Funding long-term care for older people

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Lessons from other countries

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Introduction – what is the problem?

Current approaches within the UK to the funding and provision of long-term care for older people have considerable strengths. In comparison with some other countries, levels of services are arguably good and there are increasingly strong mechanisms to safeguard their quality; there is a growing concentration of resources on those with highest levels of need; and cost containment mechanisms are reasonably effective.

Nevertheless, the recommendations of the Royal Commission on Long Term Care (1999) and the subsequent actions of the UK Government (in respect of England), the Scottish Executive and the National Assembly for Wales have prompted continuing concerns about the equity, efficiency and sustainability of the current arrangements. Current areas of concern include the following:

- There are now significant geographical differences within the UK, since personal care is free in Scotland but not in the rest of the UK. The introduction of free personal care in Scotland has, however, not been without some difficulties and its longer-term financial sustainability may be questionable.

- Particularly outside Scotland, there remain significant differences in access to public funding between older people needing mainly health-related care, free at the point of use; and those needing mainly social long-term care, which is means-tested.

- Access to public support for those without resources remains heavily dependent on stigmatising means tests, which exclude from public coverage most of those with capital resources. The consequent lack of risk pooling has the potential for inequity and inefficiency in both access to and the utilisation of long-term care, while private insurance covers too few people substantially to fill the gap.

- Current funding is argued to be too heavily skewed towards acute services and crisis intervention rather than prevention and promoting quality of life (Local Government Association, 2003; Audit Commission, 2004).

- Public opinion supports a stronger role for state funding than the UK Government appears willing to accept (Deeming and Keen, 2003).

These debates are taking place in a context of major demographic change. Between 2001 and 2051, the numbers of people aged 65+ are expected to increase by 61 per cent and those aged 85+ by 169 per cent. Future demand for long-term care arising from the illnesses and disabilities associated with advanced age can therefore be expected to increase substantially, with a corresponding growth of 118 per cent in real-term spending over the next three decades (Comas-Herrera *et al.*, 2003). There

is also considerable uncertainty about the future supply of both informal care (Pickard *et al.*, 2000) and the workforce needed to deliver formal institutional and community-based services (Henwood, 2001; Netten *et al.*, 2002).

These concerns are not unique. Other developed countries and many developing ones as well are grappling with issues of scope, access, costs and quality of long-term care (Brodsky *et al.*, 2000, 2003; Gibson *et al.*, 2003). This briefing paper focuses on the options for funding long-term care and the lessons that can be drawn from other countries' experiences.

By *funding* we mean:

- the ways resources are raised (e.g. taxation, insurance contributions, individual payments)
- the ways resources are spent (e.g. allocation decisions, services or cash payments, eligibility criteria).

By *long-term care* we mean:

- non-medical care, including nursing, personal and social care, supervision and domestic help
- care provided in institutions, by community services, in supported housing and by informal carers.

What can be learned from the approaches of other countries that might offer lessons for the UK? There is no simple solution; trade-offs are inevitable and other countries have had to make difficult decisions of the kinds facing governments here.

Dilemmas and debates in long-term care

- What are the roles of *different levels of government* – particularly the respective responsibilities of central and local government – in creating economically and politically sustainable frameworks for the funding of long-term care?
- What forms of *taxation and social insurance* (including the possibility of hypothecation) can raise revenue in ways that are equitable and economically sustainable?
- Should publicly funded support for long-term care be treated as a *universal welfare provision* or be available only for older people with *low incomes and/or assets*?

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- What is the appropriate balance between *national eligibility criteria* that in themselves confer entitlement to long-term care resources (but which may be insufficiently sensitive to some types of care needs and may inhibit cost-effectiveness if they are insufficiently flexible) and *individualised needs assessments* (which in themselves may produce less horizontal equity).
- Should long-term care resources be allocated in the form of *cash payments or services in kind*; and who should be offered one, the other, or both?
- Should *the family or society as a whole* be primarily responsible for providing care for frail older people?

In preparing this briefing, we have examined arrangements for funding long-term care in Australia, Austria, Denmark, France, Germany, Japan, the Netherlands and the USA. We have also examined the changes recently introduced in Scotland. In evaluating the experiences of these countries, we focus particularly on:

- their equity
- how far they offer dignity, choice and independence for older people
- their efficiency and effectiveness
- their economic and political sustainability.

As informal care makes such an important contribution to the overall volume of long-term care, we give specific attention to how this is supported in other funding approaches. We also consider separately the politically contentious issue of user charges (including charges linked to ownership of housing and other assets).

2 Equity

Equity is central to debates about how to fund long-term care. Equity is affected both by the ways that revenues are raised and by the ways those resources are allocated.

Raising revenue for long-term care

There are at least five broad approaches to funding long-term care (Wittenberg *et al.*, 2002). They differ in the balance between private and public resources, the nature and extent of risk pooling, and the degree to which they are progressive.

Approaches to raising revenue for long-term care

- *Private savings*, possibly through special savings accounts or use of housing equity.
- *Private insurance*, either free-standing long-term care insurance or linked to pensions or life insurance.
- *Private insurance with public sector support*, such as subsidies, tax concessions or partnership arrangements.
- *Public sector tax-based support*, funded from general tax revenues, with cash or services provided on the basis of needs and possibly also on the basis of income and assets.
- *Social insurance*, funded through an hypothecated contribution, with services or cash provided on the basis of needs and possibly contributions.

Private savings approaches are not likely to provide equal resources for equal needs. They redistribute resources across the life cycle, but do not redistribute from those with lesser to those with greater needs for long-term care. They are more costly for women; as women face a higher risk of needing care, they need higher savings than men. Savings approaches would not be widely affordable and, moreover, involve no pooling of risk. None of the countries we examined relies on private savings as the basis for long-term care funding; indeed, one of the factors prompting the introduction of long-term care insurance in Germany was the widespread concern about the limitations of a savings-based approach and the consequent impact on social assistance budgets of older people who had no savings or had already spent these down.

Private insurance is generally more efficient than private savings, in that it involves pooling of risks. It can also redistribute from those with lesser to those with greater care needs. However, adverse selection and moral hazard may create risks of ‘market failure’, which are difficult and expensive to overcome; users are ill-informed about risks and often reluctant to plan ahead; and uncertainties about future patterns

of disability, care inflation and technologies for delivering care all make it difficult to set contribution rates for affordable funded schemes. Without large public subsidy, insurance coverage for the bulk of care costs would be unaffordable. In the USA, it is claimed that 11 per cent of long-term care costs are now met from private insurance but this may be an overestimate, given that a decade ago only about 5 per cent of the older population was covered (Wiener *et al.*, 1994)

Public sector support for private insurance could address some of these problems, especially affordability; subsidies for insurance premiums and/or partnership arrangements could reduce costs to enrollees. Some US states have introduced partnership schemes, in which purchasers of approved private insurance policies receive more generous treatment of their assets under Medicaid if they require long-term care for periods exceeding their insurance cover. On this basis, about half of British users of community-based social care would qualify for benefit. However, take-up of these partnership policies has been low.

