Consumer-Directed Home and Community Services Programs in Five Countries: Policy Issues for Older People and Government

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A major innovation in long-term care for elderly persons in the United States and Europe is the development of consumer-directed home care. These governmental programs give consumers, rather than home care agencies, control over who provides services and how these services are delivered. Typically, consumer-directed programs allow the consumer to hire, train, supervise, and fire the home care worker. In some programs, beneficiaries receive cash payments enabling them to purchase the services they want. In contrast, traditional home care programs rely on public or private agencies to supply and supervise the workers who serve program beneficiaries.

The empowerment philosophy undergirding consumer-directed home care has been slow to take hold among programs serving older people because of concerns about whether older persons either want to or are capable of directing their services. How to assure quality of care without agency oversight and accountability also has been a major concern.

This article analyzes the development, design, and experience of consumer-directed home care programs in Austria, Germany, France, the Netherlands, and the United States (US). The US states included in this study are California, Colorado, Kansas, Maine, Michigan, Oregon, Washington, and Wisconsin (Tilly and Wiener 2000). In all of these countries or states, older people can and do participate in consumer-directed programs.

Information for this article comes from two sources: First, this article reviews available quantitative research from each country on program outcomes for beneficiaries, their caregivers, workers, and quality of services. The French and Dutch studies report on demonstration projects that preceded implementation of national programs (Simon and
Martin 1996; Miltenburg et al. 1996). Two other Dutch studies surveyed beneficiaries and workers about their experiences several years after implementation of the new national program (Baarveld et al. 1998; Woldringh and Ramakers 1998). Similar surveys of program beneficiaries come from Austria, Germany, and the US (Badelt et al. 1998; Runde et al. 1996; Benjamin et al. 1998).¹

Second, we conducted interviews with representatives of government, beneficiaries, unions, and home care agencies in each country. In total, forty-seven sets of interviews were conducted with government officials and key stakeholders: fourteen with government officials, ten with advocates for younger people with disabilities, six with advocates for older people, ten with home care agency association staff, and seven with union officials. The people interviewed were asked to share their views of how consumer-directed programs worked in their countries or states.

**Program Design**

In setting up their consumer-directed programs, each country had to make decisions in such key areas as administration, eligibility, resource allocation, covered services, financing, and cost containment. Table 1 provides detailed descriptions of the consumer-directed home and community services programs in the five countries; information for this table comes from the interviews. It should be noted that agency-directed programs exist in all of these countries except Austria, which only has a consumer-directed program. In the Netherlands and the US, the agency-directed programs dominate the long-term care systems, while consumer-directed programs dominate in France and Germany.

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¹ Native German and Dutch speakers translated the literature from Austria, Germany, and the Netherlands. The first author translated the French documents.
Administration

The entities administering the consumer-directed programs are either subnational insurance funds (Austria, Germany, and the Netherlands) or state or local governments (France and the US). In no country does the national government administer the entire program. The situation is particularly variable in the US because states are not required to offer consumer-directed programs.

Functional Eligibility

Every country uses some measure of ability to perform daily activities to assess whether applicants are eligible for benefits and what those benefits will be. German critics contend that the eligibility criteria do not take into account the supervision needs of people with cognitive impairment; in France, critics say the assessment instrument biases eligibility toward those who have medically related needs. People with cognitive impairment can participate in all programs, except for a few in the US. Most programs require or permit persons with cognitive impairment to have surrogate decisionmakers.

Services

The countries or states provide beneficiaries with a cash payment meant to either buy services or support informal caregivers or with a “voucher” to purchase services from an independent worker. Beneficiaries have varying degrees of choice over how to use their benefits. In Austria and Germany, there are no significant restrictions on use of the cash benefits and the national governments do not monitor how beneficiaries spend their money. In fact, most cash benefits in these two countries are passed along to informal caregivers or are contributed to household budgets rather than used for purchase of formal services. France gives beneficiaries a cash allowance, most of which must be
used to pay workers. Dutch beneficiaries receive a voucher to purchase services from individual workers or agencies. The programs in the Netherlands and France have small benefit set-asides that can be used for virtually any kind of service or equipment. The Netherlands and most of the US programs generally permit beneficiaries to hire and fire workers but have fiscal agents pay those workers. All five countries allow beneficiaries to hire or pay relatives.

