies across countries. CDCs can range from unrestricted cash payments to the care recipient, to more managed programs which, although providing less autonomy, still promote more choice and control for consumers than an agency-directed arrangement. Moreover, examples of CDC can be seen in pilots and demonstrations that are implemented outside of a country's main LTC system which may target certain groups (notably the US' embrace of CDC which is mostly directed to the poor), or be directly implemented in a country's LTC system for wider take-up (for example, universal LTC systems in Germany, Austria and the Netherlands).

Broadly, the funding of CDC has taken three main forms.

- *Cash payments to the person needing care.* Care recipients are given cash payments which they can use for their care and support services — with varying restrictions.
 - Austria: beneficiaries in the LTC system receive cash allowances (according to their assessed level of care need) which have no restrictions on the way the money can be spent — except where the allowance is used to fund residential or institutional care.
 - Germany: cash benefits have been embedded in the LTC insurance benefits options for older people receiving home care since 1995. Beneficiaries have the choice of receiving services up to a predetermined amount or receiving fixed cash payments (or a mix of both) to support themselves at home (be it to purchase services or support informal caring). The cash benefits are

roughly half the value of the service benefit amount, are the predominant form of benefits for home care, and are mostly spent on informal carers.

- England: beneficiaries have the option of cash payments, termed Direct Payments, which allows them to purchase services from a private home care provider or independent workers. While there are variations in the specific Direct Payment system between localities, generally there are restrictions on hiring family members, and care managers and financial monitoring play a significant role in ensuring funds are used appropriately. Attendance Allowances are less restrictive and provide cash benefits to persons over 65 years of age who need care at home for at least 6 months.
- *Personal budgets and consumer directed employment of care assistants.* This gives the beneficiary the ability to purchase care from alternative competing agencies, employ a personal assistant (including family members) or purchase physical aids.
 - The Netherlands: since 1995, home care beneficiaries have been given the choice of having personal budgets (*persoonsgebondenbudget*) where an amount of money is allocated to them which they can use to buy services from independent providers and agencies. There is a role for fiscal agents for high-value budgets and a copayment (reduction in the budget) is usually required. By 2002, about 10 per cent of home care beneficiaries (around 44 000 people) were personal budget holders (Weiner, Tilly and Cueller 2003).
 - The US: CDC initiatives have a long history but generally operate outside the main LTC system. Through a series of pilots and demonstrations of CDC initiatives, CDC has developed in various forms around the country. A notable demonstration of CDC is the ‘Cash & Counseling’ projects (box D.9), but there are also initiatives in different states in which the degree of autonomy extended to consumers varies.
- *Payments to informal carers.* This form of CDC facilitates more choice by supporting informal carers.
 - Australia’s Carer Allowance cash payment is an example of a CDC whereby a non-means tested amount is paid to the person who lives with and cares for somebody in their home.
 - Ireland and the UK’s Carer’s Allowance are cash payments to low-income carers who live with and care for persons needing full-time care.

Box D.9 **A model for consumer directed care: *Cash & Counseling***

Cash & Counseling is one model of consumer directed care in which beneficiaries are given direct funding and cash to employ their own caregivers and purchase care services and support, as well as counselling and fiscal and/or budgetary assistance in order to help them make sound choices. Spending plans must be developed and beneficiaries also have the option to designate a representative, such as a family member, to manage their allowance.

Cash & Counseling reflects a belief that individuals, when given the opportunity to choose the services they will receive and to direct some (or all) of them, will exercise their choice in ways that maximize their quality of life. (Cash & Counseling 2007)

In the US, Cash and Counseling Medicaid demonstration projects were first undertaken in three states — Arkansas, New Jersey and Florida — in 1998 and have since expanded across the country. Recent provisions in the *2005 Deficit Reduction Act* and the *Older Americans Act* have also reduced the barriers for states in implementing more *Cash & Counseling* programs.

According to the OECD, around 1000–2000 people aged 65 years or over participate in these experimental programs in each state.

Sources: Cash & Counseling (2007); Weiner (2007).

Ensuring quality of care

Due to the increased autonomy and control that the consumer has under CDC, processes and safeguards are often deemed necessary to help ensure that decisions are well-informed and that older people are not exploited. Some countries have significant safeguards with elements of case management, while others are less concerned about the potential misuse of funds and rely on the presumed quality of care from informal sources.