Compulsory purchase of private insurance could reduce adverse selection and other informational problems, and simultaneously improve affordability. However, this would be regressive in comparison with social insurance because premiums for private insurance are actuarially based on individually assessed risk, while payments for social insurance tend to be based on earnings or other forms of income, sometimes with additional contributions from employers. In Germany and the Netherlands, people with high incomes who have private health insurance are required to enrol in private long-term care insurance schemes with benefits at least equivalent to the public social insurance scheme.

The primary rationale for a public sector scheme is that it allows both insurance and redistribution objectives to be achieved. A public sector scheme could range from a safety net with a substantial means test for poor people, to a universal arrangement for the whole population without any means test. The main sources of funding for public schemes are general taxation and social insurance contributions, each having variants with different implications for progressivity and sustainability.

Different approaches to public sector funding

Denmark and *Australia* fund long-term care provision from general taxation, the former locally variable, the latter standard across the whole country. Central and local taxes tend to have different degrees of progressivity, especially where local taxes are mainly indirect and central taxes a combination of direct and indirect taxes.

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Germany funds long-term care from hypothecated social insurance contributions and *Japan* partly from such contributions and partly from general taxation. In both *Germany* and *the Netherlands*, contributions from employers complement those of employees. The progressivity of social insurance depends largely on the extent to which contribution rates increase as income rises. Systems with a ceiling above which no further contributions are paid, or that allow wealthy people to opt out, tend to be less progressive.

The differences between a tax-funded scheme and social insurance do not lie in insurance, since tax funding also involves risk pooling across the population. The differences are as follows:

- Hypothecation of revenues is central to social insurance (see below).
- A link between contributions and benefits is implied by private insurance but the link may be weak or non-existent in social insurance, where citizenship may bestow both an obligation to contribute and entitlement to benefit.
- National, enforceable eligibility criteria are also implied by insurance-based schemes (see below).
- The last two points imply the absence of a means test; however, insurance can also incorporate co-payments, as in Japan and the Netherlands. In principle, too, a social insurance scheme could confer benefits only on those with low incomes and assets, or could graduate benefits according to means tests of income and/or assets; however, this approach was not used in any of the approaches to long-term care funding in the countries studied.

Equity in raising resources – lessons for the UK

- The equity implications of any approach to long-term care funding depend partly on how progressive the mechanisms for raising revenue are. Both taxation and social insurance can be progressive, to a greater or lesser extent.
- Private long-term care insurance (purchased voluntarily) has low coverage, even in the USA with public sector involvement. Problems of affordability and market failure would also impair the feasibility of this approach in the UK.
- Social insurance contributions (from employers as well as employees) hypothecated for long-term care are proving a sustainable and politically acceptable way of raising revenue for long-term care in countries such as Germany and the Netherlands.

Equity in the allocation of resources for long-term care

Here it is important to distinguish between equity of access, equity in levels and mix of services relative to needs, and equity of outcomes. Equity of outcomes may be considered particularly important but, as it is difficult to assess, the other two dimensions tend to be prioritised instead. A key concern is horizontal equity – the extent to which equal resources are provided for equal needs.

The Royal Commission on Long Term Care (1999) criticised arrangements in the UK on the grounds that people with similar needs receive unequal resources, especially across the health/social care 'fault line'. The Commission questioned whether it is equitable that, for example, people with cancer should receive free personal care while those with Alzheimer's disease should receive means-tested care. Outside Scotland, this form of diagnostic inequity still exists in relation to personal care.

Long-term care systems in other countries utilise two main mechanisms for safeguarding horizontal equity (sometimes combinations of both are used).

- National eligibility criteria, which, if met, confer entitlement to long-term care resources. Such criteria are often associated with social insurance systems such as in Germany and the Netherlands, where they tend to be based on measures of individual disability and cognitive functioning. However, there is no reason in principle why entitlement to long-term care based on national eligibility criteria, should be derived solely from social insurance contributions. The entitlement-based programme in Austria is funded from general taxation, as is the French *Allocation Personnalisée d'Autonomie* (APA), while the Japanese long-term care scheme is funded partly from general taxation. Similarly in the USA, Medicaid waiver programmes have a general national minimum qualifying criterion, with individual states interpreting this in the light of local circumstances, values and priorities.

- Individualised, needs-led assessments, which offer considerable discretion to assessors in acknowledging and interpreting individual circumstances as the basis for accessing public services (as in Denmark), can also assure horizontal equity. While not necessarily involving rights that are legally enshrined (in contrast, for example, to individual social security benefit entitlements), access to individualised packages of high-quality public services can nevertheless generate strong feelings of entitlement (Baldwin, 1994). Individualised, needs-led assessments allow considerable discretion to the assessor in interpreting individual needs. The system recently introduced in Scotland is intended to increase horizontal equity by providing 'free' personal care, based on need, to older people with chronic or degenerative conditions in need of personal care.

Both national eligibility criteria and needs-based entitlements have weaknesses as well as strengths.

- National eligibility criteria need to be sufficiently sensitive to a range of conditions. Concerns about diagnostic inequities in Germany and Japan, where standard eligibility criteria and assessment processes are based on activities of daily living, indicate that national eligibility criteria must also capture the needs of people with dementia.

- National eligibility criteria can disadvantage those just above eligibility thresholds for entry or for any given level of care dependency (as assessed in Germany and Austria). Additional mechanisms may therefore be needed to direct resources at those with low-level needs, where small amounts of extra support could be highly cost-effective in generating considerable improvements in outcome.

- Where access to long-term care depends on individualised, needs-led assessments, there may be concerns about local variations in the conduct and outcomes of assessment and the subsequent provision of services. Such variations characterise long-term care in Denmark and similar concerns have recently arisen in Scotland. On the other hand, both Australian Aged Care Assessment Teams and Needs Assessment Boards (RIOs) in the Netherlands show that it is possible to combine multi-disciplinary assessments of needs with reasonably equitable and effective gatekeeping mechanisms, partly because the individualised assessment is conducted within a clear national framework about priorities and criteria. Assessment for the French APA is also intended to combine the equity advantages of a national assessment instrument, which can generate consistent national definitions of care needs, with the other equity and efficiency advantages of more individualised assessments.

