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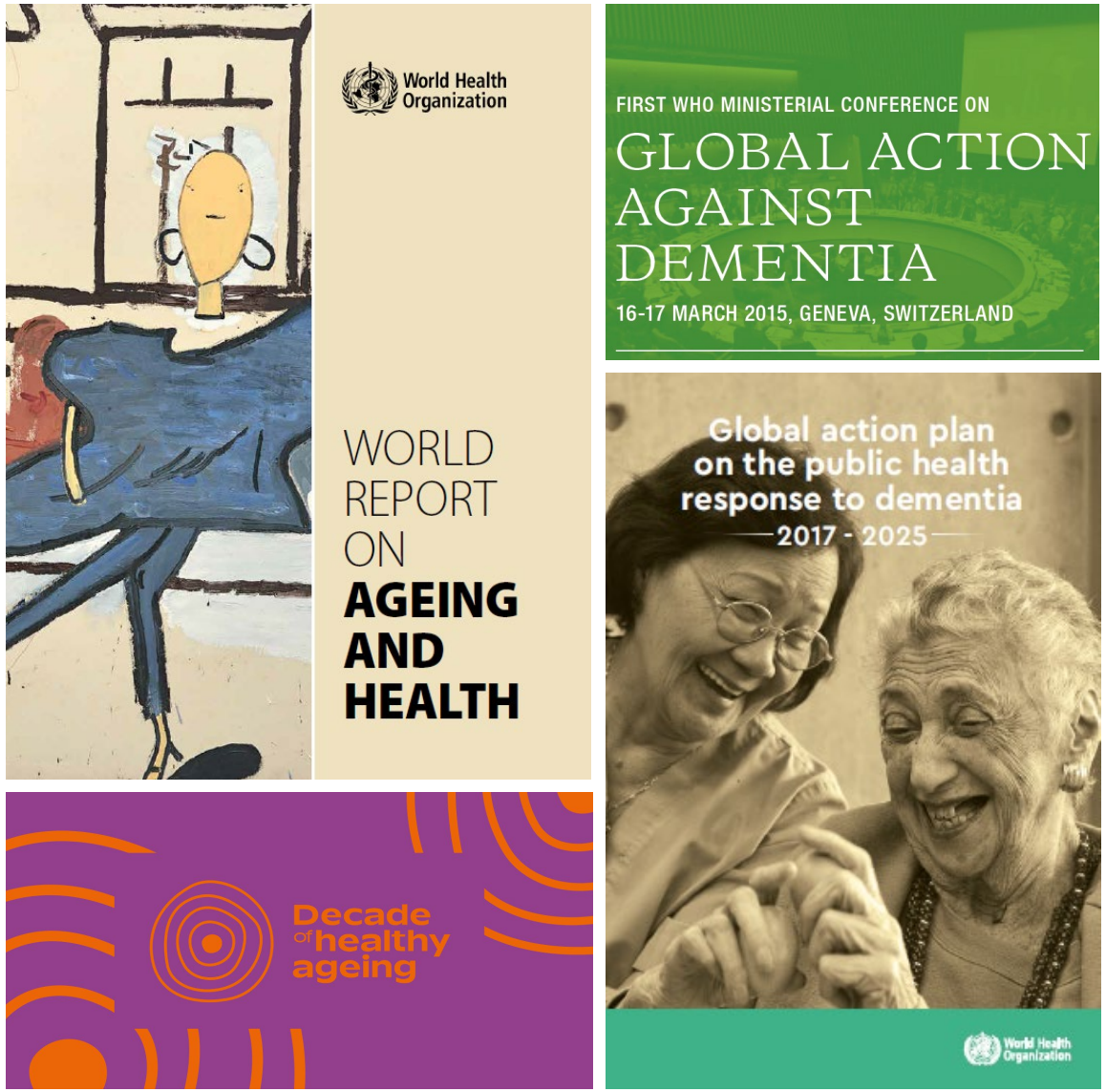
Care models for older people/people with dementia: WHO vision and current knowledge

Where are we?

In what contexts is WHO working on: (integrated and long-term) care for (older) people (with dementia)?



UN Decade, Healthy Ageing, Integrated and Long-Term Care

Decade of healthy ageing | World Health Organization

Action Areas

i. Changing how we think, feel and act towards age and ageing
ii. Developing communities in ways that foster the abilities of older people
iii. Delivering integrated care and primary health services responsive to older people
iv. Providing older people who need it with access to long-term care

Partnering for change "enablers"

i. Voice and engagement of older people , families, communities
ii. Nurturing leadership and capacity building
iii. Connecting stakeholders
iv. Data, research and innovation

The care we want: what WHO envisions

- **Integrated Care for Older People (ICOPE)**
  - Integrated health and social care services and systems
  - Transformation at the system (macro) level, service (meso) level and clinical (micro) level
  - Health and social care systems and services need to respond to the unique health and social care needs and goals of older people, which may vary over time, and should address the social determinants of health.

