

Commentary: Cash and Counseling in an International Context

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Health and long-term care policy in the United States is almost always carried out without knowledge of how other countries address similar problems. American public policy is the poorer for this ethnocentrism because other countries often have already implemented ideas which have only been proposed in the United States. To be sure, the cross-national differences in culture and the financing and organization of services do not allow for a simple transfer from one country to another, but the experiences of other countries can provide important insights.

While the Cash and Counseling demonstration was being developed and researched in the United States, similar approaches to consumer-directed long-term care were being implemented, generally in more radical forms, in other countries, including Austria, England, France, Germany, and the Netherlands (Tilly, Wiener, and Cuellar 2000; Wiener, Tilly, and Cuellar 2003; Lundsgaard 2005). The goal of this commentary is to put the American Cash and Counseling demonstration in context with similar initiatives in other countries, particularly the Netherlands, England, and Germany.

OVERVIEW OF PROGRAMS IN OTHER COUNTRIES

Consumer-directed home care is used in a number of American states as well as other countries (Tilly, Wiener, and Cuellar 2000; Tilly and Wiener, 2001; Infield 2005). While they all rely on consumers to hire their own workers, there is a great deal of variation across states and countries in how the programs are designed, especially in how the financial aspect of the program is implemented.

The Netherlands

Long-term care is primarily provided through a social insurance program in the Netherlands. Long-term care consumers have the choice of receiving

services from an agency or consumer-directed home care, using “personal budgets” (*persoonsgebondenbudget*).¹ This option has been available in the Netherlands since 1995. Under personal budgets, consumers are allocated an amount of money—a budget—that they can use to buy services from independent providers or agencies. The roles of the fiscal agents are complex and have varied over the years. There is often a copayment required, which consumers treat as a reduction in their budget.

Until recently, the national government allocated only a small level of expenditures to consumer-directed personal budgets—3–5 percent—of home care expenditures. Accompanying a switch from a budgeted to an open-ended entitlement system ordered by the courts, use of personal budgets increased rapidly. By September 2002, more than 44,000 persons, about 10 percent of home care beneficiaries, were personal budget holders.

England

Long-term care in England is primarily provided through means-tested programs administered by local governments, under the general direction of the national government. Publicly funded community care is typically available from agencies run by local governments or by private, mostly for-profit agencies. Consumer-directed home care, called “Direct Payments,” has been offered to younger adults with disabilities since 1997, and to older people, disabled children age 16 and 17, parents of disabled children, and persons with developmental disabilities since 2000. The national government is heavily promoting Direct Payments as a means of encouraging consumer empowerment and requires local governments to offer Direct Payments as an option. In practice, however, local governments have discretion in the extent to which they use the option.

Despite advocacy by the national government, take-up has been slow. As of October 2003, approximately 12,600 people in England used Direct Payments, of which only about 1,900 consumers were age 65 and older (Commission for Social Care Inspection 2004). About half of users were young adults with physical disabilities, and the rest were persons with mental health problems, children, caregivers, people with intellectual/developmental disabilities, and persons with sensory impairments. Beneficiaries using Direct Payments account for 3 percent of community care clients.

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Germany

Long-term care in Germany is primarily funded by a social insurance program administered by sickness funds. Insurance beneficiaries are placed into one of three disability categories—substantial disability, severe disability, and very severe disability—each of which is associated with a fixed maximum level of home and institutional benefits. Within home care, clients have a choice of receiving services up to a preestablished cost or receiving a fixed amount of cash, which is roughly 40–50 percent of the cost of the maximum service benefit. Cash benefits range from 205 Euros per month for substantial disability to 665 Euros per month for very severe disability. To be eligible for the cash benefit, care must be “secured,” that is, some system of caregiving must be in place, but few people are ever turned down. While these funds may be used to purchase services, they primarily provide financial support for informal caregivers. In addition, any beneficiaries who require significant supervision due to mental or developmental impairment may receive an additional flat cash payment, which is independent of their disability level or whether they choose cash or services, to be used for respite services for caregivers. This overall cash payment approach has been a component of the German social insurance program for long-term care since it began in 1995.

Consumer-directed care is the dominant type of care in the community in Germany. In 2003, 968,000 beneficiaries (76 percent of home and community beneficiaries) chose the cash benefit and an additional 203,000 persons (16 percent of home and community beneficiaries) chose a combination of cash and services (German Ministry of Labor and Social Affairs 2004). Over time, there has been slow but steady growth in the proportion of beneficiaries choosing a combination of cash and agency-provided home care services. While about 60 percent of all long-term care insurance beneficiaries choose the cash option or the combination of cash and services, these benefits account for only about 31 percent of total program expenditures.

