

CHAPTER V
EVALUATION OF CHILDCARE AND
LONG-TERM CARE PROGRAMS

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V.1 Introduction

This chapter addresses the evaluation of the two main “care” social programs: those for the very young—childcare programs—and those for the disabled though not necessarily elderly—long-term care (LTC) programs. Both classes of programs are relatively new in the social insurance mix.

By the 1970s, a number of families in many countries were already facing the dilemma of choosing between working or caring for young children, and a number of disabled individuals were in need of support that was not being provided through a traditional monetary pension scheme. Over the past decade, both issues have grown in importance within the social agenda as more women work full time and many countries experience a dramatic decline in fertility and an increased aging of their population. Other significant factors are the knowledge that a lack of care at a very early age can be very damaging to children and increased awareness of the overwhelming pressure that permanent disabilities can put on the daily life of families.

Social insurance has been a logical means of addressing the problems of financing care programs. Childcare needs are strongly correlated with work patterns while LTC programs complement support received by pension, health, and disability programs. Evaluation of care programs involves all of the processes that were described in the CISS 2008

Report (CISS 2007) and can be subject to the perspectives stated in Chapter 2 of this Report. However, it is important to stress the conditions of families and the specific issues that surround the evaluation of care in childcare and LTC programs.

Regarding childcare, it is very important to gain understanding of the manner in which parents work, especially mothers, and the way in which a program can benefit children. Regarding LTC programs, the main concerns are whether the individual, family, and community are receiving the support necessary to prevent a permanent disability from becoming a major liability in the daily life of the disabled and unduly affecting the work and leisure possibilities of all.

This chapter analyzes the issues that surround the evaluation of childcare and long-term care programs. Section 5.2 addresses childcare program objectives and the impact that evaluation has on their performance. Section 5.3 analyzes the main objectives of LTC programs and how evaluation helps the actors involved enhance program performance. Section 5.4 concludes the chapter.

V.2 Evaluation of Childcare Programs

V.2.1 Objectives of the Program

What is childcare? Is it an educational program? Is it a program to support female workers? To what extent is it an insurance program? Even though it is not possible to identify a standard model of childcare, it

has generally been viewed from two complementary perspectives. Childcare is most commonly viewed from a labor market perspective as a “complementary tool” to ease the incorporation of women into the labor force (Pautais et al. 2004). The other perspective views childcare as the right to access education (Rosetti 2002) because childcare is no longer limited to satisfying basic needs and avoiding situations that could be potentially harmful to children but also encompasses the intellectual, physical, social, and emotional development of children (Waiser 1998).

Factors such as the increase in women’s labor force participation, decrease in family size, increase in the number of single-parent families, and increase in dual-income families have driven many families to seek some type of childcare (OECD 2001). Childcare programs are often financed by social insurance funds. The models vary significantly; they include financing by providers, financing by families to pay providers, and financing by families to support family or community care. Even though informal childcare arrangements are still the main types of childcare, trends show that childcare is moving toward formal arrangements that lead to improved outcomes in two areas: early child development and the labor participation of mothers with small children. Experience has shown that childcare is an area in which participation rates cannot be forecasted with certainty; the form in which a program is organized can significantly affect families’ participation decisions.

Several studies have shown that early education has positive effects on a child’s academic performance and that the availability of childcare services increases the probability of mothers entering the labor market. These factors are why governments have taken different measures to improve access to childcare services. Childcare arrangements are so complex and varied that it is difficult to identify one single provider and financing pattern in any one country. Childcare may be provided by programs or institutions, formal care specifically designed to this end, or informal care. Informal care is usually provided

in the child’s home or in the home of the relative who cares for the child when the parents are not able to do so. Informal childcare prevails in most countries. We do not consider this type of care to be provided by a program but rather the manner in which most families care for their children. However, even in-house care is increasingly being supported financially and otherwise by public sources, including social security.

In contrast, formal care usually refers to care provided in certified institutions for young children from birth to six years of age, sometimes up to eight years of age. Preschool education is a type of formal care available in most countries, although generally restricted to children five years of age and over. Different studies have shown that preschool education promotes early development and helps children succeed in school in the short term and reduces the success gap between low-income children and more advantaged children, as well as that maternal work and the use of childcare programs do not affect child development; indeed, childcare services may actually be advantageous when of high quality (Boocock 1995). There is considerable variability in the models of formal care offered for young children. In some cases, social security or the government directly finances childcare centers; in other cases, legislation provides strong support to mothers to stay home with their children while also supporting formal care as a complement to their primary caregiving.

V.2.2 Demand for Childcare

The demographic and social changes that have occurred in recent years have increased the labor force participation of women with children. Factors such as the reduction in family size and increase in the numbers of single-parent and dual-income families have increased the need for formal childcare programs. Gelbach (2002) and Berger and Black (1992) found that childcare subsidies increase the probability of women working and paying for childcare services and that childcare services are essential for women to be able to participate in the labor market.

Connelly and Kimmel (2001) found that an increase in the cost of childcare services has a positive relationship to the granting of welfare pensions. Studies in the United States, Canada, and Germany (Anderson and Levine 1999; Cleveland et al. 1996; Connelly 1992; Lemke et al. 2000; Powell 1997; Ribar 1992 and 1995; Tekin 2002 and 2004; Wrohlich 2004) have found that an increase in the cost of childcare services has a negative impact on the employment of women with children. Caring for children makes it more difficult for women to work, and some risk becoming poor while juggling these responsibilities.