**Financing**

The countries are split as to whether these services are available on a universal basis or whether they are limited to the low-income population. Austria, Germany, and the Netherlands provide benefits without regard to financial status. In France and most programs in the US, benefits are limited to the low-income population.

Funds for the programs come from either insurance premiums or general revenues. Germany and the Netherlands finance their social insurance programs with mandatory premiums based on salary level and in Germany on retirement benefits. Although it is a non-means tested-benefit, Austria funds its program with general revenues. France and the US fund their means-tested programs from general revenues.

**Cost Containment**

A potential concern about consumer-directed programs, especially those with a cash benefit, is that they will be so desirable that demand for services and expenditures will increase uncontrollably. None of the observers reported that expenditures were out-of-control. Every country has strict limits on the eligibility, benefits, and funding of consumer-directed programs. Although Austria and Germany have universal benefits, eligibility is limited to persons with severe disabilities and benefit amounts are not
indexed for inflation. The Netherlands contains costs by setting a global budget for home care and limiting the consumer-directed portion to just 5 percent of the total. The complexity and slowness of the means-testing process in France are believed to have a deterrent effect on applications. American programs use caps on the number of beneficiaries, strict functional and financial eligibility criteria, and limits on cost per beneficiary to control expenditures.

**Experiences of Beneficiaries and Their Caregivers in Consumer-Directed Programs**

Consumer direction gives beneficiaries, rather than home care agencies, the power to hire, fire, and supervise workers. Which beneficiaries want to take on such responsibility, and how does the shift in power affect them and their caregivers?

**People Who Want Consumer Direction**

The majority of government and consumer representatives we interviewed stated that personality and personal circumstances rather than age are the most important influences on whether beneficiaries want to direct their services. People of all ages who are assertive and have a broad support network to help choose workers are most likely to want consumer direction. Some consumer advocates said that most people with disabilities, including those with cognitive impairment, could take on consumer direction with proper training and support.

Government and consumer representatives generally reported that younger people with physical disabilities are the most vocal in expressing their preference for consumer direction, primarily because they are more aware of this option and want to be independent of their families. These representatives added that older persons with disabilities are less likely to articulate a preference for consumer-direction and tend to
accept the agency structure more readily. Agency and union representatives contended that older people cannot handle the management tasks by themselves and prefer the security that agencies offer.

Several surveys in the US suggest a moderate level of interest in consumer-directed care by older persons, although substantially less than among younger persons with disabilities (Glickman et al. 1997; Desmond et al. 1998; Mahoney et al. 1998; Simon-Rusinowitz et al. 1998). Data from the Netherlands and Germany show that younger people are more likely to choose consumer direction than older people. The average age of those with allowances in 1997 was 57.5 in the Netherlands, compared with 71 for those with agency services (Woldringh and Ramakers 1998). Internal German long-term care insurance fund data show that younger, less frail beneficiaries who were new to the program were most likely to choose the cash benefit option.

Stakeholders from every country agreed that people with cognitive impairment need significant support in managing services. Observers in the US believed that people with cognitive impairment might make decisions that would be contrary to their best interests, such as failing to see a physician for medical problems, and are vulnerable to theft and abuse. French respondents reported that people with mild cognitive impairment are the most problematic because they do not meet the legal requirements for appointment of a surrogate decisionmaker and may not have anyone available to help with administrative tasks.

Despite these concerns, people with cognitive impairments are allowed to participate in at least one consumer-directed program in each country. The Netherlands tries to minimize risk to beneficiaries with cognitive impairment by requiring surrogate
decisionmakers, but the other countries do not have such a requirement. Surrogates are family members or personal advocates of some kind who act on the client's behalf.

**Beneficiary Experiences in Consumer-Directed Programs**

The government and consumer representatives we interviewed generally believed that consumer-directed programs give beneficiaries more control over their lives and choice over services. Some observers view agencies as unresponsive to consumers’ preferences because of agencies’ scheduling and staffing practices. Agencies must juggle the schedules of workers and have difficulty providing services early in the morning, late in the evening, and on weekends. Scheduling problems may also cause a beneficiary to have several different workers. In addition, agencies set rules regarding service delivery that may limit responsiveness to consumer preferences.

In contrast, agency and union representatives generally argued that consumer-directed and agency-directed services are equivalent in terms of responsiveness to beneficiaries’ preferences and choice. However, this view was not universal among this category of observers.

