A cross-national comparison on home care in Europe Summary of the findings

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The European Association of Organizations for Home Care and Help at Home has commissioned the Netherlands Institute of Primary Health Care (NIVEL) to carry out an international comparative study on home care in the member states of the European Union. The purpose of this study is to provide a systematic overview of the way home care is organized and funded in the fifteen countries. In the study, home care has been restricted to nursing care at home and home help services.

In this chapter firstly, the background and the methods of the study are described. Secondly, a cross national comparison is made on the main trends in the financing and organization of home care in the European Union based on the data collected in the separate countries. Finally, some problems in home care that arise in many countries are discussed. In the cross-national comparison, the situation of home care in each country is generalized, neglecting all kinds of variations within a country, despite the fact that in some countries the differences between regions are very large. In chapters 1 to 15, however, a detailed description of the organization and financing of home care in each separate country is given.

1 Background and research questions

Information on home care in the member states is needed because of a number of important developments in Europe.

The Unification of Europe. The Treaty of Maastricht in 1992 was an important step towards a greater integration of the countries within the European Union (EU). The Union which started as a purely economic organization called the European Economic Community (EEC), now also finds itself in a process of mutual co-operation and integration of policies in other areas such as education, culture, social security and health care. Consequently, information about the present situation in home care services is required to improve communication and co-operation among home care organizations as well as among policy makers at European Union level. In addition, the increasing integration of the member states is also reflected in the extended opportunities for nurses to work in other countries (free movement of people within Europe). Although there are EU guidelines concerning the education and training of nurses, it is also important for a country to know the organizational structure in which the foreign nurse actually worked in her/his own country, which job she/he did and how she/he was paid.

Increasing demand. Nearly all countries of the European Union are being confronted with an steady increase of the percentage of the elderly in their populations. The proportion of people over 80, in particular, is increasing rapidly [1,2]. This leads to a rise in the demand for professional home care which is enforced by the fact that the role of informal carers, such as family members and friends, is decreasing in most of the countries. Smaller families, a growth in women's employment and an increasing number of elderly single people are the main causes of this development [3].

Policy of substitution. A second common problem is the development of health care expenditure. Owing to an increase of the costs of health care, governmental policies are increasingly focused on home care instead of institutional care (both residential care for the elderly, and hospital care for the sick). The aim is to let the elderly stay in their own homes as long as possible and to limit the length of stay in hospitals [3,4].

The changing nature of home care. Besides a quantitative growth of the demand for home care, there are also important changes in the content of the care provided. Because of epidemiological developments, the policy to substitute home care for hospital care and the increase in opportunities to

France, Italy, the Netherlands and the United Kingdom. This means that there was no specific information on home care available for Austria, Greece, Ireland, Luxembourg, Portugal, Spain and Sweden. Information from the other countries also needed to be updated because major changes had recently occurred.

Experts on home nursing and/or home help services were contacted in all countries. Preference was given to people engaged in research into home care or involved in home care policy, both at the governmental or professional level, because it was important that they were able to provide a national overview. The experts were identified by means of:

- personal contacts of NIVEL: e.g. from earlier research in this field and participation in conferences about this subject;
- contributions to the literature on home care: e.g. participants in the studies of Nijkamp et al., Jamieson, and Verheij and Kerkstra [4,5,6];
- members of the European Association of Organizations for Home Care and Help at Home.

Potential experts received a letter asking them to participate or asking whether they knew others who were able to provide the information required. The first objective was to find one expert on home nursing services and one expert on home help services in each country. However, in some countries one expert for both kind of services was sufficient, and in other countries more experts were required. A complete list of all participants is given in Appendix 1.

The questionnaires, in English, were sent to all experts. There were separate questionnaires for home nursing and home help services. The questionnaires were in two parts. Part one contained questions on the organization of home nursing or home help services. Topics discussed were the organizational structure, the type of nurse or home help working in home care, the patients or clients, and the way services were provided. Part two contained questions on the financial aspects, e.g. the funding of the home care organizations, the salaries of the nurses and home helps, the insurance system and (co)-payments by patients or clients.

To allow comparison of the information from the fifteen countries, one reference date was chosen -the end of december 1993- unless important changes had taken place in 1994. When quantitative information was required, concrete and the *most recent* figures based on official statistics or research results were preferred. However, if such published information was

not available in the country, participants were asked to make their own estimate for 1993.

In addition, experts in Austria, Denmark, Finland, France, Germany, Italy, Luxembourg, Sweden and the United Kingdom were visited personally by one of the researchers to collect additional information, e.g. about recent developments.

After all information had been collected, a draft chapter of home care in each country was written and returned to the national experts for correction and additions.

It is important to note that there are differences among countries in the type and amount of information. In some countries, it was hard to get data at a national level. Because there are large differences within the country and for a lack of organizations or institutions collecting statistical data on home care.

3 Home care from a cross-national perspective

Nowadays, all fifteen member states of the European Union have organizations for home nursing as well as for home help services, although in Greece and Italy the organization of home care is still in its infancy. In many parts of these countries there are no home nursing or home help services available. In all countries home nursing is part of the health care system, whereas home help services in most countries are part of the social services. In Sweden, since 1992, as part of the reform of the health care system, home nursing will no longer belong to primary health care but to the social services. In some regions of Italy home nursing care is also provided within the social services. Consequently, home nursing and home help services are financed in a different way.

3.1 The financing of home care

Funding of home nursing organizations

In all countries studied, home nursing organizations were usually non-profit. In some countries, however, cost-containment measures include the introduction of competitive elements in the health care system. This may mean the advent of a for-profit sector in home nursing too.

Two funding models for home nursing organizations can be distinguished.

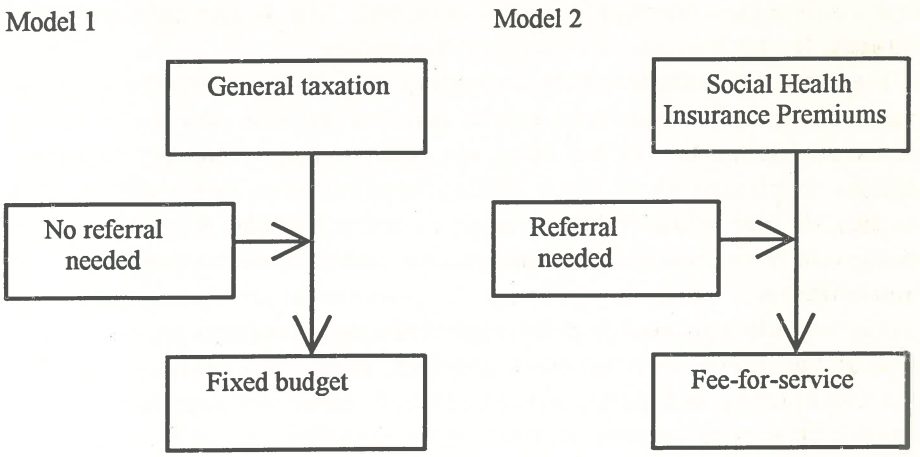

Figure 1
Two models of funding home nursing organizations in the European Union

In the first model, home nursing is mainly financed from general taxation. The home nursing organizations receive a fixed budget from the central government or local authorities. The budget generally depends on the number of inhabitants or of the elderly in the catchment area or on the number of staff. In this model, patients have direct access to the home nursing organization, that means that no referral of a doctor is needed. This is the main model in Denmark, Ireland, Italy, Portugal, Spain, Sweden and the United Kingdom.

