

## CHAPTER 43

# The Global Florida: Long-Term Care in Postindustrial Countries

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Long-term care is slowly emerging as an important public policy issue in the United States, and more rapidly in other developed countries where populations aged sixty-five and over are projected to double over the next thirty to forty years (Johnson, Toohey and Wiener 2007). The need for long-term care is greatest among those eighty and older, and this age group will increase by three-to-four fold by 2050. These demographic trends are likely to make the growing need for long-term care and its associated costs a major policy issue across the developed world over the next ten years. Several European countries and Japan have already initiated major changes in their long-term care service systems and the methods they use to finance them. We now have enough information on these initiatives to address their implications for the relative cost-effectiveness of different long-term care service delivery and financing strategies.

This chapter is divided into four sections, beginning with a comparative assessment of the divergent approaches to the provision of long-term care services in Florida and Oregon over the last twenty-five years. The second section provides a brief overview of the slow and variable development of community-based long-term care services in other states since the early 1990s. The third section is a description of recent changes in the long-term care programs of selected European countries and Japan (see Stuart and Hansen this volume; Jenike and Traphagan this volume). Most of the changes in the European countries are designed to be consistent with the social welfare traditions of the European model of social democracy, which supports a wide array of publicly funded health and social benefits. Japan's publicly funded social welfare benefits are substantially more limited, but their new long-term care system is essentially as comprehensive as those in many European countries and is largely publicly funded. The final section of the paper discusses the many

policy implications of these long-term care initiatives in the United States and other countries for the future of long-term care reform. What lessons do these experiences with systematic changes in long-term care policy hold for policy-makers looking for more cost-effective alternatives to their current long-term care systems?

### **THE EARLY FLORIDA MODEL AND ITS INFLUENCE ON OREGON**

One of the major reasons for Florida's early initiative in long-term care reform was that the population aged sixty-five and over was growing rapidly as retirees moved to the state, especially since the 1950s. The percentage of the state's population aged sixty-five and over has exceeded all other states for over thirty years, and now stands at about 17 percent, or 5 percent above the national average of 12 percent.

#### **Community and Home Care Programs**

Florida was one of the first states to implement a statewide system of community-based, in-home long-term care services designed as an alternative to nursing home placement. The Community Care for the Elderly (CCE) program was established by the Florida Legislature in 1975 as a general revenue (GR) demonstration project, and then extended statewide at the end of that decade. The CCE program provided a wide range of services to impaired older persons at risk of requiring nursing home care such as personal care, chore services, and respite for caregivers. The Home Care for the Elderly (HCE) program was also implemented statewide by the early 1980s with state GR funding. The HCE program paid a small stipend (\$80 to \$100 monthly) to caregivers of impaired older persons in order to help them maintain their caregiving role. The stipend could be used to purchase whatever the caregiver needed to keep the care recipient at home.

Both programs proved to be very popular with the public and policy-makers who increased funding for them by 25 percent or more annually, as the programs were extended statewide. By 1983, the percentage of state funding (Houser 2007)<sup>1</sup> for long-term care allocated to the two programs had risen to over 20 percent, and the percentage for Medicaid-funded nursing home care had dropped to under 80 percent from over 95 percent in the late 1970s (Wiener 1996). Florida was clearly in the process of creating an extensive home- and community-based long-term care system and reducing its dependency on expensive nursing home care, the least preferred form of long-term care among the elderly.

#### **Oregon's Innovative Long-term Care System**

Florida's pioneering efforts to create a community-based long-term care system was based on the Older Americans Act (1966), which funded local area

agencies on aging and not-for-profit service providers. This caught the eye of Oregon policy-makers and aging advocates in 1979. Richard Ladd, the Director of Senior Services in Oregon, told me in 1986, when I was director of Florida's statewide Committee on Aging,<sup>2</sup> that the Florida CCE and HCE programs were a major inspiration for the 1981 legislative act that established Oregon's framework for the creation of a long-term care system designed to build an extensive array of home- and community-based services (HCBS) and reduce the use of nursing home care. Between 1982 and 1990, Oregon largely achieved the kind of community-based, consumer-oriented long-term care system specified in the extraordinarily prescriptive language of the 1981 legislation. The state aging office essentially gained control of the long-term-care-related Medicaid budget that had previously been used to fund only nursing home care. It accomplished this by convincing Congress to allow the state to use Medicaid dollars, under a waiver provision, to fund adult foster homes and a new in-home services program similar to the Florida CCE program.