A number of researchers have studied the impact of childcare subsidies. Berger and Black (1992), Gelbach (2002), and Lemke et al. (2000) found that these subsidies increase a mother's probability of working, including women receiving welfare pensions. Tekin (2002) indicated that higher salaries increase the probability of women working and paying for their children's care. These findings show that the availability and cost of childcare services are essential factors in a mother's decision to participate in the labor market.

Childcare centers that offer limited hours of operation may make it necessary to pay for than one service and make it more difficult for women to work full-time jobs. An increase in the labor market participation rate of mothers with small children and the increasing concern to make early education available to children have generated growing demand for formal care. Demand depends upon many different factors, including cost, hours, distance, the labor market participation rate of mothers, and parents' income.

V.2.3 Supply of Childcare

Providing all children with a fair chance for early development is the main justification for developing childcare programs. Many have argued that children's well-being leads to positive externalities for society (e.g., increased human capital and less

crime and violence). In reaction, governments have proposed several policy solutions to increase the well-being of children. In some countries, childcare has become a public responsibility, yet the extent of this responsibility varies significantly. In some countries, all children receive support, in others only the children of workers are guaranteed special care, and in yet others there is no explicit obligation to provide childcare, although support is provided through income tax deductions or targeted programs (e.g., for children of low-income female workers). We could say that in general, Western Europe and Canada tend to follow the first model, that countries where "traditional" social security has entered the field tend follow the second, and that most countries tend to follow the third in some manner. As in other social areas, rarely can we find a pure application, and countries mix programs according to their own historical legacy and their attempts to coordinate childcare with other social security and educational programs.

Privately financed or non-remunerated childcare services, usually provided by relatives and/or friends, are common, although to a different extent, in all of LAC. Childcare has been legislated with the goal of either fostering female employment or improving children's educational quality and access. Legislation in LAC is mainly aimed at working women. In Chile and Argentina, labor legislation requires companies with more than a certain number of female employees to provide childcare services, which may provide an incentive not to hire more women than necessary to avoid having to provide this service. Ecuador requires employers with more than a certain number of employees, regardless of sex, to provide childcare centers. Costa Rica regulates childcare centers regardless of labor legislation, striving for universal access. In Uruguay, childcare legislation is aimed at improving quality and tightening control.

In Argentina, Brazil, Chile, and Mexico, as in most of LAC, maternity leave is covered by compensation systems that do not present an additional cost to

employers if they employ women. In Chile, maternity leave is financed through a public fund, while in Argentina, Brazil, and Mexico, maternity leave is financed by the social security system. In all three countries, health benefits are financed through the social security system. While childcare services in Chile are directly financed by female workers' contributions, childcare services in Argentina, Brazil, and Chile are financed by employers, and thus employers' costs rise as the number of female employees increases and they start demanding this benefit.

In Mexico, childcare centers, like maternity leave and healthcare benefits, are financed by social security. Social security agencies are the most important childcare providers in Mexico. While coverage has increased significantly during the last ten years, it is still low. Mandatory preschool attendance has been required since the late 1990s, and recently the government launched a national program of childcare centers for uninsured women. It is not yet clear how these alternative sources of childcare will be financed in the long run. Social security used to fund and provide these services, but since the mid-1990s it has begun to limit itself to the financing function, decreasing the cost by an estimated 60%. However, coverage remains low. According to the 2004 National Employment and Social Security Survey (ENESS), care for 15.9% of children from birth to six years of age is provided by someone other than their mother, and only about 14.2% of these children attend childcare centers. This means only 2.25% of children from birth to six years of age receive care at centers and that only 0.77% of children have access to private centers. This has a significant effect on female labor market outcomes because childcare availability, either formal (provided by childcare centers) or informal (provided by relatives or individuals who may or may not receive compensation) affects a mother's decision to work.

In Costa Rica, childcare services are regulated by Law N° 7380 (*Ley General de Guarderías Infantiles y Hogares Escuela*; General Law of Childcare Centers and

Home Schools), which aims to regulate the provision of childcare services. It does not make it compulsory for employers to finance or provide any of these services. This law provides that childcare centers must provide full-day care for children aged three to seven months while their parents are working, whereas home schools (*hogares escuela*) must provide after-school childcare for children aged seven to twelve whose parents work. These centers may be public, private, or a mix thereof, and the state provides the infrastructure and partial financing.

The Ministry of Labor and Social Security is responsible for maintaining a national registry and supervising all the centers in the country. In recent years, the state has fostered the creation of Nutrition and Education Centers and Integral Care Centers for Children (CEN-CINAI Centers) and Community Homes to care for low-income children who are not of compulsory school age (birth to six years of age), but the supply has not yet met the demand. In 1999, 97% of Costa Rican mothers aged eighteen to forty-four with children under five did not enroll their children in childcare centers, although only 65% personally took care of their children. This means that 35% of mothers who have no access to childcare centers use informal childcare services (ENSR 1999).