- A feature of both national eligibility criteria and needs-based entitlements in many countries is their universality – they operate without income and/or asset restrictions on access. In the absence of such restrictions, both mechanisms tend to help ‘non-poor’ as well as ‘poor’ older people (Brodsky *et al.*, 2002). German care insurance, for example, was initially criticised for benefiting the non-poor, while a similar point has been made about free personal care in Scotland (Hancock *et al.*, 2003). Nevertheless, long-term care systems may deliberately aim to assist the non-poor as well as the poor (see below).

Rationales for universal provision of long-term care (Wiener *et al.*, 1994; Brodsky *et al.*, 2002)

- Long-term care is a 'normal-life' risk.
- The potentially catastrophic nature of long-term care costs, such that broad segments of the population may find it difficult to pay for them and, when their resources are depleted, they risk impoverishment and becoming a burden on public assistance programmes.
- A concern to reduce the use of more costly acute care, particularly hospitalisation, by substituting long-term care.
- Concern with the broader social costs of providing care and an interest in easing the burden on informal carers (although the impact of entitlements on the provision of family care varies with the *form* that entitlements take – see below).

Equity in allocating resources – lessons for the UK

- National eligibility criteria are not specific to social insurance systems and can be used to allocate resources raised through taxation. They could therefore be introduced in the UK, even without the insurance-based funding mechanisms often associated with them. However, national eligibility criteria must be sufficiently flexible and sensitive to a range of individual needs, to avoid diagnostic inequities and reduced cost-effectiveness.
- There may be advantages in combining national definitions, such as broad eligibility criteria; regional or local definitions that can take account of geographic variations (such as local service supply and cost factors); and criteria that relate to individual circumstances and wishes.
- Extending the Scottish system of free personal care to the rest of the UK would reduce geographical inequity across the UK, but its extension could have implications for current and future public expenditure.
- The introduction of universal benefits (whether accessed through national eligibility criteria or individual needs assessment) without means tests would benefit mainly the non-poor. However, the overall redistributive impact of universal benefits rests ultimately on the progressiveness of the mechanisms by which resources are raised (Brooks *et al.*, 2002).

3 Dignity, choice and independence

Funding arrangements should ideally offer dignity, independence and choice. The meanings attached to these values will be influenced by the traditions and norms of different societies, but they can include guaranteeing security, promoting social integration and safeguarding quality and continuity of support. In the UK, future cohorts of older people are likely to have far higher expectations of independence and choice than current generations (Huber and Skidmore, 2003).

Some of the mechanisms for achieving these objectives may conflict with each other, so trade-offs will be needed. Moreover, where funding regimes and older people themselves favour heavy reliance on informal care, this may compromise the choice and independence of their relatives (see below).

Dignity and social inclusion

Means tests that require older people to contribute most of their income and/or capital to the costs of long-term care can impair dignity and social inclusion. Austria, Germany, Japan, Denmark and the Netherlands have funding regimes that provide benefits to all eligible individuals, regardless of income.

A key aim of *German* long-term care insurance was to reduce reliance on social assistance – previously, the only source of funding for those needing intensive support in institutions or the community. Spending down to become eligible for social assistance was regarded as highly stigmatising and incompatible with basic German citizenship rights.

Dignity may be sustained by the quality of services. Funding arrangements can enhance continuity and co-ordination between services – important dimensions of quality. Separate funding streams (for example, between Long-term Care Insurance and Health Insurance in Germany, and between Medicare and Aged Care in Australia) risk cost shunting and threaten continuity.

Integrating services through a single funding stream

In *Denmark*, a single resource stream from municipal taxation funds home nursing and personal care services; these services also work across the boundaries between older people's own homes, sheltered housing and nursing homes. Community health centres form the base for home help and home nursing services, often working in integrated teams and caring for both very frail older people and those living independently in the community.

Independence

In most countries, maximising independence involves enabling older people to continue living at home for as long as they wish. Relevant funding strategies include removing perverse incentives that cause premature admission to institutional care and redirecting resources from institutional to community-based services. Concerted central government intervention in both Denmark and Australia has effected major resource shifts away from institutional provision, in order to enhance the volume, range and co-ordination of community-based services. Significantly, in both countries these were achieved despite strong traditions of substantial state (Australia) and municipal (Denmark) autonomy.

Independence can also be promoted by comprehensive assessment processes that identify needs, recommend appropriate service interventions and anticipate future needs. In Denmark, all people aged 75+ receive two home visits a year to identify potential social, physical and psychological risks, offer health promotion advice and refer for further assessment where necessary.

Maximising independence by shifting resources from institutional to community-based care: the Australian Aged Care Reform Strategy (1983–96)

This aimed to redirect investment from nursing homes to residential hostels, and from both to home and community-based services. Centralised planning mechanisms were used to control both supply and demand.

- Inequities in funding between states and sectors for people with similar levels of need were replaced by a single system of reimbursement.
- Planning benchmarks (like the norms used in the UK during the 1960s) restricted the construction of new nursing homes, except in areas of local need, and encouraged the development of home and community care services instead.

Simultaneously, under the Home and Community Care (HACC) programme, resources were ring-fenced to protect them from the strong institutional lobby and used to reduce fragmentation within the poorly co-ordinated, largely independent, non-profit home-care sector. HACC expanded the range of community services, including respite care, introduced brokerage schemes for people with complex needs and used targeted funding to encourage residential hostels to provide intensive outreach support services for people living at home.

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Multi-disciplinary Aged Care Assessment Teams (ACATs) were created as part of the Aged Care Reform Strategy. These were crucially important in reducing unnecessary admissions to nursing homes and redirecting older people to community-based services.

Over the period, spending on nursing homes decreased from 80 per cent to 64 per cent of all Aged Care expenditure, spending on hostels increased from 5 per cent to 12 per cent and on home care from 15 per cent to 23 per cent.

Choice

Choice is often assumed to be associated with ‘marketised’ welfare, where providers compete for the business of purchasers, whether individual older people, statutory social welfare organisations or insurance funds. In Germany and the Netherlands, older people can in principle choose between different provider organisations, where these exist locally. In the UK, the ability of individual older people to choose between alternative providers may be restricted by the following: the nature of the contracts negotiated by local authorities with providers; the unwillingness of local authorities to devolve budgets to care managers so as to allow choices beyond a narrow range of care providers; the application of tight budget ceilings to the total care budget; and the lack of availability of local provider alternatives. Older people may also wish to choose between different ‘packages’ of services, or between formal services and informal care; however, in insurance-based systems, choices between service ‘packages’ are restricted by the range of interventions reimbursable by social insurance funds.

Choice also depends on alternatives actually being available. In Germany, the introduction of new resources, through the option of insurance reimbursement for services ‘in kind’, has led to increases in the numbers of both home-care provider organisations and employees in the home-care sector. Exercising choice also depends on information. In Japan, insurance beneficiaries have care managers who give advice, draw up care plans and manage the financial aspects of insurance benefits, although their independence is arguably compromised as they are usually employed by a care provider organisation.