By making increasingly expansive use of Medicaid waiver dollars, Oregon was able to add enough home- and community-based program slots, including an assisted living program, to stop growth in the nursing home population by 1988, even though the sixty-five and older population continued to grow by 2 to 3 percent annually. Medicaid funds were used to build a case-management and service-delivery system, based on a network of area agencies on aging and local providers. This system steadily reduced the state's reliance on nursing home care by expanding less expensive in-home and community-residential programs. At the same time, the percentage of publicly supported long-term care consumers served in the community grew from less than 10 percent in 1982 to over 70 percent in 2006. During this period, Oregon also increased the percentage of funding for all long-term care going to community programs to over 70 percent, from a starting point of just 20 percent (CMS 2007). This dramatic shift in the focus of long-term care resources allowed the state to meet the long-term care needs of many more low- and moderate-income elderly than if the state had continued the nursing home-dominated policy of the pre-1982 period (Wiener 1996).

Florida also expanded its home- and community-based long-term care system over the last twenty-five years, but at a much slower rate than either Oregon and a handful of other states. In fact, Florida now spends about as much on Medicaid-funded nursing home care (85 percent), in terms of the percentage of total public long-term care funding, as it did in 1990, and more than it did in 1983 (80 percent) when the CCE and HCE programs were beginning to become statewide alternatives to nursing homes. Florida's largest Medicaid-funded (\$217 million) HCBS program is a managed long-term care program largely operated by proprietary HMOs (Mitchell, Salmon, Polivka and Soberon-Ferrer 2006). The state is spending a great deal of money on long-term care, but it has failed to achieve the kind of HCBS-oriented long-term care system that seemed within reach over twenty years ago and that Oregon and a few other states, following Florida's early lead, have achieved since then.

## **LONG-TERM CARE IN THE UNITED STATES**

Over the last twenty years, long-term care policy and practice in most states have developed in a fashion more similar to the Florida experience than to the transformational changes that occurred in Oregon. Policy-makers, advocates, researchers, and the media have intermittently expressed concern about the need to create a more balanced long-term care system with many more HCBS options before the baby boomers, in large numbers, begin to require long-term care. Those individuals needing long-term care services are projected to increase from 3.4 million in 2000 to about 8 million in 2030 (Johnson et al. 2007). The intermittent, rather than sustained, nature of this attention to deficiencies in our long-term care system is one of the reasons for the slow growth in HCBS programs and the failure in most states to create balanced long-term care systems.

As of 2004, only seven states, including Oregon, were spending 50 percent or more of their Medicaid dollars on HCBS programs, and in fourteen states the figure was 40 percent or higher (Kaiser Commission on Medicaid and the Uninsured 2007). The seven states spending 50 percent on HCBS have adopted major features (e.g., consolidated administrative and budget availability for all long-term care services) of the Oregon long-term care system in the late 1980s. Yet, the current national average for most other states in terms of how they have allocated long-term care resources, standing at about 20 to 25 percent for HCBS programs for the aged, is closer to Florida than Oregon. Medicaid funding for HCBS programs has indeed grown considerably since 1990. Yet, Florida and the many other states that spend under 25 percent of these funds on HCBS programs have much ground to make up in approaching what has been achieved by Oregon for the elderly in its balanced long-term care system and in most state systems for the developmentally disabled.

