flexible organisations, PCGs are large organisations embedded in health authority bureaucracy. This is not the model that delivered the improved performance associated with early examples of the primary care-led NHS and which provides the rationale for the policy in the first place. In short, the government may have fallen between two stools in its plans for the future of primary care.

8. Primary health care in the UK and Japan: some comparative analysis.

The proportion of GDP spent on health care in the UK and Japan is very similar (6.7 per cent in the UK, 7.3 per cent in Japan (1993 OECD figures)) and both countries have succeeded in achieving universal access to health care. But, beyond this, the systems are very different.

Japan has a Bismarckian, pluralistic social insurance system - similar to that found in Germany - with mandatory enrolment based on employment or residence, and with premiums proportional to incomes. Funding for health care is provided through premiums paid by employers and employees to numerous company-based plans, patient co-payments, and national and local government subsidies (Ikegami and Campbell, 1995). Finance provided through the national budget represents about 25 per cent of total health care expenditure and patient co-payments represent another 12 per cent (Rapp and Shibuya, 1994). In contrast, approximately 90 per cent of the funding for the UK National Health Service comes from general taxation and - with the exception of pharmaceutical, dental and ophthalmic services - there is little cost sharing.

The ways in which doctors and hospitals are reimbursed also differ quite fundamentally. Under the Japanese Medical Service Law (*Iryou Hou*), doctors certified by the Minister of Health and Welfare are permitted to open clinics or hospitals anywhere in the country and insured individuals can receive primary medical care at any such clinic or hospital. This system has led to an abundant supply of medical care. The number of medical doctors more than doubled from 103, 131 in 1960 to 211, 797 in 1990, although the proportion of clinic-based doctors fell from 44.8 per cent to 30.5 per cent ((Rapp and Shibuya, 1994).

Doctors providing primary care from their own offices or clinics are paid on a fee-for-service basis after submitting claims to the Social Insurance Medical Reimbursement Fund (*Shakai Hoken Shinryou Houshuu Shiharai Kikin*). There is a national fee schedule which specifies all procedures and products that can be paid for through health insurance and sets their prices. Since all doctors receive the same payments under the fee schedule, the incentive for doctors to specialise is weaker in Japan than in many other countries. A review process is used to regulate the volume of care provided under the national fee schedule in order to make sure that it is not excessive. Despite this safeguard, however, there are claims that primary care doctors in Japan maximise their revenues by seeing as many patients as possible, performing large numbers of tests and prescribing large quantities of pharmaceuticals. It is also claimed that primary care doctors are reluctant to refer patients to hospital specialists (who are paid on a salaried basis) because it is feared that patients will prefer to remain with hospital specialists on an out-patient basis rather than return for clinic care. (Rapp and Shibuya, 1994).

The reimbursement fee schedule in Japan also encourages the widespread use of advanced medical technologies in clinics as well as hospitals. For example, 70 per cent of clinics have electro-cardiographs, 60 per cent have X-ray equipment and 26 per cent have ultrasonic image testing equipment (Rapp and Shibuya, 1994).

The UK payment system offers a very different set of incentives to those found in the Japan. Although a greater element of fee-for-service payment has been introduced for GPs in the NHS since 1990, the predominant capitation system does not provide any incentive to maximise services. Quite the reverse: if anything there is an incentive to under-treat, because once a patient has registered, a GP receives a payment irrespective of the level of care actually provided. Also the financial incentive to become a hospital specialist is stronger in the UK because senior hospital doctors (i.e. consultants) generally receive higher incomes than their GP counterparts. Hospital doctors can also boost their incomes through private work, whereas GPs rarely have this opportunity. As far as medical technology is concerned, a tight planning system has operated in the NHS for

many years with the result that practically all but very basic diagnostic equipment is located in hospitals. Hardly any GPs in the UK, for example, have X-ray equipment at their surgeries.

There are also differences between the UK and Japan in terms of patient choice. Patients in Japan are free to choose any primary care doctor who works under the social insurance system. Although freedom of choice is generally considered to be a desirable feature of a health care system, the way that it works in Japan appears to pose some problems. Both small clinics and large hospitals provide primary care services and compete with each other for patients. As there is no differentiation in charges, many patients choose to visit large, especially university, hospitals for primary care consultations because they believe that the quality of care is better. The result has been severe overcrowding, queuing and short consultation times of typically less than five minutes. There is a common saying in Japan that "you wait for three hours to see the doctor for three minutes".