Funding arrangements that may offer the widest choices to older people are those that allow choices between different ‘packages’ of formal services (perhaps also provided by different organisations), and between these and informal care. Such systems usually allocate resources in the form of cash allowances or cash equivalents of service entitlements, as in the Dutch Personal Budget scheme.

Particularly in the US, there are models that allow older people to mix and match the purchase of some care themselves with the receipt of traditional care-managed services. However, some choices, such as those facilitated with the Dutch Personal Budget scheme or the German insurance cash option, may compromise the dignity, independence and choices of other family members (see below and Chapter 6 on 'Informal care'); and, again, also depend on alternatives actually being available.

Offering cash allowances as a means of maximising choice for older people

In *Germany*, at each level of 'care dependency', insurance benefits can be received as:

- services in kind; or
- a much lower value cash allowance, intended as an incentive for informal care; or
- a combination of both.

When care insurance was first introduced, most beneficiaries opted for the cash allowance. However, as the availability of funding has increased the number and range of home-care services, so the numbers of beneficiaries choosing to receive some or all of their benefit as services in kind has increased, from 12 per cent in 1995 to 35 per cent in 2002.

Conversely, *the Netherlands* has recently extended its Personal Budget scheme (similar to direct payments in the UK); this is expanding rapidly, as it enables older people to bypass waiting lists for services in kind that are in short supply. Personal Budgets are allocated, like services, following assessments of care needs. They can be used to purchase any type of intervention covered by the social care insurance scheme, including home nursing, from informal or formal sources. Personal Budget funding has led to a modest increase in the number of home-care agencies. Users express great satisfaction with their enhanced choice and control, although there is controversy about the administrative burden and lack of support for Personal Budget holders.

Finally, funding systems can offer different levels of choice in the range of tasks and activities that they cover. Where long-term care is provided in the form of services, choices are restricted to those for which funding is available. Denmark is almost unique in still providing domestic (housework) services, although these are under threat in some municipalities and have been contracted out to non-statutory providers in others.

Dignity, independence and choice – lessons for the UK

- The experience of other countries suggests that dignity is impaired by means tests that restrict access to long-term care resources only to poor older people.
- The operation of social care markets in the UK does not offer choice directly to older people, partly because of commissioning and care management policies, partly because of supply constraints. However, were older people themselves able to choose between different providers, additional resources would be needed to reduce fragmentation and improve co-ordination between services, at both individual and locality levels.
- Allocating long-term care resources in the form of cash allowances can maximise opportunities for choice – between different sources of provision (including informal providers) and between different types of service inputs (including the option of choosing help with domestic tasks). However, being able to exercise such choice depends on a range of alternative sources of care actually being available and on the availability of information and advice services to support decision making.
- Both Australia and Denmark show that concerted central government action can promote independence and increase choices for those at high risk of admission to residential care, by improving the levels and co-ordination of intensive home-care services.

4 Efficiency and effectiveness

We mean by ‘effectiveness’ the achievement of the policy’s goals; by ‘efficiency’, the ratio of achievement to the value of resources consumed in producing it. ‘Target efficiencies’ relate to access: ‘horizontal target efficiency’ measures the proportion that actually receive support from among those for whom it is intended; ‘vertical target efficiency’ measures the proportion receiving services who actually satisfy the targeting criteria. Studies of ‘technical’, ‘output mix’ and ‘ input mix’ (‘allocative’) efficiencies show how improving a particular benefit or the overall welfare of one group incurs opportunity costs, in the form of other benefits and other users’ welfare foregone. Such research usefully contributes to the evaluation of different policy strategies for improving outcomes and production efficiency by better mixing service levels, given their relative prices and ‘productivities’ (i.e. outcome levels produced from a given level of service inputs).

Research shows that the funding arrangements in England since 1990 have made the system achieve some high priority policy goals by:

- targeting subsidies at those at greatest risk or for whom the benefits are greatest
- contributing to independence and support in the community and extending individual outcome goals
- responding better to individual variations in needs, risks, circumstances and wishes of users.

Current arrangements in England have also successfully shifted considerations of efficiency from a simple focus on the unit costs of services to considerations of the outcomes of services, and the costs and benefits to stakeholders of those outcomes; these changes have occurred to a greater extent than in most other countries. All these outcomes are more clearly apparent than in countries where the priority has been to introduce a general financing system for the frailest older people (and carers). Following the community care reforms, the English system has clear, and to some extent expected, patterns of service productivities, benefits from services and opportunity costs, in that gains in one kind of benefit or for one group incur losses of other benefits or for other groups. Therefore, it is likely that a new mechanism, funding or otherwise, will have opportunity costs for some kinds of benefits now achieved and for some current users.

The creation of separate funding streams for long-term care in countries like Australia, Germany and the Netherlands has assisted its development alongside other areas of health policy, though they may also risk boundary disputes, cost-shunting and exacerbated co-ordination problems. Dedicated national funding streams can also contribute to improvements in the effectiveness and efficiency of services and systems, as illustrated in many countries. Among other things they can help social and health care services complement each other in achieving their goals.

Policy goals, financing arrangements and improved vertical target efficiency – lessons for the UK

- Careful screening and assessment of those seeking admission to institutions can be highly effective in avoiding inappropriate admissions, as shown by US Medicaid waiver programmes and the Australian Aged Care Assessment Teams.
- Where policy goals are more complex, the devolution of risk assessment to trained care managers, operating under clear incentives and accountability mechanisms, has proved highly effective in several countries. Devolution of budgets, accompanied by arrangements for performance monitoring, is crucial, as the inefficiency-caused loss of benefits to other users for whose welfare inefficient care managers feel responsible are then made visible to those care managers themselves and to others in the care network.
- Where entitlement to long-term care funding depends on standard assessments of dependency (as in Germany and Austria), high horizontal and vertical target efficiencies may both be achieved, if effectiveness is defined in terms of crude individual dependency criteria, divorced from social context. However, current UK policy goals are based on values that imply a more sophisticated approach to the assessment of circumstances and desired outcomes.

Improving input and outcome mix and technical efficiencies – lessons for the UK

- Compared with some other countries, England now has a relatively efficient and well-developed supply system; has formulated clearer priorities; and has more control over their implementation. Perhaps for these reasons, productivity patterns imply that improving outcomes of one kind, or for one user group, would incur predictable opportunity costs in the form of losses with respect to other desired outcomes, or the same outcomes for other user groups. However, over time, focused management and investment can modify productivity patterns, the patterns and magnitude of opportunity costs and, therefore, the opportunity costs themselves (Davies *et al.*, 2000).
- Direct payment mechanisms, as in the Netherlands and some US states, can improve aspects of efficiency. Moreover, if care-managed service provision is sufficiently flexible, there may be considerable potential for improving efficiency by allowing some functions and services to be directly set up and managed by users (or their nominees), while relying on care-managed

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provision for other services or functions. Which functions and services should be handled in what way should depend on user preferences and circumstances.