Even with the declining impairment rates among the elderly and an overall improvement in health care status, the need for long-term care is projected to increase by 75 to 100 percent over the next thirty years, which will put a great deal of pressure on Medicaid budgets in many states (Johnson et al. 2007). Nationally, 20 to 30 percent of the Medicaid budget is already spent on long-term care services. Creating more balanced long-term care systems by expanding HCBS programs and containing the use of nursing home care is critical to meeting the growth in the need for long-term care services over the next two decades.

## **LONG-TERM CARE IN EUROPE AND JAPAN**

If the projected increase in the older population and associated long-term care costs is a major motive for long-term care reform in the United States, it is an even more urgent public policy issue in most European countries and Japan. Today, persons sixty-five years and older comprise 16 percent of the population of the European Union and 20 percent in Japan, but will explode by

2050 to 30 and 35 percent, respectively, in these two places (Kinsella this volume). Over the next several decades, the very elderly, those eighty and older, in several Western European countries, will triple from about 1.5 to over 9 percent of the population. Japan will experience an even more rapid aging surge as its oldest old increase from 3.8 to 14 percent of its population. All of these countries will experience substantially greater growth in the percentage of their populations sixty-five and older and eighty and older than the United States for the next several decades. Only 20.4 percent of the U.S. population will be sixty-five and older in 2040, compared to 28 percent or more in several European countries and Japan (OECD 2005).<sup>3</sup> This demographic trend toward rapid population growth in most European countries is a major reason for the very substantial increases in public long-term care spending that are projected for these countries over the next forty years. The four Nordic countries now spend 2.6 percent (Denmark) to 3.3 percent (Sweden) of their GDP on long-term care. The other Western European countries are spending between 0.6 percent (Italy) and 1.7 percent (Netherlands), while Japan is at 0.9 percent, the same level as the United States. Spending on long-term care as a percentage of GDP is projected to increase by between one and two GDP percentage points across these countries by 2050, including the United States, with a projected increase of 1.4 percent. These projected increases in long-term care spending appear to be sustainable, but the combination of costs associated with population aging, especially public pensions, has caused policy-makers to consider cost-containment opportunities across the board, including long-term care (OECD 2006).<sup>4</sup>

Arguably, however, an even more important reason that several European countries and Japan have undertaken major long-term care reform since the early 1990s is the perception among policy-makers that the public wants substantial improvements in the quality of long-term care services and is willing to pay for improved quality on a sustained basis. These improvements include the provision of greater choice and flexibility in long-term care options by adding in-home and community-based services. The Nordic countries of Sweden, Finland, Norway, and Denmark have provided a relatively generous array of long-term care services, from institutional to many in-home services, since the 1970s, when their elder population began to grow at accelerating rates. These countries also had the fiscal capacity to support the development of expansive public long-term care systems with taxation rates ranging from 40 to 60 percent of GDP and strong economic growth since World War II. Each of the Nordic countries spends a good amount on both institutional and formal in-home services, with 5 to 11 percent of those past age sixty-five receiving institutional care, and 8 to 25 percent receiving in-home services (Gibson, Gregory and Pandya 2003).<sup>5</sup>

All postindustrial countries, including the Nordic nations, have increasingly emphasized the expansion of in-home services and the containment of institutional care. Several European countries—Germany, Austria, and the Netherlands—are using consumer-directed home care (CDC) programs as their principal means of expanding home- and community-based service alternatives

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to institutional care. These programs are based on the payment of cash benefits for home care, often in the form of payments to caregivers.

Japan does not yet have a consumer-directed care program, but it has rapidly increased public funding from multiple sources (national and subnational taxes and individual premium cost sharing) for HCBS programs, primarily formal in-home services like personal care and home nursing services. Japan initiated development of its public long-term care system in the early 1990s, as its older population began to increase rapidly, and has modified its policy on several occasions since the late 1990s (Jenike and Traphagan this volume). Most of these modifications have involved benefit levels and funding strategies as costs exceeded original projections. These funding shortfalls have been addressed primarily by modest reductions in benefits and increases in individual fees (Gleckman 2007). Even with its new system of relatively comprehensive long-term care services and a projected growth rate in its elder population that is second only to Korea's over the next forty years, Japan's public long-term care costs are projected to increase by only 1.8 percent of GDP by 2050 (Gibson, Gregory and Pandya 2003).

