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Editorial

Following the logic of long-term care: toward an independent, but integrated sector

Population aging, coupled with the dramatic growth in chronic illness, calls into question the ability of health and social service systems in industrialised countries to adequately meet the complex, multiple, and costly needs of increasing numbers of vulnerable persons—both elderly and working age—with disabling conditions in need of long term care (LTC).

''Long-term care'' is part health care and part social service. It encompasses a wide array of primarily low-tech services provided in home, community and institutional settings by paid professionals and para-professionals and unpaid family members and other informal helpers to individuals who need assistance on a prolonged basis with personal care, household chores, and life management in order to minimise, restore or compensate for the loss of physical, cognitive and/or mental functioning.

International evidence on the organisation and delivery of LTC more or less suggests that services are poorly coordinated and disjointed, and frequently suffer from less than optimum quality, efficiency, and accountability, as well as difficult to control costs. These problems stem largely from LTC's bifurcated and ambiguous status within traditional health and social care, a complex and difficult situation, which thwarts all-important integration at the administrative, organisational, service delivery, and clinical levels. Serious efforts have been made in various countries to reshape LTC on an ad hoc basis at the nexus of funding, policy and practice. However, with an exponential increase on the horizon in the demand for LTC, growing pressures to contain public expenditures and improve efficiency, and mounting consumerism, these incremental reforms are likely to fall short of what is needed.

If we could start from scratch, what should the LTC system look like? First and foremost, logic demands that LTC should be an ''independent'' sector, buttressed by a separate social insurance program or a joint tax-based financing mechanism. This would eliminate the multiple and conflicting policies, jurisdictions, funding streams, regulations, and institutional barriers found in most of today's national systems. It would also do away with the pernicious distortions and fiscal strains caused by LTC in medical care, welfare, and housing programs designed for other purposes and populations at risk. Second, the sector should be ''comprehensive.'' Given the complex living circumstances of the LTC population, this means ensuring seamless coverage of a broad mix of health care, social services and housing in various settings, but mainly provision in the home and community. Access to a total service package would also curtail the irrational and wasteful cross-subsidisation of costs found in many current long-term care schemes. Third, this independent, comprehensive LTC sector should be a ''public'' utility that is administered and delivered directly by government agencies or by non-governmental organizations within the context of a strong state mandated structure, thus recognizing the need for accountability of public funds, the moral hazard inherent in LTC, and the powerlessness of certain LTC consumers.

Forging a single LTC home by levelling the unnatural barriers between health care and social services is only the first stage in the sector's overall modernisation. Even in the few countries that have managed to address this enormous challenge (e.g. Australia, Denmark and Sweden), they have learned that this necessary step is in and of itself, not sufficient to achieve truly integrated care. Lessons from the world of LTC tell us that, at the very least, seven additional changes are needed [1–5]:

- Long-term care should be consumer-directed, with clients being given greater control over the *what*, *how,* and *when* of service delivery. This could be accomplished through ''cash and counselling'' programmes, vouchers or ''individual budgets.'' At the most basic level, however, LTC recipients and workers should be trained in the ways of client autonomy, self-direction, and empowerment.
- Strategically located service points—with community outreach capabilities—should be developed to facilitate access to client information, advice, and intake, support family and informal carers, and engender cooperation between provider agencies.
- Comprehensive LTC assessment should be standardised and regionalised to ensure this critical process is population-based, fair and timely, and that the *right* people end up receiving access to needed levels and types of care.
- Multidisciplinary or interdisciplinary teamwork should form the backbone of the system. Finding

the most effective interpersonal and inter-organisational models to build cooperation and collaboration among and between the various professionals and paraprofessionals and agencies and institutions engaged in the LTC enterprise should take priority. However, major investments should also be made in clinical management tools, information technology (IT), and tele-health devices that promise not only more effective joint working, but also better LTC for clients and families.

- Care management should be considered a core LTC ''technology'', enabling providers to enhance choice and flexibility in service delivery, improve coordination between services, and increase the efficiency and effectiveness of community care.
- Effective links with primary care physicians and hospitals should receive major attention throughout the LTC continuum. Fully integrated care and successful client outcomes cannot be attained without the means to achieve the sustained involvement of these two important providers.
- Applied research and evaluation should go hand-in-hand with efforts to modernise the LTC sector. This is to ensure that reforms work as intended, and ''best practices'' are identified and cycled back to providers in order to improve service delivery and the quality of care.

All of us face enormous challenges in terms of how to finance, organise and deliver LTC to a burgeoning population with disabilities. In our search for what needs to be done, we must stop looking for the best ''European Model'', ''American Model,'' etc. LTC and the people who need these everyday services fundamentally constitute a country of their own where only the ''Best Model'' will do. The essential ingredients of this ''Best Model'' were outlined in this editorial. Since, in the real world, few countries would be lucky enough to wipe the slate clean and start all over, these proposals are offered as a recipe—not a roadmap—for change. Each country, therefore, must figure out how best to incorporate these reforms into their respective legal and structural frameworks, as well as the concrete steps this necessitates. The ensuing implementation challenges would be enormous, but the results would be well worth it from a societal perspective.

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