Review of Pricing Arrangements
in Residential Aged Care

Long Term Aged Care
International Perspectives

BACKGROUND PAPER No. 3

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This Paper has been prepared to assist individuals who may wish to make a submission to the Review of Pricing Arrangements in Residential Aged Care. The opinions expressed in this paper are those of the author and are not necessarily those of the Commonwealth.

Front cover

Continuing engagement in the community: an afternoon chat in the village square.
(Photo: Review of Pricing Arrangements in Residential Aged Care)

Publications Production Unit
Commonwealth Department of Health and Ageing

Commentary of the Reviewer

Australian provisions for residential aged care reflect developments over many decades by state and local governments initially and then the federal government over the past fifty years. There has been direct involvement with the provision of services as well as the devising of legislation and funding mechanisms to guide the ways in which facilities should be managed and developed. Historically each state developed health and residential aged care separately and elements of that separate set of experiences can be detected in present arrangements despite the measure of uniformity associated with federal administrative, funding and legislative arrangements.

Background Paper No. 3 turns to experiences of other countries in their provision of aged care. It comprises six short studies of how long term care for the aged is provided in Germany, Denmark, the United Kingdom (with an emphasis on England), New Zealand, Singapore and Japan. As residential care in Australia has already been described in Background Papers No.1 and 2, *The Context of the Review* and *The Commonwealth's Legislative Framework,* these case studies might be read in conjunction with them.

One particular feature of this appraisal of experiences in six countries should be noted. Not all of the countries use the term 'long term care'; nor do they necessarily attach a definition to their services for the elderly. Even so, arrangements in all of the countries may be seen as broadly consistent with the definition given in 1986 by the Institute of Medicine based in Washington, D.C.:

> … a variety of ongoing health and social services provided for individuals who need assistance on a continuing basis because of physical or mental disability. Services can be provided in an institution, the home or community, and include informal services provided by family and friends as well as formal services provided by professionals or agencies.[1]

1 As cited in Ikegami, Naoki, John P Hirdes, and Ian Carpenter, 'Long term care: a complex challenge', *OECD Observer,* 7 December 2001

Having a variety of services is not necessarily seen as adequately meeting the needs of the elderly. Authorities in all six countries are looking to strengthen integration across a continuum of care and to place greater emphasis on healthy ageing, prevention and rehabilitation. Hence, while the central concern is residential aged care the studies seek to place it in the context of broader policy, funding and service provisions.

The aim of the six studies is to promote understanding of how and why other countries provide long term care the way they do. In tackling the common challenge of meeting the needs of the elderly, each country is seeking to balance the roles of family, community and government as well as to contain costs. On balance, policy developments are evolutionary.

These countries were chosen because they illustrate a range of 'histories', cultures, political cycles, and differing stages in the ageing of their populations. Bear in mind also the substantial differences in the length of time current policies on residential aged care have been in place.

Of the six countries, Japan is the one faced most starkly with a rapidly ageing population. In contrast New Zealand is relatively 'middle aged'. Two countries have relatively small populations: New Zealand has a population spread geographically with some concentration in the northern part of the North Island; and Singapore has great concentration being a small island republic where land is scarce and property values high.

Like Australia, Japan faces particular problems in rural areas. Younger people are moving out of many rural communities leaving behind elderly parents and creating senior citizen communities. This situation is compounded by other elderly people, mostly urban dwellers, moving to resort and environmentally attractive communities in search of retirement amenities associated with good climate and attractive recreational facilities.

Long term care arrangements in Denmark and Germany have had time to 'mature', since their introduction in the early 1980s in Denmark and 1994 in Germany. In contrast, in the UK and New Zealand changes consequent to the return to office of Labour Governments in the late 1990s are settling in. For Japan and Singapore major changes have been introduced since 2000. However, Germany is in the process of again reviewing health, welfare and long term care provision for the elderly because of worries about fiscal sustainability. Between 1995 and 1999 the German long term care insurance fund shifted from a considerable surplus to a small deficit.

Care for older people in Australia shares common antecedents with care in the UK and New Zealand including expectations about the role of government and strong involvement of the

religious and charitable organisations. Religious, charitable and other community providers continue to play a significant role in all of the six countries with governments depending on such organisations to ensure that some groups of their population have access to the services they need.

The range of activities which may be undertaken by these institutions varies across the countries. Singapore offers very clear directions on the role of the religious, charitable and community organisations. There the Ministry of Health expects Voluntary Welfare Organisations to provide lower income groups with basic nursing care while private providers are encouraged to cater for the needs of those who can afford to pay for more comfortable services. The Voluntary Welfare Organisations may take private residents but no more than ten per cent of total residents; and private providers may seek government subsidies to provide care for a small number of less affluent residents.

In five of the six countries reviewed, government has opened the aged care sector to greater involvement by corporate entities seeking returns on their equity. These corporates are being encouraged to participate in the sector in various ways including as direct service providers, managers of government insurance schemes, as developers and managers of private insurance products, and providers of services to support residential and home care facilities. The exception to this strategic shift is Denmark. In Denmark, all of the homes operate on a non-profit basis with 72 per cent operated by the municipalities and the remaining 28 per cent by private non-profit organisations.

Japan and Germany, in particular, have long had strong cultural traditions around the provision of care by the family. These continue to influence policies and arrangements. Until recently the Japanese social security system made no special provision for long term care. The elderly looked to the free services of family members, typically daughters or daughters-in-law. The Japanese move to 'socialise' care is in part aimed at lifting some of this burden from families by making the care of the elderly a responsibility shared between the community and the family. Increasing emphasis on home care in all countries is increasing demands on women in terms of caring, monetary costs, and rising opportunity costs to their careers. At the same time there is recognition by governments of the need for greater involvement of women in the workforce given rising dependency rates. Women in Singapore face a further burden. Public long term care insurance premiums are higher for women because their superior longevity exposes them to higher claims risk!

Resources for long term care are generated from a range of sources varying from one country to another:

- taxpayer funded Government budgets at national, state and local government levels, not just those earmarked for aged care but also health, social security, housing and public works budgets
- public health insurance (which in Japan and the UK substantially covers the nursing care of the elderly)
- government endowment funds
- investors and capital markets
- donations to charitable organisations and the work of volunteers
- premiums paid to government and/or private long term care insurance funds
- home equity conversion schemes and comparable government funded schemes
- pensions and other forms of retirement income
- out-of-pocket payments by consumers including service co-payments, entry payments and such like
- in-kind care activities provided by family members and other people in the community.

Interactions between the sources of funding are complex so that system changes have more often than not been incremental. The countries with compulsory long term care insurance (Germany, Japan and Singapore) still depend on a mix of funding sources. Even in Denmark, where by far the bulk of care costs are financed by the government, some co-payments have been introduced and the elderly are expected to utilise their own resources and 'help themselves' wherever possible.

Another financing issue concerns 'who pays for what'. Accommodation, general care and support, and nursing care may be treated as separate responsibilities. In Denmark, the costs of accommodation and general home care are paid for by individuals while nursing care (no matter where the individual is living) is paid for by universal public insurance. All nursing care for the elderly in England is paid for by the National Health Service. In Japan all types of care services are treated similarly and largely paid for by pooled premiums and taxes, except for food which is the responsibility of the consumer.

This division of who pays for what is convenient at first sight. However, reflection may lead to some queries because nursing does not depend just on the provision of medical advice and direction and the addressing of immediate needs such as with administering of medication. The scope for effective nursing may reflect in important ways the scale and extent of services provided in a building as well as the ease of accessibility of nursing staff to residents thus allowing for effective supervision of their care.

Encouraging the participation of the private sector appears to be associated with the need to increase the number and quality of nursing homes because of the growing proportion of the elderly in the total population. In New Zealand this may have led to some excess capacity in residential facilities. Nonetheless, in all six countries there may be some level of agreement with the New Zealand notion that 'there is no "right" level of care services that should be available for a given population'.[2]

Denmark decided to reduce the number of nursing homes by which is meant high care facilities in Australian parlance. A freeze was imposed on the construction of nursing homes. Instead, emphasis has been placed on the development of integrated complexes of residential, supported and nursing care dwellings suited to the needs of the elderly and with 24-hour access to health care services. The construction of more appropriate housing is high on the list of priorities in Japan.

Japan, Germany and Singapore are faced with difficult economic circumstances that impinge on long term care provision generally and in ways very specific to each country. The impost of employer long term care insurance contributions on the cost of labour was a point of contention in developing German policies and is again being strongly debated. The Japanese Government has increased heavily its investment in privately constructed nursing homes for the elderly. In Singapore, tight economic circumstances have meant that the ElderCare Fund, a new national endowment fund, has been slower than anticipated to generate the level of income needed to fund operating subsidies for nursing homes operated by Voluntary Welfare Organisations and to fund other care services for the elderly. This shortfall reflects the relatively low level of interest rates around the world.

Ensuring the appropriateness and quality of care, whether in an individual's home or a nursing home, are critical concerns everywhere. Worries include the need for competence and the role of care managers. Appropriateness of care is often questioned where funding arrangements act as a barrier to integrated care tailored to the needs of the individual. Where cash payments are made to families to purchase care, sometimes these sums are not fully spent on care.

The care of people with dementia is a growing challenge owing to the growing proportion of the elderly in the total population. Arrangements in some systems discriminate against them. In Germany, for example, the restrictive legal definition of 'need for nursing care' means that fewer people with neuro-degenerative diseases receive insurance benefits.

2 The Hon Ruth Dyson, Associate Minister for Health, Address to Open Kerikeri Village Trust Hospital, 1 May 2002.

Workforce availability and upskilling are universal concerns. The effects of the world-wide shortage of nurses may be compounded in the future by decreasing availability of family and other people willing to provide home care. This is likely to vary across countries depending on the need for greater involvement of women in the workforce, and the availability of alternative work.

There are some common features, more or less, amongst the six studies presented in this paper. Each study contains a brief demographic section which is followed by an appraisal of how long term care has evolved over time and the social and political forces that shaped the developments. Attention is directed to government responsibility for long term care policy and the emphasis placed on care of the aged as a shared ('whole of government') responsibility.

Generally there is treatment of how the care system is funded, the roles of various providers and participants, and how quality is assured. Attention is also directed to those issues that pose challenges to the effectiveness of aged care arrangements in each of the six countries, issues identified by the relevant government, researchers or other commentators.

The six studies of national schemes for residential aged care and related activities depict a wide range of approaches. They span very different societies in Europe, Asia and the Pacific. No doubt other countries might afford no less interesting explorations than the ones treated here. However, these six countries serve to illustrate a variety of societies and the ways in arrangements have been devised to meet their objectives for the care of their older citizens.

Warren P. Hogan
Reviewer

June 2003

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Any errors are the responsibility of the Taskforce.

Contents

United Kingdom

Modernising care

Modernising care

The evolution of the long term care system in the United Kingdom for much of the 20th Century was linked with a 'welfare state' philosophy and the provision of taxation-funded universal health and community care for all. The National Health Service (NHS), established in 1948, brought hospital services, family practitioner services and community-based services into one organisation for the first time. Long term nursing care continues to be funded from taxation and provided under the auspices of the NHS.

In the early 1990s a major cultural shift took place with the introduction of the notion of the 'internal market': 'purchasers' (health authorities) were given budgets to purchase health care from 'providers' (hospitals and organisations providing care for the elderly etc). The sector was opened up to encourage greater participation by private sector providers both existing not-for-profit organisations and new corporate for-profit providers.

The new Labour Government in 1997 decided that a 'third way' was possible neither totally dependent on universal benefits under classic welfare socialism nor leaving the provision of long term care to a pure free-market solution. The Government did not abolish the internal market but refocussed it towards a collaborative rather than competitive approach. It placed emphasis on making care a matter of local responsibility based on forging much stronger links between local authorities, their local populations and service providers.

The philosophy of the Blair Government for long term care is 'the right care, at the right time, in the right place'. The emphasis is on the responsiveness of the system in providing individually appropriate care, rather than insisting that individuals respond to the system by fitting into pre-packaged services.

Long term care is seen as the care people need over an extended period of time as the result of disability, accident or illness to address both physical and mental health needs. It may require services from the NHS and/or social care. It can be provided in a range of settings, from an NHS hospital, to a nursing home or residential home, and people's own homes. There is continuing reliance on mix of private and, to a diminishing extent, public providers and a greater emphasis on means tested user-pays contributions.

Long term care is largely Budget funded but with consumers either purchasing private care for themselves or making means tested contributions to the costs of largely state-funded care services. The private sector also makes a substantial capital investment in the provision of nursing homes.

The Royal Commission on Long Term Care in the late 1990s provided a forum for lively debate on the future of care for the aged. With the most recent changes still settling in, the debate continues.

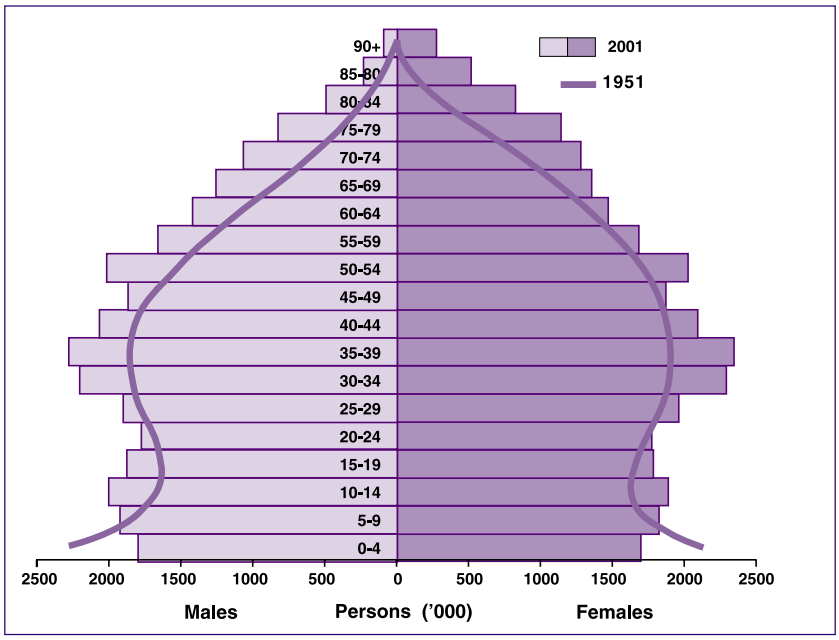
Demographics

Population

The population of the United Kingdom at the 2001 Census was 58.8 million people. This included 11.9 million people under 16 years of age and 9.4 million people over the age of 65. The population over the age of 85 stood at 1.1 million people (or 1.9 per cent of the population, increased from 0.4 per cent of the population in 1951). Women accounted for 72 per cent of this age group, and by the age of 90 years women outnumbered men by more than three to one (ONS ST330102). The rate of population growth in the UK from 1951 to 2001 is shown in Figure UK 1.

Life expectancy at birth increased by six years for men and five years for women over the last 30 years. Life expectancy at age 65 is expected to rise from 16.0 years for men and 19.1 years for

Figure UK 1: Rate of Growth of UK population 1951 to 2001



Source: ONS, 2001.

women in 2001 to 18.1 years for men and 20.8 years for women in 2021 (ONS ST330701). According to the UK Office for National Statistics, the ageing of the population reflects both improved living and health standards, and the absence of events as significant as the First and Second World Wars (ONS 2001).

The dependent population in the UK is rising although not at the high rate of other European Union countries. In 1975, the dependency rate in the UK was 22.6 per cent, rising to 24.4 per cent in 2000 and projected to rise to 32.8 per cent in 2025 and 39.2 per cent in 2050 (Department of Work and Pensions 2002).

While the current generation of older women is less likely to have spouses, it is likely that the immediate next generation of older people are more likely to have been married. They are also likely to be married when the need for long term care arises and to have children who could care for them. However, for subsequent generations a greater number of older people may have no spouse or partner to care for them because of changes in marriage patterns (ONS ST330103; Royal Commission 1999).

Employment rates for both men and women tend to decline quite sharply after age 55. By the age when they are eligible for the State Pension (60 for women; 65 for men) two thirds of men and half of women (almost three million people) have left the labour market (Department of Work and Pensions 2002). To cover an increasingly long period of retirement, retirement income is drawn from government pensions, private pensions, savings and other assets. The Government provides the foundation of pension income through the basic State Pension with spending on pensions likely to remain relatively stable (around five per cent of Gross Domestic Product) over the next five decades (Department of Work and Pensions 2002).

Research towards the recent Green Paper on pensions found that most people are saving for their retirement, either in pensions or in other forms and there has been a 40 per cent increase in pension contributions since 1997. At the same time there continues to be concern over the adequacy and security of pension provision with estimates that as many as three million people are 'seriously under-saving' for their retirement and a further five to ten million may want to consider saving more and/or working longer. Apart from helping to make people better informed about choices in retirement, the Government sees the purpose of the Green Paper as reaffirming the role and responsibilities of employers in the pensions partnership, encouraging simple and flexible savings products, and broadening access to the financial services industry (Department of Work and Pensions 2002).[1]

1 The Green Paper, *Simplicity, security and choice: working and saving for retirement*, was released for consultation in December 2002 with comments closing 28 March 2003 (see references for details).