The expansion of HCBS programs in most countries, especially in Europe, has contributed to a steady decline in rates of institutionalization since the 1980s. Denmark, for example, reduced the percentage of nursing home residents older than age sixty-five from 20 percent in 1982 to 9 percent in 2001. This was accomplished by freezing nursing home construction and using the savings to expand HCB services to 25 percent of all older persons, while reducing public long-term care spending (Gibson, Gregory and Pandya 2003). Such a shift in the use of long-term care resources from institutional to HCBS programs permitted Denmark, like Oregon in the United States, to meet a greater share of the need for long-term care services without increasing overall expenditures or significantly requiring family involvement in caregiving. The nature of family and home-based care may change as the need for formal care increases, as it seems to have occurred in Denmark. Stuart and Hansen (2006) found that contact between elderly parents and their children occurs as frequently in Denmark as in other European countries with greater long-term care obligations on the family. The contact, however, is more likely to occur within the social and emotional dimensions of care than physical caregiving, which is increasingly provided through public programs.

Consumer-directed programs, however, are designed to pay caregivers, most often family members, for the provision of care, including physical care. Austria and Germany have the most extensive consumer-directed care (CDC) programs among the postindustrial countries, although the Netherlands, Australia, Italy, Britain, and France also have substantial CDC programs, which are likely to be expanded in response to popular support and program cost-effectiveness. These are universal eligibility programs without income or asset tests and no limits on how the benefit may be used. Neither the cash payments in Austria, nor the cash payment or in-kind benefit in Germany are intended to meet the full cost of care; beneficiaries are expected to cover about half of the total cost

**Table 43.1**  
**Sources of Financing for Universal Long-term Care Programs in Four Nations, 2000**

	Austria	Germany	Netherlands	Japan
Premium or special payment	No	Yes	Yes	Yes
General (income taxation)	Yes (100%)	Yes	No	Yes (50%)
Cost-sharing	Yes, for institutional care	Yes, for all institutional care	Yes, for all services	Yes, for all services
Premium amount (payroll tax)	Not relevant	1.7% of wages, shared equally by employees and employers, subject to a wage ceiling of \$4,117 per month; retirees share cost with pension fund	10.25% of taxable income up to a wage threshold; with no employer contribution	0.9% of wages, shared equally between workers ages 40–64 and employers. Income-related premium for persons 65+, averages \$30 per month; deducted from pension

Sources: J. Brodsky, J. Habib, I. Mizrahi, *Long-term Care Laws in Five Developed Nations: A Review*. World Health Organization, 2000, p. 13; Wiener 2001.

of care at the upper end through out-of-pocket expenditures or the means-tested public assistance program. Austria funds its program from general taxes, while Germany uses a social insurance strategy based on a payroll tax. Both programs have broad political support, even though expenditures began to exceed revenues in Germany by about 3 percent in 2005 (Gleckman 2007).

With the steady growth of its CDC program, Germany now devotes over half of its public long-term care expenditures on the elderly to noninstitutional care, compared to about 20 to 25 percent in the United States. The popularity of these programs and smaller versions of them in several other countries, the declining availability and increasing costs of formal caregivers, and their apparent capacity, if properly targeted to reduce the use of institutional care, point to the possibility that consumer-directed care will become the major source of publicly supported long-term care over the next several years—in most developed countries. Developing countries may also begin to move in this direction as their older population begins to grow over the next twenty years and in the absence of an infrastructure for formal long-term care, which they are not likely to have the resources to build.