BENEFITS

One of the key issues is the extent to which beneficiaries actually receive cash and are able to choose services that they want. Beneficiaries in the Cash and Counseling demonstration actually received little in the way of cash, except for a small monthly amount to cover nominal expenses. Instead, the demonstration was a test of flexible vouchers with capped per person expenditures (Doty, Mahoney, and Simon-Rusinowitz 2007; Philips and Schneider 2007).

States controlled the range of services and equipment that could be purchased, which was consistent with government fears of fraud and abuse.

All of the three European countries give consumers cash, and England and Germany give consumers substantial control over how the money is used. In the Netherlands, the vast majority of consumers receive cash payments which are usually deposited in a separate bank account; only the most costly 5–10 percent of budget holders are automatically assigned to use a fiscal agent. Many Dutch beneficiaries, however, need only relatively light care and only receive minimal housekeeping services, which involves small sums of money. Budget holders are required to spend their funds on services covered by the long-term care insurance program, and this requirement is monitored closely. Beneficiaries must submit periodic accountings of how they spent the money. As with the Cash and Counseling demonstration, Dutch beneficiaries receive a modest monthly sum of cash which can be spent on anything and for which they do not have to submit financial reports.

In England, as with the Netherlands, beneficiaries receive cash, which is usually placed in a separate bank account. Fiscal agents are available, but not as widely used. Until recently, almost all local governments required that funds be spent on a relatively narrow range of services, but the national government is promoting using the funds broadly. For example, a recent official publication included examples where Direct Payment funds were used for assisting with shopping, helping beneficiaries work at a job or attend college, using transportation services, providing a companion on vacations, and purchasing cable television subscriptions and sports club memberships (United Kingdom Department of Health 2004; Social Care Institute for Excellence 2005).

In Germany, the cash payment is viewed more as an income supplement like Social Security than a way to purchase services. The main intent of the benefit is to promote care at home and to support family caregiving; there is no requirement that funds be used to purchase long-term care services. Beneficiaries do not have to report how the funds are spent and German government officials do not worry about fraud and abuse.

WAGES AND FRINGE BENEFITS

Long-term care workers in the United States, especially independent providers in most consumer-directed programs, are poorly paid and receive few fringe benefits (Benjamin, Matthias, and Franke 2000; Tilly and Wiener 2001). While worker satisfaction was much higher for consumer directed than for agency-

directed workers in the Cash and Counseling demonstration, wages were low (about \$10 per hour) and fringe benefits few (Foster, Dale, and Brown 2007).

Reflecting the more developed social protections in the three European countries, both agency-directed and consumer-directed home care workers have somewhat higher wages and far better fringe benefits than workers in the United States. For example, workers in the Netherlands have health insurance, sickness and vacation leave, and pension coverage, and employers must have liability insurance. In England, 4 weeks of paid vacation, holidays, and sick leave are routinely provided. While these fringe benefits improve workers' quality of life, they also add significantly to the cost of services. As few persons in Germany are formally "hired" with the cash benefit, that country's complicated system of worker protections is not required.

QUALITY OF CARE

Quality of care in consumer-directed programs in the United States is a major policy issue. Compared with agency-directed care, consumer-directed services lack the standard quality assurance structure of paraprofessional training, supervision by professionals, and provision of technical services by professionals. Despite this, the Cash and Counseling demonstration found that satisfaction was higher with consumer-directed care and there was no evidence of poorer quality outcomes (Carlson et al. 2007).

Despite some concern about service quality, the three countries have taken minimalist approaches to quality assurance. In general, consumer-directed care is outside the normal quality assurance framework for nursing homes and home care agencies. In addition, none of the countries imposes training or education requirements for consumer-directed home care workers.

In place of formal quality assurance mechanisms, consumer-directed programs in these three countries rely on two mechanisms to make sure that services are adequate. First, the programs rely on the clients' ability to fire unsatisfactory workers and hire replacements—in other words, the market. Thus, the current labor shortage in all three European countries is a potential threat to the quality of care.

Second, at least in Germany and the Netherlands, public officials appear to believe that relatives are much more likely than strangers to provide high-quality care. In the Netherlands a high percentage of consumer-directed workers are friends and relatives, and in Germany, virtually all of the people receiving money through the cash payment are informal caregivers. In En-

gland, users of Direct Payments cannot hire married or unmarried partners who live in the same household or close relatives. These restrictions are designed to avoid replacing informal care networks and to make it easier to enforce employment contracts. The adage “blood is thicker than water” may account for some of the countries’ relatively laissez-faire attitudes toward regulation of consumer-directed home care.

