



# Best Practices in Home Care for Seniors

*Synthesis Report from the 2014 International Forum*



Ministry of  
Health



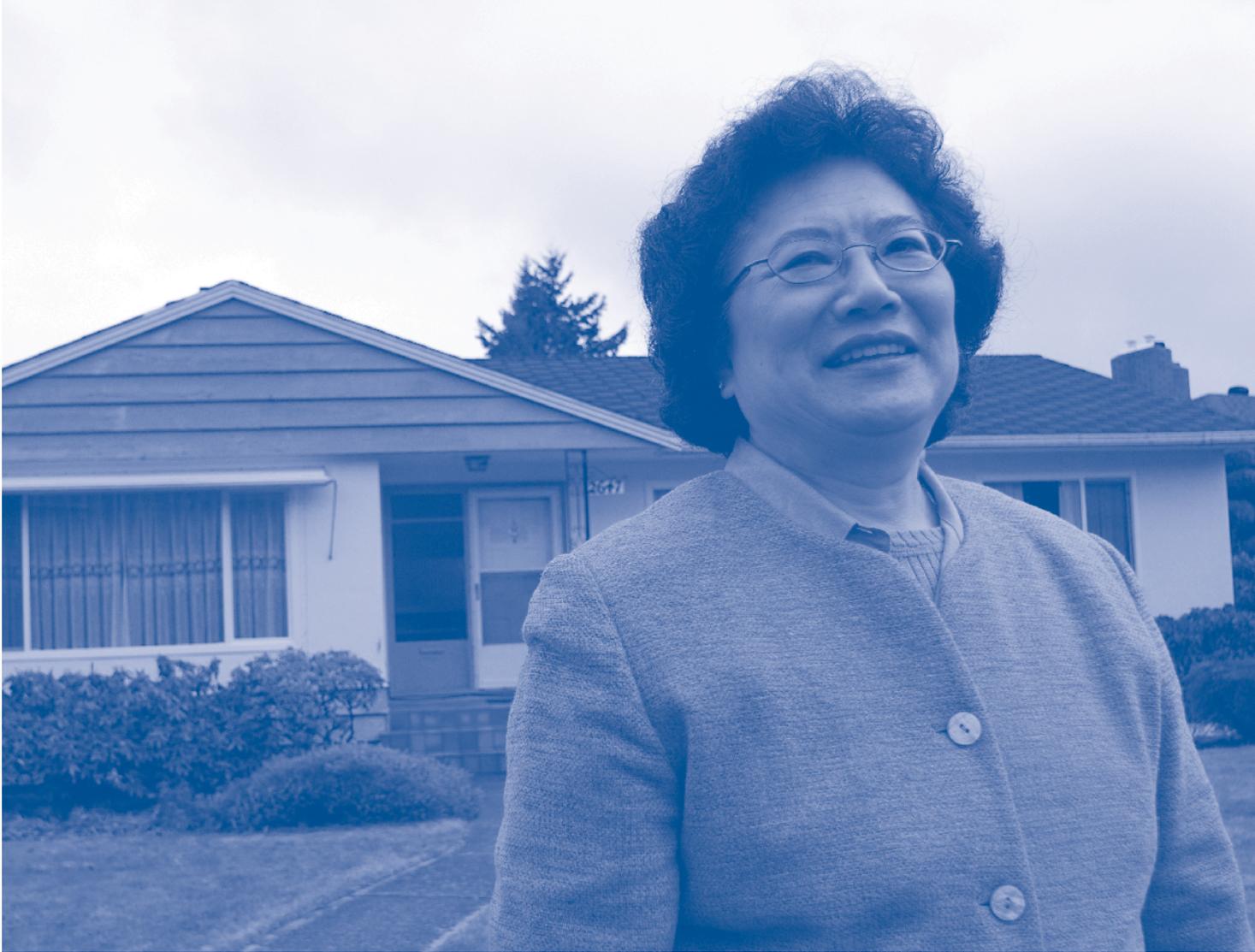
MICHAEL SMITH FOUNDATION  
FOR HEALTH RESEARCH

Discover. Connect. Engage.