In contrast, although many of the health care reforms that took place in the UK during the 1990s were supposed to increase patient choice, there is little evidence that they did so. Changing GPs for reasons other than a change of residential location is unusual. Moreover, the single payer system means that there is no choice of insurance plans and no demand-side competition for enrolees. Moreover, unlike the Japanese system, GPs are accepted as legitimate gatekeepers to hospital care by most people and there is little demand for direct access to hospital-based doctors. On the other hand, primary care consultations are not dramatically longer in the UK compared with those found in Japan (eight minutes versus five minutes). In both countries it seems that there is a degree of deference on the part of patients to doctors; certainly patients seem less demanding than they are in, say, the United States.

The traditional Japanese model of medicine did not separate the roles of pharmacist and doctor. Doctors carried medicine boxes when visiting patients and dispensed medicines. The basic elements of this system continue to this day with Japanese doctors and

hospitals dispensing most prescription drugs. Patients tend to visit doctors for drugs and doctors - who derive 25 to 30 per cent of their incomes from drug prescriptions - often prefer drug treatments to other forms of therapy. Drugs are covered by the national fee schedule but doctors frequently prescribe newer, more expensive drugs than older, cheaper ones. Patients only pay 10-30 per cent of the costs of medicines in the form of copayments. The combined result of all of these factors has been that Japan has an extremely high per capita rate of pharmaceutical consumption. In 1996 Japan accounted for 19.5 per cent of the global pharmaceutical market compared with 32.6 per cent for the US (which has twice the population of Japan) and 6.9 per cent for Germany (Ikegami, Ikeda, Kawai, 1998).

The earlier discussion of the UK described how rising pharmaceutical costs are seen as a problem too. However, the separation of the prescribing and dispensing roles in all but a minority of cases means that GPs do not have a personal financial incentive to prescribe. To the extent that there is an incentive, it is to substitute drug prescriptions (that have traditionally been paid for by the government and therefore been a free good as far as GPs are concerned) for alternative, time-consuming consultation time. Efforts to combat this perverse incentive have taken the form of overall cash limits on drugs budgets and initiatives designed to make GPs aware of the financial implications of their prescribing behaviour (e.g. GP fundholding).

9. Conclusions: primary health care policy in the UK and Japan.

This review of primary health care policy and practice in the UK and Japan has revealed a number of interesting similarities and contrasts.

At the macro-level, both countries have succeeded in controlling the growth in health expenditures and do not, therefore, face the major challenge confronting many advanced countries. Interestingly, though, they have achieved this objective through different approaches to the fundamental equation: Expenditure (E) = Price (P) *times* Quantity (Q). In the UK reliance has been placed on overall cash-limited budgets (i.e.controlling E). In

Japan, reliance has been placed on controlling P (through the national fee schedule) and, to a lesser extent, regulating Q.

It is, however, at the micro-level that the differences are most pronounced. Most notably, the 1990s have been a period of unprecedented health reform in the UK, whereas in Japan - despite some notable changes - the situation has been far more stable. Why is this the case?

One of the main reasons for this difference would appear to be the fact that the health system in Japan (along with accompanying factors associated with diet and lifestyle) has succeeded in achieving levels of health status that are probably the best in the industrialised world. Data on life expectancy, infant mortality and death rates from major diseases such as heart disease and cancer are all better in Japan than in the UK. Moreover, the Japanese have achieved these results at levels of spending that are as low as those in the UK. In the light of these results the adage "if it ain't broke, don't fix it" would seem to apply!

More generally, the thrust for health reform in the UK must been seen as one aspect of a wider move for socio-economic reform during the 1980s and 1990s. The 1980s were a period when a radical, market-oriented government under the leadership of Margaret Thatcher unleashed a series of reform initiatives. The NHS was a rather late entrant to this process, but the White Paper, *Working for Patients*, published in 1989 set out an agenda for reform that derived as much from a general ideological preference for market-based systems as from the needs of the NHS. Subsequent changes built on this platform until the election of a radical new Labour government in 1997 has, once again, set a direction of change that is informed by ideological preferences as well as technical considerations. Without these great surges of political change, the Japanese health care system would appear to have operated in a more stable overall, political environment.