However, the funding system in the United Kingdom is undergoing a significant change. In the old system, model 1 is applied, i.e. the District Health Authorities receive a fixed budget based on the number of inhabitants and the demography of the population. In the new system, the funding of the new Community Trusts is based on the services that they deliver to patients. This means a shift from fixed budget funding to a fee-for-service reimbursement. At present both systems co-exist.

In the second model home nursing is largely financed through a social health insurance scheme. In these countries the premiums for this compulsory schemes are paid by employees and/or employers. In this model home nursing organizations are reimbursed on a fee-for-service basis. To receive

reimbursement, a medical referral is required. This is the main model in Austria, Belgium, France, Germany and Luxembourg.

There are various types of reimbursement on a fee-for-service basis. In the most simple type, reimbursement takes place on the basis of a list of nursing activities (nomenclature) and states the price of these activities. This price can be reimbursed to the home nursing organization or to the patient. This method is part of the reimbursement system in Austria, Belgium, Luxembourg and France. In these countries mainly technical nursing procedures are reimbursed and hardly any preventive or psychosocial activities. Especially in Austria and in Luxembourg only technical nursing procedures prescribed by a doctor are reimbursed. In these countries, more basic nursing care like bathing and help with getting out of bed is not reimbursed and has to be paid by the patients themselves. However in Luxembourg, people living at home who need care receive as partly compensation a monthly government allocation and in Austria, since 1993, everyone who is in need for home care for more than six month can apply for an attendance allowance (*Pflegegeld*) by the municipality.

Reimbursement can also take place, based on the number of home visits. Here a distinction can be made between various types of home visits according to the type of care that is delivered during these visits. This is the case in Germany, where a distinction is made between *Grundpflege*, which involves mainly personal hygiene care, and *Behandlungspflege*, concerning technical nursing procedures as a support for medical treatment. However in 1995 in Germany the funding system is changed. Patients are categorized in three levels of need for nursing. The home nursing organization receives a reimbursement per patient per month according to the level of care dependency of the patient. There is a maximum allowance for each category. Furthermore, it is also possible to provide a budget to the patient him/herself, allowing him/her to buy his own home care.

A third type of fee-for-service reimbursement is based on the number of days of care. This is part of the system in Belgium as far as heavily or moderately dependent patients are concerned. The amount reimbursed varies with the level of care dependency of the patient.

In France, a special form of the fixed budget method exists in addition to the fee-for-service system. Here the organization is authorized by the Health Insurance funds to care for a fixed number of patients under two schemes: 'Hospitalization at home', under this scheme most patients are discharged from hospitals, and 'Elderly care at home'. Patient's reimbursement is about

three times as high for 'Hospitalization at home'.

Finally, in Finland, Greece and the Netherlands a mixture of the two models is used. Home nursing in Finland is funded from general taxation and the health centres which provide nursing care receive a yearly fixed budget from the municipalities, but patients have to be referred by a general practitioner. In Greece no referral of a doctor is needed, but only the home nursing organizations of the National Health Services and the Hellenic Red Cross receive a fixed budget; private organizations are reimbursed on a fee-for-service basis. In the Netherlands, home nursing is financed by a compulsory social health insurance scheme, but the home nursing organizations receive a 'fixed' budget based on the number of personnel, and no referral from a doctor is needed to receive home nursing care. However, in the near future the funding system will be changed i.e. the budget will be based on the number of hours of care provided.

Funding of the home help organizations

With the exception of Greece, organizations for home help services in all countries are to some extent funded or subsidized by the central government (sometimes as part of public insurance), local authorities, based on central or local taxation, or by both (table 1).

Table 1

Funding of home help organizations in the European Union *

Local authorities	Central government	Insurance
Austria	Belgium	France (partly)
Denmark (partly)	Denmark (partly)	Germany (partly)
Finland (partly)	Finland (partly)	Spain
France (partly)	Luxembourg (partly)	
Germany (partly)	Ireland	
Luxembourg (partly)	Italy	
Sweden (partly)	Portugal	
United Kingdom	The Netherlands	
	Sweden (partly)	

* In Greece home help services are not funded by the authorities or insurance schemes

In the Scandinavian countries, Denmark, Finland and Sweden, the home help services are financed through local and national taxation. In Sweden home help is mainly financed through local taxation (75%), the contribution of the central government is 17%, whereas in Finland 46% is financed through state subsidies and 46% through municipal taxes. The municipalities or local communities are responsible for the services and in the three countries they have some freedom to allocate budgets. In Austria home help services are subsidized by the province and municipality. In France, home help services for the elderly with low incomes is financed by the *départements* (30% of the budget) whereas services to clients with a higher income are reimbursed by private insurance companies (45% of the budget). In Germany, only home help provided by *Sozialstationen* in addition to nursing care is reimbursed by the public health insurance companies (Health Insurance fund). Other services, including the services provided by the *Mobilen Sozialen Hilfsdienste* receive some budget from the local authorities based on the number of staff and the number of hours of service provision. Home help services in Luxembourg are financed by the Ministry of the Family (40-50%) and by the municipality (not more than 20%). In the former United Kingdom system, the local authorities were responsible for home help services. They received funding by general taxation. The new system largely involves local authorities buying blocks of home help from independent agencies. The number of hours bought and provided varies enormously across the country. It is estimated that in this transition period some 50% of home help agencies are exclusively for-profit while the remainder are voluntary or still run by local authorities.