## Table of Contents

Introduction	5
Home care re-ablement services: England, Scotland, and Wales <i>Presented by Gerald Pilkington</i>	6
Restorative and preventative care approaches: Australia <i>Presented by Dr. Gill Lewin</i>	8
Review of the Nordic system: Denmark and Finland <i>Presented by Dr. Virpi Timonen</i>	10
Integrated community care system: Japan <i>Presented by Dr. Ryutaro Takahashi</i>	12
Benefits, challenges and recent reform proposals: Italy <i>Presented by Dr. Giovanni Lamura</i>	14
Variations in cash payment and integrated care services, and policy development for individuals with dementia: Germany <i>Presented by Dr. Hildegard Theobald</i>	16
Take home points for British Columbia	18
Moving Forward	19
Appendix A: References	20
Appendix B: Speakers biographies	21
Acknowledgements	23



## Introduction

On Jan. 15, 2014, the British Columbia Ministry of Health and the Michael Smith Foundation for Health Research held a forum to examine best practices in home care services for seniors. The forum, hosted in Vancouver, brought B.C. government representatives, health authority leaders and researchers together with international experts in research and policy.

The goal of the forum was to provide an opportunity for B.C. participants to learn how other jurisdictions are addressing the shared challenge of providing sustainable home care for seniors. The key objectives were:

- To discuss the driving forces for reforms in home care for seniors and strategies currently underway.
- To examine what changes are underway in how home care is organized, financed, provided, governed, regulated and assessed.
- To look at the evidence that exists in other jurisdictions as a way of showing the effect of system-level policy changes to home care and to the outcomes for seniors and their caregivers.

Six speakers from different jurisdictions presented on best practices in home care for seniors: Dr. Virpi Timonen, Dr. Giovanni Lamura, Mr. Gerald Pilkington, Dr. Ryutaro Takahashi, Dr. Gill Lewin and Dr. Hildegard Theobald (speaker biographies in Appendix B). Each speaker spoke about his or her country's home care program, recent innovations and responded to questions from the audience. The following summarizes the presentations and some key points of discussion.

## Home care re-ablement services: England, Scotland, and Wales<sup>1, 2</sup>

*Presented by Gerald Pilkington*

### BACKGROUND

Home care in the United Kingdom is funded by the federal government, with policies determined by the department of health and services commissioned by local government. Each local government has a council with social services responsibility that is entrusted with assessing the community needs and delivering the required services.

As in other jurisdictions, the aging population is raising concerns about the availability of financial and workforce resources needed to meet their needs. Starting ten years ago, the home care system underwent a series of structural changes and the services it offered in response to these concerns. These changes included diversifying the range of agencies delivering home care services to include non-public agencies, changing the access criteria to be more restrictive, and a paradigm shift towards the integration of services rather than organizations. Today, the local councils with social service responsibilities are no longer responsible for overseeing the delivery of house-keeping services. Instead, these services are now available to be purchased privately by clients using needs-based allowances provided by the government. The councils are now predominately in the business of overseeing the provision of personal care services.

### INNOVATION

In anticipation of the population's physical and mental health decline, a re-ablement program has been developed and introduced into the home care system to maximize the independent living of seniors and minimize the cost of care over a person's lifetime. The goal of re-ablement is to maximize clients' long-term independence and to appropriately minimize the level of ongoing support required. Clients receive re-ablement services to learn to manage daily living activities, all within the context of healthy aging. Services are typically short term, intensive home care support provided for an average of six weeks. Services involve motivation, personal care and hygiene, practical help (e.g., preparing meals), prompting medication, providing advice and information (e.g., preventing falls, local community services), helping establish social contacts and rebuilding confidence to get out (e.g., to go shopping).

Re-ablement is typically provided after rehabilitation from an acute event to maximize a senior's independence. This is different from rehabilitation and prevention services because it is not designed to improve health or avoid unplanned or unnecessary admissions to hospitals and residential care respectively. Instead, re-ablement is an outcome focused program based on the principle of helping people 'to do' for themselves rather than 'doing to or for' them.