The quantitative survey data from California, Austria, and France indicate that beneficiaries who direct their services have more control over them (Benjamin et al. 1998; Badelt et al. 1997; Simon and Martin 1996). In Germany, 85 percent of survey respondents who chose cash benefits reported that an advantage of that type of benefit is the ability to decide how to use benefits (Runde et al. 1996). Only 27 percent of those receiving agency services reported the same advantage. Californians directing their own services reported significantly more choice over their services than those with agency workers (Benjamin et al. 1998). In a randomized control trial conducted prior to
implementation of their consumer-directed program, Dutch participants with consumer-directed care said that they had more control over their services than the comparison group receiving traditional agency services (Miltenburg et al. 1996). Another Dutch study conducted several years after national program implementation found that beneficiaries directing their services had significantly more influence over services, choice of provider, method and timing of service delivery, and freedom of choice than matched controls receiving care from agencies (Woldringh and Ramakers 1998).

Agency and union representatives contended that consumer direction increases the consumers’ management burden, particularly in recruiting workers and arranging backup workers in case of emergency. The French demonstration project showed that 66 percent of respondents believed that an advantage of agency services is the avoidance of management tasks (Simon and Martin 1996).

The Dutch and French stakeholders pointed out administrative and bureaucratic obstacles to consumer direction. In the Netherlands, the fiscal agent charged with paying individual workers created problems for consumers because it was late in paying individual workers. In France, stakeholders almost universally condemned the program’s bureaucratic procedures and inefficiency (Comite National de Vigilance 1998). The French program has a means-testing procedure that involves a complicated calculation of the rental value of assets as part of income, and recovery of program benefits from the estates of deceased beneficiaries (ODAS 1998). Processing of applications is often very slow.

All study countries except France provide some assistance to help beneficiaries carry out their management tasks of recruiting, training, supervising, disciplining, and
paying their workers. This aid, however, is usually very limited. For example, in Germany and Austria, assistance consists mainly of provision of lists of participating providers and their prices to consumers and the operation of consumer hotlines. Most of the eight US states offer some very limited consumer training, education, and peer support, and lists of potential workers available from local Independent Living Centers or county governments. In the Netherlands, a consumer advocacy group provides telephone assistance and some help with bureaucratic procedures, but currently has no governmental financial support for its activities. The major management aid to consumers in the US, France, and the Netherlands is the use of fiscal agents to reimburse workers and to pay relevant taxes.

**Experiences of Workers in Consumer-Directed Programs**

Workers in traditional home care programs receive their salaries from agencies and work under agency rules. In contrast, in consumer-directed services, workers are directly answerable to beneficiaries. How do individual workers’ experiences compare to those of agency workers?

**The Role of Family Caregivers**

Family caregivers play a vital role in consumer-directed programs by continuing to care for beneficiaries informally or being willing to work for them. In the Netherlands, 60 percent of workers were family, friends, or acquaintances of beneficiaries (Baarveld et al. 1998). The French demonstration project found that 30 percent of workers were family members (Simon and Martin 1996). About 75 percent of individual workers in California were family members or friends of the beneficiaries (Benjamin et al. 1998). Although quantitative data are not available, it is widely assumed by observers in Austria
and Germany that beneficiaries rarely go into the marketplace to "hire" workers, depending instead on informal caregivers. Government representatives from four of the eight US state programs estimated that half or more of their consumer-directed beneficiaries hire informal caregivers.

Many of the stakeholders we interviewed argued that the benefits of giving money to family caregivers are support of the informal care system and an expansion of the labor pool available to provide services, an important factor in areas with labor shortages. Indeed, in Germany, most stakeholders view the cash payment primarily as a mechanism to support informal caregivers rather than a means to purchase services. In general, a minority of agency and union representatives were opposed to hiring family, contending that the program benefit becomes an income stream for the family rather than a way of increasing services for people with disabilities. Most agency and union representatives contended that family workers should have the same training, benefits, and oversight as other workers.

Some studies suggest that only a small minority of informal caregivers changed their working or caregiving situations as a result of cash allowances. Ten percent of Austrian caregivers reduced hours worked at their place of employment and 9 percent quit their jobs as a result of the allowance (Badelt et al. 1997). Half of the Austrian caregivers reported that the allowance permitted them to coordinate their loved ones’ care better, and 60 percent of caregivers said the allowance covered most of their caregiving costs.