The Green Paper also found that the UK is better placed than most other developed countries to adapt to an ageing population:

- the old-age dependency ratio is expected to increase by less in the UK than in the EU as a whole
- the employment rate for older workers has risen significantly following a steady decline during the 1980s and 1990s
- the level of private funded provision in the UK is high by international standards: by contrast, most other European countries have very few or no private pension funds
- the value of UK pensions assets is similar, relative to GDP, to that of the USA (Department of Work and Pensions 2002).

Expenditure on social care and protection

The UK Government spent a total of £398 billion in 2001, of which £61 billion was on health and £159 billion on 'social protection' such as pension payments. (ONS ST330531). In terms of gross expenditure by type of service, 46 per cent was spent on residential care provision, with 39.2 per cent on day and domiciliary provision and 14.8 per cent on assessment and care management (Department of Health 2002a).

In 2002-03, £11 169 million will be available for social services, 6.2 per cent more than in 2001-02, the majority of which will be distributed to local authorities through the Revenue Support Grant and the remainder as grants. This includes distribution of £93 million to the Residential Allowance and £85 million to Carers (Department of Health 2002a). In the last Spending Review, on a like for like basis, total resources for personal social services increased by an average of 3.3 per cent in real terms from 2001-02 to 2003-04. By comparison between 1992 and 1997 the average real terms increase was less than 0.5 per cent.

Table UK 1: Expenditure on social protection benefits in real terms by function, 1990-91 and 2000-2001

United Kingdom	£ billion at 2000-01 prices*	
	1990-91	2000-01
Other	1.2	2.6
Unemployment	9.2	7.8
Housing	9.6	14.1
Family and children	14.5	17.3
Sickness, healthcare and disability	58.1	86.7
Old age and survivors	68.6	116.9

* Adjusted to 2000-01 prices using the GDP market prices deflator

Note: 'social protection benefits' is the standard European Union term referring to programs designed to 'protect people against common sources of hardship' and it includes cash payments, goods and services.

Source: ONS, ST330801.

The Government's commitment to social care is further demonstrated by the continuing real growth in funding for personal social services with annual average growth in real terms of 6 per cent from 2003-04 to 2005-06 (NHS 2002a). The growth in expenditure between 1990-91 and 2000-01 is illustrated in Table UK 1.

Evolution of UK long term care system

Structured care for the elderly is a relatively recent phenomenon. In Victorian England, many older people who could not afford to care for themselves ended up in workhouses, doing unpaid work for food and shelter. In 1929, these became Public Assistance Institutions, but '…their character, and the stigma attached to them remained' (NHS 2003a).

For much of the latter half of the 20th century, emphasis on providing care to all those who need it was modelled on the influential *Beveridge Report* which

> …was designed to counter the five giants of illness, ignorance, disease, squalor and want. It considered the whole question of social insurance, arguing that want could be abolished by a system of social security organised for the individual by the state (NHS 2003a).

One of the lasting outcomes of Beveridge's vision was the National Health Service (NHS). Established in 1948, the NHS brought hospital services, family practitioner service and community-based services into one organisation for the first time. Over the following decades, the NHS evolved through various re-structures until in the early 1990s a major cultural shift took place (LSE 2000; NHS 2003a). The 1989 White Paper, *Working for Patients*, introduced the notion of the 'internal market'.

The philosophy of the 'internal market' was that 'purchasers' (health authorities) were given budgets to purchase health care from 'providers' (hospitals and organisations providing care for the elderly etc). Although this arrangement improved 'cost consciousness' in the NHS, it was also regarded as resulting in unnecessary duplication of services (NHS 2003a).

The new Labour Government in 1997 decided in its policy statement, *The New NHS. Modern. Dependable*, that a 'third way' was possible. The Government did not abolish the internal market but refocussed it towards a collaborative rather than a competitive approach. It placed emphasis on making health care '…a matter of local responsibility, with local doctors and nurses in the driving seat in shaping services…', on forging stronger links with these authorities and involving the public (NHS 2003a).

The Labour Government also turned its attention to modernising care for the aged. Professor Sir Stewart Sutherland was

appointed to chair the Royal Commission on Long Term Care tasked with examining:

> …the short and long term options for a sustainable system of funding of Long Term Care for elderly people, both in their own homes and in other settings, and … to recommend how, and in what circumstances, the cost of such care should be apportioned between public funds and individuals…(Royal Commission 1999).

In its report, *With Respect to Old Age,* the Royal Commission on Long Term Care ('the Commission') summarised what they regarded as the critical factors influencing the evolution of aged care and moving it towards far greater involvement of the independent sector (see Box UK 1).

The Commission reported that in 1999 there were approximately 610 000 people in the UK receiving long term care as home care, 530 000 receiving long term care as community nursing and 670 000 receiving long term care as private help. Having considered the capacity of these older people to pay for their care, the Commission concluded that nearly two thirds of those over 70 are among the poorest 40 per cent of the population. Further, it noted a growing gap since 1981 between the richest and poorest pensioners (Royal Commission 1999).

Research commissioned by the Commission into the potential cost of long term care into the future predicted that the cost of long term care for older people (which was around 1.6 per cent of GDP in 1995) is projected to be 1.5 per cent in 2010, 1.6 per cent in 2021, 1.8 per cent in 2031 and 1.9 per cent in 2051.[2] Over the same period, NHS expenditure on long term care costs for older people (1995-96 prices) was projected to rise from £2.6 billion in 1995, to £4.9 billion in 2021 and £10.9 billion in 2051.[3] In addition, local authorities were projected to increase expenditure on long term care for older people from an estimated £7.2 billion in 2021 and £16.1 billion in 2051 (Royal Commission 1999).

The Commission found that the long term care system in the late 1990s was too complex and provided no clarity as to what people could expect. There was a degree of fear about the system, which they also considered to be 'riddled with inefficiencies'. People often moved into residential care when it was not necessary and while the system helped the poorest recipients it basically required the 'impoverishment' of those with moderate wealth before they could access assistance. Overall, in light of its conclusions, the Commission considered that it was time for long term care to be properly modernised (Royal Commission 1999; see Box UK 2 for the Commission's conclusions).

2 These figures assume that GDP will grow by 2.25 per cent per annum over this period which is the long run rate of growth in the UK economy.

3 It is difficult to separate total NHS costs into costs for acute care and costs for long term care. The Commision arrived at these figures by looking at the costs of 29 000 hospital beds occupied by older people staying more than 55 days and 9 000 nursing home beds in England paid for by the NHS.

Box UK 1: How the current long term care system has evolved

4.24 Confusion and uncertainty exist as an intrinsic part of the current system. Looking at its development in its historical context shows how problems have become compounded over the years. In the post-war period, long-term care was provided in residential…Local Authority homes…for which there was a waiting list and for which a means test was applied. Particularly ill or frail people might be looked after in the NHS. Two developments changed this:

- The increasing use of social security benefits meant that a public fund, without cap and without a test of care need, and with rules that were eventually uniform throughout the country, was available to fund people in residential and nursing homes in the private sector. Expenditure grew from £350m in 1985 to £2.5bn in 1993/94 and the "market" was shaped in a particular way, driven by what could be paid for rather than what people needed;
- During the 1980s the NHS became aware of its costs for the first time, and was subject to measured performance targets. The perception was that an old person on a ward consumed resources without an easily achievable and identifiable point of recovery. Given the existence of the uncapped social security benefits, residential and nursing home care provided one "exit" from the NHS for many patients.

4.25 These changes induced a new private sector infrastructure of residential and nursing home care and a degree of capital investment that may not otherwise have occurred given restraints on capital investment in the public sector. However, it discouraged domiciliary care (Local Authorities had to provide this out of their own budgets and charges); prevented the NHS and Local Authorities developing joint working and planned commissioning; but gave some old people access to care they could not otherwise have afforded …

4.26 As the 1980s progressed, Social Security expenditure paid to people moving into independent sector residential care and nursing homes spiralled. This caused great concern. An internal Department of Health and Social Security Report – the Firth report – concluded that resources should be transferred to Local Authorities and out of the benefits system. In 1988, Sir Roy Griffiths in a report commissioned by the Government took this further, proposing that Local Authorities should have a care assessment role as well as a budget transfer from Social Security. The intention was to encourage Local Authorities to spend more money on domiciliary care than before.

4.27 Government responded to the Griffiths proposals in the 1989 White Paper *Caring for People*. The aims of Community Care were expressed thus:

- to promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible;
- to ensure that service providers make practical support for carers a high priority;
- to make a proper assessment of need and good care management the cornerstone of high quality care;
- to promote the development of a flourishing independent sector alongside good quality public services;
- to clarify the responsibilities of agencies and so make it easier to hold them to account for their performance;
- to secure better value for taxpayers' money by introducing a new funding structure for social care.

4.28 One of the departures from Griffiths was the emergence of a Residential Allowance as part of Income Support,… but only if an individual was placed in a independent sector home. … It was introduced for a variety of reasons – primarily to reflect a housing element in independent sector care in residential settings which, if the individual was in their own home, would be paid for out of Housing Benefit. It was not available to those placed in Local Authority homes. The Allowance appeared to make independent sector residential care cheaper for the Local Authority than its own homes. In that respect it may have been intended to provide an additional incentive towards the independent sector. This certainly seems to have been the outcome…

Source: Royal Commission, 1999.

Box UK 2: Summary of the Royal Commission's overall conclusions

- For the UK there is no "demographic timebomb" as far as long-term care is concerned and as a result of this, the costs of care will be affordable;
- Long-term care is a risk that is best covered by some kind of risk pooling – to rely on income or savings, as most people effectively have to do now, is not efficient or fair due to the nature of the risk and the size of the sums required;
- Private insurance will not deliver what is required at an acceptable cost, nor does the industry want to provide that degree of coverage;
- The most efficient way of pooling risk, giving the best value to the nation as a whole, across all generations, is through services underwritten by general taxation, based on need rather than wealth …;
- A hypothecated *unfunded* social insurance fund would not be appropriate for the UK system. A *prefunded* scheme would constitute a significant lifetime burden for young people and could create an uncertain and inappropriate call on future consumption;
- The answer lies in improvement of state provision, but the state cannot meet all the costs of "long-term care" in the broad sense. The elements of care which relate to living costs and housing should be met from people's income and savings, subject to means testing, as now, while the special costs of what we call "personal care" should be met by the state…;
- Currently an estimated 2.2% of taxes from earnings, pensions and investments is spent on long-term care in residential settings and in people's homes. Improving entitlements in the way we propose will add 0.3% to this bill, rising to 0.4% in the middle of the next century;
- Although people will still need to meet their living and housing costs should they need care, it will be clear what they will need to make provision for – and such provision will be affordable by more people;
- Other options are available at lesser cost to make specific improvements to the current system. They include disregarding the value of the house in the means test for 3 months, changing the limits of the means test, and making nursing care wherever it is provided free…;
- The system needs more effective pooling of budgets, including bringing the budgets for housing aids and adaptations into a single pot;
- The Commission recommend that more care is given to people in their own homes. Therefore the role of housing will be increasingly important in the provision of long-term care;
- More services should be offered to people who have an informal carer.

Source: Royal Commission, 1999.

The Commission's two main recommendations were that:

- The costs of long term care should be split between living costs, housing costs and personal care. Personal care should be available after assessment, according to need and paid for from general taxation: the rest should be subject to a co-payment according to means.
- The Government should establish a National Care Commission to monitor trends, including demography and spending, ensure transparency and accountability in the system, represent the interests of consumers, and set national benchmarks, now and in the future (Royal Commission 1999).

Among other issues identified by the Commission was the complex nature of funding arrangements particularly in relation to residential care. The Commission stated that:

> The uncertainty as to the figures is in itself a cause for concern. No-one really knows just how much public or private money goes to support older people in long-term care. Despite our best efforts in the time available, we have been unable to shed definitive light on this matter (Royal Commission 1999).

The Commission therefore recommended that the Government should work to ascertain exactly how much money was spent on aged care and the proportional input of various agencies. They also recommended:

- a more client-centred approach with a single entry point for individuals requiring care
- devolved more locally focussed budgeting
- national implementation of 'pooled budgets'
- the introduction of direct payments for people over 65
- further research into the role and effectiveness of rehabilitation; and
- examination of shifts in responsibilities that had occurred and whether there had been an appropriate transfer of resources to reflect such shifts (Royal Commission 1999).

In a note of dissent, two of the Commissioners argued that the Report's recommendations would not result in an appropriate inter-relationship of public and private sectors. The dissenting Commissioners considered that neither universal benefits under classic welfare socialism nor pure free-market thinking on welfare had proved successful: universal benefits being financially unviable and the free-market solution failing to find a way of providing adequately for those not able to provide for themselves. Rather, they argued that 'The trend is now away from pure free-market thinking on welfare' and that:

(b) There should be no distorting preference for publicly-provided over privately-provided activity or *vice versa*. The skills of the non-state sector must be harnessed, both in the provision of insurance and, even more important, in the provision of care itself; but subject to appropriate regulation which ensures that it does not exploit the old and vulnerable.

(c) Elderly people, within budgetary limits, should be given what they want. They should be empowered and their priorities met. Individual professions such as nurses, social workers, and doctors all have contributions to make in caring for elderly people, but professional vested interests often erect costly barriers, and should be demolished. Where elderly people prefer to make decisions, perhaps by receiving cash to buy services rather than receive services directly, that is what should happen (Royal Commission 1999, Note of Dissent).

The UK Government accepted the thrust of most of the Commission's recommendations except for the concept of the government paying for personal care. Local authorities until recently did provide nursing services, but the issue of nursing was brought into debate by the Coughlan court case that '…marked a watershed in the politics of long term care in Britain' (UK Government 2001a; Loux, Kerrison and Pollack 2000). The outcome of the case was that the eligibility criteria used to determine access to nursing care was deemed unfair, but the court could not undo the legislation which asserted that:

- the NHS does not have sole responsibility for nursing care
- in some cases nursing care can be provided to a person by a local authority, including for a fee (UK Government 2001a).

This reflected the practice at the time which saw nursing care provided free to those elderly people in hospital or receiving care in their own homes, but available on a means tested fee basis for those in residential care (Loux, Kerrison and Pollack 2000).

The UK Government decided to change the legislation to ensure that the NHS became responsible for all nursing care, rather than continuing with the above fragmented system.[4] Section 49 of the Health and Social Care Act 2001 was introduced in England and Wales:

> …to prohibit Local Authorities from providing and charging for nursing care in nursing homes…to introduce a system under which nursing care (which, as defined by section 49 broadly means care provided by a registered nurse) will be funded by the NHS (Public Guardianship Office 2002).

4 The situation is different in Scotland, as the Scottish Executive had already gone a step further and voted to accept the Royal Commission's recommendation to provide all personal and social care (not just nursing care) free to all elderly people. This, among other decisions, was said to '…test the meaning of devolution.' (Pollock 2001).

Policy positioning within government

The Secretary of State for Health has overall responsibility for health in England, assisted by two Ministers of State for Health. They are responsible for, respectively:

- the NHS and delivery;
- social care, long term care, disability and mental health.

There are also three Parliamentary Under Secretaries, responsible for performance and quality; public health; and emergency care and public involvement (Department of Health 2003a).

The responsibilities of the Secretary of State for Work and Pensions also impact on long term care. The Secretary is assisted by the Minister of State for Work; the Minister for Children and the Family; the Parliamentary Under Secretary (Work); Minister for Disabled People; and the Parliamentary Under Secretary of State for Sure Start (Department for Work and Pensions 2003d).

The Department of Health sets national policies and standards and provides guidance on a wide range of health-related activities including long term care for the aged. It is also responsible for 'driving forward change and modernisation' in the National Health Service.

The Department's major responsibilities include:

- ensuring coherency and developing strategies for local health services
- ensuring high-quality performance of the local health service and its organisations
- building capacity in the local health services (Department of Health 2002d).

The NHS is managed by the Department of Health and is ultimately accountable to Parliament. The NHS operates separately in England, Wales, Scotland and Northern Ireland. Its responsibilities include promoting health and preventing ill-health, diagnosing and treating injury and disease, and caring for those with a long term illness and disability who require the services of the NHS (NHS 2003b). In relation to aged care, the NHS's responsibilities include:

- primary health care
- assessment involving doctors and registered nurses
- rehabilitation and respite
- community health services; and
- palliative care (United Kingdom Government 2001a).

The Social Services Inspectorate is a professional division within the Department of Health which has the role of evaluating:

> …the quality and performance of social services authorities in the practice and delivery of their statutory responsibilities for social services and [assisting] councils in sustaining continuous improvement in their performance... There are separate Inspectorates in Wales, Scotland and Northern Ireland (Department of Health 2002i).

By 2004, the Inspectorate will be replaced by the Commission for Social Care Inspection, incorporating the Social Services Inspectorate, National Care Standards Commission and the Audit Commission.

The Department of Work and Pensions (England) is responsible for work and pension related activities, and monitors the provision of pensions and public assistance to people in England, including those receiving benefits specially designed for older people. It replaced the Department of Social Services (Department of Work and Pensions 2003d).

Arrangements for long term care in England[5]

Long term care is defined by the English Government as:

> …a general term that describes the care which people need over an extended period of time, as the result of disability, accident or illness to address both physical and mental health needs. It may require services from the NHS and/or social care. It can be provided in a range of settings, from an NHS hospital, to a nursing home or residential home, and people's own homes (UK Government 2001a).