Notwithstanding these explanations for the different perspectives on health reform in the two countries, from the point of view of a health policy analyst, there do seem to be certain features of the UK reforms that may hold some lessons for Japan. These centre on the relationship between the primary and secondary care sectors. The brief review of the Japanese system described above points to a number of perverse incentives that lead to, *inter alia*, excessive use of secondary care facilities for primary care purposes, over-investment in new medical technologies in primary care, heavy doctor workloads and excessively short patient consultation times, and very high levels of drug prescribing. These are all examples of an inefficient allocation of resources. Many of them represent an inefficient allocation between primary and secondary care.

Faced with its own inefficiencies, the way that the UK has sought to deal with the problem is by devolving budgetary responsibility to primary care doctors so that they become responsible for the allocation of resources. This approach brings together financial and clinical decision-making. It focuses on the interface between primary and secondary care where co-ordination is notoriously bad. The idea is derived from the US experience of managed care but is designed to deal with problems other than cost-containment. Rather, it seeks to encourage the use of a range of techniques for the micro-management of clinical activities - bearing in mind their financial consequences - in order to improve the quality of care. The term 'integrated care' is being used increasingly in a number of countries to describe this approach (Robinson, 1998).

Clearly, building elements an integrated care approach into the Japanese system would be difficult given the current payments systems covering doctors and hospitals, and the dispersed nature of primary care. However, if there is sufficient recognition of the deficiencies of the present system, there may be scope for pilot projects to pioneer alternative approaches and for evaluations to assess their performance. Many different forms of pilot model are possible, as the UK experience has demonstrated. Ultimately, though, international experience of health care reform suggests that they will only be

successful if there is general support for them among doctors, hospitals, patients, insurers and politicians.

References

Allsop, J. (1995). Health policy and the NHS: towards 2000. London: Longman.

Appleby, J. (1992) Financing health care in the 1990s. Buckingham: Open University Press.

Bloor, K., Maynard, A., Street, A. (1999). The cornerstone of Labour's 'New NHS': reforming primary care. Discussion paper no. 168. University of York: Centre for Health Economics.

Coulter, A. (1996). Why should health services be primary care-led? Journal of Health Services Research and Policy. 1: 122-24.

Department of Health and Social Security (1987) Promoting better health. London: HMSO.

Department of Health (1996). Choice and Opportunity. Primary care: the future. London: The Stationery Office.

Department of Health (1997). The new NHS: modern, dependable. London: The Stationery Office.

Department of Health (1998). A first class service. Quality in the new NHS. London; Department of Health.

Evans, D. (1994). Developing the primary and secondary care interface in Southampton and South West Hampshire Health Commission. Southampton; Institute for Health Policy Studies.

Glennerster, H., Matsaganis, M., Owens, P., Hancock, S. (1994) Implementing GP fundholding. Buckingham: Open University Press.

Godber, E., Robinson, R., Steiner, A. (1997). Economic evaluation and the shifting balance towards primary care: definitions, evidence and methodological issues. Health Economics. 6: 275-94.

Goodwin, N. (1999) GP fundholding in Le Grand, J., Mays, N., Mulligan, J. (eds) Learning from the NHS internal market. London: King's Fund.

Ikegami, N., Campbell, J. (1995). Medical care in Japan. The New England Journal of Medicine, 333: 1295-99.

Ikegami, N., Ikeda, S., Kawai, H. (1998). Why medical care costs in Japan have increased despite declining prices for pharmaceuticals. Pharmacoeconomics, 14, supplement: 97-105.

Killoran, A., Mays, A., Wyke, S., Malbon, G. (1999) Total purchasing. A step towards new primary care organisations. London: King's Fund.

Marks, L. (1988). Promoting better health: an analysis of the government's programme for primary health care. London: King's Fund Institute.

Mays, N., Dixon, J. (1996) Purchaser plurality in UK health care. London: King's Fund.

Moore, A. (1999). Cheque it out. The Health Service Journal. 109: 24-26.

NHS Executive (1994). Developing NHS purchasing and GP fundholding. Towards a primary care-led NHS. Leeds: NHS Executive.