*Home care re-ablement services:  
England, Scotland, and Wales*

LESSONS LEARNED

A 2008 retrospective study of the re-ablement program showed skill acquisition is saturated at eight weeks for the large majority of clients. The study found that 60 per cent of persons who received re-ablement services no longer required home care services at the end of the program and 40 per cent of graduates continued to be independent with no further home care needs upwards of two years. The most significant gains were seen in clients whose informal caregivers were included in the process, although the presence of an informal caregiver is not a requirement for program eligibility.

Each local government is responsible for ensuring everyone eligible within its jurisdiction receives the program. To circumvent issues of providing services to seniors living on the outskirts of communities, the councils with social service responsibilities are in the practice of employing locals. The hiring of newly trained re-ablement employees from within the hard-to-serve communities is encouraged and additional funding has been set aside to retain them.

## Restorative and preventative care approaches: Australia<sup>3, 4</sup>

*Presented by Dr. Gill Lewin*

### BACKGROUND

Australia's home and community care services are jointly funded by state and commonwealth governments. Home and community care services' original aim was to meet the needs of aging clients transitioning from living in the community to residential care and offer domestic services to prolong the period before requiring residential care. However, as the needs of the population grew, home and community care services struggled to maintain the resources necessary to meet increasing demand. Eligible clients encountered waitlists and those already receiving services found the services fell short of their declining independence.

### INNOVATION

In 1999, home and community care services decided to move away from this approach to an increased focus on home care. Recent research had demonstrated that disability in old age is triggered by episodic events rather than a predictable steady decline, and that timely access to services can aid recovery from such events. As such, home and community care services funded Silver Chain's Home Independence program pilot as an experiment in restorative home care.

Silver Chain is one of Western Australia's largest home care providers. The Home Independence program was developed and tested by the provider as an alternative model for home care service provision. Services have been restructured to assist seniors to address their immediate problems and maximize their functional independence, health and well-being. The program was developed to work within the confines of an individuals' physical limitations and focuses on early intervention. It includes task analysis and redesign exercises; the introduction of aids and use of equipment in daily living; strength and balance exercises; lessons in chronic disease self-management; falls prevention strategies; and training in the use of medications, continence, and skin integrity. By promoting wellness or an active aging approach, and acknowledging the importance of social connections, clients are better able to set and meet goals.

Based on early successes, Silver Chain's Restorative Home Care Services expanded beyond the initial pilot. Restorative Home Care Services are offered free of charge for six weeks for all assessed eligible clients. Clients are either referred at the community level for the Home Independence Program or, following a hospital admission, for the Personal Enablement program based on the Aged Care Gateway model. Where enablement does not suffice, traditional home and community care services are supplemented.

## *Restorative and preventative care approaches: Australia*

### LESSONS LEARNED

Silver Chain's successes in enablement have been published in detail elsewhere.<sup>4</sup> It is worth noting that a randomized control trial comparing a group of Home Independence program clients and those receiving traditional home and community care services showed that 12 months following initial recruitment, clients in the Home Independence program group were 6.5 times less likely to require ongoing care and 30 per cent less likely to use emergency department or hospital services. After adjusting for age, sex, living arrangement, having an informal caregiver and dependence level, costs of providing services to clients were also consistently lower for those in the Home Independence and Personal Enablement programs.

Silver Chain's Home Independence and Personal Enablement programs benefit from the availability of well-trained and qualified staff. As demand for the programs has expanded, the makeup of the teams assessing and providing care has evolved and shifted away from a psycho-social focus. As a result, outcomes in quality of life measures have become poorer. Given this situation, and based on research conducted in the United Kingdom and elsewhere, care co-ordinators (similar to care aides in Canada) are being trained to be care managers in lieu of care professionals. Silver Chain has found this has resulted in improved outcomes.

To alleviate issues of access to aids and equipment, the Home Independence and Personal Enablement programs rely on small aids that care managers can carry from client to client. Where appropriate, clients are encouraged to purchase the aids and equipment themselves. A small budget is appropriated to each recipient of care, but large equipment is beyond the scope of the budgets.