The English Government's goals in relation to improving services for older people, including long term care services, were announced in 2001 in the major policy document, *The National Service Framework for Older People* ('the Framework'). The Framework, a 10 year program aimed at linking services for older people, was presented as the '…first ever comprehensive strategy to ensure fair, high quality, integrated health and social care services for older people' (Department of Health 2001a).

A major focus, consistent with recommendations made by the Royal Commission, is on ensuring that those who require long term care have input into the type of care they receive (often referred to as 'person-centred care') and have access to integrated services from a range of providers that enable them to remain independent for as long as possible. The new system is characterised by devolution away from central government and the creation of locally focused agencies that can provide locally-appropriate services (UK Government 2001a).

5 While overall policies are developed for the United Kingdom, they are implemented separately by the Scottish, Welsh and English Governments. Discussion in the following sections refers largely to long term care in England.

New structure for fostering integrated, locally responsive long term care

Under the new structure, the role of the NHS has been re-defined from a central agency with a top-down structure to a largely devolved and decentralised organisation with a stronger 'local' focus.

Strategic Health Authorities

Strategic Health Authorities, each covering a population of around 1.5 million people, are managed by the four new Directors of Health and Social Care each of whom work within geographic areas with the National Health Service (Department of Health 2002d). The authorities manage the NHS on a local basis, link the Department of Health with the NHS and ensure that national priorities are implemented locally including:

- ensuring coherency and developing strategies for the local health service
- ensuring high quality performance of the local health service and its organisations, and working towards improved performance; and
- building capacity in the local health service (Department of Health 2002d).

The Strategic Health Authorities are also responsible for overseeing the NHS Trusts, Primary Care Trusts and Care Trusts within their geographic region. The NHS and its various Trusts will be responsible for funding all nursing care from April 2003, including long term nursing care provided by both NHS-funded and District nurses.

NHS Trusts, Primary Care Trusts, Care Trusts

NHS Trusts were in existence running NHS hospitals before the changes were implemented. They continue to do this but now work with the Primary Care Trusts and are accountable to the relevant Strategic Health Authority rather than directly to the Department of Health.

Initiated by the Government in July 2000, Primary Care Trusts are seen as 'the cornerstone of the NHS' under the new system. Their function is to be the leading NHS organisations for partnerships with local communities, organisations and authorities in securing the provision of health and social services. There are currently 303 Primary Care Trusts in England, each made up of GPs, nurses and other health professionals. The aim is that by 2004, the Primary Care Trusts, together, will hold 75 per cent of the NHS budget.

When fully operational, Primary Care Trusts will be responsible for planning and securing services by deciding exactly which health

services (GPs, dentists, mental health services and hospitals) their local population needs, ensuring the provision of these services and that they are integrated with social care, including long term care. The Primary Care Trusts will also have responsibility for improving the health of the community by working with the public and private sectors on public and community health. Primary Care Trusts may choose whether to commission health and social services from other organisations, or provide services themselves (or a combination of both). They are free to choose between public, private and voluntary providers (Secretary of State for Health 2002; Department of Health 2002d).

Care Trusts can be established when NHS organisations and local authorities agree to work together because closer integration is required between health and social care services in a particular area. The functions of each Care Trust are determined by the partnership organisation. So far the number of Care Trusts created is modest (Department of Health 2002d).

Local authorities

Local authorities are responsible for providing their residents (including to older people) with social care that is consistent with national priorities and policies. By April 2003, Councils are required to ensure that they can provide or commission services to meet the eligible needs of their residents, subject to Council resources. Within a Council area, individuals in similar circumstances are to be assured of receiving services capable of achieving broadly similar outcomes. The availability of services is to be made known to residents through a local charter (Department of Health 2002f). From April 2003, local authorities will no longer have responsibility for providing any form of nursing care but will continue to facilitate personal social services including personal care services in the home.

Local authorities also have responsibility for ensuring that elderly people do not unnecessarily stay in hospitals (to become 'bed-blockers'). Local authorities are provided with resources to assist older people to leave hospital as soon as it is safe to do so. If the number of blocked beds is reduced, local authorities are able to use the resources for other purposes. If not, the authority can be charged by the hospital for the costs of keeping the elderly person there unnecessarily (NHS 2002).

In keeping with the policy shift towards local responsiveness to need, local authorities may set their own eligibility criteria, service provision packages and service levels. In designing criteria and services, local authorities must take into account their budgets and costs, and local expectations and resources while bearing in mind the broader policy context and national factors.

Agreements with other agencies, such as partnership agreements with NHS Care Trusts and Primary Care Trusts must also be taken into account (Department of Health 2002f).

Working collaboratively to respond to local needs is enabled and encouraged by the *Health Act 1999 Partnership Arrangements*. Under the Act, local authorities may:

- *pool funds* so that combined resources can be put towards 'agreed projects for designated services'
- *lead commissioning* by appointing a particular organisation to take a 'lead' role in commissioning services
- *facilitate integrated service provision* by joining together their staff (from managerial level to the front line), resources, and management structures (Department of Health 1999).

Accessing long term care and support

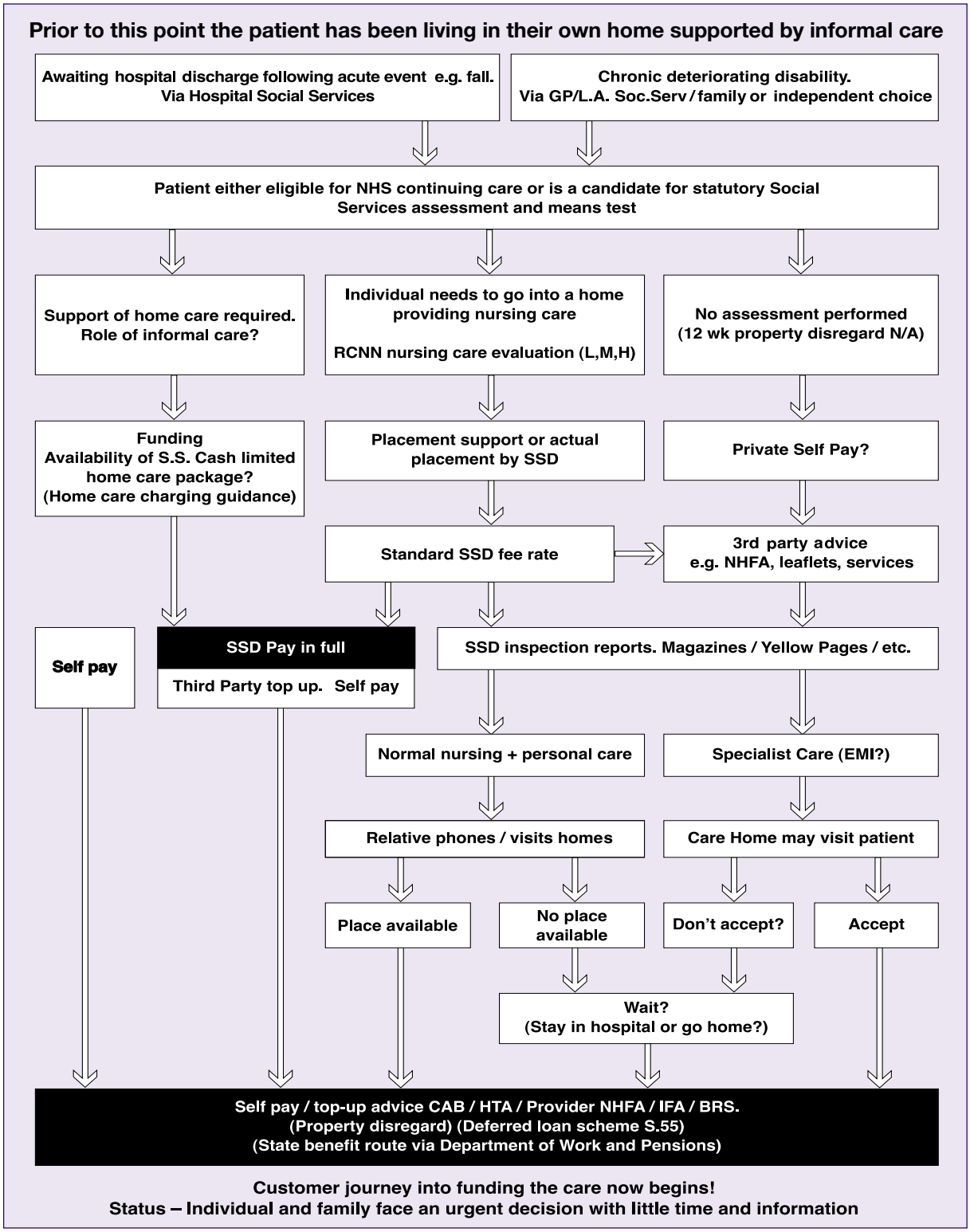
To be admitted to long term care, first the local authority and the NHS must carry out an assessment (see Figure UK 2). Health and social needs are assessed by a team which usually consists of a doctor, nurse, occupational therapist, social worker and appropriate others as required. This assessment is not 'elderly' specific; the same assessment is given to all potential social care recipients.

Assessments are made against four 'bands' relating to the risk to independence if the person's needs are not met:

- *critical* – significant health problems, serious abuse or neglect, inability to carry out vital daily activities, potential threat to life, little choice or control over immediate environment, vital social support systems unable to be maintained
- *substantial* – only partial choice or control over daily activities and environment, inability to carry out majority of personal care, abuse or neglect, majority of social support systems unable to be sustained
- *moderate* – inability to carry out several personal care activities, several social support systems unable to be sustained; and
- *low* – inability to carry out one or two personal care activities, one or two social support systems unable to be sustained (Department of Health 2002f).

If an individual is considered eligible for care, a care plan is developed outlining the individual's social and health needs, the package of care required to meet these needs and how care will be delivered. The package may be provided as intermediate, home or residential care. Intermediate encompasses a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living. Although important to avoiding unnecessary entry into residential care, intermediate care is not considered long term care (Department of Health 2002b and 2002c).

Figure UK 2: Client journey into a home providing residential or nursing care



Source: Figure prepared and provided by Philip Spiers (Nursing Home Fees Agency) and Peter Barnett (Britannic Retirement Solutions).

Note: SSD = Social Services Department. NHFA = Nursing Home Fees Agency. RCN = Royal College of Nursing. EMI = Elderly Mentally Infirm (Dementia). CAB = Citizens Advice Bureau. HTA = Health Technology Assessment. IFA = Independent Financial Advisor.

To assist people to remain independent, long term care services ('home care') may be provided in their own homes including: home care services and personal assistance (including nursing and community health services provided by the NHS); meals on wheels; rehabilitation services; and equipment or home adaptations (Department of Health, Department of Environment, Transport and Regions 2001).

There have historically been two main kinds of residential care for people who cannot manage at home: residential care homes and nursing homes:

- nursing home – personal care and accommodation, as well as nursing care provided by nurses employed directly by the home itself; and
- residential care home – accommodation and personal care, with nursing care if needed provided through NHS visits.

These types of homes were separately registered and inspected until the distinction was recently abolished. Both are now referred to as 'care homes' and are registered and inspected by the National Care Standards Commission (Kerrison and Pollack 2001).

The main difference is that nursing homes provide care for people who need a lot of attention or medical care; some homes provide both types of care (United Kingdom Government 2001a). Personal care includes help with daily activities such as toileting, bathing, dressing and eating including encouragement and the supervision in these activities.

By April 2003 local authorities are required to offer recipients the option of receiving direct payments in lieu of social care services, with a view to giving people greater choice and control over decisions about how their care is delivered. Direct payments must be at least as cost-efficient as the services which would otherwise have been commissioned and local authorities must monitor the arrangements to ensure that the recipient's care needs are being met (*Community Care (Direct Payments) Act 1996*; Department of Health accessed March 2003).

Local authorities must also ascertain whether people should make contributions towards their own care and at what level. Personal care costs are met either by care recipients or by local authorities on a means-tested basis depending on recipients' circumstances (Department of Health 2002c; see also below *Personal contributions*).

Provision of long term care

Long term care services in England are commissioned from independent (for-profit and voluntary) providers or, to a lesser extent, provided directly by local authorities.

Residential care

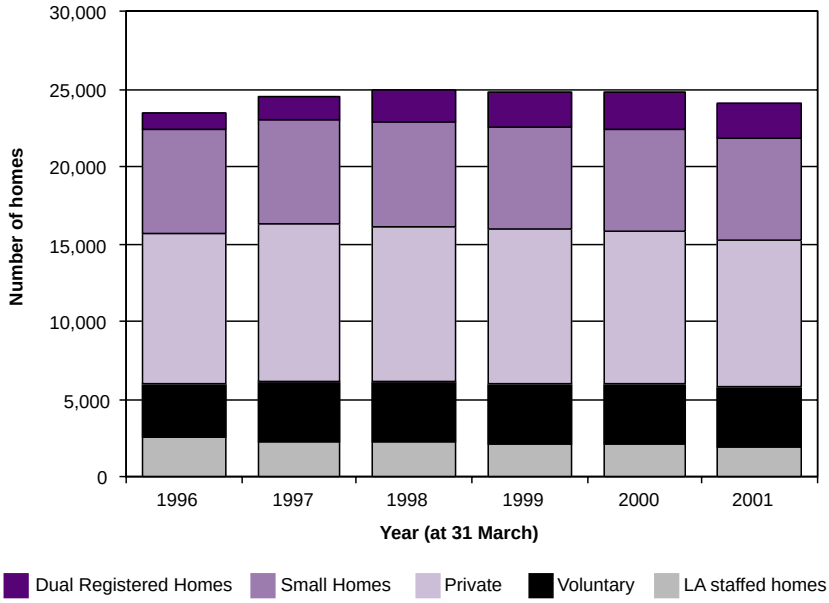
Residential care is provided in residential care homes, nursing homes or dual registered homes which provide both nursing home and residential care services. Figure UK 3 shows trends in the number of residential care homes from 1996 to 2001 when there were 24 100 homes, some 700 less than in 2000, but still higher than in 1996. By 2000, around 92 per cent of the residential care homes were operated by the independent sector while local authority home numbers dropped, reflecting the trend for local authorities to close or sell off their own homes (Department of Health 2002g; see below under 'Capital' for further discussion of corporate providers).

Similarly, the number of nursing homes in England (excluding private hospitals and clinics) has declined since 1998 unlike dual registered homes which greatly increased in their numbers, more than doubling from 1 100 in 1995-96 to 2 280 in 2001 (Department of Health 2002g). The trends in the number of both residential and nursing homes are shown in Table UK 2.

At 31 March 2001, between all residential care homes, nursing homes and private hospitals and clinics the total number of care beds was 528 000, two per cent fewer than in 2002 (see Table UK 3, Trends in the number of residential places and nursing beds, 1995-96 to 2001).

There is continuing sector and public concern regarding bed closures in private sector nursing homes and the transfer of beds

Figure UK 3: Trends in the number of residential care homes 1996-2001



Source: Department of Health, 2002g.

Table UK 2: Trends in the number of residential and nursing homes 1995-96 to 2000

England, 31 March, Rounded Numbers	1995-6[1]	1996-7[1]	1998	1999 (revised)	2000 (revised)	2001	% change 2000-01	% change 1995-96-2001
General nursing home[2]	4 730	4 680	4 820	4 700	4 370	4 170	*–4%*	*–12%*
Mental nursing home[2]	800	890	960	990	1 070	1 050	*–3%*	*+30%*
Total nursing homes[2]	***5 540***	***5 570***	***5 790***	***5 690***	***5 440***	***5 220***	***–4%***	***–6%***
Dual registered homes	1 100	1 550	2 110	2 220	2 330	2 280	*–2%*	*More than double*
Residential care homes	23 450	24 480	24 880	24 800	24 770	24 080	*–3%*	*+3%*
Total residential & nursing homes exc[3]	**27 880**	**28 500**	**28 550**	**28 270**	**27 880**	**27 020**	***–3%***	***–3%***
Total residential & nursing homes[4]	**28 230**	**28 850**	**28 950**	**28 680**	**28 320**	**27 480**	***–3%***	***–3%***

Source: Department of Health, 2002g.

1. For nursing homes, refers to the collection period of 1 October to 31 March
2. Includes dual registered homes.
3. Excluding the double counting of dual registered homes. The total number of residential care homes includes dual registered homes. The total number of nursing homes also includes dual registered homes. Private hospitals and clinics are excluded.
4. Excluding the double counting of dual registered homes. The total number of residential care homes includes dual registered homes. The total number of nursing homes also includes dual registered homes. This total includes private hospitals and clinics.

into residential care and dual registered homes. The size of the problem is a matter of debate, with estimates ranging from the loss of 19 000 to 50 000 'lost beds' since the late 1990s. Market analysts Laing and Buisson claim that 'capacity declined by 12,600 places to reach 525,900 by April 2001, as private care home closures continued on a rising trend and as local authorities and NHS Trusts continued to downsize their in-house provision'.

Causes posited are a response by the private sector to financial pressures from local authorities; or that home owners are simply cashing in on a buoyant property market (Henwood 2002; Laing and Buisson 2001a and 2001b).