Greater consumer control and choice does not necessarily require greater monitoring. In most cases, it seems there is an element of reliance on relatives and informal carers to provide sufficient guidance and support. Some countries which have quality of assurance mechanisms for CDC include:

- the US — CDC programs, including *Cash & Counseling*, have a brokerage arrangement or care manager to assist older people in making informed decisions
- Germany — there is a requirement of having ‘sufficient care’ at home before being able to receive a cash allowance. However, this is rarely scrutinised or enforced according to Weiner, Tilly and Cueller (2003). To ensure that cash benefits are used to improve the wellbeing of an older person and that the money

is used for ‘care’, assessments of an older person’s health status and wellbeing is undertaken every three or six months

- Austria — fiscal agents are allocated to beneficiaries if their personal budgets are of a high value, but in general there are no restrictions on how the cash payments are used. Lundsgaard (2005) posits that Austria’s cash system is the most consumer directed of any OECD country and yet cites recent studies on care quality that found no heightened vulnerability or neglect of older people under CDC compared with agency-directed programs.

Outcomes and popularity of CDC

Evaluations of CDC and their impact on older people have been largely positive and many studies on trials and pilots have indicated that CDC increases the level of independence, choice and control for older people. For example, in the Netherlands, more than half of the participants in a randomised control trial of CDC indicated that they had more choice and control than those under agency-directed care. A random sample of participants in California’s In-Home and Supportive Services Program found that those that directed their own care services reported higher levels of satisfaction, quality care and improved wellbeing compared with those under agency-directed care (Rees and Tilly 2007).

However, there have been reservations about the extent to which older people would take up increased direct control of their care services, particularly compared to younger people with a disability, because some older people are not cognitively able to make complex decisions (such as hiring and employing a carer) (Howe 2002). The additional burden of greater autonomy has been considered a potential barrier to CDC uptake.

Internationally, the uptake rate of CDC is not extensive, although it varies. This likely reflects the nature and restrictions of differing programs rather than an objection to the CDC philosophy itself. While pilots and demonstrations are useful in trialling and evaluating CDC initiatives, they are often quite narrowly directed and have varying eligibility requirements which affect take-up rates.

There is a general consensus that CDC at least provides a desired option for older people in having more choice and control in the care and support services they receive. As Howe stated:

CDC is not a panacea that will solve all the problems across the aged care system ... It is best seen as one option among many when looking to innovations in community care in Australia ... its effectiveness will depend on the design of CDC programs in relation to the purposes to which they are to be applied and the preparedness of governments,

providers and consumers to take on experiments that are powerful enough to achieve more than marginal outcomes. (2002, p. 17)

D.4 Workforce challenges

Many of the workforce challenges facing Australia in aged care are also being experienced internationally. As populations age, the share of dependent elderly will rise and the working age population will decline in many OECD countries. As a result, meeting the increasing demand for formal aged care workers by attracting and retaining caregivers, and adapting to a shrinking supply of informal carers, are common problems faced by many other countries (OECD 2009b).

A range of strategies have been pursued to meet these workforce challenges, mostly involving attempts to either:

- increase the supply of LTC workforce
- reduce the demand for LTC workforce.

Increasing supply: attracting and retaining workers

Some countries have tried to ensure that there is adequate supply of formal and informal caregivers, by pursuing a range of policy options that boost the attractiveness of working in the LTC sector and provide a more supportive environment for carers. Encouraging a more positive image of the sector has the dual aims of retaining those in the workforce and attracting others into the field.

Training

Improving the training of formal caregivers is a widely supported strategy, with many countries developing training programs and clearer career paths for workers in order to attract them to the field, retain them, and at the same time, help ensure quality of care for clients. For example, Denmark, the UK and the US have career advancement paths and structured work and training programs to allow for greater flexibility between LTC jobs (OECD 2009b).

Teaching Nursing Homes (TNHs) are an example of a training initiative employed to boost satisfaction of formal caregivers and improve outcomes for older people. TNHs establish strong links between institutional care homes and universities and have been steadily increasing in numbers over the past few decades (box D.10).

Box D.10 Teaching Nursing Homes

Teaching Nursing Homes (TNHs) are a partnership arrangement between universities and nursing homes which aim to increase the scope for collaborative research, evidence-based practice and ongoing education of nursing staff. By doing so, they seek to:

... bring geriatrics into mainstream medical education and thereby infuse long-term care with intellectual vigor and create an environment for medical research focused on frail residents of nursing homes. (Mezey, Mitty and Burger 2008, p. 9)

They were first established in the US in the early 1980s as a series of demonstration projects funded by the Robert Wood Johnson Foundation. There were mixed results from the program, with cultural gaps between nursing homes and college and high staff turnover identified as problems. However, TNHs were still considered a positive initiative, and in the years following, many have been established elsewhere in the world.

