ABSTRACT. **Background and aims:** Community care for older people is increasing dramatically in most European countries as the preferred option to hospital and long-term care. While there has been a rapid expansion in Evidence-Based Medicine, apart from studies of specific interventions such as home visiting and hospital at home (specialist visits or hospital services provided to people in their own homes in the community), there is little evidence of characteristics of the recipients of community care services or the organisation of services that produce the best outcomes for them and their informal carers. The AdHOC Study was designed to compare outcomes of different models of community care using a structured comparison of services and a comprehensive standardised assessment instrument across 11 European countries. This paper describes the study and baseline data. **Methods:** 4,500 people 65 years and older already receiving home care services within the urban areas selected in each country were randomly sampled. They were assessed with the MDS-HC (Minimum Data Set-Home Care) instrument, containing over 300 items, including socio-demographic, physical and cognitive characteristics of patients as well as medical diagnoses and medications received. These data were linked to information on the setting, services structures and services utilization, including use of hospital and long-term care. After baseline assessment, patients were re-evaluated at 6 months with an abbreviated version of the instrument, and then at the end of one year. Data collection was performed by specially-trained personnel. In this paper, socio-demographics, physical and cognitive function and provision of hours of formal care are compared between countries at baseline. **Results:** The final study sample comprised 3,785 patients; mean age was 82±7.2 years, 74.2% were females. Marital and living status reflected close family relationships in southern Europe relative to Nordic countries, where 5 times as many patients live alone. Recipients of community care in France and Italy are characterised by very high physical and cognitive impairment compared with those in northern Europe, who have comparatively little impairment in Activities of Daily Living and cognitive function. The provision of formal care to people with similar dependency varies extremely widely with very little formal care in Italy and more than double the average across all levels of dependency in the UK. **Conclusions:** The AdHOC study, by virtue of the use of a common comprehensive standardised assessment instrument, is a unique tool in examining older recipients of community care.
INTRODUCTION

Population aging is one of humanity's greatest triumphs, but it is also one of its greatest challenges, creating increasing economic, health and social care demands. During the late 1980s and 1990s, there were substantial health care reforms across western countries (1) aimed at controlling the escalating costs of health-care by decreasing the number of hospital beds and the length of hospital stays. However, while acute care costs tend to decline at the oldest ages, those for long-term institutional care increase significantly (2).

Community care services have been promoted as an effective alternative to long-term institutional care. Community care may attain better outcomes at lower costs than institutional services (3, 4) and be preferred by older people (5) often even when they are terminally ill (6). As a consequence, it has been one of the fastest growing segments in the health care industry in the US (7) and in many European countries (8). Progressively increasing use and complexity of community care services has been reported in Finland (9) and the Netherlands (10) and is explicit government policy in the UK (11).

In spite of these factors, health services research on care for older people has mainly focussed on in-patient hospital care, patients living in long-term care institutions (12), preventive interventions such as screening or home visiting (13), syndromes such as stroke, or specific services to prevent admission or facilitate early discharge (14-20). The findings have been summarised in two recent systematic reviews (21, 22). There are very few studies of that component of services intended purely to maintain people in their own homes, which is the sector of health and social care that is increasing so dramatically. In 1991, Raymond Illsley wrote in the introduction to Home Care for Older People in Europe (23): “We were surprised at how little experts on [these] services in their own countries … knew about practices, or even principles, pursued in other countries. Services had emerged nationally …, not through cross-country observation and learning. Because systems … have developed in response to local circumstances, it is impossible to pick and choose and put together a mosaic of the best bits.” Almost fifteen years later, there is still little information about the characteristics of older people enrolled in community care programs, nor any shared knowledge regarding models of efficient home care in Europe.

Hence, physicians and policy makers devising strategies to provide community care services continue to find “local” solutions, but these remain limited and non-reproducible experiences. Few of these “local” solutions are described in the scientific literature (24-26).

While biomedical research is transforming “conventional” medicine into Evidence Based Medicine (EBM), in the field of health services organisation there is no evidence on which to base comparisons between models of community care for older people. A major obstacle to a systematic approach to evidence based practice in community care has been the use of different non-comparable assessment instruments, protocols and procedures (27).

An EU Vth Framework project is laying the foundation for the application of EBM to community care services. The objective of this cohort study in 11 countries is to link the characteristics of community care recipients, the services they receive, and the outcomes they experience. This paper describes the design of the study and the study population at the baseline assessment.

METHODS

Study population

The study was conducted during 2001 and 2002 in 11 European nations: the Nordic countries - Denmark (DK), Finland (FI), Iceland (IS), Norway (NO) and Sweden (S); and the Czech Republic (CZ), France (F), Germany (D), Italy (I), the Netherlands (N) and England (UK). In each country, the project coordinator selected distinct municipalities (Figure 1) providing formal HC services (“targeted population”) which were considered representative of the nation’s urban areas; in 7 countries this was within the capital city. People aged 65+ already receiving services at the start of the study were identified from the records of service providers delivering ser-