NHS Executive (1996). Primary care: the future. Leeds: NHS Executive.

Office of Health Economics (1998). Compendium of health statistics.10th ed. London: Office of Health Economics.

Rapp, R., Shibuya, K. (1994). The health care system in Japan in Hoffmeyer,U, McCarthy, T. (eds) Financing health care. Dordrecht: Kluwer Academic Publishers.

Robinson, R., Hayter, P. (1995). Reluctance of general practitioners to become fundholders. British Medical Journal, 311: 166.

Robinson, R., Steiner, A. (1998) Managed health care. Buckingham: Open University Press.

Robinson, R., Le Grand, J. (1994) (eds) Evaluating the NHS reforms. London: King's Fund.

Starfield, B. (1994) Is primary care essential? Lancet. 344: 1129-33.

Taylor, D. (1991) Developing primary care: opportunities for the 1990s. London: King's Fund Institute.

Total Purchasing, National Evaluation Team (1997). Total purchasing: a profile of national pilot projects. London: King's Fund.

Total Purchasing, National Evaluation Team (1998a). What were the achievements of the total purchasing pilots in their first year and how can they be explained? London: King's Fund.

Total Purchasing, National Evaluation Team. (1998b). Total purchasing. A step towards primary care groups. London: King's Fund.

World Health Organisation (1978) Primary health care: report on the international conference, Alma-Ata, USSR. Geneva: WHO.

4章　The Finance and Provision of Long-Term Care for Elderly People

（サマリー）　　Ray Robinson

他の多くの国と同様、イギリスにおける高齢者の増加は高齢者に対する保健・社会サービスの財源や提供に関する伝統的な方法に大して大きな圧力となっている。政府の任命したRoyal Commissionは介護サービスの将来の財政に関して調査結果と勧告をまとめた報告書を発表した。

イギリスでは医療と社会サービスの財政には長い間相違があった。NHSの導入以降、実際上全ての医療サービスは利用者に無料で提供されてきた。一方で社会サービスには利用者負担が課せられている。医療と社会サービスのこのような区別が、両者の境界領域に位置する介護サービスの場合に様々な問題を引き起こしている。供給サイドでは、1980年代及び1990年代に民間やボランタリー・セクターのケア・ホームやナーシング・ホームが増え、NHSや地方自治体運営の介護施設が減少した。

グリフィス報告（1988）は1980年代における高齢者介護の財政やサービス提供にかかわる問題を明確に整理している。グリフィス報告の勧告が1991年のNHS及びコミュニティ・ケア法の基礎となった。そして、この法律が今日の政策の基本である。

高齢者介護の財政及びサービス提供の現状を分析した調査研究が最近いくつか発表されている（下院保健委員会、ジョセフ・ロウントリー財団、など）。政府もいくつか重要な政策発表を行っている。一方で、自治体の政策も裁判で争われているケースがある。これらはいずれも現在のシステムに大きな問題があることを示している。

上記の分析を基に、将来の政策の選択肢を述べる。特に、強制的な介護保険制度の導入などを勧告したロウントリー報告書の提言や1999年3月に発表された政府の介護保険に関するRoyal Commissionの報告書「With Respect to Old Age」が注目される。現在のところ政府はRoyal Commissionの勧告に対して見解を表明するより議論を喚起している。政府は公共支出の増加をコントロールすることを重視しており、Royal Commissionの勧告を実施した場合の費用負担に懸念を持っていると一般に思われている。

The Finance and Provision of Long Term Care for Elderly People

1. Introduction.

In common with many other countries, growth in the numbers of elderly people in the UK has placed pressures on traditional methods of financing and providing long-term care for this group (Henwood, 1992). In addition, the often unclear distinction between health and social care - which are subject to different charging arrangements – has posed a perennial problem for policy-makers and lays at the heart of some of the heated debates about the funding of long-term care that have taken place in the UK in recent years. As a result of these pressures, there have been a number of major initiatives and policy changes affecting the long-term care in recent years. The latest development has been a report from a government appointed Royal Commission on the future financing of long-term care. At the time of writing, the government is considering its response to the recommendations of the Royal Commission.