- In Norway, the Norwegian Teaching Nursing Home program was launched in the late 1990s in light of quality of care, workforce competence and satisfaction concerns. As the program was deemed a success and beneficial in encouraging better research, training for staff and outcomes for clients, a series of TNHs have since been permanently established around the country.
- In Australia, there are two main TNHs — one involving Deakin University and Southern Health Nursing Research Centre (Victoria) and the other between the Benevolent Society and the Australian Catholic University.

Sources: Kirkavold (2008); Mezey, Mitty and Burger (2008).

Importing foreign workers

Employing LTC workers from other countries is another strategy some countries have taken to boost the supply of their caregivers.

The nursing shortage is a global shortage. For countries like the US and Britain, the national shortage can be alleviated by recruiting top-quality nurses from low-income and lower middle-income countries around the world. (Walker 2010)

Employment can occur through specific migration programs which allow for foreign-born workers to be employed on a temporary or permanent basis, or through unmanaged immigration schemes whereby a significant number of foreign workers enter and stay illegally for work (OECD 2009b).

- Austria has a large number of immigrant LTC workers compared with other European nations, with supply from neighbouring countries like Slovakia and the Czech Republic. Temporary immigration status is often provided for foreign workers.

-
- Canada both imports and exports health (including LTC) workers. Immigrant workers from the Caribbean enter Canada while many Canadian health workers travel abroad for work (for example, the North American Free Trade Agreement allows those workers entry into the US).
 - Italy has seen increasing demand for caregivers as more women enter the formal labour force. Foreign workers are relatively free in entering and exiting, with many — primarily Romanians and Albanians — providing care services to those in the home.
 - Japan will have a growing demand for more LTC workers as its population rapidly ages, yet it is one of the least open countries to immigration. In a recent poll, 83 per cent of Japanese respondents opposed foreign workers. For the small number of domestic workers who provide services for the disabled and elderly (such as those from the Philippines), wages are relatively low and they have little social protection.
 - For over two decades, the Scandinavian countries have established mutual recognition of each other's nursing qualifications and allowed fairly free migration between countries (AARP International 2005).

There are a range of views on whether recruitment from international sources has a significant or lasting impact on the supply of LTC workers. For example, there is the propensity for foreign workers to move on from the sector as more opportunities arise for them. There are also concerns for the quality of care provided by foreign caregivers, the extent that training needs to be provided for them to provide a suitable standard of care-giving, as well as the possibility of crowding out local workers (OECD 2009b). The notion of a 'zero sum game' for source countries also adds to the hesitation in greater openness. Curren and Berger highlighted this concern in the context of global nursing migration stating that it:

... touches a particularly sensitive nerve when it involves health care workers coming from nations where the sick are routinely denied adequate care. Filipino, Indian and Africa nurses are showing up throughout developed nations, and raising concerns that the source countries are being exploited. (2010, p. 5)

However, they argue that there is a lack of evidence to support this concern and maintain that most immigrants travel back to their own country or send money back as remittances — indicating favourable labour mobility and a 'brain circulation', rather than a 'brain drain', phenomenon.

Carer support

Many OECD countries recognise the important role that informal carers play in the lives of older people, including, in terms of improving their wellbeing and their ability to remain in their home and community. The emphasis on informal caring can also alleviate the need for formal care services (and formal workers) and reduce the burden of public spending on LTC.

As such, and in light of a predicted relative decline in the supply of informal carers in the future, policies have been developed with the aim of supporting carers to continue their role. These policies operate either through easing the conflicts between informal caring and formal employment, or through easing the psychological and physical stress which the role can often entail (Hoffman and Rodrigues 2010; OECD 2009b).

Most OECD countries provide some form of financial support to informal carers, though the eligibility and benefits levels vary. Financial support can be in the form of allowances or payments made directly to the carer (for example, Australia, Canada, Denmark and the UK) or indirectly through the care recipient (for example, France, Germany and the Netherlands). The latter form of carer support is closely related to the empowerment of care recipients and consumer direction.

Given that informal carers often face a trade-off between caring for someone, and being employed in the formal workforce, support schemes to encourage a balance between caring responsibilities and formal employment responsibilities — beyond pure cash payments — have been employed in some countries. For example, in some Nordic countries, income during care leave is guaranteed (80 per cent and 70 per cent of a carer's income in Sweden and the Netherlands, respectively), while employees in Canada and the US have a job guarantee if they need to temporarily leave the labour market to care for family members. However, studies have indicated that some carers still find it difficult to re-enter the workforce after their care responsibilities have finished (Pavalko and Artis 1997; Spiess and Schneider 2003).