COST CONTAINMENT

All of the Cash and Counseling participating states face fiscal pressures. Thus, it was financially unexpected that expenditures for Cash and Counseling consumers were generally somewhat higher than those for beneficiaries receiving agency services (Dale and Brown 2007). None of the three European countries has done a cost analysis as sophisticated as the Cash and Counseling evaluation. Nonetheless, each of the countries uses payment mechanisms to try to ensure that expenditures under consumer direction are not higher than for agency-provided care. Payment rates for consumer-directed care are much lower than for agency care, partly because there is little or no payment for administrative overhead, which can be substantial for agencies.

In the Netherlands, the personal budget is calculated by multiplying the number of hours needed for each service by the national payment rate and then reducing that amount by 25 percent to account for lower overhead and by an amount for an income-related copayment. The availability of informal care is taken into account in determining the number of hours needed, a practice that is strongly opposed by consumer advocates. There is also a budget ceiling, which is roughly the cost of nursing home care. The higher likelihood of approved use of services under the more flexible service system that occurred with Cash and Counseling resonates greatly for the Netherlands, where the growth of personal budgets is a reflection of the inability to obtain agency-provided services.

Based on the local government’s assessment of need in England, which takes into account the availability of informal care, case managers compute the number of hours of service per day by type of service that each individual needs. For persons who choose Direct Payments, the localities attach a monetary value to these services and add funds for fringe benefits and recruitment and training costs. Although there is no nationally determined specific maximum budget amount, Direct Payments usually do not exceed the cost of residential care.

Finally, in Germany, cash payments are statutorily set at less than half the costs of services. While costs per individual choosing the cash benefit may be lower, these lower expenditures may be offset by an increased use of benefits by persons who would not use agency services. The highly desirable nature of cash makes the “woodwork” effect likely. While the social insurance program increased use of both services and the cash benefit, doing so was part of the program’s intent. Germany, however, has not experienced an uncontrolled increase in enrollment, although the number of beneficiaries continues to grow at a modest pace. Ironically, the unexpectedly high percentage of persons who chose the lower-cost cash benefit over the service benefit was responsible for the program running a financial surplus during its early years.

CONCLUSIONS

The Cash and Counseling demonstration and operating consumer-directed home care programs in a number of American states and the Netherlands, England, and Germany suggest a new paradigm of long-term care that gives people with disabilities more control over their services. The Cash and Counseling demonstration makes a distinctive and major contribution to the understanding of consumer direction, primarily through the rigor of its evaluation and the test of the concept in the American context. The demonstration, however, examines a program approach that is already national policy in some other countries. The experience of other countries, therefore, offers some possible implications for the next generation of Cash and Counseling.

First, variations across the three European countries in participation rates seems to depend less on the inherent characteristics of consumer-directed care and more on labor market conditions and how governments have chosen to structure the program. In the Netherlands, the rapidly increasing numbers of persons using consumer-directed home care is in response to supply constraints on nursing home beds and home care agencies’ inability to hire service workers. Participation in England is limited by the local government’s paternalistic attitudes toward the older population and people with disabilities. By contrast, Germany’s willingness to offer the cash option broadly and to monitor only minimally has resulted in extremely broad participation, and, at least thus far, there has been little or no scandal or political backlash.

Second, the administrative complexity of consumer-directed home care in the three countries varies as a function of three dimensions: how comfortable policy makers are in giving administrative responsibilities to consumers, how protective government officials are of people who work for consumer-directed beneficiaries, and how determined program administrators are to ensure that funds are spent solely on approved services. At one extreme, the Netherlands has a very complicated system because there are more checks to ensure that the money is spent properly and that workers receive that to which they are entitled. In recent years, the Dutch have simplified their administrative system, but at the cost of increasing the burden on consumers and workers. At the other extreme, in Germany, administration is very simple because consumers are left almost completely on their own to decide what to do with their funds, but they also receive little help in figuring out what services they need.

Third, Americans pay their long-term care workers poorly and provide them with few fringe benefits. While not a high paying job in the other countries, long-term care workers routinely have more fringe benefits than they do in the United States.

Fourth, consumers in the United States and the other countries seem to be at least as satisfied with consumer-directed services as they are with agency-directed services, if not more so. Nonetheless, as countries put more money into these services, there will likely be more calls for minimum training and increased monitoring.

Fifth, the major role of friends and relatives as independent providers in the Netherlands and Germany, as well as in the Cash and Counseling demonstration and other consumer-directed programs in the United States, raises the question of whether these programs should be recast more as support for informal caregivers than traditional fee-for-service, vendor payment programs. Many issues discussed above—management, training, quality assurance, and payment levels—take on a very different cast if the independent provider is a family member or friend rather than a stranger.

NOTE

1. The Netherlands is implementing a major reform of its long-term care financing system in 2007. Thus, these arrangements may change. The description in this commentary was in place at the time of the writing in Fall 2006.

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