This paper reviews the current state of finance and provision of the long-term care sector in the UK, considers the likely growth in demand and examines the policy options facing decision-makers in this area. This is followed by a brief review of policies towards long term care in Japan and some commentary on the respective UK and Japanese approaches to this area of policy. To start with, however, the paper contains a preliminary discussion of the nature of long-term care and of some of the major policy changes that have taken place in the UK over the last 50 years.

2. Definitions of long-term care.

Long-term care has been defined as:

> *...all forms of continuing personal or nursing care and associated domestic services for people who are unable to look after themselves without some degree of support, whether provided in their own homes, at a day centre, or in an NHS or care home setting.*

Joseph Rowntree Foundation (1996), p.1.

Such care involves a continuing commitment over a period of time and is typically necessary in the case of long-term chronic illness and/or disability. It covers nursing services, together

with personal assistance and domestic help. Apart from elderly people, this sector caters for the needs of people with physical disabilities, mental illness and learning difficulties. However, this paper concentrates on long-term care for elderly people. Care provided for this group falls into three main categories; namely, domiciliary care, residential home care and nursing home care.

Domiciliary care is provided in a person's own home. It may take the form of formal or informal care. Most formal domiciliary care is provided by trained care workers employed by local authorities, although some is provided by NHS community health service staff. Spending on long-term domiciliary care amounted to an estimated £2.5 billion in the UK in 1992. Public expenditure accounted for 79 per cent of the total, with the remaining 21 per cent coming from user charges levied by local authorities and personal spending on private services (Laing, 1993). In addition to the formal domiciliary care sector, there is a vast amount of informal care provided on an unpaid basis by relatives and friends of elderly people. It has been estimated that the market value of this care in 1992 was £39.1 billion (Laing, 1993).

Residential and nursing home care are provided in institutional settings. The distinction between the two forms of care relates to the level of dependency of the residents. Residential home care caters for less dependent residents and offers accommodation and assistance with everyday living. Nursing home care – as the term implies – involves a nursing component and takes place in NHS long-stay geriatric units or registered nursing homes where qualified nursing staff are required to be on duty. Residential care is provided by both the public sector (NHS hospitals and local authority homes) and the independent sector (private and voluntary homes). Funding comes from both the public and private sectors. In 1992, expenditure on residential care for the elderly amounted to approximately £4.7 billion – public expenditure accounted for 66 per cent of total spending with the remaining 34 per cent coming from user charges (Laing, 1993).

3. Some background history.

There has been a long-standing division between the financial arrangements for health and social care in the UK. The origins of the financing of social care can be traced back to the Elizabethan Poor Relief Act of the 17th century. This set up poor houses to cater for paupers

of all kinds. The Victorian workhouses of the 19th century were a subsequent example of social care institutions designed to cope with the needs of old, sick and infirm people. When the UK welfare state was set up after the Second World War, social care arrangements for elderly people were treated as a residual category. They were not included in the mainstream social insurance arrangements. While the health care needs of the sick were met by the NHS and provided free of charge, responsibility for providing social care for elderly people rested with the local government and was subject to means testing (Richards, 1996).

During the 30 year period following the end of World War II there was a broad expansion of publicly funded, long-term care services for elderly people, provided by NHS long-stay geriatric hospitals and wards, local authority residential homes and private and voluntary sector homes. Places were provided free of charge in NHS hospitals and, despite the existence of means testing, the majority of people qualified for free care in local authority homes. Local authorities met the costs of about 60 per cent of private and voluntary sector residents. Public funds were, however, subject to cash limits and so there was considerable unmet need. In addition, as had always been the case, the bulk of care was provided on an informal, unpaid basis.

From the mid 1970s, tight controls over public expenditure generally – resulting from the needs of macro-economic policies associated with sharp rises in oil prices – meant that local authorities were finding it increasingly difficult to meet the spending requirements of the growing demand for long-term care. Pressure built up for the central government funded Supplementary Benefit system (i.e. a system offering cash benefits to low-income groups) to meet the costs of residential care for those people who could not afford fees and for whom local authorities were unable to pay. Payments under this system became widespread and, in 1983, it became part of national policy when anyone with less than #3,000 in capital became eligible to apply for Supplementary Benefit as a right in order to meet the costs of residential or nursing home care. No assessment of need was required in order to qualify for benefits. This system remained in place until 1993, although the capital limit was increased from #3,000 to #8,000.