### COMPARATIVE TRENDS IN LONG-TERM CARE

Perhaps the most pressing and contentious long-term care issues confronting postindustrial countries with their large and growing populations of older people are: (1) how to finance the comprehensive, HCBS-oriented long-term care system virtually all of them are developing or plan to develop over the next twenty years; and (2) whether or not to make eligibility for the program universal or means tested and targeted to the low-income elderly with few assets. As noted in Table 43.1, several European countries and Japan have universal long-term care programs that base eligibility on the assessed need for services with no regard for income and assets. On the other hand, most English-speaking countries use income and asset levels (means test) to determine eligibility for HCBS programs (Gibson 2006). The United States also uses a means test to determine eligibility for nursing home care in the Medicaid program. The United States relies far more on private (out of pocket or private insurance) sources to pay for long-term care as well as acute care services. Unlike almost all other postindustrial nations, the United States does not provide universal, medically related home care without beneficiary cost-sharing. Most other such nations also provide nonmedical home care on a universal basis as well, though with varying levels of beneficiary cost-sharing.

A recent summary of a 2003 World Health Organization report on social health insurance in European countries noted that:

support for providing services to the broader population, rather than just to the poor, has several rationales, including the desire to provide protection through social insurance, viewing long-term care as a “normal life” risk. This rationale is reinforced by difficulties in developing private long-term care insurance, as well as the risk that broad

segments of the population may become impoverished by paying for long-term care services, and hence burden public programs. Another rationale is the desire to substitute long-term care services for more costly acute care (particularly hospitalization), as was the case in Japan. Finally, movement toward universal programs may also reflect a desire to reduce stress on families, with a related interest in preserving family care by providing assistance to help sustain caregiving. (Gibson, Gregory and Pandya 2003:14)

In the absence of a universal public long-term care program, a significantly greater share of the total spending on long-term care in the United States than in other developed countries comes from private sources as shown in Table 43.2. As a share of total long-term care spending, private sources contribute 42 percent in the United States, which is four times higher than in Japan, twice the level in Australia and Canada, and higher than all other postindustrial countries except New Zealand. This discrepancy reflects the fact that families in the United States are expected to provide and pay for a substantially greater share of long-term care than in other postindustrial countries where long-term care policies are better designed to support families and sustain caregiving.

Most postindustrial countries have made significant changes in their long-term care systems over the last two decades by steadily increasing the availability of home- and community-based services and reducing the use of nursing

**Table 43.2**  
**Public and Private Long-term Care Spending, 1995 and 2000 (as Percent of GDP)**

% GDP US\$, PPP*	Total Long-term Care Expenditures		Public Long-term Care Expenditures		Private Long-term Care Expenditures	
	1995	2000	1995	2000	1995	2000
Australia	0.63%	0.80%	0.49%	0.62%	0.14%	0.18%
Canada	1.04%	1.29%	0.78%	1.03%	0.26%	0.26%
Denmark	2.02%	2.12%	NA	NA	NA	NA
France	0.31%	0.35%	0.31%	0.35%		
Germany	1.09%	1.23%	NA	NA	NA	NA
Japan	0.26%	0.69%	0.22%	0.62%	0.03%	0.07%
Netherlands		2.88%	NA			NA
United States	1.43%	1.29%	0.87%	0.74%	0.56%	0.54%

NA = Not available; data for these countries are derived from the OECD provider classification for Nursing and Residential Care Facilities (HP.2). Public and private spending are not reported in this classification; however, long-term care in these countries is funded primarily by public sources. Australian data for 2000 are from the Australian Department of Health and Ageing.

\*PPP = Purchasing Power Parity

Source: Analysis by AARP Public Policy Institute. Gibson, Gregory, and Pandya (2003). "Long-term Care in Developed Nations: A Brief Overview."

home care. Many of these countries have also undertaken initiatives to improve the quality of care and life in their institutional programs, mainly through increased staffing, improved employee pay and benefits, and regulatory changes designed to achieve a more home-like and resident-oriented living environment. In the United States, these changes have been pushed with growing success by the “culture change” movement that has been inspired by the Eden Alternative and Greenhouse initiatives led by Dr. Bill Thomas, and the assisted living philosophy with its emphasis on resident rights related to autonomy, dignity, and privacy (see Kane 2007; Thomas this volume; McLean this volume).