Home help services in Belgium, Ireland, Italy, the Netherlands and Portugal are funded by the central government by central taxation. In Belgium, this involves 75% of the costs of home help services and the subsidy is based on the number of clients, home helps and cleaners. The number of hours of home help that can be reimbursed is fixed per organization. Public funding of the home help services in Ireland takes the form of a fixed budget which is negotiated from year to year, based on assumptions about the number of home help organizers, the estimated number of clients served and historical criteria such as the given pay rates for a particular Health Board. These latter vary greatly for home helps and to a lesser extent for home help organizers. The social services of the local authorities in Italy are for about 50% financed through general tax revenues. The state contribution is distributed among the local authorities by the regions. The amount of subsidies is based on the

number of potential users, the actual users, the available personnel and the functions of the social services. In some regions, local authorities contract out the home help services to private organizations, the social co-operatives. These private organizations are reimbursed on the number of hours that home help is delivered and receive no structural funding. In the Netherlands, since 1 January 1989, about 90% of the costs of home help services have been financed by a system of public insurance based on the General Act on Exceptional Medical Expenses (AWBZ). The premiums are collected through taxes by the central government. The organizations receive a fixed budget based upon the number of inhabitants in the catchment area and the age distribution of inhabitants. In Portugal, the Ministry of Employment and Social Security provides a financial contribution to public as well as private non-profit home help organizations. The budget of each organization is based on the number of clients and types of services provided.

As part of the social services in Spain, the costs of home help services are covered by public insurance. For instance, in the zone of influence of *INSERSO*, about 90% home help services are funded by social welfare administration and the allocated budget is based on the number of hours of care delivered.

Finally, in Greece the home help services delivered by the Hellenic Red Cross and the Orthodox Church are funded by their own resources and from voluntary contributions. The costs of home help from private organizations have to be paid by the clients themselves.

Co-payments by the clients

In the majority of the member states there is no co-payment for home nursing, that is home nursing services are usually free of charge or are reimbursed by the patients' health insurance. Table 2 shows that in Denmark, Germany, Ireland, Portugal, Spain and the United Kingdom patients do not have to pay for home nursing. In Belgium and the Netherlands only small membership fees have to be paid to the home nursing organization. The membership fee in the Netherlands is about NLG 50 a year per family and in Belgium the membership fee of the White/Yellow Cross varies between BEF 500 and 1000 per family per year. Furthermore, in Belgium and France co-payment depends on the type of insurance of the patient. However, in these countries most people are additionally insured and therefore do not have to pay.

Table 2
Co-payment for home nursing in the European Union

No co-payment required	Sometimes co-payment required	Co-payment required
Denmark	Austria (dependent on type of care)	Belgium (membership fee)
Germany	France (dependent on insurance)	Finland
Ireland	Italy (dependent on type of organization)	Greece
Portugal	Luxembourg (dependent on type of care)	Netherlands (membership fee)
Spain		Sweden
United Kingdom		

As mentioned before, in Austria and Luxembourg co-payment is required for general basic nursing care, but not for technical nursing care prescribed by a doctor. In Italy it depends on the type of organization, whether or not co-payment is required. Home nursing provided by the local health units of the National Health Services is free of charges, whereas for home nursing provided by the social services of the communities and by private organizations, co-payment is required. The level of co-payment is income-related and varies between the communities because the amount is determined by the local authorities. In some communities no co-payment is required.

Finland, Greece and Sweden are the only countries where all patients have to pay fees themselves. For occasional nursing care in Finland, a fee of FIM 30 per visit by a nurse is charged. Concerning a longer episode of care, all patients have to pay a percentage of the costs themselves. The level of co-payment depends on monthly income and the size of the family and varied, in 1994, from 11 to 35%. In Greece for all nursing services at home an co-payment of about 20% of the costs is required. With regard to co-payment in Sweden a distinction must be made between home nursing care provided by county councils (health care) and by the municipalities (social services). In the first situation, patient's fees for home nursing care are a part of a general co-payment scheme for primary health care (with a maximum amount of SEK 1,600 a year in 1994). However, this also includes other kinds of primary health care such as dental care and pharmaceutics. The exact amount

charged per home nursing visit can differ between the regions. It is estimated that the average is about SEK 50. The fees are not income-related. The municipalities providing home care can operate different co-payment schemes for home nursing activities. Sometimes they are included in the total home care fees (including also home help) and it is also possible that the municipalities include the fees in the health care payment system which is mentioned above.

In contrast to home nursing, in most countries co-payment for home help services is required, mostly related to the income of the family and sometimes also to the composition of the household (table 3).

Table 3
Co-payment for home help services in the European Union

Country	co-payment	average % of total costs
Austria	yes, dependent on income	13
Belgium	yes, dependent on income and household composition	20
Denmark	no	
France	not below a certain income, otherwise dependent on old age insurance	
Finland	yes, dependent on income and household composition	11-35
Germany	not for home help in addition to home nursing, otherwise yes	10 *(Sozialstationen)* 20 (other)
Greece	yes, for private organizations full amount of costs	20
Ireland	yes, dependent on the Health Board	10
Italy	yes, dependent on the means of the family	50
Luxembourg	yes, dependent on income	30
The Netherlands	yes, dependent on income and household composition	10
Portugal	yes, dependent on income	n.a.
Spain	yes, dependent on income	10
Sweden	yes, dependent on income and hours of care	n.a.
United Kingdom	yes, different systems	20

Denmark is the only country in which the home help services are usually free of charge, there is only some co-payment for acute home help of non-permanent character (usually for younger persons after accidents), and for additional services like gardening.

In the United Kingdom the arrangements about co-payments vary among the local authorities because there are no national guidelines. In some municipalities each client pays the same amount regardless of the means available, in other municipalities payment is according to income or to the means available, while in yet other municipalities no co-payment is required. In Ireland the amount of co-payment varies among the Health Boards and is also influenced by the negotiating abilities of the clients.

In Germany clients have to pay for the home help services of the *Mobilen sozialen Hilfstdienste* and if the home help is not in addition to home nursing. And in Greece co-payments (for the full costs) are only required by private organizations, not for the services of the Red Cross and the Orthodox Church.

Finally, Table 3 shows that if co-payment is required, the co-payments contribute 10 to 20% of the budget for home help services in the countries. Only in Luxembourg is this contribution about 30% and Italy even about 50%.

3.2 The organization of home care

Organizational structure of home nursing

As mentioned before, in all fifteen member states of the European Union home nursing is part of the health care system. Only in Sweden, since 1992, as part of the reform of the health care system, home nursing will no longer belong to primary health care, but to the social services. Although home nursing belongs to health care in the European Union, there are large differences between the member states both in terms of the history of home nursing and the way it is organized. In Belgium, the United Kingdom, Denmark, Finland, Ireland and the Netherlands home nursing already has a long tradition and has been developed many years ago, whereas in some other countries like Austria, Italy, Spain, Greece, Luxembourg and Portugal home nursing only developed in the last fifteen years or is still being developed. In some countries home nursing has a religious background. For example in (West-) Germany; this can still be seen in the system of umbrella organizations each with its own religious affiliation. But in e.g. home nursing

became the responsibility of the local government at a relatively early stage. France, Spain, Italy and especially Greece do not yet have home nursing in every region of the country.