It is very important to take into account the effects of financial incentives on labor market decisions. Childcare programs may not only increase labor force participation by offering families a satisfactory way of caring for small children but may also decrease labor force participation by providing more support for mothers who spend more time with their children, and may even encourage women to have more children. The effects of childcare on work may depend upon worker level of education and income. A number of studies have attempted to analyze which effect is stronger. Brewer (2003) found that for the United Kingdom, most families with a large number of children prefer to receive income support rather than work more hours. On the other hand, he found that the higher an individual's level of education, the

stronger the preference to resolve childcare dilemmas through increased labor force participation. When Brewer analyzed individuals by age, he found that their preference depended upon their marital status. Single individuals have a stronger preference for working more hours while married individuals have a stronger preference for receiving more income support. Brewer's analysis indicates that because each family has a different situation, applying one solution in the same way to all families may not be a good strategy. Consequently, evaluation must consider the different problems faced by different families.

In OECD countries, most benefits that are conditional on employment are targeted at low-income families. These benefits are usually paid in cash or as tax credits, often non-wastable, meaning that families apply the credit towards their tax liabilities and do not have to refund the money to the government. These non-wastable tax credits may even result in a "negative tax," which means that the family may ultimately receive additional cash. In certain countries, these benefits are designed for employees regardless of the number of family members. In other countries, benefits increase according to the number of children in the family. Examples of the latter include Canada (non-wastable tax credits), France (non-wastable tax credits), Germany (lower social security contributions in addition to childcare benefits), Ireland (cash benefits), the Netherlands (tax credits), New Zealand (non-wastable tax credits), the United Kingdom (non-wastable tax credits), and the United States (non-wastable tax credits).

For the United States, MaCurdy and McIntyre (2004) have suggested redesigning the Earned Income Tax Credit (EITC) to increase the incentive to work and targeting benefits to poor working families by applying an EITC benefit schedule based upon family hourly wages as well as earnings. In contrast, existing EITC benefits are based upon annual family earnings, regardless of whether these earnings are the result of more hours worked at lower wages or less hours worked at higher wages. The wage-based EITC benefit

schedule would essentially raise net hourly wages above their non-EITC values for low-wage workers, supporting a family for hours worked up to the equivalent of one full-time worker, with the benefit rate declining as the family's market wage rises. The wage-subsidy EITC would increase net hourly wages for low-wage workers, supporting a family up to the minimum-wage threshold; this higher wage would apply to every hour worked up to full time. Consequently, both EITC redesigns would make work more attractive until the family reaches full-time employment.

It must be mentioned that although it does not have a national program that provides childcare services, the United States supports families with childcare expenditures for children up to thirteen or fourteen years of age through subsidies and tax credits. A general message that can be taken from this discussion is that separating the financing from the provision function can help in finding a solution to integrating the childcare system with the overall educational system and generally providing support to families in caring for their children.

In Canada, the National Child Benefit (NCB) Supplement plays an important role in enhancing financial incentives to work. The NCB Supplement is the Canadian government's contribution to the federal/provincial/territorial NCB Initiative aimed at preventing and reducing child poverty. The initiative promotes participation in the workforce by ensuring that families have a higher standard of living if they work. In most jurisdictions in Canada, the NCB Supplement operates in a manner similar to the way that an in-work benefit operates in certain transitions from social assistance to the labor market. Individuals with children receiving provincial/territorial Social Assistance (SA) have their SA benefits reduced by an amount equivalent to the NCB Supplement while employed individuals with children receive the NCB Supplement, depending upon their income. Provinces and territories reinvest SA savings in new or enhanced measures for low-income families with children, which can provide additional support to parents making the transition from SA to work.

The Netherlands, another country with employment-conditional programs, replaced income-based childcare benefits with a childcare tax credit in 2004. France has an integrated educational and childcare system for children aged three and over that includes the provision of preschool activities in the morning and before- and after-school care. Families with children under three receive substantial family allocations to care for their children.

Expanding its in-work benefit programs, New Zealand recently introduced new childcare provisions aimed at working parents. The maximum number of hours required to qualify for the income-based Childcare Subsidy (payable to the childcare provider) and Out-of-School Care and Recreation (OSCAR) subsidy was raised from thirty to thirty-seven hours per week. On the supply side, additional funding has been provided to increase the number and quality of OSCAR providers so that childcare access does not become an obstacle for beneficiaries and low-income workers planning to enter or remain in the workforce. In the United Kingdom, the Working Family Tax Credit includes a generous childcare component whereby families are entitled to a tax credit for 70% of childcare costs up to a certain limit, according to the number of children.

Through its National System for Family Welfare (SNBF), both the private and public sector in Colombia are primary childcare service providers. Although there are other programs run by local governments and non-governmental organizations, public SNBF childcare centers deserve special attention because of their scope, financing, and characteristics. The SNBF is coordinated by the Ministry of Social Protection through the Colombian Institute for Family Welfare (ICBF), an institution created by Law 75 of 1968. From programs that provide support to pregnant mothers to programs that provide assistance to abused children and adolescents, the wide range of services provided by the ICBF is mainly oriented towards providing protection to the poorest population, focusing upon children and vulnerable

groups (i.e., ethnic and rural populations, the elderly, and people with disabilities). The objective of these services is to strengthen family ties while ensuring each household member fulfills his or her duties and protect the rights and safety of children and families.