There is some evidence that family workers have higher emotional stress than do nonfamily workers. Family caregivers who worked for California beneficiaries were
more likely to feel close to their beneficiaries than other types of workers (Benjamin et al. 1998). However, they also experienced increased emotional burden—for example, worrying about safety issues more than other individual workers.

**Workers’ Relationships with Beneficiaries**

The majority of observers we interviewed said that individual workers have closer working relationships with beneficiaries than do agency workers. These relationships develop from individual workers knowing beneficiaries before becoming their employees, having fewer clients, and staying with clients for long periods of time. In the Netherlands, 90 percent of Dutch individual workers reported positive personal relationships with beneficiaries and work environments (Baarveld et al. 1998). In California, about 75 percent of individual workers knew the consumers before starting work versus only 7 percent of agency workers, and the average agency worker had about four clients versus 1.4 for independent workers (Benjamin et al. 1998).

**Workers’ Control over Their Environments**

The majority of stakeholders we interviewed argued that individual workers have more control over their work schedules and tasks than do agency workers because individual workers are not subject to agency rules. In contrast, about half the union representatives said that individual workers had less control over their schedules than agency workers because individual workers have to adjust to the demands of their clients. A survey of Dutch agency workers, who also worked for consumer-directed beneficiaries, found that workers had more control over their own work when employed by beneficiaries directly (Baarveld et al. 1998).
Disadvantages of Working Directly for Consumers

While there are advantages, there are also downsides to being an individual worker. Close relationships with beneficiaries can lead individual workers to provide more care than they are paid to deliver. About 61 percent of independent workers in California provided unpaid assistance to consumers, compared with 12 percent of agency workers (Benjamin et al. 1998). Four-fifths of family workers provide unpaid assistance, whereas 43 percent of other individual workers do so. In addition, individual workers are likely to be isolated from their peers. According to most observers, agency workers benefit from peer support, supervision, and emergency backup when scheduling problems occur. However, the reality of agency supervision may be limited. In California, about 37 percent of agency workers reported no or very little supervision (Benjamin et al. 1998).

Another downside of being an individual worker relates to fringe benefits. Stakeholders agreed that individual workers tend to have fewer fringe benefits than agency workers. Fringe benefits include vacation and sick leave, travel pay, health and pension plans, workers compensation insurance, and unemployment insurance. About 40 percent of California agency workers reported receiving health benefits, paid sick leave, and paid vacation, and about 60 percent of agency workers reported receiving paid holidays and payment for travel costs (Benjamin et al. 1998). Few individual providers reported receiving these benefits.

Disparities in access to fringe benefits also exist in the Netherlands and, until 1998, in France. Dutch beneficiaries who employ an individual worker less than 12 hours a week do not have to pay certain taxes that those employing full-time workers
must pay. In addition, individual workers do not benefit from collective labor agreements that guarantee agency workers short- and long-term disability insurance as well as other benefits such as reimbursement for travel expenses. Until recently, certain French beneficiaries employing individual workers did not have to pay the same social security taxes that agencies did. Agencies complained and successfully won exemption from these taxes, decreasing benefits for agency workers.

Some of the Austrians we interviewed expressed concern about the development of a “gray market” for home care workers. This may be developing in Austria because that country requires beneficiaries hiring individual workers to pay all relevant social insurance taxes. As a result, some beneficiaries may be hiring low-cost workers from neighboring countries, such as the Czech Republic or Hungary, to avoid paying these taxes. These workers would not receive the social insurance benefits that Austrian workers do.

While individual workers do not have access to the fringe benefits that many agency workers do, comparisons between the wages of individual and agency workers are difficult because the available data are inconsistent. Most observers from the Netherlands and France said that individual workers have lower hourly wages than agency workers. While lower wages for individual workers is widely believed to be the case in the US, government and consumer representatives in several states reported that it is at least possible for individual workers to receive higher wages than agency workers if the former have longevity with a beneficiary or perform certain types of tasks. In addition, research on the Netherlands’ national program did not find significant wage differentials between individual and agency workers (Baarveld et al. 1998).
Quality of Consumer-Directed Services

The quality of consumer-directed services is probably the most highly contested issue facing policymakers. Traditional home and community services programs for older persons attempt to assure quality by relying heavily on government regulations that require the provision of services by professionals, training requirements for paraprofessional staff, and agency supervision of paraprofessionals. Almost all of these mechanisms are lacking in consumer-directed care.