Home care

Local authorities purchased or directly provided an estimated 2.8 million contact hours of home care[6] during a survey week in September 2000, an increase of four per cent on 1999 and a total increase of 65 per cent since 1992.

6 Services that assist the user to function as independently as possible and/or continue to live in their own home including routine household tasks, personal care and respite care but not meals on wheels or day care (Department of Health 2002g).

Table UK 3: Trends in the number of residential places and nursing beds, 1995-96 to 2001

England, 31 March, Rounded Numbers	1995-6[1]	1996-7[1]	1998	1999 (revised)	2000 (revised)	2001	% change 2000-01	% change 1995-96-2001
Nursing beds in general nursing homes[2]	150 900	154 200	165 800	160 200	150 700	144 000	*–4%*	*–5%*
Nursing beds in mental nursing home[2]	28 300	31 300	28 700	30 500	31 800	31 900	*Small +ve change*	*+13%*
Total nursing beds[3]	***179 200***	***185 500***	***194 500***	***190 700***	***182 600***	***176 000***	***–4%***	***–2%***
Nursing beds in hospitals & clinics	11 400	10 800	11 100	11 400	10 800	10 800	*+1%*	*–5%*
Residential places in resi care homes[4]	323 000	338 100	347 900	344 000	345 900	341 200	*–1%*	*+6%*
Total resi places & nursing beds exc[5]	**502 200**	**523 600**	**542 400**	**534 700**	**528 500**	**517 200**	***–2%***	***+3%***
Total resi places & nursing beds[6]	**513 600**	**534 400**	**553 500**	**546 200**	**539 200**	**528 000**	***–2%***	***+3%***

Source: Department of Health, 2002g.

1. For nursing homes refers to the collection period of 1 October to 31 March. 2. Includes nursing beds in dual registered homes. 3. Excluding beds in private hospitals and clinics. 4. Includes residential places in dual registered homes. 5. Private hospitals and clinics are excluded. 6. This total includes private hospitals and clinics.

Over that period, the number of contact hours directly provided by local authorities has fallen from 98 per cent of total hours to 44 per cent.

The number of households receiving home care in 2000 was around 398 000 involving some 415 000 people. Household numbers had decreased 6 per cent since 1999 and 25 per cent since 1992 (partly reflecting a change to the way the statistics were collected). More households received care from the independent sector, rising from just 10 600 in 1992, to 167 900 in 1999 and 190 000 in 2000, in many cases as a direct result of local authorities' decisions to commission more services from the independent sector and reduce their own direct services (Department of Health 2002g).

Since 1992, the number of households receiving low intensity care (ie, one visit and two hours or less per week) had dropped from over 40 per cent to 19 per cent, while those receiving high intensity care (ie, six or more visits and five hours per week) had increased from just over 10 per cent to 36 per cent (Department of Health 2002g).

Financing long term care

Long term care is largely Budget funded but with consumers either purchasing private care for themselves or making means tested contributions to the costs of largely state-funded care services. The private sector also makes a substantial capital investment in the provision of nursing homes.

Even though the Royal Commission found that it was not easy to establish just how much private or public money goes to support older people in long term care, it estimated that the cost in 1995 (the latest year for which they could obtain figures) was £11.1 billion. The components of their estimates are shown in Table UK 4.

Government contributions

Of the total, about £7.1 billion was paid for by the state directly via the NHS and social services. Older people themselves paid an estimated £4 billion. About £8.3 billion was spent on residential care and nursing homes and the remaining £2.7 billion on home care. The Commission's estimates did not take account of capital investment in private nursing homes by the private sector.

At the local level, funds have been received through three streams: NHS funds from general taxation; local authorities'

Table UK 4: Estimated expenditure on long term services 1995-96

Type of Expenditure UK£ million	NHS	PSS net[1]	Private		Total
			Charges[2]	Fees[3]	
Home care	–	970	75	–	1 045
Community nurse	675	–	–	–	675
Day care	125	235	20	–	380
Private domestic	–	–	–	210	210
Meals	–	95	70	35	200
Chiropody	145	–	–	70	215
Residential care homes	–	1 910	1 030	1 200	4 140
Nursing homes	195	1 300	530	750	2 775
Long stay hospital	1 425	–	–	–	1 425
Total	**2 565**	**4 510**	**1 725**	**2 265**	**11 065**

Source: Royal Commission, 1999.

Notes: 1. PSS = expenditure on Personal Social Services for elderly people by local authorities, net of charges. The expenditure under PSS also includes people who were in residential care and nursing homes prior to 1 April 1993 and have preserved rights to higher levels of income support as if they were local authority funded.

2. Charges are paid by individuals for social services provided by local authorities usually at subsidised rates.

3. Fees are paid by individuals directly to private service providers.

funding combining an allocation from general taxation via a Government grant and money raised locally through council taxes and fees and charges for services; and payments by individuals. Central Government funding for long term care has been paid to local authorities as a grant (covering a number of service blocks; eg, personal care) and with the local authority having discretion on how much to spend on each service.

The amount of the annual grant has been determined according to a formula reflecting local needs after consultation with Local Authority Associations and has been published as a Personal Social Services standard spending assessment (PSS SSA). In 2002-03 the total provision for PSS was £11.2 billion of which the PSS SSA share was £9.2 billion and the remainder was for revenue grants for particular national issues like AIDS or Mental Health. The PSS for 2003-04 will be 5.5 per cent higher than 2002-03 (Royal Commission 1999; Mills 2003; Department of Health 2002k).

From April 2003, changes to the funding streams from Central Government will be fully phased in. All funding for nursing care will be streamed through the NHS and its various Trusts, with both NHS-funded and District nurses providing home nursing for people in need of long term care. Local authorities will no longer have responsibility for providing any form of nursing care but will continue to facilitate PSSs including personal care services in the home.

Payment to providers is on a 'spot-contract' basis in which fees are paid per resident, rather than by block payment (regardless of use) although block payments are often used when the provider is 'in-house' rather than external.

In relation to residential care, although some local authorities pay different fees to different providers, most pay a flat fee rate to each provider or pay different fee levels, based on the dependency level of the care recipient. In terms of home care, most authorities do pay different fees to different providers, unrelated to the dependency level of the recipient (Department of Health 2002g).

A new source of funding, the PSS Performance Fund, will start in 2003-04 worth £100 million, of which £96 million will be distributed on a 'fair shares' basis. The 2003-04 Performance Fund's allocations have been calculated using a similar method but with new Formula Spending Shares (FSS) replacing the standard spending assessments or SSAs. Up to one third of each council's Performance Fund allocation may be spent on general expenditure or in support of intermediate care services. Amounts and conditions under the Performance Fund will be predicated on a star system (UK Government 2001b; Department of Health 2002h).

These arrangements both facilitate and depend on local authorities using their purchasing weight within their location to drive down prices.

The sector considers that there has been consistent under-investment for some years and see this as a cause for bed closures and a threat to quality. In a study for the Joseph Rowntree Foundation, Laing and Buisson claim that long term care is under-funded by £1 billion a year. The analysts found that the fees paid by local authorities are between £75 and £85 a week below the reasonable costs of running an efficient and good-quality care home. Instead, they argue that 'local authority fees, backed by central government funding, should be based on the local costs of running a typical, efficient care home that meets national minimum standards'. A broad coalition of private, voluntary and public sector organisations is calling for improvements in local authority fee levels, improved monitoring and transparency of local authority care commissioning, and research into future pricing and levels of need (Laing and Buisson 2002; Joseph Rowntree Foundation 2002; Seniors Network 2002).

Personal contributions

Personal contributions are paid from savings and income and, in some cases, from long term care insurance.

It is the responsibility of the local authority to decide whether a potential recipient has the means to pay for, or contribute to the cost of, their own care. Generally, if people have savings of more than £16 000, they will be expected to pay for the full cost of their care. If their savings are less than this, they do not have to pay the full cost of their care. In assessing whether they should make contributions towards their own care and at what level, the financial situation of the individual and any social security benefits are taken into account. If the local authority does assist them, they are left with a certain amount of money each week for personal expenses and contribute the rest. Nobody should be left with less than 'basic' Income Support[7], plus 25 per cent, including after paying for any disability-related expenditure such as equipment costs. However, if the client chooses to go into a home that is more expensive than the Pension Service will pay, the client will need to find a way to pay the difference (Department of Work and Pensions 2003a; United Kingdom Government 2001b).

7 Income Support: extra money paid each week on top of the pension for those incapable of working including because of old age. For people over 60 years it is referred to as Minimum Income Guarantee. It is available to all people over 60 regardless of whether they live in a facility or their own homes although place of residence does affect the eligibility threshold (savings of £12 000 or less if not in residential care; or savings of £16 000 or less if in residential care). (Department for Work and Pensions 2003c).

Nursing care is restricted to those who have been formally assessed as requiring it, and anyone who requests nursing care outside this arrangement is charged for the care they receive (Department of Health 2001b; United Kingdom Government 2001b).

Local authorities are not required to charge for community care. If they do decide to charge they are obliged to follow a framework designed to help councils ensure that their 'charging policies are fair and operate consistently with their overall social care objectives'. People who receive Income Support, but no other support such as the Attendance Allowance[8] are exempt from paying for community-based care (United Kingdom Government 2001b; Department of Health 2002e).

Possible use of private sector products to cover personal contributions

The Royal Commission considered alternative ways in which individuals might cover their share of the costs of care including through the use of private sector financial products. Private long term care insurance (voluntary or compulsory), tax incentives (to pay for long term care premiums) equity release schemes (eg, reverse mortgage), and the use of pensions to cover aged care costs were considered. The Commission concluded that while individuals may see such products as worthwhile, 'private sector solutions do not and in the foreseeable future, will not offer a universal solution' (see Box 2 for specific conclusions). At the same time, the Commission was concerned that those who wish to make use of private sector products should have the assurance of an appropriate regulatory framework. Hence, it recommended that Treasury and the Financial Services Authority look at the regulatory issue as a matter of urgency (Royal Commission 1999).

The Treasury sought views on whether the selling and marketing of long term care insurance should be regulated by the Financial Services Authority under the *Financial Services and Markets Act 2000*. The consultation paper noted that the market for long term care financial plans was very small with the consequence that the 'lack of a significant claims history poses serious challenges to actuaries in the pricing of insurance plans'. Since 1991, 14 companies have offered such products with only about 34 000 policies being held (HM-Treasury 2000).

8 Attendance Allowance: paid to those who require help to look after themselves, or those who become ill or disabled on or after their 65th birthday. The rate is based on the level of disability and how much the individual is affected by it. It is available only to those outside residential or hospital care. It is not linked to savings, and is not considered as 'income' for the purposes of means testing for income support etc (Department of Work and Pensions 2003c).

In January 2003, the Treasury confirmed that regulation of both mortgages and long term care insurance will come into effect on 31 October 2004. The Government regarded the early introduction of long term care insurance regulation as a priority 'because of the potential for consumer detriment from such products and to meet the government's earlier commitments to regulate long term care insurance' (HM-Treasury 2003).

In relation to the question of private insurance to fund health care, the Government has clearly reiterated its commitment to public funding and ruled out Government subsidies for private insurance:

> Private medical insurance is inequitable. Subsidising private health insurance will use taxpayers funds to expand two-tier access to healthcare, reducing equitable access to needed care. … Private medical insurance shifts the burden of paying for health care from the healthy, young and wealthy to the unhealthy, old and poor (NHS 2000).
>
> Many [private insurance] systems are not only more expensive than taxation but leave millions uninsured, without any cover at all. We believe that the benefit of a universal tax based model is that it is an insurance policy with no 'ifs' or 'buts': whatever your illness, however long it lasts, you get cover as long as you need it (NHS 2002).

As the Government has committed to providing all nursing care free through the NHS, it may be reasonable to assume that its position in relation to private insurance for health care extends to nursing care.

Capital

Capital for constructing or upgrading private care homes is largely supplied by the private sector. At the same time, local authorities have little means of upgrading the remainder of their own nursing care stock.

In 2001, around 92 per cent of homes were controlled by the independent sector ie, private and voluntary providers (NHS 2002; Department of Health 2002g). It has been suggested that the introduction of supplementary benefits (later called Income Support) by the Department of Social Security in the early 1980s 'fuelled the rapid expansion of private residential care' and the entry of new players (Player and Pollock 2001, quoting Laing and Buisson). Six categories of individual and corporate providers have been identified:

1. traditional owner/managers – either new entrants with training in a caring profession, predominantly nursing, or those involved in a career change…;
2. colonizer chains – over time some of these cottage industries were transformed into 'colonizer chains' by business people seeking new areas of investment. Such ventures included 'new start-ups' backed by the government-subsidized Business Expansion Scheme (BES)…;

3. hotel and leisure interests – companies with subsidiaries in gambling and brewing …;
4. construction and property groups …;
5. private for-profit health care groups including UK and US corporations such as Community hospitals and Westminster Health Care …;
6. private not-for-profit health care groups including BUPA, Nuffield Hospitals and GM Healthcare (Player and Pollock 2001).

Many of these were backed by extensive financial and management resources, combined with considerable investment reserves. By 1993, the sector had begun to consolidate with the big leisure and property companies withdrawing, the flotation of some generic long term care providers on the stock exchange, and new corporate providers beginning to develop large, purpose built nursing homes. The late 1990s saw a fall in the number of new nursing homes registered (but largely offset by increasing numbers of dual registered care homes) and a rising trend in the closure rates for nursing homes. The commissioning of services at the local level with tighter control of prices has been seen by some analysts as a factor in these trends. Other analysts see the trends as a part of the restructuring any market might experience as the sector matures including through:

- consolidation and acquisition: the number of major for-profit providers dropped from 295 in 1996 to 285 in 1998 (quoted companies from eleven to six), but the market share in nursing places grew through acquisitions and the increased size of newly registered homes
- integration: in response to financial pressures including from local authority fees levels, some corporate providers sought integration with specialist health care groups, others with major investment funds; and
- sale and leaseback: to avoid the drawbacks of direct investment in large-scale commercial property and influenced by the US practice of separating ownership and operation, some companies have sold their properties to a specialist investment fund/property company which then leases the property back to the care home company. Part of the attraction of this arrangement is that 'revenue streams from care home rentals can be structured in such a way as to offer safe investment "guaranteed" or underwritten by government funding', and increasing use of indirect property investment vehicles and Real Estate Investment Trusts. In consequence, in the late 1990s there was significant growth in the care home investment fund sector attracting finance from the UK, US, Kuwait and the Eurosterling market. For some of the players, such as Nursing Home Properties (NHP), the experience was less than profitable (Player and Pollock 2001).

Table UK 5: UK Long term nursing care market value by sector 1988-2000

Year	Private sector (£ million)			Voluntary sector (£ million)			Public sector (£ million)			All
	Resi.	Nursing	All	Resi.	Nursing	All	Resi.	Nursing	All	
1988	971	763	1 734	326	107	433	976	1 368	2 344	4 511
1992	1 664	2 274	3 939	459	205	659	1 104	1 505	2 609	7 207
1996	1 968	3 077	5 044	701	295	996	1 130	1 250	2 380	8 420
1998	2 103	3 219	5 322	715	341	1 057	963	1 092	2 054	8 433
2000	2 347	3 248	5 597	764	367	1 131	890	997	1 886	8 614

Source: Laing and Buisson 2000, as cited by Player and Pollock, 2001.

Table UK 5 represents the UK long term nursing care market value by sector from 1988 to 2000 demonstrating that the for-profit sector rapidly increased its share of the market to become the dominant player (Player and Pollack 2001).

In April 2001, nursing home occupancy averaged 91.3 per cent in the UK, residential homes 90.4 per cent and dual registered homes 90 per cent. Even so Laing and Buisson reported that because local authorities had constrained fees paid to providers, care home margins were under pressure. Laing and Buisson suggested that in the context of 'spot' contracts, a reasonable return on capital would be 16 per cent per annum (Laing and Buisson 2001; Joseph Rowntree Foundation 2002).

Quality

The star ratings (mentioned above) are designed to give a rounded picture of each council's performance in carrying out its social services functions. Each council also receives a Performance Letter, giving details about strengths and areas for improvement. The social services star ratings form part of the comprehensive performance assessment which is being led by the Audit Commission. Local authorities were made aware of their star rating and consequent grant in January 2003.

Councils with either three stars for social services or a comprehensive performance assessment of 'excellent' will have no conditions attached to their PSS Performance Fund payment. For zero and one star authorities, if compliance does not occur the Department will be able to reclaim the misused funds. In the future, it will be the responsibility of the proposed Commission for Social Care Inspection to publish the ratings for social services (Department of Health 2002h; UK Government 2001b).

The passing of the *Care Standards Act 2000* marked a major step towards a new regulatory framework and national standards. The

Act established the National Care Standards Commission and accompanying National Minimum Standards applicable to aged care homes and residential care for those aged 18 to 65. The Commission was established in April 2001 and was fully operational in April 2002. The Commission is independent and has powers to inspect services and enforce adherence to the Standards (Department of Health 2001c).

Under the *Care Standards Act 2000* all care homes in England caring for older people are required to adhere to 38 National Minimum Standards, under the following sections:

- choice of home
- health and personal care
- daily life and social activities
- complaints and protection
- environment
- staffing; and
- management and administration (Department of Health 2001d).