The ICBF's main funding source is the quasi-tax, which accounts for almost 99% of its income. This tax is levied on private and public companies and directly collected by the ICBF. Even though the ICBF is funded by taxes paid by formal labor market employers, benefits are seldom targeted at them or their employees. Instead, these programs target, as noted above, the poorest population, particularly individuals who qualify as beneficiaries according to the welfare system (the SISBEN). This feature makes the SNBF an important income redistribution agent in Colombia. The ICBF provides different childcare programs, including Hogares Comunitarios de Bienestar (Community Welfare Homes), Hogares Infantiles (Child Homes), and Lactantes y Preescolares (Babies and Preschool Children). With significant exceptions, these programs usually care for children on a full-time basis. The ICBF also operates educational programs such as Jardines Comunitarios (Community Kindergartens) and Family, Women, and Children's (FAMI) Homes, whose functions and the functions of other childcare programs sometimes overlap. HCB is the SNBF's most important and most rapidly growing childcare program. Community participation in the provision of childcare services has fostered the program's growth. HCB cares for children in extreme poverty (under SISBEN standards) and provides health, nutrition, and pedagogical services.

Family Allowance (FA) programs, whose main component is a cash benefit for minors dependent upon insured members, are important in the Southern Cone countries. Argentina adds further benefits and Uruguay extends the benefit to households with low incomes whose members work within the informal economic sector. Brazil has the lowest age limit (up to a maximum of fourteen years of age) to receive

benefits. There is no age limit for disabled children, who usually receive twice the normal benefit, except in Brazil, where both parents, if they are enrolled in social security, receive identical allowances. Most of the objectives of the FA programs in Argentina, Brazil, and Uruguay are the same as those of most social security programs. Uruguay reached a conceptual turning point for this type of scheme in 1999 and again in 2004 when low-income families became eligible for the FA program even if they are not covered by social security (BPS 2007a).

Over the past fifteen years, certain Latin American countries have introduced new instruments of public policy to provide support for families with children, intended primarily to alleviate poverty among children and foster social inclusion, in addition to traditional social security programs such as FA and other state programs. It is important to bear in mind that more than 50% of the EAPs in this region is targeted to those engaged in informal employment (without social security protection) and that with the exception of Uruguay, traditional FA programs are not designed to reach a high percentage of the

population, particularly the poor population, whose households include more children compared with the population in general and whose members are generally either unemployed or working within the informal economic sector.

In LAC, coverage rates are quite low. High private center prices and insufficient public care centers are a barrier to the provision of childcare. The fact that few children who are enrolled in the programs attend the centers regularly is also a problem. In industrialized countries, policies are oriented towards the inclusion of childcare programs. Different studies have shown that preschool education promotes early development and helps children succeed in school in the short term, that education closes the success gap between low-income children and more advantaged children, and that maternal work and utilization of childcare programs do not affect child development but can be beneficial if program quality is high (Boocock 1995). Box 5.1 discusses the return to human capital that investing in childcare provides.

Box V.1

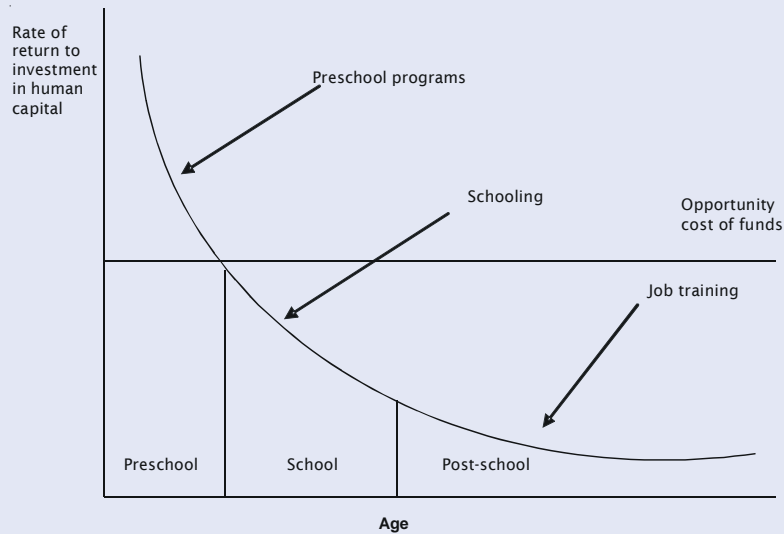
Return to Human Capital Provided by Investment in Childcare

Probably the most important study evaluating interventions for children published in many years is “Interpreting the Evidence on Life Cycle Skill Formation” by Cunha et al. (2005). The researchers’ principal message is that childhood has several stages and that skills form as a result of complementary and multiplicative process whereby one skill generates more skills. They point out that skill acquisition begins in the mother’s womb and continues throughout the lifespan. In this process, families have a more important role than do schools. Several skills are particularly important for success in adulthood, some of which are inherited and others learned. However, because the traditional debate on “nature versus environment” is scientifically obsolete, it is not possible to identify the genetic characteristics that are useful in forecasting future success.

What is known is that the achievement of skills in a certain stage of life increases achievements at later stages (i.e., increases self-productivity), and that early educational investments facilitate later productivity (i.e., it is complementary). Early investments are not productive if they are not followed by later investments. This is why returns on investment in human capital at early stages of life are very expensive. Repairing bad initial investments is highly costly as a consequence of their self-productive and complementary nature.