These common programmatic trends, however, stand in rather sharp contrast to the differences between the United States and most other postindustrial nations in the way long-term care services are financed and the extent of individual responsibility for covering the cost of long-term care services.

Over the last two decades, several European countries and Japan have created universal long-term care programs funded by a range of social insurance strategies, mainly from payroll taxes or from general revenues. This trend is likely to continue across most of postindustrial Europe for two major reasons. First, universal long-term care coverage reflects the value that most of these nations have placed on the concept of solidarity among their citizens (a sense of mutual responsibility), social cohesion, and intergenerational reciprocity. Second, universal coverage programs appear to be fiscally sustainable over the next thirty to forty years with some, mainly Scandinavian countries, experiencing very small increases in already high percentages of GDP spent on long-term care (2.5 to 3 percent), and others with relatively modest projected increases of 1 to 2 percent (Gibson, Gregory and Pandya 2003). Long-term care costs in Japan, however, may not be sustainable without significant changes in current policy, which has proven to be more expensive than originally estimated as more people than were expected have qualified for services (Gleckman 2007). Sustainable does not mean unchallenging, and many countries will likely have to make a series of mid-course adjustments in response to economic changes and political developments, including the increased targeting of benefits, more beneficiary cost-sharing, and an expanded role for competition and private, for-profit involvement in service delivery.

Recent efforts to reduce future Medicaid expenditures and the conservative campaign to increase the role of private insurance in paying for long-term care indicate that the United States is not likely to join the emerging trend toward universal public long-term care any time soon. The United States’ outlier status in terms of long-term care and health care policy more generally could change with the aging of the population and shift in the political tide; but for the near future, it would appear that the long-term care policy gap between the United States and the rest of the postindustrial world is likely to widen. Several proposals have been made by policy-makers, health policy analysts, and advocates over the last several years to create a universal long-term care program, including recommendations to add long-term care, or at least an HCBS program as a benefit under the Medicare program, which is a universal health care program

for citizens sixty-five years of age or older—the only U.S. universal health care program. The failed Clinton health care reform proposal of 1994 included a very substantial long-term care program that would have greatly expanded the availability of home- and community-based services (Wiener et al. 2001).

More recently, however, the conservative opposition to universal health care, or virtually any form of publicly supported health care, has sought to pass federal legislation designed to privatize the Medicare program. The Medicare Modernization Act of 2003 includes several privatization-oriented provisions, including a new drug benefit, which, unlike any other Medicare benefit, is administered by private insurance companies. The law contains a prohibition against the federal government bargaining with drug companies to reduce drug prices, which are far higher in the United States than in any other country. The Act also includes subsidies for managed care companies to offer more benefits and potentially lower out-of-pocket costs to beneficiaries in the Medicare Advantage program in an effort to reduce the number of beneficiaries in the traditional Medicare program (Polivka 2007). Although managed care programs are 12 percent more expensive than the traditional fee-for-service Medicare, conservative supporters of privatization consider it worth the cost if it leads to a collapse of the traditional Medicare program and its absorption into the corporate health care sector, which already constitutes the largest single sector in the U.S. economy.

Conservative efforts to privatize the Medicare program, or to prevent expanding eligibility for long-term care services in the Medicaid program, are part of a larger ideological initiative. This initiative is designed to diminish the public sector and privatize as many traditional government functions as possible at the federal, state, and local levels by contracting out these functions to private, usually proprietary firms, including many very large corporations like General Electric, which in 2006 bought out a nursing home chain with 186 facilities for 1.5 billion dollars.

The rationale for sweeping privatization is based on conservative economic theory, which is now often referred to as neoliberalism and the notion that market competition is the most efficient method of allocating goods, including those like health, education, and social services that are often thought of as “public” goods (Harvey 2006). Contracts, however, are often awarded in the absence of any true competition and little follow-up accountability. There is very little evidence supporting the superior efficiency and cost-effectiveness of privatization compared to government-operated programs. For example, the Medicare Managed Care program, which is dominated by proprietary HMOs, has never demonstrated greater efficiency or better clinical outcomes than the traditional Medicare program (Geyman 2006). As noted earlier, the current Medicare Advantage program *actually costs more* than the traditional program.