There are also a range of non-financial forms of support for informal carers which aim to improve working conditions and reduce the stress and anxiety often encountered by informal carers after a prolonged duration of providing care. These services include counselling and advocacy, training and assistance, and day-care centres. Respite services — available in Australia, the US, and the UK among other OECD countries — also play an important role in providing temporary relief and a break for informal carers. However, the availability of respite care and carer support services is widely viewed as inadequate. The need for improvement in the

information provision on services and a greater appreciation of these services on carers' ability to perform their duties have also been raised (Hoffman and Rodrigues 2010; OECD 2009b).

Reducing demand for LTC workers

Another approach is to seek to reduce the need and demand for LTC workers by encouraging the development of alternative support and care mechanisms for older people.

The use of technology

Greater reliance on information and communications technology (ICT) — such as telehealth, electronic health records, smart homes and phone/video support — can assist in providing care and support for older people and alleviate some of the need for formal or informal workers. The use of ICT in the LTC sector has been recognised as being advantageous in many aspects. According to Rodrigues (2010), the potential benefits include:

- improved coordination between health and social care (e.g. information sharing through electronic health records)
- more patient focus
- enhanced independent living
- improved quality of care — embedded in care practices, quality management, increased transparency
- training and empowerment of carers.

Other studies confirm the importance of these benefits and emphasise the positive effects on older people and their carers (Chambers and Connor 2002; OECD 2009b).

Even so, there has not been widespread deployment of ICT for care delivery in most OECD countries. For example, a recent study of ICT use in the UK, Germany, Italy and Spain (table D.1) provides an overview of the use of ICT in the four countries), found that:

... in spite of a relatively well-developed market supply, very limited deployment of ICT-based solutions to support the person cared for can be observed. The only solution deployed on a large scale is the first generation tele-alarm. (Kluzer, Redecker and Centeno 2010, p. 13)

Table D.1 **ICT deployment in LTC**

Italy, Spain, Germany and UK

	<i>Italy</i>	<i>Spain</i>	<i>Germany</i>	<i>UK</i>
6 Mainstream (wide) 5 Mainstream (local) 4 Pilots (many) 3 Pilots (single) 2 trials/experiments 1 not available				
Social alarms	6	6	6	6
Telecare	4	4	4	5
Telehealth	2	3	3	4
Smart Homes	2	2	2	2
PC, mobile phone, email, GPS	6	6	6	6
Online information	6	6	6	6
Phone helplines	5	6	5	6
Online peer support	1	3	1	5
Online medical advice	4	3	4	6
Online Courses	1	4	1	4
Multilingual websites	1	1	3	4
Multilingual phone support	1	1	1	4

Source: Kluzer, Redecker and Centeno (2010).

The limited uptake of ICT has been attributed to several factors. A major consideration for governments and industry is the cost-effectiveness of adopting ICT. While it may improve quality of care for older people, the take-up of ICT needs to be considered against the costs of establishment, maintaining infrastructure and other funding pressures. Moreover, the level of ICT literacy of users (both older people and carers), the willingness of industry to embrace innovation, and ethical concerns are considered barriers to wider uptake. Generally, there seems to be a reluctance in adopting more ICT — instead using pilots and trials — because of a general lack of evidence about the extent to which ICT ‘works’ for the LTC industry and whether it is a worthwhile investment in the long run (OECD 2009b; Rodrigues 2010).

Healthy ageing and self care

Related to the use of technology is an orientation towards encouraging more self-care and healthy ageing in order to alleviate some of the pressures on future service needs, and hence workforce demands. Examples include home modifications and healthy ageing activities which may assist older people in being more self sufficient and independent. Some reviews and studies have indicated a link between preventative health techniques and reductions in the intensity of future care needs for older people (OECD 2009b). However, the willingness of older people to change their lifestyles and the lack of evidence on the effectiveness of different

healthy ageing programs has meant that preventative health and healthy ageing are still in their early development stage for most OECD countries.