The following graph summarizes empirical evidence from a number of studies. While not a “theoretical” graph, its data are supported by the research of many academics over many years.

Box V.1 (continued)



The rate of return to human capital investment assumes investment to initially be equal across all ages.

The literature points out that early experiences in life with consequences important to development, interacting with genetics, have a profound influence on socio-emotional outcomes. Early experience in life may change nerve cell biochemistry and architecture, and there are sensitive periods for these events. During sensitive periods, some connectivity pathways among neurons became steady as a result of environmental influences to which the child gradually adapts. During sensitive periods, these paths can be distorted, but once established as structures, is difficult to change them.

Several critical periods have been identified, including those that lead to the development of binocular vision in the mammalian cortex, hearing space processing, and the learning of songs in birds. The period of acquisition of language is one of the most important periods for human beings because children tend to acquire language skills better than do adults in spite of their being more limited in most of the cognitive domain. The age of exposure to language is negatively related to the skill that is ultimately acquired in that language. The decline in proficiency begins between four and six years of age and continues until a plateau is reached in adulthood. This pattern is evident for many aspects of language proficiency, such as control of sounds and grammatical structure, for both first and second languages. Nevertheless, different aspects of language can be acquired in different stages at different ages. For example, acquisition of vocabulary and semantic processing can be accomplished relatively easily in adulthood, while the more formal dimensions of language, such as syntax, phonology, and morphology, are more difficult to acquire (Newport 2002).

In summary, scientific evidence strongly supports the beneficial effects of social interventions that support child development and early education, which are more beneficial than interventions provided in traditional educational systems. The vision of the programs of childcare as support to the working mother is limited. Profitability is very large in programs that encourage mothers to remain with their children during the first years of life, complemented by educational programs oriented to the youngest children. Certainly, it will not be possible to establish these programs by charging them to the company payroll because doing so will lead to discrimination against working mothers.

Source: Cunha et al. 2005

V.2.4 Regulation

Childcare and educational service providers should be licensed by national or local governments. In general, regulations should encompass group size, adult-to-child ratio by age, staffing, basic care requirements, nutrition, physical facilities, and health and safety practices according to center type (e.g., daycare center, family-based childcare, etc.). In addition to complying with state regulations, many centers also choose to undergo voluntary accreditation and voluntarily meet quality standards stricter than state requirements established by professional associations. Certification helps parents choose the type of care they want for their children. One issue that must be resolved is the relationship between childcare center regulation and the laws of the educational system. The advancement of governments towards establishing educational programs for younger children demands the coordination of both factors.

With the heightened demand for daycare in the United States has come a growing concern with the quality of provision. The parents of the child (purchasers) often find it difficult to assess the quality of care, and are aware that the consequences of poor quality daycare are potentially serious. Public intervention in daycare markets might be justified using either arguments commonly made for the public provision of education or arguments regarding imperfect information. State regulators, recognizing both arguments, have imposed minimum quality requirements on daycare providers. Chipty and Witte (1994) found that imposing minimum requirements has an impact on the equilibrium of prices, hours, and quality as measured by staff-to-child ratio.

V.2.5 Evaluation of Childcare

The following aspects should be considered regarding the evaluation of childcare programs:

- marketing: differentiate childcare and educational services from traditional daycare offerings and interest activity programs

- service quality: childcare and educational programs must be provided by degreed and certified educators, childcare workers, tutors, and subject-matter industry professionals in a collegiate environment
- reputation: maintain a highly regarded reputation for excellence in childcare, education, and community involvement
- profitability: control costs and manage budgets in accordance with goals

It is important to highlight the importance of having an agency or entity that regulates licensing. The primary purpose of licensing a child daycare center is to safeguard the well-being of the children served. By granting a license, the agency verifies that the childcare center has safe buildings and grounds; that staff is appropriately trained and responsible; and that the program shall, in practice, reflect an understanding of the healthy growth and development of children. Furthermore, the license provides assurance to parents and the community that children are being cared for in a safe, healthy environment where appropriate activities, time schedules, food, materials, equipment, and staff are consistently available and are used for encouraging and supporting the children's physical, social, emotional, and intellectual growth (Witte and Queralt 2001).

The application for a license generally includes the following:

- name, address, mailing address, and phone number of the prospective center
- the full name and address of the applicant
- information on the building in which the center program will be housed, including sketches of the indoor area showing the activity rooms that will be used for childcare, the kitchen or food preparation area, the bathrooms for children and staff, and the office space
- detailed information on the outdoor play area, including a sketch of this area showing accessibility to the building and the rooms used for childcare

- specification on the number and ages of children served, age groupings, and staff-to-child child ratio
- complete information on staffing, including the name and qualifications of the director, site coordinator, and other identified staff
- staff medical information
- staff employment history and criminal record
- objective of the program, including the daily schedule of activities, the philosophy of the program, and the developmental goals upon which the program is based
- A listing of the equipment and materials, both indoor and outdoor, available for the implementation of the program
- information on the daily feeding program
- financial information, including the means of financing and anticipated yearly budget for the program
- a statement signed by the applicant, acknowledging that he or has read and agreed to comply with the regulations for licensure

In the United States, the method of licensing is designed to fulfill the state's obligation to families whose children attend daycare centers (regulation purposes). A license is granted after a detailed evaluation of the facility and program has shown that it conforms to established regulations. For monitoring purposes, the licensing agency may require the licensee to make its records, staff, populace, and facilities available on an announced or unannounced basis. The monitoring activities may include reviews of financial, staff, and child records; interviews with staff; interviews with children in care and parents; and site inspections of the facilities..