WHO (2019) Integrated care for older people (ICOPE) implementation framework: guidance for systems and services

- **Long-term care systems**
  - Services are people-centred, coordinated
  - Empower older people and carers, ensuring their dignity and autonomy
  - Continuum of care address specific needs
  - Integrated, coordinated health and social care systems
  - Accessible and affordable; part of UHC
  - Older people's preferences on where to stay & receive services; ageing in place
  - Multi-disciplinary and inter-sectoral
  - Support for unpaid, informal carers

WHO (2021) Framework for countries to achieve an integrated continuum of long-term care

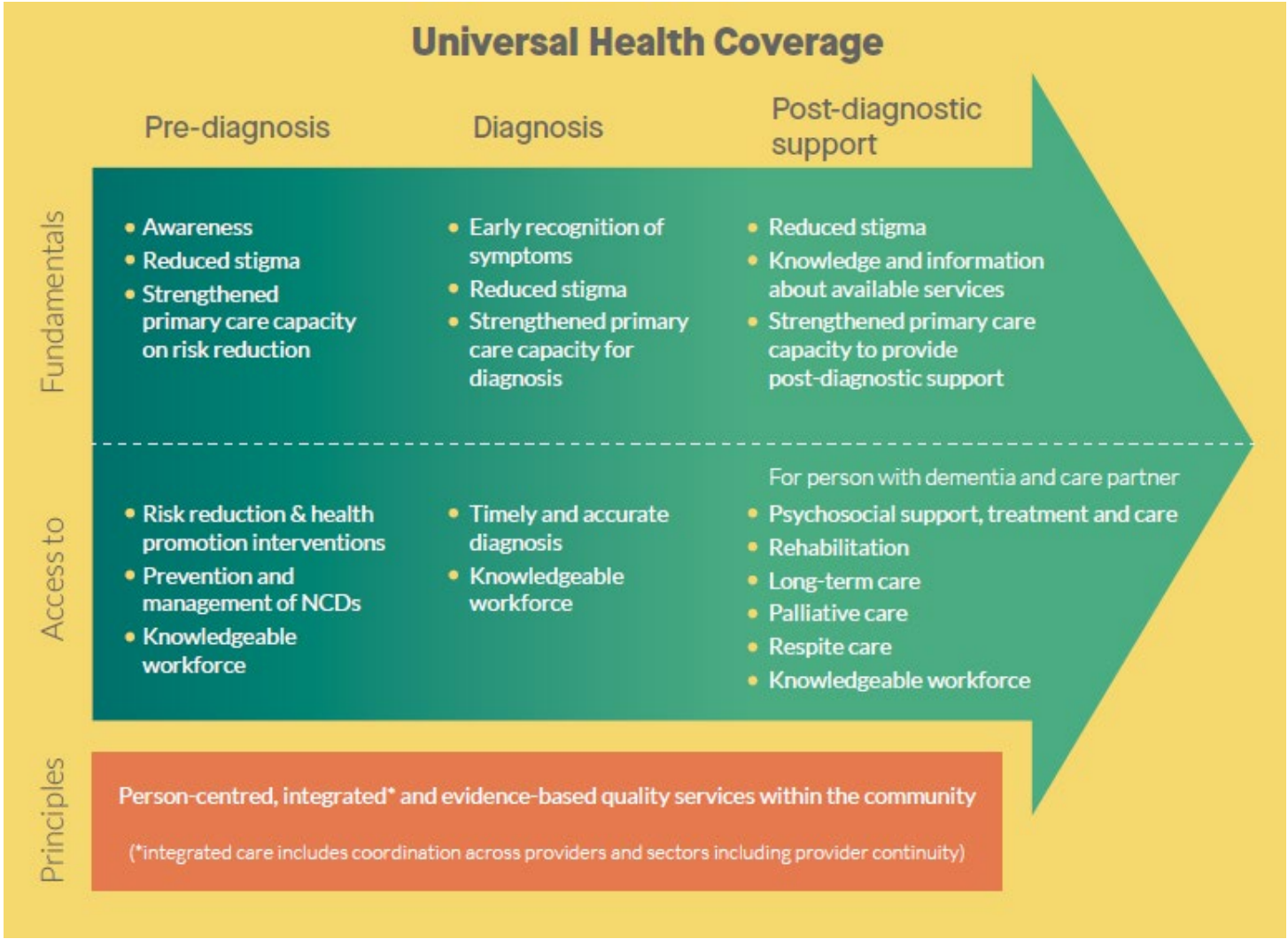
The care we want: what WHO envisions

- **Principles of care systems for dementia**
  - Providing sustainable care across the continuum from diagnosis to the end of life requires:
  - timely diagnosis;
  - the integration of dementia treatment and care into primary care;
  - coordinated continuity of health and social care including long-term care between different providers and system levels, multidisciplinary collaboration and active cooperation between paid and unpaid carers.
- **Proposed actions**
  - Develop a pathway of efficient, coordinated care for people with dementia that is embedded in the health and social care system (including long-term care), to provide integrated, person-centred care as and when it is required.
  - Systematically shift the locus of care away from hospitals towards community-based care settings and multidisciplinary, community-based networks that integrate social and health systems and provide quality care and evidence-based interventions.

WHO (2017) Global action plan on the public health response to dementia 2017–2025

Model for integrated dementia care

- **Multidisciplinary and multi-component** care models for dementia are effective when **integrated within primary care**.
- A recent systematic review of 10 trials examined post-diagnostic dementia care models delivered by primary care in four countries (Germany, Netherlands, Singapore, the United States) and found that **primary care provider (PCP)–case management** partnerships for people living with dementia and their carers improved several important outcomes, including neuropsychiatric symptoms experienced by people living with dementia, as well as **carer burden and costs** associated with the health system.
- PCP-led care also yielded better outcomes, including **decreased hospital and memory clinic costs** and **improved carer mental health**.



WHO (2021) Global status report on the public health response to dementia

Lessons learned from case studies of pricing LTC

- **Public investments in formal LTC systems are important because of population ageing and declines in the availability of family caregivers, many of whom are women.** At the individual level, it is impossible to plan for how much money is needed to pay for LTC.
- **The overall objectives of a given LTC system will have an influence on how care is organized and financed in that system.**
- **A separate funding stream may help ensure that LTC funding is not diverted to other purposes,** while it may pose problems in coordination across health and social care.