Related to the differences in financing of home nursing, there are also differences in the organizational structure of home nursing between the member states. The countries differ e.g. with respect to the number of different organizations that provide home nursing (Table 4).

Table 4
Organizational structure of home nursing in the European Union

Mainly one type of organization	Mainly two types of organizations	Three or more types of organizations
Denmark	Belgium	Austria
Finland	France	Greece
Ireland	Germany	Italy
The Netherlands	Luxembourg	
Portugal	Spain	
Sweden		
United Kingdom		

In seven countries, Denmark, Finland, Ireland, the Netherlands, Portugal, Sweden and the United Kingdom, home nursing is provided by mainly one type of organization. As mentioned before, in all of these countries the community nursing organizations receive a fixed budget, although the Netherlands and the United Kingdom are in a transition period towards a fee-for-service funding. In Denmark home nursing is provided by the municipalities (the local communities) by the same department as home help services. At national level the association of communities negotiates with the nurses' association about general guidelines for the relationship between the number of head nurses, nurses and assistant nurse at community level. In Finland health care is also mainly the responsibility of the municipalities. The actual home care is provided from health centres. The local authorities appoint a health board which put a health manager in charge of the health centre. In Ireland home nursing is provided by public health nurses employed by statutory Health Boards, which operate in eight geographical areas. In the Netherlands home nurses are employed by the so-called Regional Cross

Associations or Home Care Organizations. The Cross Associations are members of the umbrella organization The National Association for Home Care which determines policy on the national level. In Portugal the National Health Service covers the whole country with a network of health centres. Home nursing is provided by nurses employed by the health centres. In Sweden the county councils were responsible for home nursing. The care was mostly delivered from primary health care centres. However, The Care of the Elderly reform in 1992 moved the responsibility for the care for the elderly, including home nursing, towards the municipalities. At the end of 1994, in about 50% of the counties home nursing has already been delegated to the municipalities, and this reform process is still going on. As a consequence of this reform, home nursing becomes a part of social services and will belong to the same organization as the home help services. Finally, in the United Kingdom home nursing is also part of the National Health Service and is provided by the community unit of the District Health Authorities or since the reform of the National Health Services in 1990 by the Community Trusts.

In three countries, Belgium, France and Germany, home nursing is provided by mainly two types of organizations. As we have seen before the home nursing organizations in these countries are reimbursed on a fee-for-service basis. In Belgium the largest organization is the White/Yellow Cross which covers the whole country and performs about 50% of all home nursing activities. The much smaller organization is Solidarity for the Family, which provides both home nursing and home help services. Besides these two organizations an increasing number of independent nurses are working in private practices. It is estimated that about 40% of the market is covered by independent nurses. In France the majority of home nursing activities is provided by private non-profit organizations. About one third is delivered by the municipalities. And in addition, there is a large number of independent nurses. In many cases independent nurses are hired by home nursing organizations. And in Germany home nursing is provided by the so-called *Gemeindekrankenpflegestationen* and increasingly by the so-called *Sozialstationen* which also provide home help services. The total of all those non-profit organizations is called the *Freie Wohlfartspflege*. Though the market of home nursing is dominated by non-profit organizations, in recent years a growing number of nurses have decided to work freelance or have developed for-profit nursing organizations, especially in the urban areas. For instance, in Hamburg, 60% of home nursing is delivered by for-profit providers.

Finally, in five countries - Austria, Greece, Italy, Luxembourg and Spain - home nursing is provided by three or more different organizations. Those are also the countries in which home nursing was only developed recently or still has to be developed in some parts of the country. Nowadays professional home nursing exists nearly everywhere in Austria. In most provinces of Austria four or more types of organizations provide home nursing. Some of them provide home help services as well. Home nursing care is provided mainly by independent charity associations but also by organizations which are set up by political parties and by self-organized groups in private business. There are, however large differences between the provinces in the way home nursing is organized. In many parts of Greece home nursing services still do not exist. In some regions home nursing is provided through the National Health Services by nurses from the hospitals, in the big cities home nursing is mostly delivered by for-profit private organizations or by the non-profit Hellenic Red Cross. A main problem in the description of home nursing in Italy is the lack of a general terminology about what kind of services should be provided. For example there is still a discussion whether home care for the chronically ill is a matter of the health care service or of the social services. Officially, home nursing services are part of the National Health Service, but they are not yet extended to the entire country. However in many places home nursing is still organized by the social services of the municipalities. Besides, there are an increasing number of private organizations providing home nursing. In the smallest member state of the European Union Luxembourg the two largest organizations for home nursing are *Hellef Doheem* and the *Croix-Rouge*. In addition there are four smaller organizations, two of them are non-profit organizations that also provide home help services. All those six organizations cover together the whole country. Finally, home nursing is provided within the Spanish primary health care system, which now covers approximately 65% of the total Spanish population. Between the communities large differences exist in the types of home nursing provided. Home nursing has still to be developed in the more rural parts of the country.

Manpower. In eleven countries there are at least two levels of expertise in home nursing. In general, the length of the basic training for the first expert level nurses varies between three and four years. The length of education of the second expert level nurses varies between one and three years. So, there is a lot of variety. A second level home nurse from the Netherlands, for example, has had three times as much training as a second level home nurse

in France. In the remaining four countries, i.e. Italy, Luxembourg, Portugal and Spain, only registered or first level nurses are employed in home care. Maybe, this is due to the fact that home nursing in these countries only recently started. An other reason is that, for example in Portugal, the tasks of home nurses are strictly limited to technical nursing procedures, health education, psychosocial care and support of informal carers. Personal hygiene care like bathing is not a nurse's task.

In all countries, lower level nurses are always more involved with personal hygiene care and uncomplicated technical nursing than those with higher level qualifications. The most highly differentiated system is used in United Kingdom: the clinical grading structure for nursing staff, which was introduced in 1988, has nine grades. Each grade has its own task profile and required qualification and experience. In Belgium, on the contrary, there is no task differentiation between first and second level nurses in home care; both types of nurses have the same legal competence.

Unfortunately it is not possible to make a cross-national comparison on nurse: population ratios, because only organization-specific information about the number of nurses is available for most countries; for other countries this information is only available for particular regions.