Witte and Queralt (2004) have shown that placing childcare provider inspection and complaint reports on the Internet has changed the behavior of childcare inspectors and improved the quality of childcare received by low-income children. The results became widely known in part because (1) the media widely

reported the availability of this information on the Internet, (2) the information was easy to locate and use, and (3) the inspector's name and contact information appeared on the first page of the reports. The researchers found that after childcare provider inspection and complaint reports have been made available on the Internet (1) inspectors produce significantly more inspection reports and (2) inspectors become significantly more likely to provide mixed reviews of centers in the course of their routine inspections, finding that centers sometimes meet minimum standards and other times fail to do so. After inspection reports are made available on the Internet, there is also significant improvement in classroom environment and center management at centers serving low-income children with childcare subsidies, comparable in degree to the improvements often achieved by more expensive approaches to improving the classroom environment or curriculum.

V.3 Evaluation of Long-Term Care Programs

V.3.1 Objectives of the Program

LTC includes a variety of services and means of support to meet healthcare and/or personal care needs over an extended period. Most LTC is provided by non-skilled personal care assistants who help with performing activities of daily living (ADLs), which include bathing, dressing, using the toilet, transferring to and from the bed and chair, and eating. The objective of an LTC program is to help older adults maximize their independence and functioning at a time when they are unable to be fully independent. LTC is needed when a person has a chronic illness or disability that causes him or her to need assistance with ADLs. While most people who need LTC are aged 65 or older, a person can need LTC services at any age. In the United States, 40% of people currently receiving LTC are adults 18 to 64 years of age (OECD 2006).

V.3.2 Demand for Long-Term Care

Individuals may need LTC for one or more of the following:

- care or assistance with ADLs in home from an unpaid caregiver, who may be a family member or friend
- services at home from a nurse, home health/home-care aide, therapist, or homemaker
- care in the community
- care in any of a variety of long-term facilities

Generally, services provided by caregivers who are family or friends are unpaid. This is sometimes called informal care whereas paid services are sometimes referred to as formal care. Paid services often supplement the services provided by family and friends. Many people who need LTC develop the need for care gradually. They may begin needing care only a few times a week or one or two times a day for specific functions, such as bathing or dressing. Care needs often progress as people age or as a chronic illness or disability become more debilitating, creating the need for care on a more continuous basis.

Some people need LTC in a facility for a relatively short period while they are recovering from a sudden illness or injury, and then may be able to be cared for at home. Others may need LTC services on an ongoing basis, such as a person who is disabled by a severe stroke. Some people may need to move to a nursing home or other type of facility-based setting for more extensive care or supervision if their needs can no longer be met at home. *The Americas Social Security Report* (CISS 2006) presents a complete section on the current and projected demand for LTC in LAC.

V.3.3 Supply of Long-Term Care

In general, the provision of LTC services is achieved through fragmented and uncoordinated systems. A wide range of services and support are provided by many different public and private agencies and organizations. In the United States, for example, a person's ability to access public programs is governed

by complicated state rules about financial and functional eligibility that differ by state but exist under an overarching federal framework.

The governments of many OECD countries have tried various ways to give dependent persons receiving care at home and their families more choice among care options. Doing so often involves providing cash to pay for care. These benefits come in various forms, including personal budgets to employ professional care assistants, direct payments to the person needing care without constraints on how it is used, or direct payments to informal caregivers in the form of income support. With "consumer-directed employment of care assistants" (personal budgets), older persons can employ a personal attendant, frequently with the option that this person can be a relative. Income support payments to informal caregivers have been designed for the dual purpose of increasing flexibility and mobilizing a broader carer potential that enables older persons to remain in the community longer and reduces the need for expensive institutional care (OECD 2002).

In LAC, public institutions have established several nursing home centers and, in a few cases, even programs of home-based care that more resemble healthcare than LTC, and as such are being financed with health funds (CISS 2006). In general, the LTC resources for older adults in LAC are in a stage of development or, in some cases, nonexistent. In the Southern Cone countries, nonprofit and profit organizations have developed an alternative means of supplying LTC resources due to the low supply of public resources. The National Program for Home-Based Care Givers in Argentina and the National Program of Older Adults Caregivers in Brazil are trying to professionalize home-based care for older adults and the frail or disabled population while also helping generate formal employment (BPS 2007b).