- Care management is widely used as a means of securing input and outcome mix efficiencies in a context of fragmented services. However, evidence from the US, Australia and the UK shows that its effectiveness depends greatly on the training and flexibility of care managers; their resourcefulness in working within the local care environment; and the flexibility of agencies within that environment.
- Models of care management that improve the integration of acute and long-term health and social care for people with complex needs often demonstrate increased efficiency. Such models usually involve the pooling of public subsidies from separate funding streams. Examples include US programmes of All-inclusive Care for the Elderly and other US area-wide care-management programmes for users eligible for both Medicare and Medicaid; and the work of some Australian ACATs.
- Integrated information systems covering commissioning, quality, expenditure allocation and control can greatly support care management and hence promote efficiency.

5 Economic and political sustainability

The long-term economic and political sustainability of long-term care funding arrangements is important because this contributes to dignity and security for older people. A major source of controversy in the UK is the frustrated expectation among current cohorts of older people that their earlier contributions to national insurance and taxation would have secured the necessary funding for their long-term care.

Considerations of sustainability need to take into account the following:

- Future demographic trends, particularly the projected rapid increase over the next 40 years in numbers of very old people; this will substantially increase demand for long-term care provision.

- Policies promoting women's labour market participation, pressures to extend working life and changing patterns of retirement; these factors will affect the supply of informal care.

In the long term, economic (and, indirectly, political) sustainability depends on overall economic performance and competing demands on public expenditure.

An active role for central government appears key to securing both the political and economic sustainability of long-term care funding arrangements. Active central government involvement that views long-term care as a normal life risk extends the scope of risk sharing – between affluent and poorer older people, between generations and across the life cycle. This is the case even in Australia and the US, with their tensions between Commonwealth/Federal and State responsibilities. In Denmark, too, with similar traditions of decentralisation, central government sets the national legislative framework within which municipalities have freedom to raise and spend resources.

One way in which central government can enhance economic sustainability is through the creation of a separate, ring-fenced funding stream for long-term care provision, whether in the form of cash payments, institutions or community services. Australia acted early (in the 1960s) to disentangle long-term care funding from health funding, as did the Netherlands with the 1968 Exceptional Medical Expenses Act (AWBZ) and subsequently Germany with the 1993 introduction of long-term care insurance separate from health insurance. Similarly, a major impetus behind reform in Japan was the growing medical insurance deficit, caused by the over-use of hospitals by people needing long-term care. In all these countries, the separation of 'cure' from 'care' funding has created long-term care budgets that are easier to control; has offered health budgets some protection from the pressures of demographic ageing; and has secured political legitimacy for collective funding of non-health care services.

National government intervention can also exert powerful levers over investment and the redirection of resources from less to more efficient patterns of spending. The Australian Aged Care Reform Strategy (see above) was successful because the Federal government exercised substantial levels of influence and control, through a combination of Commonwealth financing, supply-side and central planning mechanisms.

Denmark also relied heavily on institutional care. The 1987 Act on Housing for Older and Disabled Persons prohibited the construction of any more nursing homes by municipalities and provided for their replacement by sheltered housing and community services. Savings in nursing home care were used to expand home and community-based services and extend them to almost a quarter of all older people. Public long-term care funding dropped from 2.6 per cent to 2.3 per cent of GDP between 1982 and 1994.

In contrast, until 2001 expenditure by the Netherlands AWBZ insurance scheme was controlled by central government, which set a global budget. However, this was ruled to be incompatible with insurance principles; but with the conversion to an open-ended system, cost containment has become a major issue.

Nationally uniform, comprehensive assessment arrangements that act as effective gatekeepers to long-term care or to specific levels of support or funding according to assessed levels of need can constitute powerful cost-containment mechanisms (though, in some circumstances, this can lead to expanded demand, as with the French *Allocation Personalisée d'Autonomie*). Standard national assessments also make it easier to estimate future demand and public expenditure, particularly if assessments are restricted to individual functional (dis)abilities. Germany, Austria, Japan and the Netherlands have all introduced these gatekeeping mechanisms (although older people whose needs are assessed as falling just below the standard eligibility threshold have no access to any public support for long-term care). It is not clear that the new Single Assessment Process in England will provide the necessary levels of rigour, comprehensiveness or consistency, partly because it aims to capture the diversity of individual needs and circumstances. On the other hand, this more individualised approach can potentially offer some support to those whose needs are at the margins of eligibility.

Cost containment – the example of Germany

Germany's long-term care insurance has several powerful cost-containment mechanisms.

- Levels of contributions and benefits are all fixed by Federal law, regardless of inflation or wage increases. Contributions and benefits have not been increased since the start of the scheme.
- Access to care insurance depends on a standard national assessment. With accurate information about the current and anticipated future incidence of disability ('care dependency'), projected future expenditure on care insurance can be estimated with reasonable certainty.
- Levels of benefit are determined by national 'care dependency' guidelines. Even recent changes to improve support for people with very intense supervision needs (mainly those with dementia) did not amend or relax these 'care dependency' guidelines, but simply provided additional benefits for this group.
- Benefits can be received as a lower-value cash allowance or 'in kind' as services. The cash-benefit option has consistently proved more popular than the more expensive 'in-kind' service option.
- The cash-benefit option has increased the capacity of informal care, thus helping to shift the balance from institutional to community-based care.

These cost-control mechanisms led to a surplus of contributions in the first few years. However, as benefits have failed to keep pace with inflation and service costs, up to 40 per cent of older people in institutional care are now drawing social assistance to supplement their insurance benefits. Moreover, wider economic pressures (continuing high unemployment, expanding demands on the health and pensions insurance schemes) are now raising concern about the viability of long-term care insurance. Proposals currently being discussed include a reduction in benefits payable for institutional care and an increase in contributions by childless working-age people.

Compulsory co-payments and discounts are further mechanisms for containing expenditure. A standard 10 per cent user fee is charged to all Japanese insurance beneficiaries and income-related co-payments are required from Dutch Personal Budget users. It is common for these co-payments to be treated as discounts on assessed entitlements and not to be made, so users therefore receive less support than they are assessed as needing.