Because the Supplementary Benefit system was part of the non-cash limited Social Security system, these payments fuelled a major expansion of the residential and nursing home care

sector. As table1 shows, the total number of long-term care places for elderly people grew from 279,086 beds in 1983 to 467,066 beds in 1993. Moreover, these payments were made during a period when the Conservative government - under Prime Minister, Margaret Thatcher - was keen to expand the private sector of the economy at the expense of the public sector. In keeping with this objective, Supplementary Benefit payments were payable to residents of private and voluntary homes but not to residents of local authority homes. As a result, the numbers of private residential homes grew rapidly from the mid 1980s while the local authority sector at first remained static and then fell in size. As table1 shows, the number of long-term care places in the private and voluntary sectors increased by more than threefold between 1983 and 1993, whereas the number of places in the local authority sector declined by nearly a third over the same period.

Another trend revealed by table 1 is the decline in the number of long-term care places provided by the NHS. These fell from 55,600 in 1983 to 40,300 in 1993. This situation arose because, faced with rising pressures on their cash limited budgets, many health authorities transferred patients from NHS care to the independent sector in the knowledge that the costs of this care would be met by the non-cash limited, social security system. Although this was never an explicit policy objective sanctioned by government, it became a widespread local practice. (As will be explained subsequently, the withdrawal of the NHS from the long-term care sector is currently a hotly debated issue that has been the subject of legal proceedings).

The dramatic increase in social security spending on long-term care attracted a number of criticisms. It was claimed that the system provided a perverse incentive for people to enter residential care rather than receive domiciliary care in their own homes. An Audit Commission report, *Making a Reality of Community Care*, published in 1986 pointed to #500 million spent on residential care from the social security budget and argued that many people could have been cared for quite adequately in their own homes at a lower cost (HMSO, 1986). The House of Commons, Public Accounts Committee claimed that 77 per cent of those elderly people in institutions could be cared for in the community if appropriate domiciliary services were made available (Baggot, 1998).

Reacting to these criticisms, the then Prime Minister, Margaret Thatcher, asked her policy adviser, Sir Roy Griffiths, to examine the situation and to make recommendations. (In passing,

it is worth noting that the tendency to ask a trusted individual to carry out a short-term, action-related review - rather than establish a large scale Royal Commission - was very much part of the Thatcher government's approach). The subsequent Griffiths Report (DHSS, 1988) was based upon three main objectives. First, to ensure that public resources were targeted on those people who needed them most. Second, that recipients of long-term care should have more choice about the services that were offered to them. Third, that wherever possible, people should be given assistance to enable them to remain in their own homes (Hunter and Judge, 1988).

The principal financial recommendation of the Griffiths report was that budgetary responsibility for funding long-term care should be transferred from the central government, social security budget to local authorities. Under this system, all elderly people requiring long-term care would be subject to a needs assessment carried out by a case manager from their local authority, social services department. On the basis of this assessment, an appropriate package of care - which could involve domiciliary, residential or nursing home care - would be agreed. In the case of nursing home and residential home care, those individuals qualifying for public funding would have their costs met by the local authority. But there would be an expectation that more cost-effective packages of care would reduce the emphasis on residential care.

An important financial consequence of the Griffiths proposals was that they replaced non-cash-limited, non-means-tested social security payments with cash-limited grants to local authorities and needs-assessed provision of long-term care.

The Griffiths proposals formed the basis of the White Paper, *Caring for People*, published in 1989 (HMSO, 1989) and went on to be embodied in the National Health Service and Community Care Act, 1990. After some delay, the reforms were implemented in April 1993. While the Griffiths principles were a central feature of the new financing system, the government added some of its own gloss. For example, it made it clear that maximum use should be made of the private and voluntary sectors. Thus local authorities were required to allocate 85 per cent of any new money received from the central government to services provided by the private sector. This continued the earlier emphasis on the expansion of private residential and nursing homes. There was also an expansion of privately provided

domiciliary services. In 1992, only 2 per cent of home care contact hours funded by local authorities in England was provided by the independent sector. By 1995, the proportion had risen to 29 per cent (Baggot, 1998).