Quantitative studies of quality of care have focused on consumer satisfaction, rather than other measures, such as delay of functional decline or absence of avoidable hospitalizations, that may be important indicators of quality. In a study of California home care beneficiaries, consumer-directed respondents reported more satisfaction with their services and more freedom to select them, higher perceived quality of care, and higher emotional, social, and physical well-being than did agency-directed respondents (Benjamin et al. 1998). Consumer-directed respondents also reported greater satisfaction with the providers’ ability to assist them than did agency-directed clients.

In a study of persons receiving Medicaid personal care in Maryland, Michigan, and Texas, beneficiaries with a great deal of choice consistently reported more satisfaction with their services than did those without choice (Taylor et al. 1991; Doty et al. 1996). For example, about 60 percent of those reporting little choice were very satisfied with their aides, compared with 90 percent of those reporting a great deal of choice.

Most government representatives believed that beneficiaries with consumer direction are more satisfied, have more control over services, or have better quality of life
than those receiving agency services. The opinion of disability representatives was uniform—they all believed that consumers have better-quality services under consumer direction and cite reasons similar to those of government representatives. Most aging representatives shared these opinions. The majority of home care agency and union representatives believed that there are no differences in quality between the two models in terms of quality.

When it came to people with cognitive impairment, virtually every government official and stakeholder expressed concern about the potential for problems with quality of care. Respondents worried that individual workers might not deliver the services they were paid to deliver and that people with cognitive impairment might have trouble with management responsibilities under consumer direction.

Despite these concerns, beneficiaries in all countries are primarily responsible for quality assurance in consumer-directed programs. Governmental quality assurance activities in all of the study countries for consumer-directed programs are fairly minimal, consisting mostly of responding to complaints, periodic home visits, and telephone contact with beneficiaries.

**Conclusion**

As the US considers expanding consumer-directed home and community services programs to the older population, much can be learned from program and research developments here and abroad. What lessons can be drawn from the experiences of the US, Germany, Austria, France, and the Netherlands?

First, quantitative surveys and interview results indicate that older people are less likely to want consumer direction than younger persons, but that a significant minority
prefer consumer direction. Programs should be flexible enough to allow beneficiaries to manage their own services when they want to, while providing agency services for those who do not want to or are incapable of management. The bottom line is that older persons are not homogeneous and should have a choice of management models.

Second, while some older persons want to and currently do direct their own services, a significant portion of stakeholders raised questions about the capacity of older people to manage their own care, largely related to the prevalence of cognitive impairment among the older population. Despite these concerns, every study country allows cognitively impaired persons to participate in these programs, relying on surrogates to make the decisions for the consumers. While a reasonable accommodation to the limits of the cognitively impaired, it should be recognized that the decisions of surrogates are not perfect representations of the choices that the clients would have made if they were not impaired. Most countries and states do relatively little to help clients cope with the management tasks inherent in consumer direction, leaving clients to find their own way, with the exception of those sites using fiscal agents to pay workers.

Third, probably the most controversial issue relating to consumer-directed programs relates to whether quality of care is adequate and how services should be monitored. Compared to agency-directed care, consumer-directed services lack the standard quality assurance mechanisms. Nonetheless, limited quantitative research and interviews with stakeholders suggest that at least client satisfaction, if not quality of care, with consumer-directed services is comparable to agency-directed care and may be higher. Stakeholders were more anxious about the quality of care for people with cognitive impairment because of their vulnerability to abuse.
In place of formal quality assurance mechanisms, consumer-directed programs rely on the ability of clients to fire unsatisfactory workers and to hire replacements to assure quality—in other words, the market. The current labor shortage in the US, which makes recruitment difficult for all long-term care services, may threaten the quality of these services by undermining the willingness of clients to fire poor-quality workers, perhaps increasing the need for more formal quality assurance mechanisms.

Fourth, independent workers appear to fare better than agency workers in their work environment (although this is contested by home care and union representatives), but do less well financially. Clearly, part of the attraction to policymakers of the consumer-directed model is its low per-person cost. Payment rates for consumer-directed care are much lower than for agency-directed care, partly due to the lack of agencies' administrative overhead and partly because workers receive less in the way of health benefits, vacation, and other fringe benefits. At least in some of the study countries and states, workers' hourly wage rates do not appear to be much different between the consumer-directed and agency-directed models.