Achieving political sustainability may not be straightforward; the lengthy debates that preceded the introduction of comprehensive changes to funding arrangements in Germany and Austria suggest that political consensus was not easy to achieve. These debates variously involved employers' organisations, trades unions and regional/provincial governments. The former stakeholders are not likely to play such a major role in the UK, although achieving greater consistency in the context of political devolution would necessarily involve negotiation with administrations in Scotland, Wales and Northern Ireland.

Major political challenges arise in justifying the introduction of new items of public expenditure or reorganising and extending existing programmes. It may be argued that the hypothecation of revenue contributions can assist in this, because it ensures that a specified level of resources is guaranteed for a specified purpose. Indeed, social insurance contributions hypothecated for long-term care are proving a viable means of raising revenue for long-term care in countries such as Germany. Hypothecated funds for long-term care would mean that social care funding would no longer compete directly with funding of other services. Ultimately, however, resources are limited and the need to prioritise is clearly not circumvented. Hypothecation has also been advanced as more acceptable to the public than an increase in general taxation, but this is debatable. Moreover, hypothecation is not without drawbacks. In any given year, revenues raised from earnings-related taxes or contributions may be affected by the economic cycle, so supplementation from general tax revenues or borrowing could be needed. Furthermore, within the UK context, the introduction of hypothecation for one welfare sector would require robust political justification of the reasons for protecting that particular sector.

The Rowntree Inquiry (Joseph Rowntree Foundation, 1996) proposed a funded insurance scheme, in order to transfer long-term care resources into the future. It may be easier to secure political support for a funded scheme than an unfunded scheme if the public had more confidence in an arrangement under which individuals' contributions were potentially identifiable. However, there were no cases of funded social insurance for long-term care in any of the countries studied; in Germany, for example, the 'pay-as-you-go' nature of long-term care insurance has helped ensure its sustainability (see above). Moreover, a funded scheme would not guarantee enhanced economic sustainability (Barr, 1993) and would seemingly require one generation of working age to contribute twice.

Demonstrating increased equity may be a key factor in securing political support for any new funding arrangements. In 1997, Australia proposed that new entrants to nursing homes should pay a means-tested, lump-sum 'accommodation bond'. This would have generated about 50 per cent of the costs for less dependent residents,

but would have generally required the sale of their homes and would also have increased inequities between people receiving free care in hospital and those in nursing homes. Following widespread opposition, the proposal was dropped. In the UK, proposals that involve greater equity between different groups of older people, fewer pressures to 'spend down' assets and income, and reduced reliance on means testing may help secure political support for any increased expenditure. However, securing political sustainability by improving equity will still need to be balanced against long-term economic sustainability, as current concerns in Scotland about the costs of free personal care illustrate.

Finally, while arrangements such as social insurance may appear incompatible with traditions in the UK, the experience of Japan shows that countries can break sharply with both public and private family traditions. In Japan, the public sector has a much more extensive role in financing long-term care than in other areas of the economy. Moreover, the new insurance scheme specifically aimed to reduce reliance on informal care giving, especially by daughters-in-law who had hitherto provided home-based care for older people.

Securing economic and political sustainability – lessons for the UK

- Economic and political sustainability appears to be assisted by strong leadership from central government. This can:
  - maximise the scope of risk sharing across different groups of older people
  - legitimate public expenditure on long-term care
  - overcome provider interests and remove perverse incentives in order to redirect investment from less to more efficient forms of care.
- The creation of a funding stream for long-term care that is separate from acute health care also appears to enhance political and economic sustainability. This does not need to be derived from hypothecated revenue contributions – the Australian budget for Aged Care services is derived from general taxation. Although separate funding streams may appear incompatible with current UK policy pressures towards closer integration of health and social care services, there is no reason why these funding streams could not be pooled in situations and for services where improved outcomes were likely to result.
- Requiring co-payments, whether flat rate or graduated according to means, may be effective in containing expenditure, but they may have an adverse impact on choice and on outcomes if they deter people from using services they need.

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- There is no evidence that funded schemes for long-term care are either politically or economically more sustainable than ‘pay-as-you-go’ arrangements.

6 Informal care

Informal care, that is unpaid care by relatives and friends, is given special attention here for two reasons. First, informal care is the dominant form of care for older people throughout the world (Wiener, 2003). Second, informal care is qualitatively different from other forms of funding long-term care. Informal care is often treated as a 'free' resource in long-term care systems, although the 'hidden' costs of informal care are borne primarily by carers themselves (and to a lesser extent by the public sector and society more widely). There is uncertainty in the UK and elsewhere about the availability of informal care in future years and considerable ambiguity in many systems about the treatment of informal care.

Internationally, long-term care systems exhibit two main types of response to these dilemmas.

- First, there are systems, such as Germany, which include incentives for the provision of informal care in the form of cash payments, together with some protection and compensation for the disadvantages that would otherwise be borne by carers in the form of training, entitlement to respite care and pensions protection. Programmes relating to informal care givers in many other countries, including Australia, Austria and Canada (Quebec), aim to support and encourage informal care-giving through, for example, information and training, respite care, tax/pension benefits and/or payments to informal carers, partly in order to ensure that carers will continue to provide care and partly to promote carers' welfare as an end in itself (Gibson *et al.*, 2003; Wiener, 2003).

- Second, there are systems, such as Denmark, Japan and, to some extent, Scotland, that allow for some substitution of formal for informal care. The two countries that have most recently reformed their long-term care systems, Japan and Scotland, have both assumed a reduction in informal care. These countries also have some policies designed to support informal carers who choose to provide care (for example, a national carers' strategy in Scotland and some entitlement to respite care in Japan).

Approaches to informal care in two recently reformed systems

Japan's long-term care insurance scheme (introduced in 2000) was designed partly to reduce the burden on family care givers by making formal care, especially community-based services, more available to older people. There are therefore no incentives to provide informal care, such as cash payments. Instead, all benefits take the form of services and there are incentives to obtain care from formal providers, many of which are private companies. The system is intended to encourage the 'marketisation' of elder care.

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It was anticipated that the introduction of free personal care in *Scotland* in 2002 would lead to some substitution of formal home-based services for informal care. It is the policy of the Scottish Executive that eligibility for free personal care should be irrespective of the care contribution made by unpaid carers.

The most recent experiences of long-term care funding reforms suggest that the form of any new entitlement to long-term care is crucial to its impact on the provision of informal care. This was illustrated in the Japanese reforms, where the most controversial issue was whether the entitlement should take the form of cash or services.

The debate in Japan over cash payments (Campbell and Ikegami, 2003)
Arguments in favour of cash allowances
Cash allowances would:

- maximise consumer choice
- recognise and reward the contribution of family care-givers
- avoid poor care-giving by paid strangers
- save money (assuming that cash allowances would be lower than the value of direct services at each level of eligibility, as in Germany).