Understanding little about public programs for which they might be eligible, many people believe that nursing home or family care are the only alternatives when they or a relative becomes frail or disabled. In most cases, they are unaware of the aging network

and its services and support system. One means of resolving this issue is providing electronic tools to the potential beneficiaries in order to provide information and assistance to older adults regarding LTC options. These tools should provide the following information:

- awareness and information: public education and information about options
- assistance: options, benefits and employment counseling, referral to other programs and benefits, and crisis intervention
- access: eligibility screening, comprehensive assessment, programming and financial eligibility determination, one-stop access to all public programs, access to private-pay services, and planning for future needs

V.3.4 Evaluation of Long-Term Care

Evaluation is an essential element of a control and reporting system. It is important to accurately assess what has been or is happening compared to what was or is expected to happen (Young 2003). Monitoring helps determine whether a program has been worthwhile and effective. An ongoing process, monitoring is usually quite structured, with the aim of helping managers remain aware of agency functions in a simple manner (Whiteley 1996). It entails routinely collecting data and measuring progress towards a program's objectives through assessing the extent to which planned activities are held, services are provided, and how well the services are provided.

Monitoring is similar to the concept of evaluation but with an important difference: it focuses more strongly upon ongoing feedback to improve a program's functioning. Evaluation can perform the same function but tends to examine programs in terms of whether they have made a difference. Evaluation is "the process of determining the merit or worth or value of something; or the product of that process" (Scriven 1991) by systematically collecting and analyzing information to assess an organization's effectiveness in achieving its goals. It

provides regular feedback to help analyze impacts, outcomes, and results of activities and helps assess their relevance, scope, and sustainability.

The quality of LTC services, where they are available, varies widely both between and within countries. Consequently, the quality of services often does not meet the expectations of the public or the users of the services and their families. Examples of inadequate care in institutional and community settings are numerous. Some of the effects of inadequate care are inadequate housing, poor social relationships, and lack of privacy in nursing homes. Policies to bring LTC quality up to expectations promote increasing public spending and initiatives for better regulation of LTC services, such as by establishing quality assessment and monitoring of continuous improvement. Improvement in outcomes and not only infrastructure should be the basis for setting quality standards. Some have proposed making information on the quality of care and the prevalence of adverse outcomes more open and accessible to the public on a regular basis. Publicly available information on quality assessment at the level of the provider could lead to improved consumer protection and create a climate of competition for quality, in particular when combined with greater choice on the part of consumers.

Nursing Homes

In general, the evaluation of LTC programs in nursing homes involves evaluation of the eligibility criteria (patient evaluation by the program) and evaluation by users and their families in order to obtain the best option available.

Several aspects that families should consider when evaluating LTC facilities for a relative are the following:

- staff (hiring policies and restrictions, training, turnover, and staff-to-resident ratio on all shifts)
- safety of and technology within the facility
- communication among staff, families, and residents

- safety procedures at the facilities, including plans for emergencies
- health issues (availability of a family doctor, frequency that patients are examined by a doctor, etc.)
- medications (policies regarding storing and distribution of medications, safeguards, etc.)
- provisions for ADLs

The American Association of Retired People (AARP; 2008) provides a checklist for a family considering a nursing home for an older adult relative. The checklist recommends evaluation of the following prior to making a decision: (1) basic information (e.g., whether the nursing home is licensed, its visiting policy, patient-to-staff ratio, nurse-to-patient ratio, aide-to-patient ratio, and discharge policy); (2) safety (e.g., stairs and hallways are well lighted and handrails and call buttons present); (3) care issues (e.g., exercise, quality and variety of diet, and therapies offered); and (4) quality of life issues (e.g., respect for the user, friendly staff, and outdoor facilities for visits).

The quality of LTC is fundamentally multidimensional, encompassing clinical care issues, functional independence, quality of life, and patient and family satisfaction with care (Mor et al. 2005). The patient assessment systems in all U.S. nursing homes and all home healthcare agencies (HHAs) serving Medicare beneficiaries are computerized. These assessments are performed by the nursing staff when the patient is admitted into the service and periodically thereafter (for HHAs, upon discharge). Only those patients cared for long enough to have had two assessments are included in the calculation of an aggregated measure of provider quality.

In many countries, the drive to raise quality standards in acute healthcare has been accompanied by governments taking a more active role in regulating and inspecting the quality of LTC services with two aims in mind: reducing the risk of receiving poor quality care (including the risk of harmful care) and raising average standards of service. Comprehensive

publication of quality assessment could become a key to improving consumer protection and fostering a climate of competition for quality (Huber 2004). Unlike the United States, many countries have no explicit criteria or standards defining quality of care and only superficial monitoring. Funding, regulation, and monitoring of LTC of the elderly differ widely among industrialized countries. When it exists, regulation of institutional care is stricter than is that of home care. The lack of focus on outcomes of LTC may reflect difficulty in accessing relevant data or a different perspective on the value of data in assessing quality of care (Hughes et al. 2000).

Home- and Community-Based Care

People who receive home- and community-based LTC services and support comprise an inherently vulnerable population. Because they require assistance with everyday activities, these individuals are at great risk of harm if those who provide support services fail to report to work, provide services in an indifferent or incompetent manner, or act in a coercive manner. Yet despite these risks, the home environment is where most people with disabilities choose to remain for as long as possible. Providing the support that enables the elderly with care needs to remain at home for as long as possible can greatly help improve their condition. Moreover, supporting the elderly in their own homes generally costs less than supporting them in a nursing home or other residential care facility. A key factor in providing high-quality home-based care is to offer a broad range of support services, including respite care that gives informal caregivers “time off,” as well as providing professional guidance to families.