The Health Minister at the time stated that:

> …for too long there has been a lack of independence, coherence and consistency in the regulation of care homes. These minimum standards…will change that. They will help us to protect older people living in care homes, whilst promoting their health, welfare and quality of life (Department of Health 2001d).

After consultation with providers and residents and their families, it was decided that the standards relating to room sizes and doors, availability of single rooms and the number of lifts and baths should be relaxed. The relaxation meant that homes existing before April 2002 would not be required to change their facilities to meet the physical environment standards. The decision was taken against a backdrop of home closures and was meant to ensure that '…the application of the new standards does not lead to the closure of good quality homes' (Department of Health 2002j and 2003b).

Issues

When a system is still under development such as that in England, it is difficult to ascertain what the 'issues' involved may be. Some commentators have, however, raised some concerns about recent developments which should be examined, and the English Government itself has made some announcements about its plans over the next few years.

Access

- There is continuing concern regarding bed closures in private sector nursing homes and the transfer of beds into residential

care and dual registered homes. The size of the problem is a matter of debate, with estimates ranging from the loss of 19 000 to 50 000 'lost beds' since the late 1990s. Causes posited are a response by the private sector to financial pressures from local authorities; or that home owners are simply cashing in on a buoyant property market (Henwood 2002).

- Distribution of nursing homes is uneven with some areas still experiencing an oversupply (Henwood 2002).
- Waiting lists and delayed discharges continue to be a challenge, despite the Department of Health's initiatives aimed at ameliorating the situation (Henwood 2002).
- In order to improve access, the Government stated that by 2004, an extra £1.4 billion would be available annually to go towards extra beds and places: around 5 000 more NHS beds and 50 000 more home care places (Department of Health 2002c).

Quality

- Continuity of care is seen as being threatened by home closures, 'the interplay of demand and supply for a commodified set of services' including decisions to reconfigure service mix and staffing to those of greater profitability, for example, to cease rehabilitation services (Player and Pollock 2001).
- Further development of care that fully addresses the 'continuum of care' is needed through innovative solutions rather than 'more of the same' (Henwood 2002).
- The Government's research into past, current and future trends in the residential care sector found that larger care homes tend to be able to charge lower fees, suggesting there are benefits in economies of scale. However the research did not investigate the relationship between fee levels and quality of care (Department of Health 2002g).

Dementia

- Many homes, even those that are newly built, do not take into account design innovations aimed at improving the well being of those with dementia (Marshall 2001).
- Dementia units need to be places where highly skilled staff with access to continuous training operate in an environment of support and encouragement. Too often they are places where staff are dispassionate and lack energy etc (Marshall 2001).

Workforce issues

- Employment in the sector is characterised by 'low pay and poor or non-existent employment benefits' affecting the

capacity to attract qualified staff and jeopardising the quality of care (Player and Pollock 2001).

Long term care: a medical or social responsibility?

- The Government's agreement that all nursing care should come within the responsibility of the NHS, including for people in homes, is seen as perpetuating the existence of long-term care in 'parallel and hierarchical universes' (Henwood 2002).
- Concerns have been raised about placing older peoples' care within the realm of 'social' rather than 'health' care. It is thought that this 'demeans' older people by creating barriers between them and health professionals by implying that most of their care needs and problems can be dealt with by family members (Heath 2002).

Privatisation

- The School of Public Policy at University College London released a paper stating that the National Care Standards Commission has not been adequately resourced to perform its role as the industry inspectorate and that the Government made too many concessions on industry regulation to the industry itself (Kerrison and Pollack 2001).
- The School also raised concerns about the privatisation of the industry, suggesting that the UK should learn from Australia and the United States, countries that have not adequately protected residents against the interests of the industry and its shareholders. They also raise concerns about a lack of accountability, both financial and care-related, on the part of the private sector (Kerrison and Pollack 2001).

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Germany

Solidarity and human investment

GERMANY

Solidarity and human investment

From a German point of view: Care of the elderly is … part of an overall strategy of investment into human skill and mobility which is – even in this brave new world of shareholder values – the most important factor in economic growth (Dr Rudolf J Vollmer, Deputy Secretary, Ministry of Health 2000)

The ideal of 'social solidarity' has long been a theme in German social policy debate: the belief that strong collective arrangements that protect everyone against the exigencies of life are preferable to systems that differentiate 'the poor' from other citizens. At the same time, commitment to social solidarity goes hand-in-hand with principle of subsidiarity.

The 1994 introduction of a universal coverage social insurance program for long term care put financing for the care of the aged on a par with the provision of acute care financing and in a manner consistent with social solidarity. Long term care insurance (LTCI) helps to cover the cost of long term care provided either at home or in institutions. The system relies heavily on informal, home-based care providers.

Broad goals of the new system included: spreading the financial burden more widely and relieving the pressure on the Laender (states) and municipalities; lessening dependence on means tested welfare; expanding home and community based services and support for informal carers; and increasing the supply of long term care services.

Since the introduction of the LTCI system there has been expansion and increase in the supply of services and some diminution of the pressure on the Laender. However, there is still a high degree of dependence on means tested welfare among residents in institutional care and ensuring the quality of informal home-based services will continue to be a challenge.

Traditional influences are still clearly evident in Germany's long term care policy and current arrangements:

> Most of all, there has been a long tradition of generally separating the '*social*' from *the 'medical' problem definitions* in the area of policy formation. And this tradition of separation has materialized in many respects: as an *organizational principle* in the form of *separated administrations* (for 'health policy' and for 'social affairs') operating on and often against each other on the local level, on the

state level as well as on the federal level; in the form of *different legal provisions* and procedures, working on the base of *different legal responsibilities*; in the form of different specializations in academic life and in academic institutions within the medical and social arena; in the form of persistent *professional images* and vocational perspectives serving this separation on the side of the professional groups working in these fields (von Kondratowitz, Tesch-Romer and Motel-Klingebiel 2002).

The recent report to the Bundestag by the Enquete Commission on 'Demographic Change: Challenges posed by our ageing society to citizens and policy-makers' (2002) considers health care, nursing care and social services in some detail (especially the interactions between the three systems) and makes recommendations for better integrating the systems and changing some of the funding arrangements for nursing care.

Demographics

Population

The German population at 31 December 2001 was 82.44 million, with the 65-and-over population at 14.07 million or around 17.06 per cent (Federal Statistical Office Germany 2003). The population in Germany over the age of 60 was 23.7 per cent in 2001, up from 20.5 per cent in 1991 (World Health Organization 2003).

German life expectancy at birth in 2001 was 75.1 years for males and 81.1 years for females with a healthy life expectancy of 68.3 years and 72.2 years for males and females respectively.

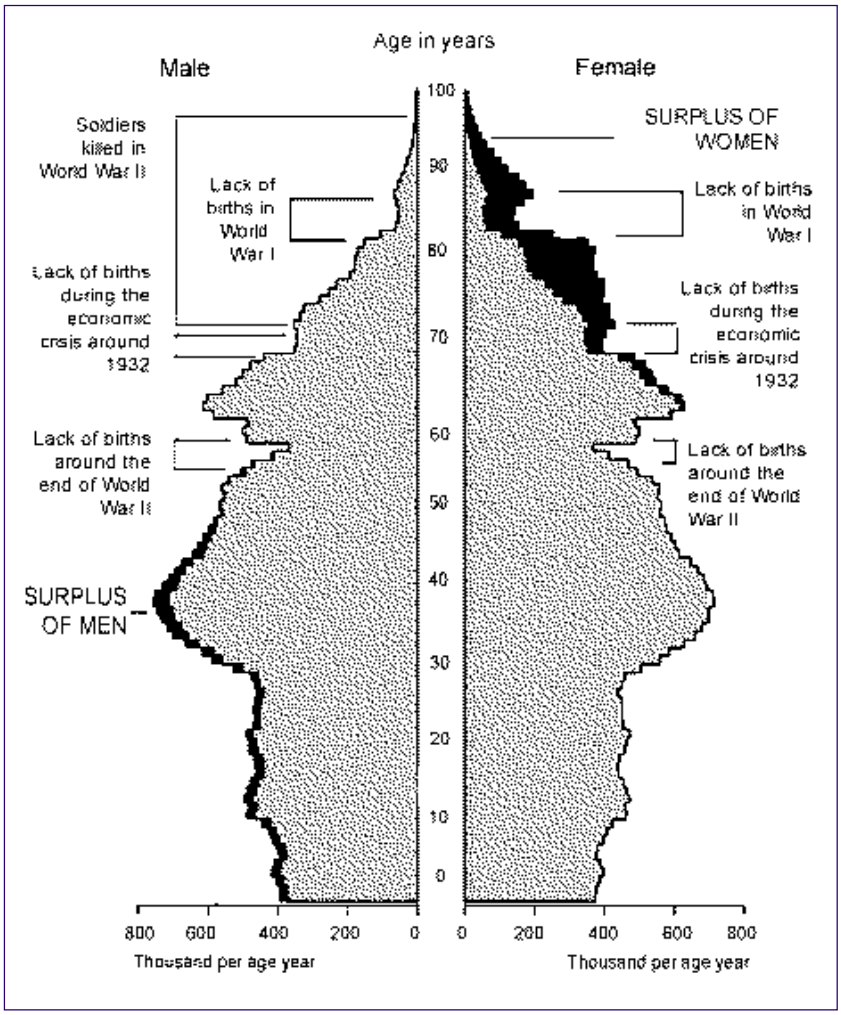
The total fertility rate in Germany is slowly falling, with a rate of 1.4 births in 1991 as opposed to 1.3 in 2001. The dependency rate is slowly increasing, with 47 per 100 recorded in 2001, up from 45 per 100 in 1991 (World Health Organization 2003).

The following diagram (Figure G 1) illustrates the ageing of Germany's population, with a large number of people reaching retirement age in the next 20-25 years, but a significantly smaller population available to support them.

The diagram also demonstrates that women are over-represented in the 60-plus age group in Germany. Although most countries have a similar phenomenon because women tend to live longer than men, in Germany the situation is amplified because of the large number of men lost in the First and Second World Wars.

Nearly one-third of the over 60 year-olds in Germany live alone, close to 75 per cent of them after the death of their spouse. This trend is stronger for women with 44 per cent of over 60 year-old women living in single-person households but on only 15 per cent of over 60 year-old men. Even more striking is the proportion of

Figure G 1. Age structure of the population of Germany on 31 December 2000



Source: Federal Statistical Office, Germany, 2003.

the oldest age groups who live alone with some 41.3 per cent of 70 to 85 year-olds living alone. However, it has been suggested that this trend will slow with the expected increased longevity of men (Enquete Commission 2002).

Social welfare

The German population is insured by a number of schemes in relation to health and social services: the statutory pension and health schemes and social nursing insurance. The statutory pension insurance scheme covered a large number of members in 2000, split into wage earners' insurance, salaried employees' insurance and the miners' pension insurance. The majority was in the second category with 22.5 million members, followed closely by those in the wage earners' scheme with 20.2 million members.

In 2000 the German Government spent a total of €680.8 billion on its social welfare budget which represented 33.6 per cent of GDP for that year. Included in this amount was €445.6 billion for 'general systems' expenditure including insurance expenditure covering pensions, €217.4 billion; long-term care insurance, €16.7 billion; and health insurance, €132 billion (Federal Statistical Office Germany 2003).

The evolution of long term care in Germany

German sickness insurance has traditionally drawn a sharp division between curable illness and long term dependency on care. Prior to 1988, only medical treatment for curable illnesses was covered by health insurance. Partial coverage of domiciliary care for people with serious handicaps was introduced in 1988 with the option of benefits in kind or a cash benefit if private care givers were available (Alber 1996).

Sickness insurance and family solidarity

By 1990, the proportion of people aged 75 and over in Germany had risen from 3.4 per cent in 1960 to 7.3 per cent, the demand for aged care continued to grow and care needs had to be met and financed by groups of diminishing size. Women, many of them already beyond pensionable age themselves, were becoming increasingly burdened by care responsibilities (Alber 1996; Geraedts, Heller and Harrington 2000). However, residential care remained without insurance cover so that a high proportion of people in need of care continued to depend on the means tested social assistance scheme. Means tested assistance and the 'requirement' to spend down assets to gain such assistance were regarded by many people as demeaning (Cuellar and Wiener 2000; Harrington, Geraedts and Heller 2002).

At the same time, aggregate expenditure for long term care from the social assistance scheme roughly tripled from the mid-1970s to 1990. Given that some 86 per cent of this expenditure was paid by local authorities, the local authority associations sought to decrease their expenditures by pushing to have the social security provisions extended to cover the cost of residential care, and by shifting consumers to the less expensive domiciliary care sector (Alber 1996; Geraedts, Heller and Harrington 2000; Eisen 1997).

Apart from the interest in reigning in expenditure by increasing domiciliary care, the cultural values of several main players in the policy debate also supported giving priority to domiciliary care. The Christian Union and the churches championed the role of the family, and the principles of subsidiarity and family solidarity had long been institutionalised in welfare and long term care policies. A 1984 amendment to the social assistance law stipulated that:

> …home care should be considered the standard type of long term care, and that residential care should be paid only if other forms of care are not available or if the individual's circumstances make residential care indispensable (Alber 1996).

Players in the policy debate included: the Christian Union parties, the Liberals, the Social Democrats, the unions and the employers, the state governments, and the various autonomous non-profit voluntary agencies. Neither the clients nor the private providers were included in the debate. Most players argued for some form of insurance scheme with options ranging from a private insurance solution (voluntary or compulsory) to a new social insurance, or an extension of the existing sickness insurance. Various tax transfer schemes also received some support but this support faded over time, in part to avoid institutional differentiation between sickness and long term care provisions resulting in perverse incentives that could lead to shifting of clients between the two to the detriment of holistic case management. Further, the costs of reunification threatened the state's fiscal solvency and containing costs became even more important. To introduce a tax transfer scheme would have signalled a huge break away from Germany's values of social responsibility and the existing social insurance arrangements. Besides, it would have been very difficult to promote given the fiscal situation (Alber 1996).

Hence, in 1993, not surprisingly 77 per cent of all disabled elderly living in private households were cared for by one main care giver: wife, mother, married daughter or daughter-in-law (Eisen 1997). Even so, around five per cent of the population of necessity sought accommodation in residential care facilities and it was necessary to maintain an adequate supply of facilities.

The introduction of long term care insurance

A range of social insurance schemes evolved with two bills being considered both for schemes that would cover only the cost of care, not 'hotel' charges which would be paid for by clients. Eventually, the *Long Term Care Insurance Act*[1] was passed in April 1994.

The introduction of LTCI shifted costs and payment responsibilities from the local, community-based public assistance system to the federally based social insurance system with the LTCI funds making the payments for long term care services. To some degree it also shifted costs from the health insurance funds to the LTCI funds while at the same time reducing the need to increase health insurance premiums (Geraedts, Heller, and Harrington 2000).

1 *Pflege-Versicherungsgesetz*; also referred to as the *Nursing Care Insurance Act.* Both terms are used in this paper depending on usage in source documents.

The system has several cost-containment mechanisms that distinguish it from statutory health insurance:

> First, as monthly costs are capped, program outlays do not depend on the amount of services provided per person or on provider payment levels, but rather on the number of eligible persons. Second, it also apparently freed the federal government from direct liability for program deficits, although it left out the question of what would happen if deficits were to arise. In addition, no automatic mechanisms have been built into the law, and benefit increases require new legislation – they do automatically increase with inflation (Brodsky, Habib and Mizrahi 2000).[2]

While a considerable surplus of revenue was generated in the first two years of operation, by 1999 this had been reduced to a small deficit (see Table G 1; von Kondratowitz, Tesch-Romer and Motel-Klingebiel 2002). Overall expenditure for the LTCI system for 1999 has been estimated at 0.9 per cent of German Gross National Product (GNP) (Brodsky, Habib and Mizrahi 2000).

Table G 1: Financial development of long term care insurance

Indication	1995	1996	1997	1998	1999
			In bill. DM		
Revenue					
Revenue total	**16,44**	**23,55**	**31,18**	**31,30**	**31,92**
Expenditures					
Expenditures total	**9,72**	**21,24**	**29,61**	**31,05**	**31,98**
Cash benefits	5,94	8,68	8,45	8,38	8,29
Benefits in kind	1,35	3,02	3,47	3,89	4,17
Respite care	0,26	0,26	0,10	0,11	0,14
Day/Night care	0,02	0,05	0,07	0,09	0,10
Short term care	0,09	0,17	0,19	0,21	0,24
Institutional care	0,00	5,27	12,54	13,37	14,04
Institutional care for the disabled	0,00	0,01	0,26	0,46	0,39
Liquidity					
Surplus of revenue (+) or expenditure (–)	**+6,72**	**+2,30**	**+1,57**	**+0,25**	**–0,06**
Balance of means at end of the year	**5,62**	**7,92**	**9,50**	**9,75**	**9,68**

Note: Deviations in sums due to rounding.
Source: von Kondratowitz, Tesch-Romer and Motel-Klingebiel, 2002.

2 See also Enquete Commission 2002, section 2.4 for a discussion of the extent to which this will erode benefits over time.

Alber notes that throughout the protracted public debate much of the emphasis was on financing mechanisms and costs, and on ensuring that costs to industry did not impede investments or jeopardise competitiveness in international markets: 'The question of to what extent the new scheme would or would not meet the demand for long-term care was of little public concern' (Alber 1996).