## Review of the Nordic system: Denmark and Finland<sup>5-9</sup>

*Presented by Dr. Virpi Timonen*

### BACKGROUND

As two examples of the Nordic system, Denmark and Finland share common elements of home care provision and drivers of reform in administration and delivery. Both countries employ a highly trained workforce: home care staff have one to three years of formal training with opportunities for additional training built into their career trajectory. Also, both have experienced the diversification of service providers from the core public sector in recent years. Policies favouring deinstitutionalization have been popular in the culture of care since the 1980s, and the intensification of services has funneled resources to support the aged population with the greatest needs.

Despite these similarities, there are distinct differences between Denmark and Finland, particularly in how services are provided. Denmark's universal coverage provides home care free of charge for those with established needs, while Finland offers services with income tested fees. Secondly, while Denmark enjoys uniform service delivery across the country, considerable variation persists at the local authority level in Finland. Furthermore, informal caregivers play a bigger role in the social care structure in Finland. Incentives to support the needs of aging family members are provided in the forms of a taxable allowance for every family caregiver based on an assessment of his or her abilities to care for the client. The proportion of care provided by the informal caregiver and the formal home care services vary by municipality. Nationwide, three respite days per month are offered to full-time family caregivers and services are available through contracted providers.

### INNOVATION

In Denmark a large emphasis has been placed on measuring and improving the quality of services while managing the competing interest of resource efficiency. Centred on rehabilitation, the Danish system focuses on regaining lost abilities. The *hjaelp-til-selvhjaelp* (help to help oneself) program is developed around individual clients' needs and goals. Each participating client is provided with a formal written contract specifying personal goals and how the service provider and client will work to achieve them.

Finland has focused on linking health and social care tasks through home care personnel training. Home care workers have evolved into practical nurses responsible for home nursing and home help. Home care has moved away from a focus on household tasks to a concentration on personal bodily care. Eligibility is extended to all seniors and access to home care can be made via personal request or referral from an informal caregiver or medical professional on the client's behalf. Within seven days of a request for home care, the client's needs are assessed. Qualified clients then receive a care liaison who organizes care based on the needs assessment.

## *Review of the Nordic system: Denmark and Finland*

### LESSONS LEARNED

A Danish home care commission report recently documented the decline in the percentage of seniors receiving home care and attributes some of the success to the *hjælp-til-selvhjælp* program. While the system is repeatedly demonstrated to be efficient, it has been criticized for its very specific (minute to minute) scheduling. The use of palm pilots and other IT applications in the monitoring of service delivery remains unwelcome. As such, home care workers' schedules are shifting from detailed, itemized tasks to more flexible care plans that respect the general needs of the client. To do so, support categories have been developed to guide workers' tasks during each visit.

Finland has learned that in order to improve services, progress needs to be measured using indicators that matter to the recipients and providers. As elsewhere, Finland is limited by its home care workforce availability. This is particularly problematic in rural communities, and during the summer and winter holidays—affecting the ability to provide respite services. To address staffing needs, students in home care programs and lesser trained casual workers are recruited for specific times of the year.

## Integrated community care system: Japan<sup>10, 11</sup>

*Presented by Dr. Ryutaro Takahashi*

### BACKGROUND

The needs of the aging population in Japan are notable for two reasons. First, by 2025, it is estimated that one third of its population will be over the age of 65, making it the country with the largest proportion of seniors. Secondly, recent shifts away from the mixed generation household structure are adding strains to the formalized home care system. While Japan currently has low per capita health and long-term care expenditures, maintaining the status quo will be challenging. The unprecedented inversion of the traditional population pyramid, along with dramatic increases in single person households, will put considerable strain on the current home care system.