A major worker-related issue is that a high portion of independent workers are family members. At least in California and the Netherlands, the vast majority of independent workers were known by the client before they became paid caregivers. In Germany and Austria, the norm is to use the long-term care payments to support informal caregivers. Many of the 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. The adage that "blood is thicker than water" may account for some of the countries, and states' relatively "laissez-faire"
approach to program management and for some of the positive results on consumer satisfaction.

In sum, the notion of consumer-directed home care challenges the protective nature of most home and community services programs for older people by asserting that clients want to and are capable of managing their own care. While there seems to be little reason for cognitively intact persons not to be able to do so if they want to, the situation is much more complicated for persons with cognitive impairment. To aid consumers, countries may want to consider whether a more activist approach to providing supports, such as worker registries and monitoring of client satisfaction, would be desirable.
References


<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Austria</th>
<th>Germany</th>
<th>France</th>
<th>The Netherlands</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Functional eligibility</strong></td>
<td>Age 3+ and need for 50+ hours of care a month or be in a wheelchair.</td>
<td>Need for assistance with 2 ADLs and some IADLs.</td>
<td>Need for assistance with toileting and dressing.</td>
<td>Need for help with ADLs or IADLs; need for nursing care cannot exceed 3 hours a day.</td>
<td>Need for assistance with ADLs and IADLs.</td>
</tr>
<tr>
<td><strong>Number of beneficiaries</strong></td>
<td>310,000.</td>
<td>1.28 million home care beneficiaries.</td>
<td>86,000.</td>
<td>7,260.</td>
<td>Ranges from about 4,000 to 200,000 per program.</td>
</tr>
<tr>
<td><strong>Services covered</strong></td>
<td>Any services desired.</td>
<td>Any services desired.</td>
<td>Primarily assistance with ADLs and IADLs. Small amount of benefit set aside for flexible use.</td>
<td>Primarily assistance with ADLs and IADLs. Small amount of benefit set aside for flexible use.</td>
<td>Primarily assistance with ADLs and IADLs.</td>
</tr>
<tr>
<td><strong>Benefit amounts</strong></td>
<td>7 benefit levels relating to the number of hours of care needed and levels are not indexed for inflation.</td>
<td>3 benefit levels based on severity of disability. Beneficiaries choosing cash receive about half of the value of services benefits. Benefits are not indexed for inflation.</td>
<td>National maximum benefit is 5726F a month for a single person. Departments multiply the hours in the care plan by the appropriate payment rate to arrive at the beneficiary’s benefit. Then income-related deductions are taken.</td>
<td>Hours of care needed are multiplied by national, standard rates to determine the benefit level. Income-related deductions are taken.</td>
<td>States limit hours of care or set dollar limits on benefits. Two states have no benefit limits.</td>
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<tr>
<td><strong>Funding sources</strong></td>
<td>General tax revenues.</td>
<td>1.7% of salaries and pensions shared by employees and</td>
<td>Departments’ local taxes.</td>
<td>Worker premiums.</td>
<td>Generally, states combine Medicaid and state-only funds.</td>
</tr>
<tr>
<td>Possible to hire a relative</td>
<td>Yes.</td>
<td>Yes.</td>
<td>Yes, except for spouses, live-in partners, and people receiving retirement income.</td>
<td>Yes.</td>
<td>Yes, but most states prohibit hiring spouses.</td>
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<tr>
<td>Quality assurance</td>
<td>Visits to randomly selected beneficiaries to make sure they are getting care.</td>
<td>Periodic visits to determine that cash beneficiaries are receiving adequate care.</td>
<td>Annual visits to beneficiaries to ensure they receive effective services.</td>
<td>Budget holders have a legal obligation to obtain good-quality care. Social insurance banks take random samples of budget holders to determine if money is well spent.</td>
<td>All states monitor quality in some manner.</td>
</tr>
</tbody>
</table>

Notes:
1. Austrian data are from 1997; German, French, and Dutch data are from 1998; and US data are from 1999.
2. ADLs are activities of daily living, which include such tasks as eating, bathing, and dressing. IADLs are instrumental activities of daily living, which include such tasks as shopping, preparing meals, using the telephone, and medication management.