Concern about labour competitiveness has continued. In the current economic climate there is again strong debate about the issue. Boersch-Supan (2002) notes that labour receives amongst the highest levels of compensation in the world with about 50 per cent derived from social insurance contributions including retirement, health and long term insurance (see also: Vollmer 2000; Enquete Commission 2002, dissenting opinion by member of the parliamentary group of the FDP, and by Mr Knappe; and von Kondratowitz, Tesch-Romer and Motel-Klingebiel 2002).

Policy positioning within government

The power to legislate in health and nursing home matters is shared between the Federal and Laender Governments. The Laender have legislative powers covering certain areas as long as, and to the extent that, the Federal Government does not make use of its powers (eg, in relation to social insurance including health).

The Federal Ministry for Health (Bundesministerium fur Gesundheit) has responsibility for laws covering many aspects of health including the *Statutory Health Insurance Act* (Social Security Code Book V) and the *Nursing Care Insurance Act* or *Long Term Care Insurance Act* (Social Security Code Book XI) (Enquete Commission 2002).

Other Ministries with related responsibilities include:

- The Federal Ministry of Labour and Social Affairs: *inter alia* the pension insurance system; the statutory pension; and assistance for the disabled.
- The Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (Bundesministerium fur Familie, Senioren, Frauen und Jungend): *inter alia* the Federal Act on Care for the Elderly (Altenpflege-und Heimgesetz); the Registered Homes Staff Ordinance; and voluntary welfare agencies (Federal Ministry for Health 2001).

The Laender are required by Section 9 of Social Security Code Book XI to provide funding for the creation of 'a sufficient number of efficient and cost-effective nursing care facilities' and to put in place appropriate regulations (Enquete Commission 2002).

Arrangements for long term care

Long term care insurance

The *Long Term Care Insurance Act* has three general objectives: that domestic care be given priority over institutional care; that LTCI benefits should as much as possible reduce the risk of becoming dependent on social assistance solely due to the need for nursing; and to ensure adequate nursing care infrastructure. Unlike German statutory health insurance, LTCI is a 'partial coverage insurance'[3] with individuals or families responsible for covering the balance should their insurance benefits be insufficient (Federal Ministry of Health 2000; Enquete Commission 2002; von Kondratowitz, Tesch-Romer and Motel-Klingebiel 2002).

German LTCI is a mandatory, universal system with complementary social and private components. Everyone with an income below 'the income level for mandatory health and LTC insurance' is required to contribute to social LTCI. High income earners may contribute but if they decide not to it is mandatory that they buy private LTCI (Eisen 1997).

Employees, their employers, the unemployed and pensioners all contribute:

- employees and employers make equal contributions with the level of contributions being in direct proportion to an employee's income up to a maximum premium rate (each contributing 0.85 per cent of employee's gross wages, ie 1.7 per cent). From 31 December 2004, the level of payments will be less for contributors raising children (Enquete Commission 2002)
- the families of employees with incomes below a certain level are automatically covered by the employee's contributions
- contributions for the unemployed are paid by the Federal Employment Agency; and
- pensioners contribute half their premiums out-of-pocket with their pension scheme paying the other half of their premiums (Harrington, Geraedts and Heller 2002).

As statutory LTCI is closely aligned with statutory health insurance it is implemented through the nation-wide network of health insurance funds offices. The health insurance funds receive payments from the LTCI funds to cover administrative costs (€1.5 billion in 2000). In addition, the capital investment of all nursing homes and services – public, non-profit and private – is financed and re-financed by the state (Laender and municipalities) from general taxation (Vollmer 2000).[4]

3 The Ministry of Health brochure explaining German social security law refers to long term care insurance as 'a new kind of safety net'.

4 See also below, 'Long term care market trends' which would indicate that for-profit providers seek capital elsewhere.

Social LTCI was held by about 70.89 million people in January 2002, and a further 8.36 million were covered by private LTCI as of December 2000 (Federal Ministry of Health 2002). Altogether, around 88 per cent of the population belong to the public LTCI scheme, around 75 per cent because they fall within the income limit and the balance opting to join despite being high income earners. It has been suggested that high income earners may opt for the public scheme because a single premium would cover the benefits for the whole family, whereas private insurance funds would be entitled to charge a premium for each member (Geraedts, Heller and Harrington 2000).

A further ten per cent purchase private LTCI while the remaining two per cent (including the military) receive free government insurance. People purchasing private insurance are encouraged to choose between suppliers approved by the social LTCI funds. Premiums cannot exceed the maximum contribution for statutory LTCI. Benefits provided under private insurance (the 'service package') must be at least equivalent to those under social LTCI. Penalties in the form of lower benefits apply if a non-approved supplier is used (German Embassy Washington 2003; Eisen 1997; Federal Ministry of Labour and Social Affairs 2002).

Table G 2 summarises the proportion of beneficiaries receiving long term care at home or in a nursing home, by care level, and according to whether they are covered by statutory or private insurance. In total, some 1.34 million people received benefits for home care and 0.61 million received benefits for residential care, including some younger disabled people (Federal Ministry for Health 2002).

Table G 2: Statutory and private LTCI beneficiaries by care level

	Level I	Level II	Level III
Beneficiaries in home care			
Statutory LTCI			
31 Dec 2000	681 658 (54.1%)	448 406 (35.6%)	130 696 (10.4%)
31 Dec 2001	697 714 (55.3%)	436 693 (34.6%)	127 260 (10.1%)
Private Compulsory LTCI[1]			
31 Dec 2000	36 334 (49.1%)	27 602 (37.3%)	10 064 (13.6%)
Beneficiaries in institutional care			
Statutory LTCI			
31 Dec 2000	210 883 (37.6%)	234 836 (41.8%)	115 625 (20.6%)
31 Dec 2001	218 909 (37.9%)	242 779 (42.0%)	116 247 (20.1%)
Private Compulsory LTCI			
31 Dec 2000	7 821 (23.7%)	15 114 (45.8%)	10 065 (30.5%)

1. Figures for private compulsory LTCI are approximations based on information provided by the Ministry for Health.

Source: Federal Ministry for Health, 2003.

Access to benefits is pitched to three 'indemnity levels', according to levels of impairment defined by ADLs (activities of daily living) and instrumental ADLs, with level I being the lowest level of impairment, and level III the highest. In 2000, most beneficiaries were categorised as care levels I and II, defined as 'considerable' or 'severe' need for care: 89.5 per cent and 78.9 per cent of those receiving home care and institutional care respectively were assessed as requiring level I or II care. The remaining members were assessed as needing care level III requiring round the clock help every day.

There is also a preference for home care over institutional care, with 69.2 per cent of all beneficiaries receiving in-home care. While the rates are higher for beneficiaries requiring the lower levels of care, even 52.8 per cent of those classified as requiring level III care are receiving that care in the home.

These figures demonstrate that the LTCI legislation provides strong incentives for in-home care by the family through a preference for cash support for home care provided by family members. However, if the member's LTCI benefits are insufficient to provide for care needs the family may be obliged to make up the shortfall from the property and income of family members (Geraedts, Heller and Harrington 2000; Schunk and Estes 2001; Eisen 1997; Bertelsmann Foundation 2003).

The involvement and responsibilities of all players in the LTCI system are summarised in Table G 3.

From 1 January 2003 funding for acute care will be on the basis of prospective payments for DRGs (Diagnosis Related Groups).[5] This is expected to reduce the average length of hospital stay by up to 50 per cent. There is also an expectation that the introduction of DRGs will have an impact on nursing homes, in the short term by increasing the number of older patients in need of after-care or rehabilitation facilities and, possibly, in the long run through the development of DRGs for nursing care in the home and in nursing facilities. Concerns are being raised that DRG-based funding may further discriminate against people with chronic diseases (von Kondratowitz, Tesch-Romer and Motel-Klingebiel 2002). In addition, the Enquete Commission (2002) notes that:

> Nursing facilities as defined in Social Security Code Book XI will be affected by the reform of the [Hospital Financing Act], which is particularly relevant if – as in the case of full inpatient care or short term care – medical-therapeutic care services are refinanced from the grant of nursing care funds.

5 The Australian AN-DRG system is being adapted to German needs.

Table G 3: The German long term care insurance system – Players and involvement

Players	Involvement
Members Employees and their families; pensioners; unemployed people	• Contribute to mandatory social insurance schemes (including LTCI and health insurance) if income below mandatory level • If income above mandatory level, choose either to contribute to public LTCI or to purchase private LTCI • Choose between LTC services in the home or in a nursing home • If in the home, choose whether to take cash and family members provide the services; informal carers may also access free training LTC courses and may receive contributions to statutory pensions insurance if they provide more than 14 hours home nursing care per week
Public long term care insurance funds Self-governing, non-profit corporate organisations with boards on which there is equal representation of employers and employees	• Employees can choose which health fund but are assigned to the LTCI fund attached to their health fund. Each of the 500 or so statutory health insurance funds also has an LTCI fund • 76 per cent of beneficiaries are concentrated in two associations that incorporate the 18 regional insurance funds and seven federally organised 'substitute' insurance funds – by law these are the leading players • Must guarantee portability between funds; members may change funds once a year • Obliged to regulate the system in accordance with the needs of consumers by negotiating and entering into contracts with each other • Collect members' contributions • Help members to understand LTCI issues • Provide members with lists of licensed providers and their prices • Reimburse providers for home and institutional care within the limits of their budgets • Determine members' eligibility for services — Fund's medical service department assesses applicants in their homes according to nation-wide set of criteria — Covers personal hygiene, eating, mobility, housekeeping • Take an active role in quality matters and participate in evaluations driven by the Federal Long-Term Care Committee • Do not cover the cost of 'hotel services' or 'social care'
Private long term care funds Seven associations of social health and LTCI funds	• Represent the main classifications of insurance funds (two main players as above) • Develop products for employees with incomes higher than the mandatory level with benefits at least equivalent to the public LTCI scheme • Assess members for eligibility for specific benefits against care levels I to III.
Associations of LTCI insurance funds	• Negotiate on a regional level with professional and institutional care providers to establish fee schedules. The goal is to allow members to buy all necessary services within their benefits and minimise the need to pay for services on their own • Negotiate individual fee schedules annually for different levels of care with individual institutional care providers: nursing care, board, assisted living amenities
Federal government	• Policy development and legislation • Federal Employment Agency makes contributions on behalf of the unemployed • Oversight the two major LTCI funds associations • Licensing of institutional LTC facilities and home health care agencies
Laender (state governments)	• Policy development and legislation in those areas not covered by the Federal government • Provide funding to ensure the supply of nursing homes as required by Section 9 of Social Security Code Book XI • Fund and regulate nursing homes
Federal Long-Term Care Committee	• Responsible for quality assurance and evaluation of the LTCI system • 53 members representing federal, state and community government, associations of LTCI funds, and associations of ambulatory and institutional care providers • Advise the federal government on all aspects of LTCI
Providers	• Families and relatives; home health providers; part-time and short-term institutional care facilities; assisted living facilities • Provide care according to quality expectations

Access to benefits

To determine members' eligibility for services, medical staff of the sickness funds (primarily physicians who are reimbursed by the care funds) assess applicants in their homes according to nation-wide set of criteria. The criteria cover the broad areas of personal hygiene, eating, mobility and housekeeping. Benefits levels depend upon the extent and hours of daily help required over the long term, that is six months or more (Brodsky, Habib and Mizrahi 2000).

There are three main categories of benefits:

1. cash benefits to informal care givers up to US$739 per month (in late 1990s) and payments for items such as special beds and modifications to homes, up to US $2 841 per project.
2. benefits in kind (up to the value of US$1 591 to $2 131 per month) for the services of professional care providers, such as home health care agencies.
3. cash payments to facilities for institutional care.

Members receiving care in the home may receive a mix of benefits from 1 and 2. As benefits are constant for all members but contributions reflect capacity to pay, this results in a redistribution of income from the wealthier members to the poorest.

Informal home carers may also access benefits covering the services of respite care givers for up to four weeks a year and free nursing-care courses. In addition, informal carers who provide more than 14 hours care per week receive payments into their own statutory pension insurance fund as compensation for either having to leave the workforce or cut back on workforce hours (Geraedts, Heller and Harrington 2000). By far the majority of home carers are women, close relatives of the person in need of care, most of whom are themselves already older and often referred to as the 'female nursing reserve' (Enquete Commission 2002).

For institutional care, the social insurance funds pay for basic care, social services and treatment up to US$1 591 per month (at care level III). Recipients of care are required by law to pay at least 25 per cent of the nursing homes charges, and to pick up the total costs for room and board and other services. In the case of recipients below the poverty threshold, such costs are covered by social assistance payments. Overall, LTCI benefits cover around 50 per cent of the average cost of institutional care, and around 90 per cent of people requiring level III care still receive social assistance payments (Geraedts, Heller and Harrington 2000; Schunk and Estes 2001).

In 1998, close to 1.8 million people received benefits from public and private LTCI funds, 80 per cent of whom were older than 60 years. This represented roughly 75 per cent of those

Table G 4: Recipients of benefits of the LTCI per annual average and according to kind of benefits (calculated on basis of days of receiving benefits) in per cent [1; 2]

	1995 [3]	1996 [4]	1997	1998	1999
Outpatient total	98.5	75.9	72.3	70.7	70.3
Cash benefit	84.3	79.6	77.8	75.9	74.0
Benefit in kind	7.9	8.9	9.6	10.6	11.5
Combination of both	7.8	11.4	12.6	13.5	14.5
Respite care	1.0	0.4	0.2	0.2	0.3
Day or night care	0.2	0.2	0.3	0.4	0.5
Short term care	0.3	0.4	0.3	0.3	0.4
Institutional care	–	22.7	24.6	25.2	25.7
Institutional care for disabled	–	0.4	2.2	3.2	2.9
Total	100	100	100	100	100

1. Deviations in sums due to rounding
2. Including multiple countings because of receiving several benefits at the same time
3. Only outpatient care
4. Half year due to start of benefits in institutional care since 1.7.96

Source: von Kondratowitz, Tesch-Romer and Motel-Klingebiel, 2002.

members who applied for benefits. Cash benefits for informal care givers (US$4.76 billion) comprised by far the greatest part of benefits expenditure in 1998, although the cash benefits to benefits-in-kind ratio had decreased since 1996 (Geraedts, Heller and Harrington 2000). By 2000, 1.31 million out of 1.86 million beneficiaries were receiving nursing care at home with an increasing preference for benefits-in-kind (Enquete Commission 2002; and see also Table G 4). It has been suggested that the popularity of cash benefits for care in the home may have been influenced by the high level of unemployment in both East and West Germany. A study of the use of cash payments has shown that they are primarily used to supplement the family budget rather than to purchase services (Brodsky, Habib and Mizrahi 2000).

In practice, gaining access to benefits may not be as straight-forward as the above description might suggest. Defining the pivotal term 'need for nursing care assistance' in law was given much consideration to clarify levels of benefits, to distinguish between the responsibilities of the sickness and long-term care funds and to ensure that LTCI does not pick up the cost of 'hotel services' (Geraedts, Heller and Harrington 2000). German sickness insurance has traditionally drawn a sharp division between curable illness and long term dependency on care and up to 1988 only medical treatment for curable illnesses was covered by insurance.

The Enquete Commission sees the legal definition as problematic because '…it does not lead to any separate needs concept independent of medical categories because there is only a need for nursing care if it is based on disease or disability'. Such a narrow definition excludes therapeutic nursing care, a distinction not in keeping with current practice. The Commission notes that:

> As a result of the restrictive legal definition of 'need for nursing care', the proportion of the population that receives benefits from the Nursing Care Insurance is much lower than the proportion of the population that can be considered to be in need of nursing care, based on criteria of gerontology and nursing science. …
>
> The shortcomings of the definition … are particularly blatant when it comes to the needs of persons who suffer from mental illnesses, dementia, and brain injuries. …So the need for nursing care is only recognised with regard to the everyday routine activities of daily living …while the intensive care and general supervision actually needed is not covered in the catalogue of nursing care benefits … (Enquete Commission 2002).[6]

The narrowness of the legal concept of 'need for nursing care' is also critical to the question of whether a person's costs are covered by health insurance or LTCI, and/or themselves. Because the definition is illness based, a person usually receives benefits from statutory health insurance until it is clear that medical treatment has failed to restore their ability to perform activities of daily living. Then they become eligible for LTCI benefits. There are further complications in relation to what is referred to as 'medical-therapeutic nursing care' and whether such services are provided in the home or a nursing home (Enquete Commission 2002; see also von Kondratowitz, Tesch-Romer and Motel-Klingebiel 2002).

Future demand for professional nursing care

While acknowledging that demand will undoubtedly increase in the future, the Enquete Commission (2002) notes that any published projections reflect the limitations of the definition in current legislation. Apart from the legislative framework, the Commission considers that potential demand will be influenced by:

- *The effects of higher life expectancy including*: morbidity trends and opportunities for delaying the effects of some categories of disease through prevention and rehabilitation; and dementia with, each year, up to 25 per cent of dementia patients living in private households moving to nursing homes so that dementia is the single most important cause for institutionalising people in need of care.

6 This shortcoming had already been identified by the Ministry of Health (see Vollmer 2000) and informed 'A First Bill to Improve the Care of People Suffering from Dementia', 2000.