### INNOVATIONS

To effectively manage the growing financial demands anticipated from the aging population, Japan established a long-term care insurance plan in 2000. Revised in 2006, its objective is to establish a sustainable insurance system capable of coping with the expected long-term care expenses. The insurance plan is part of a series of comprehensive social security and tax reforms recently set in place. Starting at the age of 40, every person pays an annual premium. In some instances, as much as 50% of the premium is paid by the employer. This premium, along with public funding from national and municipal levels, goes towards covering home care expenses. In turn, seniors are entitled to a series of home care services, including in-home help, short-term stays, nursing and personal care based on their needs assessments. In 2011, on demand 24-hour in-home care/nursing services and secure residential care systems were added to the range of services available. The plan is set to cover 90 per cent of the costs of the services approved, with the client covering the remaining 10 per cent. Each hospital has a discharge support division designed to identify clients eligible for home care services and to reduce inappropriate hospital stays by helping people transition back to their homes as seamlessly as possible.

Additionally, in 2005, Japan began developing integrated community care systems to provide housing, medical care, long-term care, prevention services and livelihood support in a centralized location within each community. This improvement allows seniors to continue living independently, but near needed services should a medical event arise. Each community care system has a catchment equivalent to the local junior high school district. Challenges to the integrated community care system include administration and workforce availability constraints. Part of this has been rectified by the establishment of care manager leaders who liaise with the client, family and professionals providing the care services.

## *Integrated community care system: Japan*

### LESSONS LEARNED

Securing the support personnel needed for the success of the integrated community care system has included recognizing the high turnover, low recruitment and retention rates of home care workers. To do so, the Health and Welfare Bureau for the Elderly in Japan is working towards raising the wages of those engaged in long-term care, shifting underlying cultural stigmas against college programs, and developing appropriate career paths that encourage upward mobility.

Another challenge is the tendency of physicians to specialize in Japan. There is a high need for general practitioners and geriatricians, but recruiting medical students into these fields is difficult.

Finally, the integrated community care system is most effective when based on the needs of the local community. However, the exchange of necessary medical information between involved parties is difficult, encumbering efforts for holistic care. Furthermore, some municipalities (particularly in rural regions) have limited capacity to provide the full spectrum of services.

## Benefits, challenges and recent reform proposals: Italy<sup>12, 13</sup>

*Presented by Dr. Giovanni Lamura*

### BACKGROUND

Italy is second only to Japan in its proportion of seniors in the general population. As such, the country is having to cope with growing demands for long-term care while managing issues related to the health, social exclusion, poverty and technological needs of the aging population. Home care is offered in three forms in Italy. Integrated health and social home care is a combination of nursing, rehabilitation and personal care services delivered at the health district level and accessed by approximately 4 per cent of the elderly population. Home help is offered at the municipal level and used by 1.4 per cent of the older population. Planned medical home care is offered by general practitioners and is universally accessed.

To accommodate the needs of the population, two systems have evolved in parallel. The first is the formal domain of care provision, which provides in-kind home and residential services and cash-for-care financing schemes to informal caregivers. The second is the informal network comprised of family, volunteers, friends and neighbors. This second system is possible in part because few women between the ages of 55-64 are in the formal workforce.

### INNOVATION

To assist families in the management of their senior parents' care needs, the cash-for-care scheme was implemented. Beginning in the early 2000s, there was an upswing in the percentage of Italians who received long-term care through cash-for-care services compared with those receiving in-kind home care services or residential care. In Italy's cash-for-care scheme, a dependent person receives a care allowance from the state and, in many municipalities, this is supplemented with a means tested additional 300-500 euros per month in unrestricted income for those over the age of 65. This has encouraged the hiring of private help to assist with activities of daily living. A large number of these workers are immigrants employed to supplement the family's support or cohabit with the client.

## *Benefits, challenges and recent reform proposals: Italy*

### LESSONS LEARNED

Employing migrant workers allows for the ability to tailor services to the senior's needs, as well as delaying institutionalization. The wage differential and reduced costs of living for resident home care workers also provides economic incentives for immigrants. However, this quasi-underground system raises several concerns. First is the inability to maintain standards of care, particularly when the workforce lacks accreditation. Second is the concern that families or senior clients may exploit immigrant home care workers. Third, these workers often work in isolation from their families and communities for prolonged periods of times, which raises concerns for their mental health.