However hazardous, it was still considered useful to look at the way in which levels of expertise relate to each other. Table 5 gives the ratios between level of expertise in home nursing in the fifteen countries.

Table 5
Ratios between levels of expertise of home nurses (FTEs) in the European Union

Country	
Austria	
qualified nurse: geriatric aid: assistant nurse	n.a.
Belgium (White/Yellow Cross, liberals excluded)	
graduate nurse : brevetted : hospital assistant nurse	1 : 1.1 : 0.1
Denmark	
home nurse : assistant nurse	n.a.
Finland	
public health nurse : registered nurse : practical nurse	1 : 0.3 : 0.3
France	
salaried and independent nurse : auxiliary	1 : 0.9
Germany (*Sozialstationen*)	
(community) nurses : geriatric aid : auxiliary	1 : 0.2 : 0.1
Greece	
visiting nurse + health visitor : assistant : auxiliary	1 : 1.9 : 17.8
Ireland	
public health nurse : enrolled : home care attendant	1 : .07 : .07
Italy	
registered nurse : -	1 : 0
Luxembourg	
registered nurse : -	1 : 0
The Netherlands (Cross- and Home Care Organizations)	
community nurse : general nurse : auxiliary	1 : 0.1 : .04
Portugal	
registered + public health nurses : -	1 : 0
Spain	
registered nurses : -	1 : 0
Sweden	
registered nurse : home care assistant	1 : 4.4
United Kingdom	
district nurses : RGN : enrolled nurse : auxiliary	1 : 0.2 : 0.3 : 0.4

The ratio's dependent of course on the definition of first and lower levels in each country and the figures should be considered with much caution, but it is legitimate to state that Greece, Belgium and France have a high number of lower level nurses compared to the other countries. Special attention must also be given to the fact that the figures of Greece are based on estimates and the severe shortage of qualified nurses. In Sweden the home care assistants include nursing assistants and qualified home helps. No differentiation is made between these two types of professionals, because their actual tasks look more and more alike. However, one has to keep in mind that about 80% of their working time are spent on home help activities instead of home nursing care. Comparison with the figures of the study of Verheij and Kerkstra [5] showed that, during the last few years, the relative number of lower level nurses in the Netherlands and the United Kingdom has increased; while in Belgium the number of second level nurses has decreased in relative terms.

Provision of services. In all countries it is largely the elderly who receive nursing care at home. They form the largest client population for home nurses. When patients need nursing care at home, they have no choice in almost all cases as to which home nursing organization they can approach because there is only one home nursing organization in their region or because, like in Austria, the health insurance company of the patient has a contract with a particular home nursing organization. Belgium is the only exception: recently the opportunity to choose between home nursing care delivered by formal organizations like the White/Yellow Cross and home care by independent nurses has increased considerably.

As mentioned before, in some countries a medical referral is required for nursing care at home; while in other countries patients can contact the home nursing organizations themselves. In Denmark, Greece, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden and the United Kingdom no medical referral is needed. In Austria and Luxembourg, a formal referral is only needed for (complicated) technical nursing, necessary for reimbursement, and not for other types of nursing care. In France and Germany, a physician's prescription is needed for all types of care eligible for reimbursement. In Belgium this is true with the exception of hygiene care.

As a consequence, countries also differ in respect of who makes the assessment of the patients' need (Table 6).

Table 6
Professionals who are making the assessment of patients' need for home nursing in the European Union

Qualified home nurse	Qualified home nurse and/or physician	Physician
Austria	Belgium	France
Denmark	Finland	Germany
Ireland	Greece	
The Netherlands (partly)	Italy	
Sweden (partly)	Luxembourg	
United Kingdom	Portugal	
	Spain	

In Austria, Denmark, Ireland and United Kingdom, the assessment is made by the first level nurse who is also going to provide the care or have it provided by a lower level nurse. In the Netherlands, within the process of integration of the home help services, most home care organizations plan to combine assessment of patient need for home help and nursing care. There is a debate about who pays the assessment visits: a first level nurse who also provides care, a manager of the home help services or a special assessment team. The fact is that the health insurance companies demand more standardized and objective methods of assessment and support solutions, including special assessment teams, more or less outside the care-giving organization. At this moment therefore, who pays the assessment visits depends on the organization. Within the Swedish home nursing system, two different methods exist. When the nursing care is the responsibility of the county councils, the assessment is made by a registered nurse working in a primary health care centre, but when the care is provided by the municipalities, the assessment is the responsibility of the home help administrator of the social service department. The decision is made within the frame work of the Social Services Act. The home help administrator mostly assesses the total need for home care: both home nursing and home help needs.

In Finland, Greece, Italy, Luxembourg, Portugal and Spain frequently the assessment is carried out by a nurse together with/or by a physician, (sometimes) depending on the patient's need. In Belgium, patients have a

prescription from their general practitioner, which is necessary for reimbursement of all nursing activities except ADL-assistance. After a referral by a doctor, a first or second level nurse pays an assessment visit to decide whether it concerns a dependent, a very dependent or an independent patient. A standardized form (*De aangepaste KATZ-schaal*) is used to determine the patient's degree of care dependency. This assessment of dependency determines for how the care will be financed. And finally, in Germany and France the assessment is always done by a doctor, who prescribes the nursing care.

In summary, there is a tendency that in the countries where a prescription of a doctor is needed, home nurses are less autonomous in the assessment of the need for nursing care and the decision about the provided care compared with home nurses in countries where no medical referral is required.

Organizational structure of home help services

All fifteen member states of the European Union have organizations for home help services as well, although in Greece and Italy the organization of these services is still in development. In some parts of those countries there are no home help services available.

Home help services are not a part of the health care system in most countries but belong to the social services and are organized by and the responsibility of the local authorities, ie. the municipalities.

Table 7 shows that this is the case in Denmark, Finland, Luxembourg, Spain, Sweden and the United Kingdom, whereas in Austria the provinces are responsible for the home help services. Belgium, France, Italy and Portugal have a mixture of home help organizations organized by the municipalities and private organizations. Ireland, Germany and the Netherlands are the only three countries in which home help services are part of the health care system. However, in Germany, this only involves home help services in addition to home nursing delivered by the *Sozialstationen* or *Haus- und Familiepflegestationen*. Home help and additional services for the elderly provided by the *Mobilen sozialen Hilfsdienste* like meals-on-wheels and cleaning services are not part of the health care system. In Ireland, home help services are provided directly by the Health Boards or by voluntary organizations funded by a Health Board. Finally, in Greece home help services are provided by a mixture of private organizations, non-profit organizations like the Hellenic Red Cross and Greek Orthodox Church and

voluntary organizations.