- **Funding to LTC should be linked with need and the care provided.**
- **Where cost control is the primary objective and eligibility criteria are stringent, unmet needs may emerge.**
- **Funding to LTC should be based on a secure reliable source that reduces any regional inequities in resources available.**
- **Price adjustments and add-on payments could be used more broadly to foster equity in provider payment.**
- **Quality measurement in LTC is an important area requiring further policy development, which can be linked to price levels and payment mechanisms.**

WHO (2021) Pricing long-term care for older persons

Country case example: Qatar

- **Home setting:** Nationally coordinated integrated home care and mobile health care services provide centralized referral management, collaborating with social services and PHC centres.
- **Long-term inpatient setting:** A specialized on-site team delivers comprehensive care to those require prolonged nursing and medical care, based on daily assessments to help patients to reduce dependency on supportive devices and regain as functional independence.
- **Specialized care centres for older people** adopts a person-centred, care-based approach, including a focus on compassionate patient–provider interactions, access to information, family and patient involvement and the physical environment of care.
- **Community-based residential care services** help transition from long-stay acute care to home environment through compensatory strategies and activities for the engagement of residents via social activities, group therapy, and family engagement programmes, which further prepare for reintegration into the community.
- **Mental health**: the National Mental Health Strategy for Qatar, 2013–2018, focused on providing most mental health services in primary and community settings, and supported **transition towards community-based care**.

WHO (2021) Framework for countries to achieve an integrated continuum of long-term care

Country case example: Australia

- **The HealthOne Mount Druitt program** is a state-wide initiative in Western Sydney, run by the New South Wales Ministry of Health.
- The program target older people with chronic and complex illness who are at risk of further exacerbation and/or hospitalization.
- The program provides a **community-based model** of care that is patient-focused, continuing, and coordinated across the primary care – hospital interface.
- Care is delivered in the most appropriate setting(s) (e.g., home, general practice, health facilities, community outreach or community hub) by multidisciplinary teams.
- **General practice liaison nurses visit homes**, identify needs, organize multidisciplinary case conferences, coordinate care between involved providers, and ensure information is shared with the GP or case manager. Patients and carers actively participate in care planning and management, attending case conferences.
- Funding is split between levels of government. Community health staff are employed by the Local Health District, funded by the NSW Health. General practitioners work on fee-for-service under the Commonwealth Medicare system, but not all reimbursed for the entire tasks for care coordination, which makes implementation challenging.