To accommodate this migrant workforce, Italy has undertaken a series of legal and policy reforms to formalize the system. Illegal migrants now have the means to gain legitimate workers' status. Fiscal incentives have been introduced to discourage households from employing undeclared workers. Starting in 2007, domestic workers now sign contracts to reduce the potential for employer abuse. Finally, training and accreditation programs for migrant workers have been developed by local municipalities to raise the workforce's skillset. At the same time, stricter controls for access to cash-for-care allowances for seniors are now in place.

## Variations in cash payment and integrated care services, and policy development for individuals with dementia: Germany<sup>14, 15</sup>

*Presented by Dr. Hildegard Theobald*

### BACKGROUND

In Germany, the home care system has been built around family care. This care system relies on tax policies, insurance programs and means testing to succeed and emphasizes universality, cost containment, choice and the use of the regulated market. Through a series of capped benefits, functional orientation and provision of both domestic and family care, services are extended to everyone. A three level dependency scheme is used to distribute services equitably. Clients are expected to pay for services privately or through insurance where appropriate. A combination of home care and residential services along with cash options are offered to eligible clients. The government is responsible for registering service providers, negotiating the price and overseeing the quality of services offered by for-profit and not-for-profit providers through the different insurance providers.

Since the 1970s, nursing care has been a staple of seniors care. This has recently been augmented by insurance providers offering coverage for personal care and household services.

### INNOVATION

To encourage home care over more costly residential care, and to support a strong desire on the part of families to care for their senior relatives, Germany has begun providing a cash payment to senior clients. The purpose of the cash payment is to allow clients to use the money to hire additional services to meet their specific needs. This has led to an increase of migrant worker employment.

In addition, beginning in 2002, the Complementary Nursing Act (amended in 2008) was passed to help alleviate the burden on informal caregivers managing seniors with dementia. Nurses are provided for day, night or short-term care visits through home care service providers and civil society organizations.

Finally, to cope with growing workforce needs, volunteers are being recruited to offer leisure activities in small care groups or one-on-one settings within the community under the guidance of professionals. These volunteers have received training and are registered at the federal level. However there is discussion as to what constitutes “volunteer,” and whether remuneration should be provided in the form of different types of allowances.

*Variations in cash payment and integrated care services, and policy development for individuals with dementia: Germany*

LESSONS LEARNED

The cash payment scheme developed to encourage the hiring of caregivers has not aligned with the cultural values of the country. There is a strong sentiment that the family is the primary provider of care and strangers in the home are not always welcomed. This is most obvious in the difference between how German natives and immigrants select their benefits, with German natives more likely to choose the cash benefits option.

## Take home points for British Columbia

At the end of the day, the forum held a reflections and next steps discussion where the forum participants discussed some of the key lessons from the presentations:

- Seniors want to retain their independence for as long as possible. Services that enable clients to stay within their homes and carry out activities of daily living are preferred. Home care options that emphasize re-ablement provide savings to the health care system by reducing longer term need for home care services. However, as the population ages and more people require services, cost-containment strategies are also needed.
- Home care providers should not adopt a model of care that assumes a continuum towards increasing needs with age. Research is showing that health decline is not gradual but rather punctuated by medical events as the person progresses with age. Programs or services that teach clients to maintain their independence through learned modifications to carry out activities of daily living enable them live at home unassisted for longer.
- Governments, health care providers and clients all benefit from frequent assessments of client needs. Regular assessments identify who would benefit from early interventions and re-ablement strategies, along with the needs and goals of the clients.
- Tied to frequent needs assessments is the need to develop progress indicators that reflect the interests of all stakeholders. These indicators need to be sensitive enough to capture the effects of changes in services or care delivery strategies within a short period of time and general enough that they are comparable across different care settings.
- Care models should be conceptualized broadly. The services that are provided to each client should be modular—tailored around the unique needs of the individual instead of selected from a fixed list of services. These packages should be centred on specific goals the client has and allow the home care provider flexibility in how these goals are accomplished. The emphasis should be placed on reaching goals rather than completing tasks.
- Evidence shows that home care workers can receive enhanced training and that clients, health care providers and informal caregivers benefit from the added training and expertise. The training enables home care workers to fill in gaps in health care when nursing staff is not available and retains workers for longer through a diversification of career prospects. Home care programs are most effective when informal caregivers are included in identifying client goals and developing a care plan to achieve those goals.
- Where cash incentives are incorporated into the system of home care for purchasing services, the incentives must be culturally appropriate and anticipate potential hiring practices.