Arguments against cash allowances (put forward primarily by feminists)
Cash allowances would:

- inhibit demand for services and, therefore, supply by service providers
- prolong oppressive care-giving patterns, particularly the provision of care by daughters-in-law
- prolong poor standards of care by families
- cost more, because demands for services would be lower than demand for cash payments.

In Japan, the arguments against cash allowances prevailed.

The debate over cash payments in Japan illustrates the tensions that can exist between the interests of older people and their families. Whereas cash payments are consistent with ideas of empowering older people, services or vouchers for services are more likely to reduce the burden on carers.

The approach to informal carers adopted by different countries depends on attitudes to a central issue in long-term care policy – whether the individual/family or society as a whole should be responsible for providing and caring for frailer older people. Policies in the US, for example, emphasise that primary responsibility belongs with individuals/families and that government should act only as a payer of last resort for those unable to provide for themselves. At the other end of the policy spectrum are countries like Denmark and Japan, where it is believed that long-term care is a societal responsibility and that formal care should play a large role in meeting the needs of older people.

An important driver of policies for informal carers is the increasing employment of women, who have traditionally been the providers of unpaid care. Cash payments, for example in Austria and Germany, are intended to encourage women to leave work or reduce their hours of work and instead provide help to older relatives with disabilities, though the effectiveness of cash payments in achieving this is not clear (Wiener, 2003). Conversely, in countries like Denmark and Japan, reducing dependence on informal care is seen as a way of enabling women to participate more fully in the labour force. A very high level of labour-force participation by women is a corollary of the long-term care and other welfare policies pursued in Denmark.

Informal care – lessons for the UK

- It is important to provide adequate and appropriate support for informal carers who wish to provide unpaid care.
- New millennium policies on informal care are recognising the uncertainties regarding the provision of informal care in the future and are giving greater recognition to long-term care as a societal responsibility, by allowing for some substitution of formal for informal care.
- Entitlements to long-term care in the form of cash payments tend to be used as an incentive for informal care, whereas entitlements in the form of services (or vouchers for services) tend to encourage formal service provision.

7 User charges

User charges are among the most contentious aspects of debate about long-term care funding. Debates may cover the services (if any) on which charges should be levied; the forms that charges should take; the role of means testing (including the size and scope of the family unit whose means are taken into account); and whether income, savings and housing equity should be included in calculating user charges. The latter issues are often highly contentious and have implications for intergenerational equity through the impact on inheritance.

User charges can perform two key functions in the funding of long-term care. First, they can be a mechanism for constraining demand for services. In particular, they are likely to discourage people who place low value on (additional) services from seeking or accepting them. Efficiency can therefore be increased where services are concentrated on those who value them more highly. Cost containment can be promoted where prices act as a device for rationing limited resources.

Second, user charges can increase the total revenues available for long-term care. They form an important source of private funding for formal care. Without user charges, the volume of publicly subsidised services, for any level of net public expenditure, would be lower.

These two arguments in favour of user charges are to a considerable extent conflicting. Where the elasticity of demand for services is high, user charges will be more effective in containing demand than in raising resources. Where it is low, they will be more effective in raising revenue than containing demand. Only where elasticity of demand is low among those in greatest need (who stand to benefit most from services) but considerable among other groups can the two advantages be combined.

There are four different forms of long-term care provision on which charges may be levied:

- home nursing, for which few countries levy user charges, probably because of links with health care

- home care, for which many countries levy user charges, often under rules set at local level, but which is free in countries like Denmark, Germany and Scotland

- care services in care homes, for which many countries levy user charges, in various different forms, generally under a national system

- hotel services in care homes, for which most countries levy user charges, on the basis that individuals are normally responsible for general housing and living expenses in their own homes.

It is also important to distinguish between the designation of user resources as an eligibility criterion for publicly subsidised care and the levying of user charges as contributions to care costs. Under Medicaid in the USA, those with assets above a prescribed level are not eligible for publicly subsidised care – in effect, a wealth eligibility criterion. Under the Japanese long-term care system, in contrast, there is a standard co-payment rate of 10 per cent but no wealth criterion.

It is also helpful to distinguish between systems that require users to:

- contribute almost all their income above a specified level towards care costs, especially care costs in care homes, such as Medicaid in the USA
- contribute a specified proportion of their care costs, such as the Japanese long-term care system
- meet any shortfall between the public scheme's contribution and the actual costs of care, such as tends to arise under the German long-term care insurance scheme, whose benefits increasingly fall short of care home fees.

The treatment of housing assets, which tends to be especially controversial, also varies between countries; Australia and the UK take housing assets into account in their means tests (with some exemptions). In Australia, opposition to 1997 proposals requiring the sale of a home in order to finance lump-sum 'accommodation entry bonds' payable on admission to nursing homes illustrated the political limitations to the use of user charges to fund long-term care.

User charges – lessons for the UK

- The extent to which a reduction in, or abolition of, user charges would lead to increased demand is uncertain, in the absence of evidence on the elasticity of demand for long-term care in the UK.
- User charges are not necessarily always accompanied by a capital limit that places a wealth criterion on eligibility for publicly subsidised care. Co-payment requirements as in Japan or implicit requirements to top up a public subsidy as in Germany are alternatives, though a shift to such arrangements in the UK (other than for personal care in Scotland) would probably require extra resources and would have distributional consequences.
- Housing assets could be disregarded in a wider range of circumstances, for a longer period than 12 weeks, or altogether, though this would clearly require extra resources and would have distributional consequences.

8 Conclusions

Examination of the policies and experiences of other countries in the funding of long-term care reveals a number of difficult choices, for which there are no simple technocratic solutions. To take but one example, providing support for long-term care in the form of cash payments appears to have the potential to maximise choices for older people (so long as a range of support options on which those payments can be spent actually exists). However, to the extent that such payments are intended wholly or partially to constitute incentives for informal care-giving, they may severely compromise the choices and independence of carers. Similarly, extensive systems of means testing and co-payments may contain costs and enhance economic sustainability, but at the potential expense of improved efficiency and equity (depending on the type of means test).

Examination of arrangements for funding long-term care in a number of other countries reveals the following conclusions.

- There are limits to how far any system of funding long-term care can be protected from wider economic pressures and performance. Even Germany, whose long-term care insurance system contains a substantial number of highly effective mechanisms for controlling social insurance expenditure, is not immune to pressures arising from continuing high unemployment and budget deficits. Moreover, as the proportion of total spending from social insurance is held constant and that from private sources correspondingly increases, the equity and other performance criteria of the scheme may be adversely affected.