The need for more evidence

Although several strategies have been put in place to deal with LTC workforce issues, a recurring theme for many countries seems to be a lack of rigorous and comprehensive evaluation and evidence on which strategies are most effective. While some consideration has to be given to cross country variations affecting the reception and impact of some strategies, overall the OECD posits that there is an insufficient evidence base on what actually ‘works’:

... further research on the impact of various policies to mitigate LTC workforce needs — what works best and what works less — would help improve the knowledge base and help in designing better coping strategies ... Strategies are still pretty much at the experimental stage in OECD countries, though. The consequences of different approaches are also not well understood — an area that would benefit from further investigation. (2009b, p. 50)

Broader consideration of the indirect consequences also needs to be undertaken when viewing policies and strategies that address the specific issues of LTC workers:

... all the policy options ... have a cost — for the public sector, for individuals and their families, and/or other private providers ... Addressing trade-offs and cost-sustainability remains a major future challenge. (OECD 2009b, p. 50)

There is also a lack of evidence in understanding and evaluating what impact such strategies have on broader aspects of the community. For example, immigration programs may boost the supply of LTC workers, but there will also be a need for physical and social infrastructure to provide these new immigrants with support as they settle into a new environment. Higher wages and better conditions for the formal LTC workforce may help retain and attract workers, but this will have implications for government expenditure as most LTC is heavily reliant on government funding. More carer support may assist the informal workforce, but could also lead to greater detachment from the formal labour market.

D.5 Research and evaluation

In the midst of the global phenomenon of population ageing, many OECD countries have been cognisant of the need to develop a research focus on ageing and age-related areas to meet future challenges. Much like the state of ageing research in

Australia, many countries have a number of different research centres and institutes devoted to ageing.

For example, in the US there are several foundations that fund research into ageing (and LTC more broadly), such as the Robert Wood John Foundation, the Retirement Research Foundation, Atlantic Philanthropies and the Commonwealth Fund. Government agencies such as the National Institute of Aging, the Centers for Medicare and Medicaid services and various university-based centres also carry out and fund research on ageing and evaluations of age-related programs.

Similar to Australia's experience (chapter 16), there seems to be growing concerns in some OECD countries about a lack of focus and inadequate funding for ageing research. In Europe, recent discussions have revolved around the lack of national or regional focus in research and the extent of collaboration between centres.

The UK has recognised the need for more coordinated research efforts in its recent blueprint — *A strategy for collaborative ageing research in the UK* — launched by research councils and health departments. In the foreword to the report, Leszek Borysiewicz recognised that:

... key challenges in ageing – such as reducing morbidity, maintaining independence and wellbeing and providing cost effective care – cannot be solved in research silos but require a pluralistic approach. We must also encourage enterprising world-class researchers who seek to combine their expertise with others to tackle the cross-cutting challenges and exploit the new opportunities associated with an ageing population. (Medical Research Council 2010, p. 2)

The strategy identified areas that the UK research should target, including improving mental wellbeing and physical health in old age, and enhancing mobility and independence of older people. A major recommendation was also to enhance collaboration between researchers:

... we have the potential to make a significant impact by joining forces across disciplines and sectors to bring innovative approaches to tackling complex ageing-related research challenges. (Medical Research Council 2010, p. 13)

In the European Union, there has also been recognition of the lack of sufficient linkages between centres of excellence and research institutes on ageing and the need for a more holistic approach. Launched in September 2009, *FUTURAGE* is a European Commission funded two-year project that aims to produce the definitive Road Map for ageing research in Europe for the next 10–15 years (box D.11).

Box D.11 **FUTURAGE — the European Union**

The FUTURAGE program involves a series of events which bring together a wide range of stakeholders to reach consensus on the emerging and important research priorities in ageing for Europe for the next 10–15 years. FUTURAGE represents a significant collaboration and brings together:

... 23 partners from across Europe to collaborate on the Road Map. Embodying a range of disciplinary and non-academic specialisms, all partners are committed to securing the future of ageing research in Europe. Members of the European Research Area in Ageing (ERA-AGE 2) are the major partners in FUTURAGE.

Relying on extensive consultation with scientists and stakeholders — including those in industry, government, and consumers — the project has four broad areas of focus for research: bio-gerontology; social and economic resources; environments of ageing; and healthy ageing and wellbeing.

The three broad aims of the research are:

- to develop a concerted approach to this highly important research area
- promote a multi-disciplinary perspective on ageing research
- ensure that both the research priorities and research outputs reflect the broader European goal of quality of life of citizens.

A focus on user involvement in research has also been highlighted, with two workshops on user engagement held in Brussels and Barcelona in early and mid 2010.

Source: AGE Platform Europe (2010).

In the US, the level of funding for ageing research has been a recent concern for research groups. In contrast to Europe, where funding for ageing research is purported to be given priority, research in the US has been argued to be constrained by severe underfunding (Wadman 2010). In response to researchers' concerns, Richard Hodes (the National Institute of Aging Director), posted an open letter addressing this:

We at NIA recognize and empathize with the struggle that our constrained funding creates for the research community, and feel that it is vital that we do everything we can to sustain the momentum of investigator-generated research in this successful and vibrant field, as we continue to make a difference in health and well-being in later life. (2010, p. 1)