## Moving Forward

Following the next steps discussion, the group identified a core set of objectives that could help guide them into refining and developing improved models of home care for the British Columbian population:

1. No one should have to repeat his or her story. The care plan should be easily understood and additional information on the client and his or her needs should be available before a home care worker visits the home for the first time.
2. Integrate family physicians into care planning.
3. Include the primary caregiver in the development and execution of the care plan.
4. The plan that is developed should have a clear set of goals and all services within that plan should lead to the realization of those goals.
5. The pathway for accessing different services or programs should be clear as should the division of tasks between health care professionals, formal caregivers and informal but primary caregivers.
6. Provide each client with a case manager who co-ordinates services, identifies and assists the client in accessing services available in the community, and ensures that home care workers are well-informed about the client's needs.

## Appendix A: References

1. Gerald Pilkington. Homecare Re-ablement services in the UK. (2014).
2. Parvaneh Rabiee & Caroline Glendinning. *The organisation and content of home care re-ablement services*. 4 (Social Policy Research Unit, 2010).
3. Gill Lewin. Restorative Home Care in Australia. (2014).
4. Gill Lewin & Suzanne Vandermeulen. A non-randomised controlled trial of the Home Independence Program (HIP): an Australian restorative programme for older home-care clients. *Health Soc. Care Community* 18, 91–99 (2010).
5. Virpi Timonen. The Finish and Danish Cases. (2014).
6. Marta Szebehely & Gun-Britt Trydegard. Home care for older people in Sweden: a universal model in transition. *Health Soc. Care Community* 20, 300–309 (2012).
7. Mia Vabo. Norwegian home care in transition - heading for accountability, off-loading responsibilities. *Health Soc. Care Community* 20, 283–291 (2012).
8. Teppo Kroger & Anu Leinonen. Transformation by stealth: the retargeting of home care services in Finland. *Health Soc. Care Community* 20, 319–327 (2012).
9. Tine Rostgaard. Quality reforms in Danish home care - balancing between standardisation and individualisation. *Health Soc. Care Community* 20, 247–254 (2012).
10. Ryutaro Takahashi. Integrated Community Care System in Japan: A new system implemented and the role of the care manager. (2014).
11. Health and Welfare Bureau for the Elderly. (2013).
12. Giovanni Lamura. Benefits and challenges of Italy's LTC system and reform proposals in the home care sector. (2014).
13. Fabrizio Tediosi & Stefania Gabriele. *The Long-term Care System for the Elderly in Italy*. (European Network of Economic Policy Research Institutes, 2010).
14. Hildegard Theobald. Long-term care policies in Germany: Approach, consumer choice and home care services for beneficiaries suffering by dementia illness. (2014).
15. Theobald, H. *Long-term Care Insurance in Germany: Assessments, benefits, care arrangements and funding*. 55 (Institute for Future Studies, 2011).

## Appendix B: Speakers biographies

### *Dr. Virpi Timonen*

Dr. Virpi Timonen is professor of social policy and ageing at Trinity College Dublin, Ireland and adjunct professor of social and public policy at the University of Jyväskylä, Finland. She is a graduate of the University of Durham (BA, 1995) and the University of Oxford (MPhil, 1997 and DPhil, 2001). She was first appointed to Trinity College Dublin in 2003 and established the Social Policy and Ageing Research Centre in 2005. Professor Timonen has published over 60 peer-reviewed articles and chapters on social gerontology and welfare state responses to population ageing in leading international journals and books. She has authored five books, including a comparative study of home care in Denmark, the US and Germany, and co-edited the first book on grandparenting practices across the world. Dr. Timonen has supervised to successful completion the first seven PhDs to have graduated in social gerontology in Trinity College, and is currently supervising four PhD students. She has designed six new undergraduate courses and authored *Ageing Societies*, a major undergraduate textbook. Alongside and related to her academic publications, Professor Timonen has made influential contributions to policy formulation and critique in the area of long-term care services, in particular home care provision in Ireland and other European countries.