- *Changes in family structures and the availability of home carers*: the Commission suggests that contrary to concerns that the 'family is undergoing a crisis', changes in family and household structure as yet do not necessarily mean that older single people in need of care are living in isolation; rather they are living with, or in the same neighbourhoods as, close relatives and other older people take a part in the nursing care. This may change in the future with the decrease in the 'female nursing care reserve', the decline in the number of children in families, and an emerging willingness in 'bourgeois milieus' to purchase professional services.
- *Trends in the ratio of professional to home nursing care*: while traditionally moving to a nursing home has been regarded as a 'last resort', aligned with the willingness to purchase services is a greater acceptance of moving to a nursing home. Further, there is a growing awareness that providing nursing care at home reduces helpers' prospects of paid employment outside the home.
- *Differentiation in nursing care requirements* to meet the needs of people with dementia (by upgrading the skills of home and professional carers), older migrants (where there is a greater reliance on care in the home and less knowledge about entitlements to benefits and the services available), older single people (by supporting more flexible mixes of informal and formal help), and older people with a handicap (by devising support and housing that enable them maintain independence within their familiar social environments).

Several modelling exercises have attempted to project future demand for nursing care, all taking as given the narrow definition of 'need for nursing care' in the legal definition. Depending upon their chosen assumptions, estimates range from:

- an increase of nearly 61 to around 76 per cent by 2040 (Rothgang as cited by Enquete Commission 2002)
- an increase of 145 per cent between 1999 and 2050 (DIW – German Institute of Economic Research as cited by Enquete Commission 2002).

Quality assurance

Quality provisions applying to the German health insurance system have been extended to LTCI and new systems designed. Nursing home care is subject to a wide range of legislation reflecting the relationships between nursing care, health, social security and insurance:

- *Nursing Care Insurance Act* or *Long Term Care Insurance Act* (Social Security Code Book XI)
- *Statutory Health Insurance Act* (Social Security Code Book V)
- *Nursing Home Act*

- *Nursing Care Quality Assurance Act 2001*
- *Federal Social Assistance Act*
- Other regulations including industrial health and safety regulations, fire regulations, Hazardous Substances Ordinance, Food Ordinance and rules on hygiene.

Each of these provisions obliges providers to develop and maintain some aspects of quality care. Under the *Nursing Care Insurance Act*, the only services to be funded are quality ones; or to reflect the legislative language, those that are 'generally recognised [as] state of the art in medicine and nursing care' (Sections 11(1), 28(3) and (4) of the Social Security Code Book XI; Section 2 of Social Security Code Book V; Section 6 of the *Nursing Home Act* as quoted in Enquete Commission 2002).

Defining 'quality' and setting standards to operationalise this broad guidance in the legislation has largely been done through negotiations between the associations of LTCI funds and the associations of providers. Providers are required to cooperate with quality assurance arrangements and inspections undertaken by the care and sickness funds. There has been relatively little involvement by representatives of nursing science or the professional nursing associations (Enquete Commission 2002). The Commission expressed concerns about existing standards and means of quality assurance and suggested the need for incentives and more cooperative strategies to bring about greater commitment to quality.

For care in the home, the insurance funds are required to provide free care training to care providers. Formal service providers visit homes several times a year to monitor quality and provide advice. Only a low level of compensation is provided for quality monitoring visits. It has been questioned whether the use of formal service providers in this role may give rise to a conflict of interest as the visits could be used to 'advertise' formal services (Brodsky, Habib and Mizrahi 2000).

There is a lack of quality standards for home care and no standards for evaluating home care. In part this is seen as responding to a reluctance to 'invade the private sphere of familial care relationships' and the difficulty of evaluating the emotional components of such care (Enquete Commission 2002).

Long term care infrastructure

With the introduction of the LTCI scheme measures were taken to encourage the upgrading of infrastructure for formal long term care services in Germany.

Sixteen Laender passed legislation to promote investments in long-term care facilities and the number of nursing homes increased from 4 300 in 1992 to about 8 100 in 1999, with most

of the growth in the first two years. The increase largely reflected the entry of for-profit providers into the aged care system and the role conversion and re-certification of former residential homes as qualified nursing homes. While in 1998 there was some excess capacity, some regions were still experiencing shortages especially in relation to part-time and short-term facilities (Brodsky, Habib and Mizrahi 2000; Cuellar and Wiener 2000; Geraedts, Heller and Harrington 2000).

Funding for assisted living services under LTCI has also provided incentives for the development of home health care agencies with the number of providers increasing from about 4 000 in 1992 to around 11 700, again resulting in some excess capacity.

The viability of both private nursing homes and rehabilitation facilities is being affected by the current economic circumstances (IKB Deutsche Industriebanke 2002; Marseille-Kliniken 2003).

The Enquete Commission (2002) notes that the nature of nursing care needs for the elderly calls for 'a differentiated care delivery system in which various services and structures should interact'. However, there are regulatory gaps and inconsistencies with no clear attribution of responsibility for ensuring an integrated nursing care infrastructure: the states, nursing care funds and local authorities all bear some responsibility. The level of coordination and cooperation is seen as inadequate across the system, between helpers, funding institutions and service providers and including 'at the interfaces between domestic care, nursing homes and hospitals'. Individuals looking for help are left to put together their own packages of care and experience considerable difficulty in doing so. This problem in part has arisen from historical legal and institutional factors and is complicated by the fact that older people in need of nursing care can not easily comprehend the range of services available to them in the market.

The Commission recommends a number of changes aimed at improving infrastructure and service delivery:

- the introduction of case management as a way of offsetting this fragmentation and 'optimising nursing care arrangements' (see also von Kondratowitz, Tesch-Romer and Motel-Klingebiel 2002)
- further facilitation of tailor-made, inter-disciplinary 'outpatient' services by the Laender and removal of the impediments to these in current legislative requirements
- switching 'from the current system of funding facilities to providing funds for individuals by further developing the current forms of nursing home allowances'
- further consideration of the interaction of all the relevant sections of the Social Security Code Books with a view to removing contradictions and integrating their provisions where possible.

In a context of nation-wide unemployment, the introduction of the LTCI system provided around 70 000 new employment opportunities, especially for nurses. Unemployment also is thought to have contributed to the ready availability of informal home carers (Geraedts, Heller and Harrington 2000).

However, with the increasing demand for professional nursing services in the home and the expected increased demand for nursing home services in the future, the current supply of approximately 220 000 nursing care professionals must be increased. DIW estimates that by 2050 nursing homes will require a professional workforce of between 280 000 if there is no change in the pattern of usage, and 500 000 with increased demand for intensive nursing. For outpatient nursing (in homes and intermediate facilities) DIW predicts that some 62 400 full time positions will be needed by 2050 if families continue to prefer cash benefits, rising to 82 000 if the emerging trend to benefits-in-kind continues. Meeting this increase will be a challenge as the labour market eases up and the profession of 'geriatric nurse' is seen as less attractive (Enquete Commission 2002).

Among the issues that need addressing to attract younger, better qualified nursing professionals, the Commission identified the rigidity of definitions in the context of nursing care insurance, the complexity of the professional skills needed, and the inadequacy of current arrangements for professional training. It recommended, *inter alia*, higher pay, better career prospects and opportunities for specialisation.

Long term care market trends

Three perspectives on market trends are provided by an overview of the market at the time of the 2000 International Trade Fair, a forecast by IKB Deutsche Industriebank for 2002, and a report on the performance of Marseille-Kliniken, one of the biggest private service providers.

At the time of the Altenpflege 2000 International Trade Fair in Hannover, the market was described as comprising:

- 13 300 out-patient nursing homes, an increase of ten per cent over the previous three years
- 9 400 hospital nursing care centres
- 22 650 in- and out-patient nursing institutions catering to the increasing number of seniors and elderly requiring care.

The average German nursing home offered approximately 84 support and care units, and 49 single rooms. Private suppliers accounted for 33.6 per cent of the market total in 1999, up 9.6 per cent over 1996, with non-profit communal and religious organisations accounting for 54.2 per cent, down 7.8 per cent from 1996. Since 1996, the workforce had increased by 26 per

cent to total 363 000 with the majority of new jobs in the private sector. Private investors had increased their financial support for assisted living centres and nursing homes with 45.3 per cent of all institutions being not-for-profit, and 46.2 per cent being privately-held businesses (Altenpflege 2000).

IKB Deutsche Industriebank's market analysis for 2002 noted that with annual sales of around €80 billion, the combined hospital, rehabilitation, and nursing home sector represented one of Germany's most important industries. It suggested that the introduction of the DRG system in hospitals would have significant impact on the rehabilitation sector, pushing up utilisation but with higher costs because patients would arrive in a weaker state and requiring more costly treatment. Organisations in a position to move into rehabilitation and to forge close links with partner hospitals could benefit from the changes.

In relation to nursing homes, the bank noted that 2001 was 'characterized by spectacular bankruptcies'. The new quality standards and a foreshadowed tightening of building standards were expected to increase costs in 2002 and result in accelerated consolidation with smaller homes unlikely to survive. Even so, the Bank expected the sector to continue to expand with the ageing of the population and some 50 000 extra people likely to be seeking care. Meeting this demand would require an investment of nearly €4 billion (excluding modernisation of existing stock).

Marseille-Kliniken, one of the biggest private service providers in the German health market, claims to be the first company providing in-patient nursing (nursing home) care for the elderly to have obtained a rating from Standard and Poors: BB-/neutral. Company share will be listed in the new 'Prime Standard' segment from March 2003. The group operates 54 facilities: 43 nursing homes (5 700 beds, an increase of 1 000 for the year) and 11 rehabilitation clinics (1 801 beds, a decrease of 19). The increase in nursing home beds was achieved though take overs, redevelopment of existing properties, and the opening of new locations.

In the context of growth in the German economy in 2002 amounting to only 0.2 per cent, Marseille-Kliniken reported a 7.2 per cent increase in nursing home operational sales and 93.3 per cent occupancy. Occupancy in their rehabilitation division had dropped 3.8 per cent. The EBITDAR margin fell from 32.2 per cent to 29.9 per cent, the EBITDA margin from 25.7 per cent to 23.8 per cent and the EBIT margin from 17.2 per cent to 15.9 per cent, largely due to disappointing performance in rehabilitation. The report noted that:

> The new requirements made by the government on the quality of nursing care are the crucial factor here. They are making life difficult for business models that focus exclusively on size and not at the same time on quality and economically sound operation.

However, Marseille-Kliniken predicted that demand for rehabilitation will grow in the long run with the wider introduction of DRGs providing lump sum payments for acute patients in hospitals and patients leaving hospital more quickly and in need of post-operative care (Marseille-Kliniken 2003).

Issues

No overall evaluation of the system has been undertaken. There is some evidence on the first four years of operation during which time progress was encouraging. The Enquete Commission on Demographic Change established in 1999 included consideration of health care, nursing care and social services. The Commission has made wide-ranging recommendations on better integration of the health insurance, nursing insurance and social assistance systems, improving service delivery, and the recruitment of working staff.

However, pressures on the German economy are again fuelling the debate on the social insurance system as a whole. Recently, a Commission was appointed to look at reforming the welfare state. It is likely that LTCI (including its viability) will come within the scope of the review (Personal communication from Professor Boersch-Supan, 12 February 2003).

Other issues identified by researchers are briefly identified below.

Quality and effectiveness

- The health and long-term care systems are not well integrated. Nor do the arrangements provide incentives for rehabilitation. Even though LTCI is administered by the sickness funds, it is funded and managed separately. Incentives remain for cost shifting between the funds and between various levels of the state to the detriment of prevention and rehabilitation (Schunk and Estes 2001; Bertlesmann Foundation 2003; Geraedts, Heller and Harrington 2000; Brodsky, Habib and Mizrahi 2000; von Kondratowitz, Tesch-Romer and Motel-Klingebiel 2002).
- Possible inequities in the system:
  - There is some early evidence that private care insurance fund assessments assigned high levels of care dependency, and denied benefits to a smaller proportion of applicants than do public care insurance funds (Schunk and Estes 2001).
  - Only 23 per cent of residents in institutional care are categorised as care level III (high care) causing some concern that care intended for those with high level care needs is dominated by people with lower care needs. This may be because people in institutions before the

introduction of LTCI were allowed to remain there (Geraedts, Heller and Harrington 2000).

- Cuellar and Wiener (2000) suggest a conflict between equity and efficiency: while payments to informal carers may reward them for their sacrifices, it could be argued that considerable funding is being provided but with relatively little behavioural change in the delivery of care.
- Main responsibility for quality rests with the funds which are also the main financing bodies. Further, no funds are specifically set aside for quality improvement (Schunk and Estes 2001).

Dementia

- People with dementia related illnesses may not be receiving appropriate ratings – and hence equitable access to services – compared with people with physical incapacities (Schunk and Estes 2001; Brodsky, Habib and Mizrahi 2000). In part this stems from the narrowness of the definition of 'the need for nursing care' in the Social Security Code Book XI (Enquete Commission 2002).
- Nearly two-thirds of people suffering from dementia are looked after by family members at home, and nearly two-thirds of people suffering from dementia do not claim any LTCI benefits. These figures raise questions about access carers have to appropriate information on dementia care and the quality of care dementia patients are receiving (Enquete Commission 2002).

Cost/affordability, LTCI benefits

- Boersch-Supan (2002) notes that labour receives amongst the highest levels of compensation in the world with about 50 per cent derived from social insurance contributions (including retirement, health and long term insurance). There is growing debate about the competitiveness of German labour which may again focus on the cost to business and industry of LTCI – which was a sticking point in gaining agreement to its introduction (see also Enquete Commission 2002, dissenting opinion by member of the parliamentary group of the FDP, and by Mr Knappe; von Kondratowitz, Tesch-Romer and Motel-Klingebiel 2002).
- There are limits to LTCI benefits with consumers making up the balance of costs – with a sizeable proportion of these people dependent on means-tested social assistance payments to cover the extra costs (Brodsky, Habib and Mizrahi 2000; Geraedts, Heller and Harrington 2000; von Kondratowitz, Tesch-Romer and Motel-Klingebiel 2002). Schunk and Estes (2001) note that 'Between 60 to 80 per cent of people in institutional care still have to "spend down" and end up on social assistance rolls'.

- It is estimated that, for demographic reasons alone, a contribution rate of 3.0 to 3.3 per cent will be required for LTCI by 2040 compared with the current rate of 1.7 per cent combined employee/employer contribution (Enquete Commission 2002). Possible rates of 2.4 per cent up to 2.8 per cent are under discussion (von Kondratowitz, Tesch-Romer and Motel-Klingebiel 2002).
- The provisions of the *Long Term Care Insurance Act* stipulate that benefits should only be adjusted to price increases within the framework of a constant contribution rate. Any index linkage below the rate of increase in wages and salaries will therefore reduce the purchasing power of benefits; ie, the consequence of a stable contribution rate over time to 2040 would be a drastic increase in the number of residents also needing social assistance (Enquete Commission 2002).
- Services that do not neatly fit within the place- and time-based categories of care (long term home, outpatient or nursing home care; short term and day care) cannot be adequately funded. It would be easier to support innovation if the value of cash benefits was the same as for benefits-in-kind. Individuals could then be given a personal budget to use as they see fit (Enquete Commission 2002).

Workforce and informal carers

- While the early years created employment opportunities for nurses there is now some concern that only 35 per cent of staff are skilled nurses and that new nursing care knowledge and skills are not flowing into the sector. Legislation requiring that by 1998 at least 50 per cent must be skilled nurses was postponed (Geraedts, Heller and Harrington 2000).
- Increasing female labour force participation is one of the strategies considered for reducing the retirement burden (Boersch-Supan 2002). Given the current preference for home care largely supplied by the family, increased labour force participation could reduce the provision of long term care in the home.
- Women are the main providers of informal care in the home. There is some evidence that they 'experience massive economic and health related "costs" as a result' (Schunk and Estes 2001).

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Denmark

Continuity, autonomy and use of personal resources

DENMARK

Continuity, autonomy and use of personal resources

Denmark has one of the most decentralised governments in Europe with substantial autonomy resting with the 14 counties and 275 Municipalities. Each level has the right to determine and collect local taxes and the counties and municipalities decide the mix of services for their populations (Denmark 2003b). In 2000, 65 per cent of revenue was raised at the national level and 35 per cent by local government however local government spent 57 per cent of the public budget compared to 43 per cent by the national government (Ministry of the Interior and Health 2002).

The basic principle of the Danish welfare system, often referred to as the Scandinavian welfare model, is that citizens have equal rights to social security. The system has evolved around this principle since its introduction in the 1890s with political parties of all persuasions having contributed to its development. The Danish welfare model is supported by one of the highest taxation levels in the world and an increasing national debt (Denmark 2003a).

Demographics

Population

The number of elderly in Denmark (ie, those aged more than 64 years) is projected to rise by 50 per cent between 1999 and 2040. It will increase rapidly from 2010 when people born post-World War II will begin to retire. During the same period the working age population will be reduced by 3.5 per cent. The number of people aged 67 and over increased by 23 per cent between 1975 and 2000; those aged 80 and over increased by 75 per cent while the oldest group (90 and over) increased by 182 per cent. Even so, compared with most OECD countries and with Italy and Japan in particular, the impact of ageing on Denmark is less marked (Denmark 2001a; Ministry of Economic Affairs 2000).