4. The current system.

The system that has developed since the implementation of the NHS and Community Care Act in 1993 was described by the Royal Commission on long-term care in the following terms:

> *'The current system is particularly characterised by complexity and unfairness in the way it operates. It has grown up piecemeal and apparently haphazardly over the years It contains a number of providers and funders of care, each of whom has different management and financial interest which may work against the interests of the individual client.'*
>
> Royal Commission (1999), para 4.1, p.33.

As the earlier account in this paper shows, the complexity arises from different payment systems and different providers. Long-term care services provided by the NHS -whether domiciliary or residential - are provided free of charge. But, over time, the NHS has cut back on the provision of, particularly, long-term residential care. The number of NHS long-stay beds has been reduced by about 38 per cent since 1983 (21,300 beds) while the supply of private nursing home beds has increased by 900 per cent (141,000 beds).

Long-term domiciliary services provide by local authorities are subject to charges. However, there is wide variation between different local authorities in the application of these charges. Some of them charge a small flat rate, while others charge full costs. Local authorities also vary in the extent to which means tests are used as a basis for determining payment. Revenue from charges amounted to about #200 million in 1996/97. But it is in the area of payment for residential or nursing home care that large anomalies have arisen and most discontent has been expressed.

If an individual is assessed by the local authority social services department as being in need of nursing home or residential care, his or her eligibility for financial assistance with the fees

will depend upon their income and capital assets. If the individual's income is sufficiently high, they will be expected to pay the full fees. At the moment, however, very few retired people fall into this category. If they hold assets of #16,000 or more (including assets held in the form of equity in their homes), they will also be expected to meet the full fees. These currently amount to an average of #270 per week for a residential care place and #350 per week for a nursing home place. If individuals have capital assets of #10,000 to #16,000 they are expected to make a contribution towards fees. Only if assets are less than #10,000 are they disregarded as far as charges for residential care are concerned.

As owner-occupation levels have increased (just under 60 per cent of UK households with a head of household 65 years of age or older is currently an owner occupier),and property values have increased, these requirements have meant that a growing number of elderly people have been required to draw on their equity holdings in their homes in order to finance long-term care. Currently around 56 per cent of single over-75 owner occupiers are thought to have assets of #16,000 or more.

This state of affairs has led to widespread and vocal discontent. People who have paid taxes all their working lives and expected the welfare state to look after them in their old age are now finding that they are required to use their savings to fund care. There is a general view that the government has reneged on its social contract with elderly people. In fact, as the preceding account has shown, there never really was such a contract. Social care in the UK has always been subject to means-testing. The sense of betrayal felt by many elderly people (and their relatives and heirs) arises because this fact was not apparent as long as the NHS took responsibility for providing social care as well as health care needs, and while the numbers of elderly people meant that local authorities could offer sufficient accommodation to avoid widespread discontent. The rapid and unchecked growth in social security payments up to 1993 also fuelled expectations. Now government has decided that these arrangements are not sustainable, the true nature of the social care system has become apparent.

Whatever the origins of existing views about the long-term care system, the Royal Commission - in common with the earlier Joseph Rowntree Committee of Inquiry and the House of Commons Select Committee on health - concluded that the current system is failing.

It is, however, far easier to diagnose problems than put forward proposals for reform that meet economic, social and political objectives.

5. The future demand and cost of long-term care.

As with all forecasting, predicting the future demand for long-term care involves a number of uncertainties. Nonetheless, some basic predictions can be made on the basis of the future age composition of the population and their expected levels of dependency.

Table 2 presents some projections based upon the Government Actuaries figures. These show that the number of people over the age of 65 years of age is expected to increase from 9.1 million in 2000 to 14.7 million in 2040. Thereafter the numbers are expected to fall back to 14.1 million by 2050. Although these projections indicate a substantial rise in the size of the elderly population, it is the increase in the numbers of very elderly people (i.e. 80 years of age and over) that is the more striking. Their numbers are expected to more than double - from 2.4 million to 5.4 million - between 2000 and 2050. It is also relevant to note that the number of people of working age (16-64 years) per person over the age of 65 years will fall from 4.1 to 2.1 over the period 2000 to 2040, thereby reducing the size of the taxpayer base able to fund long term care on a pay-as-you-go basis.