### *Dr. Giovanni Lamura*

Dr. Giovanni Lamura is a social gerontologist with an international and interdisciplinary background. Since 1992, he has worked at the Italian National Institute of Health and Science on Aging. He graduated in economics (Italy) in 1990; obtained a PhD in life course and social policy at Bremen University (Germany) in 1995; was a visiting fellow in 2006-07 at the University of Hamburg-Eppendorf (Germany); and a research director of “health and care” at the European Centre for Social Welfare Policy and Research in Vienna (Austria) in 2010-11. He has gained experience in international research projects mainly focused on family and long-term care of dependent older people; work-life balance; migrant care work; prevention of elder abuse and neglect; ICT-based initiatives to support informal carers; intergenerational solidarity; and interdisciplinary research on aging in general.

### *Mr. Gerald Pilkington*

Mr. Gerald Pilkington has over 28 years of experience working in health and social care across the independent sector (acute, long-term care and rehabilitation) and National Health Service. From November 2005 until March 2011 Gerald was the national lead for home care re-ablement within the care services efficiency delivery programme at England’s Department of Health, supporting 152 local authorities to achieve their efficiency targets within adult social care. Working with services and academic research teams, he built the most comprehensive body of evidence of the effectiveness of home care re-ablement within the United Kingdom. Gerald

continues to work with a range of public, for-profit and not-for-profit organizations to help them establish services and enhance existing services to maximize the benefits for both the clients and funding authorities. He also undertakes work to assist extra care and telecare services.

### *Dr. Ryutaro Takahashi*

Dr. Ryutaro Takahashi graduated from Kyoto university school of medicine in 1976 and trained as an internal medicine resident at the department of geriatric medicine in Kyoto university hospital and Tokyo metropolitan geriatric hospital. He worked as a diabetes specialist for more than 10 years at Tokyo metropolitan geriatric hospital, and has experience working in a small village hospital in rural Japan. In 1995, he started research at the Tokyo Metropolitan Institute of Gerontology. His main area of research is focused on quality of life and end of life care for frail older people. Dr. Takahashi is now conducting a study on the promotion of advanced directives among community-dwelling older people.

### *Dr. Gill Lewin*

Dr. Gill Lewin currently holds two positions, research director at Silver Chain and professor of ageing at Curtin University of Technology. Gill has been working in health and aged care research since joining Silver Chain to manage their research department twenty years ago. During this time she has been involved, both on her own and in collaboration with many other providers and researchers, in a large number of projects. Her particular research interests are the development and testing of service models that promote independence and evidence-based clinical practice.

### *Dr. Hildegard Theobald*

Dr. Hildegard Theobald is professor of organizational gerontology at the University of Vechta, Germany. In her research on home care, she focuses on cross-country comparisons of long-term care policies, the intersection of national and international policy developments and its effects on professional care services, care users, caregivers and care workers. She participated in several international comparative projects on home care development, home care reforms and home care for older adults at risk of marginalization. Furthermore, she was involved in projects related to international policy advice to Spain, Japan and France. With two colleagues—Viola Burau and Robert H. Blank—she wrote a monograph, “Governing Home Care – a Cross-National Comparison,” published by Edward Elgar in 2007.

## Acknowledgements

The Ministry of Health and the Michael Smith Foundation for Health Research would like to thank the following individuals who contributed their time and effort in planning and organizing the forum, and reviewing and editing this report:

- Christine Massey, Ministry of Health
- Karen Archibald, Ministry of Health
- Isabelle Linden, Michael Smith Foundation for Health Research

We wish to extend our appreciation to Anne-Martin Matthews, University of British Columbia, who assisted in the selection and recruitment of the six international experts in home care.

And finally, our sincere thanks to Dimitra Panagiotoglou, PhD student in the School of Population and Public Health, who prepared this report.



Ministry of  
Health



MICHAEL SMITH FOUNDATION  
FOR HEALTH RESEARCH

Discover. Connect. Engage.