In many OECD countries, home care now accounts for more than 30% of public resources spent on LTC (OECD 2002). As a result, more elderly who depend upon care can now remain in their own homes. Enabling dependent older people to stay in their own homes is not only a question of increased public spending. It has also been made easier because even

when one person needs care, his or her spouse is increasingly likely to remain healthier longer. In addition, today's pensioners have higher incomes than did previous pensioners and can afford to pay more for their own care, and housing standards have risen. In addition to progress with the expansion of services such as respite care in a number of countries, there have been other initiatives to support informal caregivers. These include granting pension credits for time spent providing care and giving payments to caregivers to compensate for loss of earnings. These policies, however, raise the question of the long-term consequences of providing incentives for caregivers to leave the labor market to provide care, particularly as many of them are women, and it may be extremely difficult for them to get back into the job market later.

The U.S. LTC system has developed an elaborate regulatory system to monitor quality in nursing home settings and, to a lesser degree, the skilled home healthcare services delivered by agencies. These systems have focused predominantly upon standards such as licensing and staff training requirements and less on evaluating the quality of life and satisfaction of the consumers. Little has been done to address quality assurance in personal care programs and the home- and community-based LTC services provided by largely unskilled workers.

Part of the difficulty in developing any quality assurance system for home-delivered services is the difficulty of monitoring the care delivered in the home. However, the increase in public funding for home- and community-based services makes the development of better systems for assuring quality essential. The growth of publicly funded home-care services and support for persons with disabilities has led federal and state governments in the United States to devote increased attention to the quality of care being provided. Traditional methods of assessing quality, such as developing standards for home-care agencies and workers, have been found inadequate in addressing whether consumers are satisfied with the care that they receive, whether they receive the type and duration of care that they believe that they need,

and whether their quality of life has been maintained or improved.

As consumers have become more assertive in expressing their expectations of care providers regarding their own care and quality of life, advocates and public officials have stepped up efforts to create more "person-centered" initiatives to improve the quality of care in the home. With the support of the federal government, states are developing new quality-assurance systems around the concept of person-centered care. The Centers for Medicare and Medicaid Services (CMS) has created a quality framework for state Medicaid home- and community-based programs that requires states to address each focus area, such as consumer choice and control, with program-design strategies, continual evaluation, and problem correction. The CMS has also developed a grant system that provides funds for states to build quality systems in which program participants take active roles, to obtain consumer feedback, and to develop methods to ensure improved responsiveness to consumer needs and goals by service providers (U.S. Centers for Medicare and Medicaid Services 2008).

The United States has developed an intensive monitoring system for the assessment of care plan processes to ensure that consumer needs are being correctly addressed by care managers, who are key players in the system. In Washington, DC, a new comprehensive assessment system provides more consistent and reliable measurement of consumer needs. A fast-track financial eligibility determination process is increasing the speed of consumer access to services. Careful monitoring of care manager performance is helping ensure the development of appropriate care plans for the consumer, effective delivery of services, and improved training for care managers (Washington Aging and Disability Services Administration 2008). South Carolina is utilizing advanced IT to help care managers assist and respond to consumers more quickly and monitor consumer needs in both everyday situations and emergencies. The state has also developed an electronic monitoring system to verify that a worker is present when he or

she should be and ensure backup if a worker fails to report to work.

The federal government is guiding states toward improved person-centered quality assurance systems for home- and community-based service programs, and has imposed more stringent program requirements to ensure that quality standards are being met by the states. Its actions include the following:

- establishing a quality framework to guide state quality system redesign
- requiring concrete evidence from states that they are systematically monitoring activities and correcting problems
- crafting a new Medicaid waiver program application that requires more detailed information from states on their quality-management systems
- providing substantial grant support for quality-redesign initiatives

This approach is designed to improve the real effect on the daily lives of consumers by ensuring that authorized services are actually delivered, eligibility is determined in a timely manner, and the voices of consumers are heard by care managers and home-care workers. Much work remains, however, on measuring and documenting the outcomes of home care.

Argentina and Brazil, as previously mentioned, are developing programs in order to improve home-based care. The Argentinean National Program of Home-Based Care has a coordinator of cases whose responsibility is to select and supervise caregivers, but there is no information available regarding the evaluation system or criteria (BPS 2007b).

V.4 Conclusions

This chapter addressed the evaluation of the two main “care” social programs: childcare and LTC. Both classes of programs are relative newcomers in the social insurance area. Because childcare needs are strongly correlated with work patterns while LTC programs are complemented by pension, health, and disability programs, providing social insurance has been a logical manner of addressing the problems associated with the financing of care programs.

Childcare and LTC programs face numerous challenges because their services overlap with those of other healthcare and social services, as well as with informal care provided at home by family and friends. Problems in coordinating acute healthcare, rehabilitation, and LTC, for example, can lead to unsatisfactory outcomes for patients and inefficient use of both healthcare and LTC resources. Policies to improve coordination must be implemented in many countries through a range of measures, including national strategic frameworks. Such coordination is often conducted by multidisciplinary teams, which provide advice to households and consumers about the alternatives available and the best choices for them.

Part of the difficulty in developing any quality-assurance system for home-based services is the difficulty of monitoring the care delivered in the home. However, the increase in public funding for home- and community-based services makes the development of better systems for quality assessment essential.