## CONCLUSION

The neoliberal privatization campaign in the United States has made substantial progress over the last twenty-five years. This has widened the

ideological and public policy gulf between the United States and most other postindustrial countries, especially in Europe, where mixed economies and strong social welfare policies still prevail in most countries. This difference is clearly evident in the area of long-term care policy as many European countries move toward adding universal, publicly funded programs featuring home- and community-based services to their already relatively expansive public health care systems—more expansive, but less expensive than the U.S. health care system (Tsolova and Mortensen 2006). In the United States, on the other hand, conservative supporters of privatization have tried to undermine the expansion of long-term care coverage in the Medicaid program through budget cuts and more restrictive eligibility criteria, and to weaken the Medicare program by expanding the role of for-profit HMOs, even in the face of growing evidence that many future retirees will not be able to afford health care, including long-term care, on their own (Geyman 2006). This larger political context and the fundamental conflict in political values between neoliberalism and social democracy are more likely to shape the future of long-term care policy and health care policy broadly across the postindustrial world than the combined forces of demographic changes and economic globalization (see Fry this volume).

European countries are not immune from neoliberal influences on social and health policy, including long-term care policy. The limited “marketization” of long-term care services has already emerged in several countries over the past ten years, although under the relatively tight regulatory control of the public sector. Marketization strategies have not led to much of an increase in provider competition, which is the principal rationale for these strategies, nor a significant reduction in the rate of increased public spending for long-term care services. These strategies have, however, changed the nature of the relationship between the state and provider organizations in a few countries, especially Britain and, to a lesser extent, Germany, where state agencies have introduced “contracting out” procedures like competitive bidding and a greater focus on measurable outcomes and cost-effectiveness. These procedures have created a more formal, less trust-based relationship between the public and private sectors, and limited the amount of autonomy and independent advocacy that non-profit provider organizations have historically practiced as they have increasingly become extensions of the state (Ascoli and Ranci 2002).

The evolution of marketization procedures could lead to a slow reversal of these power relationships and the emergence of a long-term care system dominated by for-profit organizations with growing influence over the policy-making process. This has occurred with the turning towards for-profit HMOs in the U.S. Medicare Advantage program and the Medicaid Long-Term Care program, which are dominated by for-profit nursing homes in most states. Powerful private equity firms like the Carlyle and Blackstone groups are now beginning to invest in the nursing home industry and create complex ownership structures designed to frustrate regulatory efforts to ensure an adequate quality of care for nursing home residents, especially sufficient staffing levels (Duhigg

2007). The marketization (privatization) of long-term care in Europe along the lines characteristic of the U.S. model would almost certainly make long-term care more expensive and gradually less available to those dependent on publicly supported services.

## NOTES

1. Public funding for long-term care includes state general revenue and federal dollars, mainly in the Medicaid program, which the federal government funds about 55 percent of on a national basis. About 35 percent of all long-term care costs are paid privately (Houser 2007).

2. The Committee on Aging was established by Governor Bob Graham to develop a comprehensive plan to shift the focus of Florida's long-term care system from nursing home care to home- and community-based care over a ten-year period.

3. This study reports on the latest trends in long-term care policies in nineteen OECD countries—trends in expenditures, financing, and number of care recipients are analyzed based on new data on cross-country differences (OECD 2005).

4. The total health and long-term care spending is projected to increase on average across OECD countries in the range of 3.5 to 6 percentage points of GDP for the period 2005–2050 (OECD 2006).

5. As their populations age, all developed nations are tackling issues of access, cost, and quality of long-term care services; the United States ranks twenty-ninth among the world's "oldest" countries (Gibson, Gregory, and Pandya 2003).