Table 7
Organizational structure of home help services in the European Union *

Social services Municipalities	Social services Municipalities and private organizations	Health care system
Austria	Belgium	Ireland
Denmark	France	Germany (partly)
Finland	Italy	the Netherlands
Luxembourg	Portugal	
Spain		
Sweden		
United Kingdom		

Manpower. In all countries direct help to the clients is provided by home helps. In most countries these home helps do not have formal training, but a few short courses and a 'training on the job'. Only in Belgium, Germany, Italy, Sweden and about 65% of the home helps in Finland and about 20% of the home helps in the Netherlands do have specific training varying from six months to three years in duration. In Denmark, only recently a one year education programme for home helps was introduced.

There are large differences among EU countries in the availability of home help manpower (table 8).

* Home help services in Greece are provided by voluntary non-profit organizations and private agencies. They are not a part of the public health care or social security scheme

Table 8

Number of inhabitants per one FTE home help in the European Union *

Country	Inhabitants per home help (FTE)
Austria (Vienna)	749
Belgium (Flanders)	448
Denmark	161
Finland	528
France	1,410
Ireland	1,165
Italy (Genoa) **	5,690
Luxembourg	6,400
The Netherlands	496
Spain	5,055
Sweden	111
United Kingdom	1,100

Table 8 shows that, in terms of the number of inhabitants, the density of home helps is the highest in Denmark, Finland, Belgium, Sweden and the Netherlands, whereas in Italy, Luxembourg and Spain relatively few home helps are available. A possible explanation for these differences is that in Italy (Genoa), Luxembourg and Spain, home help services only developed during the last ten years and that people in those countries make considerable use of informal care.

Provision of services. Most clients of the home help services are the elderly, many of them living alone. In some countries, like Germany, the Netherlands, Finland and Luxembourg home help was originally aimed at assistance to families with young children in case of the illness or hospitalization of the mother, but gradually emphasis has shifted to helping elderly people. Only in

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* These figures were not available for Germany, Greece and Portugal.

** The figure of Genoa is not representative for the whole country: the national figure is higher.

Finland 35% of the clients are under 65 years of age. Especially, families with young children use home help care, for instance when children are ill and parents have to go to work.

In most countries, there is only one home help organization in a region. Consequently, people do not have a choice what organization they should approach when they need home help. Only in Belgium, there are in some cases more organizations in one region. And of course, people are always free to arrange private help for household tasks, but this solution might be more expensive.

In none of the countries, a referral from an other professional care provider is required for home help services. So, the clients may contact the organizations themselves.

Table 9
First contact with home help services initiated by: *

Client (> 70%)	Client or care provider	Care-providers (> 70%)
Italy	Austria	France
Luxembourg	Belgium	Ireland
The Netherlands	Greece	United Kingdom
Spain	Portugal	
Sweden		

As table 9 shows, in Italy, Luxembourg, the Netherlands, Spain and Sweden most of the clients or their families contact the organizations themselves; whereas in France, Ireland and the United Kingdom, the majority of the clients are referred by other professional care-providers, like general practitioners, hospitals and home nurses. In Belgium, Greece and Portugal about half of the clients contact the organizations themselves, the others are referred.

In all countries, except in Sweden, the assessment of the need for home help is made by a professional (home care organizer), who is not involved in direct home help care. In nearly all countries this professional is a social

* No data were available on this subject for Denmark, Finland and Germany

worker, but exceptions are made in integrated organizations for home help services and home nursing; in that case the assessment is sometimes made together with a nurse or by a nurse. In Sweden the assessment is made by home help administrators of the local social services. They are also involved in the actual care providing process; mostly in counselling and advice, both to the client as well as to the family members. In most countries, the home care organizer also decides about the amount and type of home help care to be provided. Belgium, Ireland and Italy are exceptions in this respect. For example, in Belgium the decision about the type of home help care to be provided and the period of time is made by the service managers or special committees of the organizations. In Ireland normally the home help organizer and the public health nurse decide jointly what care needs to be provided and in some communities in Italy the decision is made by a special team consisting of the social worker, a nurse and home helps.

The next step is the actual provision of the care to the clients by home helps. Table 10 gives an overview of the different tasks performed by the home helps in the fifteen countries.

Table 10
Tasks performed by home helps in of the European Union

country	homemaking activities	personal care	general support	stimulating informal care	moral support
Belgium	x	x	x	x	x
Greece	x	x	x	x	x
Ireland	x	x	x	x	x
Luxembourg	x	x	x	x	x
The Netherlands	x	x	x	x	x
Denmark	x	x	x	x	x
Austria	x	x	x		x
France	x		x	x	x
Portugal	x	x	x	x	
Italy	x	x	x		
Spain	x	x	x		
United Kingdom	x	x	x		
Sweden	x	x	x		
Germany	x	x	x		
Finland	x	x			x

The main tasks of home helps can be described as homemaking activities (preparing meals, washing dishes, cleaning, doing the laundry etc.), hygiene and other personal care (bathing, ADL-help), general and family support (shopping, going for a walk with the client, administrative support), stimulating informal care (ie. help from family members, neighbours or friends) and moral support with psychosocial problems (counselling and advice). As we can see in Table 10, all these tasks are performed by home helps in Belgium, Greece, Ireland, Luxembourg and the Netherlands. Furthermore, France is the only country in which home helps are not allowed to provide personal care. In addition, though frequent, family support, stimulating informal care and moral support are not officially part of the home help's job in France. Sweden is the only country in which home helps, home care assistants, also perform routine technical nursing procedures (e.g. injections, dressings). In all countries home helps spend most of their time on housework.

3.3 Relations between home nursing and home help services

The growth in the number of the elderly induces a greater need for home help and home nursing services. Consequently, in many countries policy makers recognize the advantages not only of co-operation, but also merging the two services into one organization.

Within Europe there seems to be a tendency towards integrating home nursing and home help services. Table 11 shows that in Denmark and Ireland both services are part of the same organization. In Denmark the services are organized by the municipalities and in Ireland the two services are broadly under the community care programme of the Health Boards, but their relationship is not uniform in all regions. In Austria, Finland, France, Germany, the Netherlands and Sweden both services are often integrated. In Germany the two services are integrated in the *Sozialstationen* and are provided from the same location, improving possibilities of contact between different professions. The number of integrated *Sozialstationen* is still increasing. In the Netherlands, the umbrella organizations for community nursing and for home help services merged in 1990. At this moment this integration is taking place at the regional level. About 50% of the home nursing organizations have already merged with organizations for home help services. It is hoped that the integration will increase the efficiency in home

Table 11
Level of integration of home nursing and home help services in the same organization in the European Union

Part of the same organizations	In many organizations	In some organization
Denmark	Austria	Belgium
Ireland	Finland	Greece
	France	Italy
	Germany	Luxembourg
	The Netherlands	United Kingdom
	Sweden	Spain
		Portugal

care and will avoid unnecessary overlap between home nursing and home help services. As already mentioned, the Swedish act on 'The Care of the Elderly reform' in 1992 moved the responsibility for the care for the elderly, including home nursing, towards the municipalities. At the end of 1994, in about 50% of the counties home nursing has already been delegated to the municipalities, and this reform process is still going on. As a consequence of this reform, home nursing becomes a part of social services and will belong to the same organization as the home help services. In some regions home nurse and home helps work already together in a team. They discuss mutual patients and are more able to tune their tasks.