WHO (2022, upcoming) A service package of long-term care interventions

Country case example: Australia

- The Transition Care Program provides short-term, goal-oriented and therapy-focused services to older people in their own home or residential facility following a hospital stay.
- Care is provided for 12 weeks, with an extension of up to 6 weeks available subject to a needs assessment. In 2018–19, the average length of an episode of transition care was 53.2 days (Department of Health 2019a).
- The aim of the program is to improve an older person's independence and functioning and to delay their entry into residential aged care (if they are living at home). It is provided as a package of care services that may include physiotherapy, occupational therapy, social work, nursing care and personal care.
- Transition Care is funded by the national government and managed by the state and territory governments who determine the service models that best suit local and individuals' care needs.
- All state and territory governments have arrangements with external providers to deliver transition care. As of 30 June 2019, there were 4060 funded transition care places. During 2018–19, a total of 24 432 people received transition care.

WHO (2021) Pricing long-term care for older persons

Country case example: Korea

- **Long-term care insurance** system exists, separately from national health insurance, but managed by a single payer (NHI services)
- Eligibility is for people aged 65 years or older, or individuals with geriatric diseases, e.g. **dementia**, cerebrovascular disease. In 2018, LTCI covered 8.4% of older people over 65 (doubled in 10 years).
- LTCI provides in-kind benefits for institutional and home-based care, and cash benefits are available only in exceptional cases.
- Provider payment is based on the visit (e.g. home-based care) or day (e.g. institutional care).
- The proportion of home-based care in total expenditure for LTCI 54.5% (2019). Home-based care consists of visiting care, visiting bathing, visiting nursing, day and night care, short-term care and welfare equipment.
- The financing mix of LTCI consists of contributions (60-65%), tax subsidies (20%), and copayment by service users, which is 20% for institutional services, 15% for home-based services, and 15% for welfare equipment. The coinsurance rate for institutional care is higher than that for home-based care in order to promote de-institutionalization and community-based care.

WHO (2021) Pricing long-term care for older persons

Country case example: Korea

- Although the centralized single pool has the benefit of equity in financing and efficiency of risk pooling, it has not been so far effective in organizing LTC delivery at the local level.
- Informal care is not covered by LTCI, as LTCI covers only when LTC is provided by formal care providers. According to a national survey, among the people who needed support and received some care, only 19% relied on LTCI while 89% received some support from family members, mainly their spouses.
- The lack of coordination between health care and LTC remains a policy challenge. Overlapped inpatient services are provided by LTC facilities/institutions (under LTCI) and LTC hospitals (under NHI) for older people with similar health and functional status.

WHO (2021) Pricing long-term care for older persons

Conclusions and next steps

- Integrated long-term care for healthy ageing of older people has become an UN-wide decade goal but is still in the early phase of development and not necessarily prioritized by health sectors.
- Dementia has been recognized as a public health priority and there is more emphasis on integration between health and social care, being one of the major targets of long-term care.
- There have been focuses on coordination, continuum and integration between different providers and system levels, multidisciplinary collaboration, including the role of care coordination and case management.
- The growing burden and needs of support for informal/unpaid carers are rising even in LMICs without proper LTC systems, in line with changing labor market participation and gender issues.
- Although the integrated continuum of (long-term) care for (older) people (with dementia) at primary/community levels is getting more attention, there needs more concrete evidence and innovative experiments to implement care models to be institutionalized.
- WHO will continuing document best practices and provide guidance for countries to adapt appropriate care models.

Comparison with U.S. systems

	US	Other countries
Eligibility/coverage	Specific, either over 65 or low-income; covers 1-2%	Universal schemes exist; usually 3-5% of total population
Services/settings	Coverage of settings depends on the eligibility (Medicaid only covers low-income)	Mix of LTC program/insurance and social health insurance covers continuum of care/settings

- In the USA, LTC operates **as a social safety net** targeted to people without the ability to pay for needed services; thus, **coverage is more limited**.
- Public LTC is funded by general tax revenue (national and local) and eligibility and co-payments are based on needs assessments and means-testing. In such a system, the overall objective is poverty alleviation and protection of vulnerable groups.
- Eligibility for public funding is subject to **means-testing** and only granted after a person depletes his/her own financial resources and has a high level of disability.
- Individual negotiation for prices is typically associated with **private health insurance** in the USA. Despite the strong case for risk pooling, there are **few private insurance options for LTC**. Private insurance for LTC remains a niche product covering only a small proportion of total LTC costs. Given that the role of private health insurance in covering LTC services for older persons is quite limited, **individual negotiations of prices between purchasers and providers is also limited**.

WHO (2021) Pricing long-term care for older persons