- None of the countries included in this study has introduced a funded insurance scheme for long-term care. Requiring one generation effectively to pay twice for long-term care appears substantially to risk intergenerational conflict, without any obvious counterbalancing gains in sustainability. Countries such as Germany, the Netherlands and (in part) Japan that have adopted social insurance principles for funding long-term care have all introduced pay-as-you go schemes. Other countries rely on mixtures of national and local taxation (with varying levels of private contributions from user co-payments and means tests). Funding the care needs of current generations of older people through current taxation and/or insurance contributions (including those paid by more affluent older people themselves) therefore appears to be the only viable option. Moreover, in none of the countries that have adopted this approach is there any evidence of intergenerational conflict.

- Debates about the funding of long-term care necessarily need to include both the mechanisms by which revenues are raised and the mechanisms by which these are allocated. Methods of allocating resources – particularly the micro-allocation

processes associated with individual needs assessments and the incentives attached to more or less costly types of care (including informal care) – directly impact on the equity, efficiency and ultimately the sustainability of any particular system.

More specifically, the experiences of other countries suggest a number of areas where debates about the future of long-term care funding in the UK should usefully focus.

Issues for debate in the UK

- What mechanisms should be used to raise resources for long-term care? What is the role of local and national taxation? Should an element of taxation be hypothecated specifically for long-term care? What is the role of social insurance contributions, including those contributed by employers? What are the impacts of lower and upper income ceilings in both taxation and social insurance on progressivity and redistribution between income groups, age cohorts and gender?
- Is there scope for increasing equity through greater standardisation of assessment processes, over and above those being introduced by the new Single Assessment Process? If so, how can assessment procedures avoid diagnostic inequities? Should assessment procedures be linked to some notion of 'entitlement', whereby everyone assessed as having care needs above a particular threshold has some claim to public resources for long-term care? Should assessments aim to identify different levels of severity of care needs above this basic threshold, with entitlement to different levels of resources graduated accordingly?
- Should (elements of) public funding for long-term care aim primarily to provide incentives for family care giving, or encourage the provision of care by formal care providers?
- Although there is considerable rhetoric about the importance of 'choice' for users of public services, the opportunities for older people to choose between different providers of institutional or home-care services are relatively small, unless they are purchasing services entirely from their own private resources – and even here choice is likely to be restricted by problems of supply. Supply problems are intrinsically related to the availability of funding and to commissioning and contracting arrangements. Changes in any of these could be introduced to encourage new providers and increase diversity of supply. What funding mechanisms could be introduced in the UK to improve supply and choice, while at the same time safeguarding overall efficiency and quality?

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- Are there grounds for reviewing the balance of user contributions and co-payments that are derived respectively from income and assets (including the particularly contentious asset of home ownership)? Can these contributions be made more equitable and more consistent across both community and institutional services, without reducing demand for formal care to such an extent that they reduce the effectiveness of overall care arrangements?
- Should there be a review of the role of assets tests in severely restricting access to publicly funded long-term institutional care (apart from nursing-related costs) for all older people with more than very modest resources? Instead, should funding arrangements guarantee to *all* older people (above a given threshold of care needs and perhaps graduated according to level of severity) some public support for long-term care, with the balance of their needs being met from private income/assets or means-tested public resources, as necessary?

Underpinning this last area of debate is the fundamental question of whether public support for long-term care needs is seen as a universal responsibility that embodies and reflects fundamental principles of social solidarity and social justice, or whether public support should be reserved primarily for poorer older people. Despite the economic difficulties with which many ageing societies are currently struggling, the approaches of many other countries do nevertheless appear, to a greater or lesser extent, to embody principles of universality in responding to the risks of long-term care.

In considering the experiences of other countries, it is important to recognise that these may reflect different objectives. Which countries and which aspects of their long-term care systems have valuable lessons for the UK depends on a clear articulation of the perceived strengths and weaknesses of both the current UK arrangements and those elsewhere in respect of specific objectives. In particular, considerable opportunity costs may be incurred in introducing arrangements from other countries that attach different values to the goals that have informed UK policies over recent years.

Nevertheless, elements of other approaches to funding long-term care – many not highly costly or difficult to implement – could increase the fairness, effectiveness, efficiency and sustainability of the UK system. In considering their transferability to the UK context, it will be particularly important to ensure that the goals of the alternative measures in their original countries and contexts – increasing equity, improving efficiency, enhancing sustainability and so on – are appropriate and compatible with their intended objectives in the UK.

Successive UK governments have tended to adopt a relatively incremental and piecemeal approach to long-term care policies. It may, for example, be more realistic to consider the adoption of a number of specific incremental measures, such as national eligibility criteria or lower user charges, than the wholesale implementation of an entirely different system. However, despite the strengths of the UK system of funding long-term care, this approach has arguably also contributed to the current inequitable divergence between English and Scottish arrangements. Moreover, the experience of other countries shows that radical changes could realistically be considered. The recent experience of Japan shows that system-wide change can be accomplished, even in the face of strong institutional and cultural traditions. Developments in Australia during the 1980s and in Austria in the 1990s were similarly accomplished despite major constitutional barriers.

In summary, the experiences of other countries show that radical system-wide transformations in arrangements for funding long-term care can be accomplished. However, the nature of those changes, and their relative costs and benefits over and above current arrangements, requires full and open political, economic, social and ethical debates. Such debates hold the key to the long-term sustainability of the future funding of long-term care in the UK.

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Appendix
How this briefing was compiled

In August 2003, the Joseph Rowntree Foundation Policy and Practice Development Programme on Paying for Long-term Care commissioned a study of overseas models of paying for long-term care, to inform the development of its Programme. The study team, from the Personal Social Services Research Unit at the London School of Economics and the Social Policy Research Unit at the University of York proposed a study that would:

- describe a range of different approaches to the funding of long-term care for older people in a number of other countries

- evaluate these against a range of criteria.

The study covered the funding of the full range of non-medical health, personal and social support, including that received in institutional and community settings and from waged and informal carers. It also covered both how revenue for long-term care is raised and the ways in which it is spent.

Eight countries outside the UK were included in the study: Germany, Japan, Denmark, Australia, some US states, the Netherlands, France and Austria. They were selected to reflect a diverse range of funding arrangements, or because they had recently implemented major reforms of long-term care funding arrangements. The study also included Scotland, as the one UK country recently to introduce free personal care.

A review of literature published in English on long-term care arrangements in these countries was carried out. This formed the basis of a report of arrangements in each country. The accuracy of these reports was checked with policy experts in each country, who were also asked to add details of any very recent developments or debates.

In order to develop the criteria against which long-term care funding arrangements should be evaluated, a seminar of academic and policy experts was held. This was valuable in elaborating the dimensions of criteria such as equity, efficiency and sustainability, and in providing the structure for this briefing document.

The authors of the briefing are very grateful for the help provided by the overseas informants and the seminar participants.