Belgium, Greece and Luxembourg have some organizations for both types of services. In addition, in Belgium multi-disciplinary co-operation initiatives are subsidized on the condition that general practitioners, community nurses, home helps, social workers as well as three other professions take part in them. In the private sector of the United Kingdom there are organizations which provide both home nursing and home help services. Furthermore, one of the major conditions for the new approach in home care in the public health system is an extended co-operation between home nursing and home help services ie. consultation between social services and health agencies is required. Finally, in Portugal and Spain too, developments are taking place towards more intensive co-operation between the two disciplines. Integration of the two services has recently been established in a few places, sometimes as an experiment.

3.4 Reported problems

Finally, attention is paid to some problems in home care that seem to obtain in many countries.

First, *waiting lists* for home help services are common in most countries. In Denmark, Finland, Germany, Luxembourg, Sweden and the United Kingdom no waiting lists are reported. According to the experts, the waiting lists are caused by *budget problems*, i.e. the budgets are too low, while the demand for home help services is increasing. The lack of sufficient resources is, according the experts in many countries, due to the fact the home help services have a low priority in policy. In some countries it was also reported that it was difficult to target the available resources to the right people: those who really need home help.

In many countries there is a *shortage of home helps* which is related to the first problem. Experts claim the profession is considered unattractive, because it has low status, it is poorly paid and the training is considered to be inadequate.

A shortage of qualified home nurses was reported in Austria, Denmark, France, Ireland, Greece, Italy, Portugal and Luxembourg. In some countries the experts reported that hospital nurses were better paid than home nurses and that equal payment would help. An increasing number of part-timers was also reported to be a reason for staff shortage, as well as the fact that nurses remain in the profession only a short time.

In a number of countries, Austria, France, Greece, Ireland, Italy, Portugal, Spain, large differences obtain among the regions in the supply of the home care. Consequently, the accessibility of the services is not the same for people who need home nursing or home help services. In many parts of Greece, Italy and Spain, there are no home care services. This means that within the policy of substitution of home care for hospital care, patients have to stay in the hospital too long or have to rely solely on the informal care of their families.

Finally, with regard to the *co-ordination of care*, in many countries the home helps complain about the co-operation with hospitals and General Practitioners. The reason for the unwillingness of the GPs and the hospitals to co-operate is that home helps are viewed as professionals with a low status. Furthermore, the experts of nearly all countries reported problems in the co-

operation between hospitals and home nursing. These problems concern the preparations for discharge, time-continuity between hospital care and home care and the lack of knowledge of hospitals about the possibilities of aftercare at home. In addition, in some countries (France, Germany, Greece and Spain) problems in the co-operation with General Practitioners were mentioned.

3.5 Conclusions

All member states of the European Union are confronted with an increase of the demand for home care. First because of socio-demographic pressures, like the ageing of the population, the fertility trend towards smaller family size and an increased female participation in the labour market. Secondly, because of the policy of substitution of home care for hospital care in order to control the health care expenditure.

However, there are large differences between the member states in the level of development of home care services. In countries like Denmark, the Netherlands, Belgium, Finland, Ireland, Sweden and the United Kingdom, home nursing and home help services are rather well developed, although in Ireland and the United Kingdom regional differences still exist in the supply of home care and in the level of co-payment for home help services by the clients. While in countries like Austria, Greece, Italy and Spain, home care is still in its infancy. In addition, there are large differences among the countries regarding the level of co-ordination of home nursing and home help services.

In general, there is a trend toward more co-operation between the two services, in a move towards efficient supply of home care, but much still has to be done in this area. A major problem in many countries is the separation between health and social services. Whereas home nursing is financed by general taxation or social insurance; home help services are usually administrated and financed by local government or sometimes by voluntary organizations. In general there are also large differences between the countries in the way home care is financed. In tables 12 and 13 (at the end of this chapter), the main features of organization and financing of home care in all countries are summarized. With regard to home nursing there seems to be a relation between the way of funding and the organizational structure. In member states where the organizations receive a fixed budget, based on the number of inhabitants or the demography of the catchment area, home nursing is mainly provided by one type of organization and is free accessible

for the patients. In this situation there is little competition between the organizations, also because the catchment areas of the regional organizations do not overlap. On the other hand, in countries like Belgium, France and Germany, where organizations are reimbursed according to a fee-for-service principle and a referral of a doctor is required, home nursing is provided by different types of organizations and also by independent nurses. It seems that fee-for-service reimbursement stimulates competition between providers and a market oriented home care. In addition, a fee-for-service method of funding has also the consequence that mainly technical nursing procedures and some basic care like bathing the patient are reimbursed, which leaves little room for nurses to perform preventive and psychosocial activities and to provide more integrated care. In the Netherlands and the United Kingdom the financing of home nursing is in a transition period from budget funding to fee-for-service reimbursement. On the basis of the experiences in other countries one can expect that the nurses in the Netherlands and the United Kingdom will be confronted with changes in the content of their job: more time has to be devoted to (complicated) technical nursing procedures and less time will be available for preventive activities and psychosocial problems of the patients and their informal carers.

On the other hand, the countries resemble one another in the problems they face in home care. In many countries, there are waiting lists for home help services, mainly due to budget problems, low policy priorities or shortage of personnel. And also shortages of home nurses were reported.

In summary, it can be concluded that the unification of Europe with regard to the organization and financing of home care is still far away, but that the problems encountered in home care seem to ignore the borders of the member states. However, for social, economic and political reasons, home care is the best service to respond to the challenge of the ageing population. It is mostly not only more cost effective than intramural or residential care but it meets the aspirations of both politicians and older people to allow the latter to stay in their own homes for as long as possible.