Of course not every elderly person will be in need of long-term care. As table 3 shows, even among those people of 85+ years, severe dependency rates only occur among one in five men and one in three women.

By combining projections of overall demographic change, assumptions about dependency rates and predictions about changes in the unit costs of long-term care over time, it is possible to estimate the increase in the total costs of long-term care likely to be experienced in the future. One set of estimates, produced by the Institute of Actuaries is shown in Table 4. The calculations suggest that the combined effect of changes in demand and cost will increase the share of GNP devoted to long-term care from 7.7 per cent to 10.8 per cent between 2001 and 2031. Sensitivity analysis carried out by varying the assumptions indicates that under the most pessimistic scenario, costs could rise to account for around 15 per cent of GNP.

Clearly the costs of meeting long term care in the future are going to pose problems for government. In the next section we look at some of the options for future policy with particular emphasis on the proposals put forward by the Royal Commission on Long-Term Care in 1999.

6. Options for the future funding of long-term care.

The previous discussion in this paper has highlighted the serious shortcomings in the present long-term care financing system. Prominent among these are:

- Inconsistent charging principles, i.e. free long-term care in the NHS versus means-tested social care.
- Severe reductions in NHS provision of long-term residential care.
- Haphazard variations in charges for domiciliary care between local authority areas.
- a widely held view that a social contract with the elderly has been broken forcing many of them to draw on their housing equity in order to fund long-term care.

Projections of the future growth in demand suggest that these shortcomings will become even more serious if policy remains unchanged. For these reasons, most commentators who have examined policy in this area have concluded that a continuation of the *status quo* is not a sensible option.

In considering alternative approaches, some broad lines of policy may be identified. First, there is the choice between publicly and privately funded schemes. Within the public sector, schemes based on general taxation on a pay-as-you-go basis (as at present) may be developed in different forms. Alternatively, a social insurance arrangement may be developed in which contributions are earmarked for spending on long-term care and collected primarily through employment-based taxes. Such a scheme could be pay-as-you-go or be on a funded basis, i.e. contributions are paid into a fund which accumulates over time and is used to pay benefits. In the private sector, there are a range of possible insurance arrangements that could be developed to cover individual costs of long-term care, although these are unlikely to be able to offer universal coverage on their own. For this reason, a mixed system in which public and private funding are drawn upon in defined ways is another option.

The most recent, well-publicised option for the future funding of long-term care was put forward by the Royal Commission on Long term Care in their report *With Respect to Old Age* published in March 1999. The Royal Commission started from the premise that there is no 'demographic timebomb' and that the future costs of long-term care are affordable. Further they maintained that it is not efficient or fair for people to have to rely on their income or savings to cover these costs - as many people do at present - and argued for a system of risk pooling. They rejected the idea that this should be based on private insurance, arguing that it would not provide cover at an acceptable cost. They also rejected the idea of social insurance either on a pay-as-you-go or funded basis.

Having rejected these options, they argued for services to be funded through general taxation, maintaining that this is the most efficient method of risk pooling and the fairest across all generations. However, recognising that a major increase in general taxation aimed at funding long-term care might not be feasible, they argued for a distinction to be made between *personal care, living costs* and *housing costs*. They proposed that the costs of personal care should be universally available, non-means tested and paid for through general taxation. Living costs and housing costs could, however, be subject to user payments according to means. The Commission claims that, at present, an estimated 2.2 per cent of the revenues collected by the government from tax payments levied on earnings, pensions and investment income is spent on long-term care in residential settings and in people's homes. By improving entitlements so that all nursing care is provided free of charge, they estimate that this bill would rise to 2.5 per cent of total tax revenue by 2051. Put another way: the percentage of GDP devoted to the public funding of long-term care would rise from 1 per cent to 1.3 per cent.

Two members of the Commission, however, did not accept their colleagues views on the future cost of care and their proposals for the way in which it should be funded, and issued a Note of Dissent. They argued that the majority proposals would initially add #1.1 billion to public sector costs rising to #6 billion in 2051. Moreover, they maintained that this would not increase the quantity or quality of long-term care but simple represent a transfer from existing private expenditure to public expenditure. This, they argued, was an inefficient and inequitable use of scarce public funds. They were prepared to see the existing means-test modified so that it did not penalise people with small amounts of wealth or force them to sell