Table 12
Overview of the organization and financing of home nursing in Europe

Country	Main providers	Medical referral required	Assessment of needs	Funding of organization	Co-payments by patients
Austria	Different organizations, varying between provinces. Mainly private non-profit organizations.	Yes, for technical home nursing care only.	By qualified nurse using a standardized form.	Fee-for-service: payment per nursing activity.	Yes, for general basic nursing care.
Belgium	One nationwide private non-profit organization (White/Yellow Cross), some smaller organizations and a large number of independent nurses.	Yes, for technical nursing care such as injections.	By home nurse using a national standardized form (Katz-scale).	Fee-for-service: per diem or per activity determined by level of dependency of patient.	Yes, mainly membership fee.
Denmark	Home care department of municipalities.	No	By social counsellor or nurse. No standardized assessment forms.	Fixed budget funded by national and local taxes.	No, except in some very specific cases.

Finland	Local health (and social) care centres (NHS).	Yes	By physician, health visitor or registered nurse. Standardized forms are used.	Budget determined by local authorities.	Yes, income- and household-related.
France	Mainly private non-profit organizations, some services by municipalities and a large number of independent nurses.	Yes	By nurse using standardized forms.	Fee-for-service (payment per activity) and budget for a fixed number of patients.	Yes, but mostly paid by additional insurance.
Germany	Mainly private non-profit organizations. In some regions, mainly for-profit organizations.	Yes	By physician in co-operation with head nurse, using standardized forms.	Fee-for-service.	No
Greece	NHS-organizations, private organizations (both for- and non-profit).	No	By physician, health visitor or visiting nurse. No standardized form.	NHS and Red Cross organizations: fixed budget; others: fee-for-service.	Yes, for all services.
Ireland	One type organization: Health Boards.	No	By public health nurse. No national standardized forms.	Fixed budget.	No

Country	Main providers	Medical referral required	Assessment of needs	Funding of organization	Co-payments by patients
Italy	Different organizations: NHS, social services of municipalities, private organizations (for- and non-profit).	No	Nurse, physician or special team. No national standardized forms.	Public organizations: budgets. Private organizations: fee-for-service.	Yes, in social services and private organizations. Not in NHS.
Luxembourg	Two large private non-profit organizations and four smaller ones (two non-profit).	Yes, for technical nursing activities only.	Physicians or specialized nurse. A special form can be used.	Mainly Fee-for-service; the four smaller ones also receive an additional state budget.	Yes, for general basic nursing care.
Netherlands	The National Association of Home Care which consists of Regional Cross Associations or Home Care Organizations (all are private non-profit).	No	Home care nurse (in Regional Cross Associations); nurse, home help manager or special team (in Home Care Organizations). No national standardized forms.	Fixed budget based on the number of personnel.	Yes, membership fee.

Portugal	Mainly NHS-health care centres and some private non-profit organizations.	No	Nurse or physician. No standardized forms.	Fixed budget based on historical costs with adjustments for inflation.	No
Spain	NHS-health care centres.	No	Nurse or physician using a standardized form.	Fixed budget.	No
Sweden	NHS-health care centres or social services of municipalities.	No, only in a few regions.	Registered nurse (in health care centres). Home help administrator (in social services). No standardized forms.	Fixed budget.	Yes
United Kingdom	Part of NHS: community unit of DHAs or independent Community Trusts (after reform of NHS).	No	By the team leader (a qualified nurse). No national standardized forms.	Old system: fixed budget based on number of inhabitants and demography of population. New system: fee-for-service.	No

Table 13
Overview of the organization and financing of home help services in Europe

Country	Main providers	Assessment of needs	Funding of organization	Co-payments by clients
Austria	Different organizations, varying between provinces. Mainly private non-profit organizations.	By a qualified nurse of a special governmental agency, with standardized forms.	Subsidized by province and municipalities and payment per hour.	Yes, depending on income.
Belgium	Social services of municipality and some private organizations.	By social worker or social nurse, using a national standardized form.	Subsidized by central government: based on number of personnel and clients.	Yes, depending on income and household composition.
Denmark	Home care department of municipalities.	By social counsellor or nurse. No standardized form.	Fixed budget, funded by national and local taxes.	No

Finland	Local health and social care centres, social welfare board of municipality and private non-profit organizations.	By leading home maker or social worker (social welfare) or health visitor or registered nurse (health and social centres). Standardized forms are used.	Budget determined by local authorities.	Yes, income and household-related.
France	Mixture of social services of municipalities and private organizations.	By social worker.	Funding by municipality (low-income group) or private insurance.	Not below a certain income. Otherwise dependent on old age insurance.
Germany	Mainly private non-profit organizations. Different organizations for services in addition to home nursing (*Sozial-stationen*) and for home help for elderly(MSDs).	Mostly by a nurse or social worker, using standardized forms.	Fee-for-service (by patient or insurance). For MSDs a global budget from municipalities is added, based on number of personnel and output.	Yes, except for home help in addition to home nursing.
Greece	Private organizations (both for- and non-profit).	By visiting nurse or social worker. No standardized form.	Fee-for-service. No funding by authorities or insurances.	Yes, in private for-profit organizations only.

Country	Main providers	Assessment of needs	Funding of organization	Co-payments by clients
Ireland	Mainly one public organization: Health Boards and some voluntary organizations.	By public health nurse or home help organizer. No national standardized forms.	Fixed budget.	Yes, but different regulations in health Boards.
Italy	Social services of municipalities and private organizations (for- and non-profit).	Large differences between organizations. No national standardized forms.	Social services: budgets. Private organizations: fee-for-service.	Yes, but large differences between organizations.
Luxembourg	Mainly private non-profit organizations.	By head of regional service: social worker or specialized nurse.	Mainly budgets financed by Ministry of Health and municipalities.	Yes, income-related.
Netherlands	The National Association of Home Care which consists of Home Help Organizations or Home Care Organizations (private non-profit).	Home help manager (Home Help); nurse, home help manager or special team (Home Care. No national standardized forms.	Fixed budget from central government based on number of inhabitants and age distribution in catchment area.	Yes, dependent on income and household composition.

Portugal	Social services of municipalities and some private non-profit social solidarity organizations.	Social worker. No standardized forms.	Fixed budget from central government, based on number of clients and types of services.	Yes, income-related.
Spain	Social services of municipalities.	Social worker. In some parts of the country a standardized form are used.	Fixed budget based on number of hours of care.	Yes, income-related.
Sweden	Social services of municipalities.	Home help administrator. No standardized forms.	Fixed budget from municipalities and central government.	Yes, dependent on income and number of hours of care.
United Kingdom	Social Services of municipalities and private organizations: both for- and non-profit.	Care manager (social worker). No national standardized forms.	Social services: budgets. Private organizations: fee-for-service.	Yes, different regulations exist.

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