Since 1960 life expectancy in Denmark has increased slowly in comparison with other European countries. However, there has been a notable increase between 1995 and 1999: from 77.8 to 78.8 years for women and from 72.6 to 74.0 years for men (Ministry of Health 2001).

The official normal retirement age, 67 years, will gradually be reduced to 65 years. However, the actual average age for

withdrawal from the workforce is around 61-62 years, in part because of the so-called transitional benefit scheme from 1979, which enabled a large part of the labour force to leave the labour market with an income corresponding roughly to the unemployment benefit. In 1999, the rules of the scheme were tightened in order to curb the trend of earlier retirement (Denmark 2003a).

Provision for retirement

Virtually all citizens aged 67 and over receive the public aged pension which is residence based, independent of their previous relation to the labour market and with the level depending on family income. As from 2004, this pension will be available from age 65 (Ministry of Economic Affairs 2000).

As in other Scandinavian countries, a supplementary welfare system funded though individual contributions has emerged in recent years and is strengthening the system in relation to the demographic challenge. This supplementary system includes:

- contribution-financed and savings-based statutory pensions: Labour Market Supplementary Pension, Special Pension Savings Scheme and Employees Capital Pension Fund (4.1 million members in the Labour Market Supplementary Pension in 1998)
- publicly financed labour market pension for civil servants and employees in civil servant-like jobs: Civil Service Retirement Payments (93 000 people received payments in 1997)
- savings based schemes agreed by the labour market or individual company: Labour Market Pension and Company Pensions (just over 1.6 million payers)
- individual pension savings with banks, insurance and pension institutes (over 1.1 million people pay to individual schemes) (Ministry of Economic Affairs 2000).

Pension assets have increased steeply since 1987 with the expansion of contribution and savings-based schemes so that reserves have more than doubled (measured as per cent of GDP). In 2000 overall assets amounted to just over 100 per cent of GDP: of this, private schemes accounted for around 75 per cent (see Table D 1: Assets in pension funds).

The Government reviewed the sustainability of the pension system and the cost of future care for the elderly in 2000. The review concluded that to lay the foundations for continuing sustainability, individuals must be prepared to maintain high savings; labour market pension contribution rates would need to be increased from five to six per cent to nine per cent; an extra 80 000 people would be needed in the labour market; and tight fiscal policy should aim for public finance surpluses of approximately two per cent of GDP (Ministry of Economic Affairs 2000; see also Ministry of Social Affairs 2002a).

Table D 1: Assets in pension funds 1986 to 2000

	Per cent of GDP			
	1986	1990	1995	2000
Occupational pension schemes etc	10.3	13.3	16.1	18.8
Life insurance companies	20.6	24.4	31.2	43.6
Banks	8.3	11.6	14.2	17.1
Total non statutory schemes	*39.2*	*49.3*	*61.5*	*79.4*
Supplementary pension schemes[1]	10.6	13.2	16.1	25.4
Total	**49.8**	**62.5**	**77.6**	**104.8**

Source: Ministry of Social Affairs, 2002a.

1 Including Supplementary Earnings-Related Pension Scheme (ATP), Employee's Capital Pension Fund, Special Pension Saving Scheme (SP) and the Temporary Pension Savings Scheme which was abolished and replaced by the SP.

Evolution of the Danish long term care system

Denmark recognised far earlier than many countries that ageing of the population would place pressure on the economy and capacity to provide services. A Commission on Ageing was established in 1979 to review public measures relating to the elderly and to make recommendations on future policy impacts.

Reversing the trend to more nursing home beds

The Commission recommended that future policies should be guided by 'adherence to the principles of continuity, self determination and use of [people's] own resources' and that policies should 'enable the elderly to remain as long as possible in a life which has quality in the individual's own view' (as quoted in Stuart and Weinrich 2001a). The Commission specifically recommended the expansion of 24-hour care services for people in their own homes.

Following the Commission's reports, the trend to ever-increasing numbers of nursing home beds was reversed with the number of beds decreasing by 30 per cent between 1985 and 1997. Municipalities concentrated instead on the development of housing more suited to the living and care/home help needs of the elderly. Overall it is estimated that between 1985 and 1998 the number of adapted dwellings increased by 331 per cent from 9 622 to 31 854 (Stuart and Weinrich 2001b).

Legislative changes in 1987 and 1990 reinforced the shift from institutional care to home and community-based care. These changes included: a freeze on financing for the construction of nursing homes; permanent home help free of charge to those who needed it; improvements in financial conditions for pensioners; the option of paying pensions directly to nursing

home residents; and the establishment of multi-stage training requirements for the health and other workers who provide home care services. Further legislative action in 1988 concerned the de-institutionalisation of the elderly and in 1997 addressed quality issues by requiring that new housing for elders must have at least a bedroom, sitting room, kitchen and bathroom (Stuart and Weinrich 2001a, 2001b).

Integrating care

A leader in this trend was the Municipality of Skaevinge which established its successful Integrated Health Care Project for older People in 1984. This innovative project saw the former nursing home shifted to become part of a Health Care Centre with the complex also including private residences for rent. Integrated 24-hour health care services were put into operation and made accessible to all of the Municipality's 5 000 elderly people in institutions or their own homes. Long-term evaluations of the Skaevinge project report positive health and social outcomes and containment of costs. In the early stages savings from changing the role of the nursing home were used to extend home care to more people. By 1999, some additional funds were available because of savings in hospital care (Wagner 2001; Stuart and Weinrich 2001a, 2001b).

The integrated care model pioneered by Skaevinge was widely adopted by other municipalities during the 1990s and is now used by around 75 per cent of them. In general, outcomes have been similar to those achieved at Skaevinge. In 1985, Denmark was spending approximately twice what the USA was spending per capita on long term care – by 1997 per capita expenditures were roughly comparable (Stuart and Weinrich 2001b; Wagner 2001; Stuart and Weinrich 2001a).

In 1982, 16 per cent of people over 75 were living in residential/ nursing type accommodation. By 1999 the proportion had dropped to seven per cent, with a further 11 per cent living in specially designed dwellings (Denmark 2003a).

Expenditure on social services made up 30 per cent of GDP in 1998. On the face of it, this places Denmark third among EU countries for social expenditure after Sweden and France but the figures are subject to differences in the make up of social expenditure across the countries. In 1999, expenditure on the elderly (pensions, nursing homes and home help) comprised 41 per cent (DKK 143 billion) of Denmark's total social services expenditure (Denmark 2001a).

Policy positioning within government

At the national level, policy responsibilities shaping long term care are shared by the Ministers for Social Affairs, Health, and Housing, reflecting the Government's overarching objective of supporting people remaining in their homes as long as possible. The success of the long-term care system depends on the interplay of social services, health, social security, and housing policies:

- services for the elderly are provided under the *Social Services Benefits Act 1998* (MISSOC 2002a)
- rules for the old-age pension are laid down in the *Social Pensions Act* including provision for the direct payment of the full pension to recipients to encourage continuing independence, and rent allowances under certain circumstances
- under the Danish health services, preventative services, including home care for the elderly, is provided by the municipalities
- in keeping with the *Housing for the Elderly Act 1987*, housing policy encourages the provision of homes adapted to the needs of older citizens and discourages the building of nursing homes.

Arrangements for long term aged care

The principles of Danish ageing policy echoes those set by the 1979 Commission on Ageing:

- continuity in the individual's life
- use of personal resources
- autonomy and influence on own circumstances – including options (Ministry of Social Affairs 2002b).

Financing care

Denmark has been widely recognised as a leader in European countries in largely providing long term care in the home and community. Danish long term care policy is characterised by:

- policies of comprehensive, universal, tax-financed health and welfare services. Almost all long-term care and other health services are financed through public taxes largely by county and municipal governments
- a high degree of decentralisation in both funding and decision making across all levels of government: national, regional and the municipalities. An overall policy framework and the bulk of the funding is provided at the national level while the regions/ counties and municipalities have primary responsibility for providing and managing the nursing services that are largely the foundation of long term care (Stuart and Weinrich 2001a; Ministry of the Interior and Health 2002)

- provision of benefits in kind comprising: home care (personal hygiene, domestic help, assistance with maintaining functionality); semi-stationary care; nursing home care (in homes or special apartments); other benefits (eg, respite services, changes to buildings and equipment).

Non-means tested benefits are provided to 'Any person [regardless of age] that is suffering from an injury or an infirmity and is not capable to provide him/herself personal care, cleaning, shopping or any other necessary function' (MISSOC 2002a). Out of approximately 699 500 people in Denmark over the age of 66, around 171 500 received home help in 2001 (Denmark 2002).

Accommodation and general home care are treated separately from nursing no matter where the individual is living. Accommodation is always the financial responsibility of the individual but care is mostly covered by universal insurance under the *Social Services Benefits Act 1998.*

Table D 2 summarises the types of services, and numbers of institutions and clients for 2000 and 2001 for adults and elderly people. In line with continuing emphasis on home care, there was an increase in the numbers using permanent home help and a decrease in the number of residents in nursing homes, together with a small drop in the number of nursing homes.

Home care

More elderly Danes (approximately 169 500) receive home care than in Norway or Sweden. Unlike other European countries, individuals receiving permanent home help pay no user fees,

Table D 2: Welfare institutions and services: measures for adults and elderly people 2001

Measure	No. of institutions		Number of clients			
			Users		Residents	
	2000	2001	2000	2001	2000	2001
Permanent home help	–	–	198 426[1]	201 258[1]	–	–
Residential nursing homes	744	740	7 838	8 004	28 400	27 806
Protected dwellings	185[2]	173[2]	–	–	4 424	4 051
Dwellings for elderly people	–	–	–	–	35 935	37 860
Other dwellings for elderly people	–	–	–	–	21 204	21 175
Day care centres	686	686	50 407	48 859	–	–

Sources: Denmark, 2001b and 2002.

1 Number of people receiving home help includes those receiving 24 hour care

2 Number of buildings

however temporary help is paid for according to the person's financial situation (Hollander 2000; Stuart and Weinrich 2001a; MISSOC 2002b).

Access to home care assistance is determined on the basis of assessment of an individual's health, mobility, living standards, social networks and access to community facilities (eg, shopping). It is designed to 'help people help themselves' and the type of care may change as circumstances change.

The government has emphasised the development of housing units throughout the country designed to meet the needs of the elderly, rather than building more residential nursing homes. Out of approximately 699 500 people in Denmark over the age of 66, around 61 500 lived in residential homes for the elderly, protected dwellings, or dwellings for the elderly in March 2001, significantly more than live in nursing homes (Denmark 2002a).

This move has been backed up by 24-hour home nursing services and the provision of home care technology to assist in ensuring access to nurses. Over 6 000 call systems have been installed in homes to enable people to contact a centrally located home care centre staffed by nurses. This 24-hour access is coordinated to work collaboratively with hospitals so that it helps avoid the unnecessary hospitalisation of older people and shortens waiting lists for nursing home beds.

Home care may include a wide range of personal and domestic help, assistance with maintaining functionality and nursing care. In addition the elderly have access to other benefits that assist them in continuing to live independently such as respite services, changes to buildings and the loan of care equipment. The elderly participate in the planning and monitoring of the home care they wish to access or purchase (Hollander 2000).

The hours of nursing care provided in the home depend on assessment of the needs of the individual. Most receive three to four hours per week, with a small number of older people with much greater needs receiving over 20 hours care per week. Assessment of need takes into account the presence of a spouse but not the availability of help from children.

As the same organisation (and where possible the same care staff) provides services for people no matter whether they are living in ordinary housing, assisted living units, or nursing homes, continuity of care is improved. Some of the services previously provided by local authorities have recently been privatised and this shift is likely to increase in the next few years. This shift is claimed to place increasing emphasis on productivity and quality in home care (Stuart and Weinrich 2001b; Hollander 2000).

As municipalities have considerable autonomy, there are variations in service availability and quality across municipalities. Similarly there is considerable variation (up to 300 per cent) in the cost of assisted living units (Stuart and Weinrich 2001a).

Consumer satisfaction surveys show that about one in ten of the elderly report dissatisfaction with the level of help they receive in the home. Even more importantly, they express 'the highest degree of dissatisfaction with the amount of time reserved for social interaction'. As assistance in the home is essential to maintaining well-being and functional independence, such dissatisfaction is of concern to the overall continuing success of home-based care in Denmark (Ministry of Finance 2000).

Nursing homes

Despite the continuing closures of nursing homes, 1 740 homes were providing care in 2000. All of the homes operate on a non-profit basis with 72 per cent operated by the municipalities and the remaining 28 per cent by private non-profit organisations. As with the Skaevinge project, nursing homes are not necessarily stand alone facilities but rather are part of integrated complexes that also provide rental units and sheltered housing. The number of beds per nursing home averages 39. Most residents stay in a single room (Meijer et al 2000; Denmark 2002).

Table D 3 compares the number of residents living in nursing and day homes with those living elsewhere in dwellings for the elderly or making day use of nursing and day homes. While overall those who do not live in nursing homes out number those who do, not surprisingly residents in nursing homes increase relative to those not in nursing homes up to age 80-89, but it is only among those aged 90+ years that numbers are close to even (Denmark 2002).

Table D 3: Residents in nursing homes and other dwellings for the elderly 2001

	Number by age group					Number per 100 persons by age group				
	< 67 years	67-79 years	80-89 years	90+ years	Total	< 67 years[1]	67-79 years	80-89 years	90+ years	Total
Total	9 259	21 570	33 510	13 382	77 721	0.6	4.4	18.4	42.1	3.6
Nursing & day homes residents	2 589	6 147	12 514	6 556	27 806	0.2	1.3	6.9	20.6	1.3
Nursing & day homes users	996	2 750	3 369	889	8 004	0.1	0.6	1.9	2.8	0.4
Protected dwellings	595	1 057	1 731	668	4 051	–	0.2	1.0	2.1	0.2
Dwellings for the elderly	5 079	11 616	15 896	5 269	37 860	0.3	2.4	8.7	16.6	1.7

Source: Denmark, 2002.

1 Calculated for the 45-66 year age group.

No national data is available on residents' characteristics such as the proportion of female residents, or the demand for dementia care, although there is some evidence that dementia patients are mostly cared for in the same institutions or wards as non-dementia residents. Nor are there national statistics on average length of stay, however data for the municipality of Copenhagen indicate an average stay of 2.8 years. Even so it is thought that residents of nursing homes are now sicker, older and more dependent than they have been in previous years, thus increasing the workload of nursing home staff (Meijer et al 2000).

All nursing care in nursing homes is paid for by general taxation. As noted above, accommodation is treated separately with residents paying for rent, electricity and heating. Residents also pay for any extra services they use. As residents are encouraged to maintain independence and control over their affairs, the costs of services are not deducted directly from their pensions. Instead, they receive their full pension and 'pay as they go' for the services they need in the same way they would if still living at home or in an assisted living arrangement (Meijer et al 2000; Blackman 2001; Merlis 2000).

To discourage cost-shifting between levels of government, municipalities (which are responsible for funding long term care) must pay hospitals (funded by county governments) if patients must remain in hospital because long term care is not available (Merlis 2000).

Older people in nursing homes, too, expressed dissatisfaction with the time given to social interaction. Even so, most felt satisfied with the food, the level of care and the respect of the staff (Ministry of Finance 2000).

Issues

The Danish Government acknowledges that the scale of funding for the care of the elderly in Denmark continues to place pressure on public expenditure, the welfare system and the provision of long term care. The Government suggests that there are various ways of countering this pressure.

Greater emphasis could be placed on personal contributions to funding by pensioners in the future, who will generally be more affluent than today's pensioners. However, the Government realises that such a move could be seen inconsistent with the basis of Danish welfare policy, given that personal contributions tend to be 'socially imbalanced'. Further, the expectation of universal access across the population means that there is strong interest in maintaining the present system and improving the quality of care.

Other options include attempting to increase the labour provided by the ten per cent of the employable part of the population currently working to only a limited extent, and improving efficiency in the health and especially the social sector where the Government considers that 'much can probably be gained by professionalism' (Denmark 2003a).

Issues raised by other commentators include:

- the possibility that reducing the number of nursing homes may limit choice in the type of care preferred with the risk of care in the community denying the frail elderly the quality of care and security available in a good nursing home (Blackman 2001).
- the relatively expensive cost of providing over 20 hours home nursing care per week to a small number of older people. While such people are not forced to shift even though they might be better catered for in a nursing home, the viability of this approach into the future is questioned (Hollander 2000; Merlis 2000).

Overall, Blackman has noted that changes are likely to be incremental rather than radical:

> … opposition to rationalizing provision is strong because the services are universal and a wide range of older voters and their families have a stake in them, and continue to press for improvements. The fact that these services employ large numbers of women and facilitate others in going out to work also generates political support for the high spending that sustains them. Although changes are being made, with greater targeting of services and the development of support for family carers, … [Denmark is] essentially locked into a model of high social spending in which care work is largely a state responsibility (Blackman 2001).

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Singapore

Many helping hands

SINGAPORE

Many helping hands

The financing of long term nursing home care is inter-woven with total health financing, retirement savings and social insurance arrangements.

The financing philosophy of Singapore's provision for the aged is based on individual responsibility and community support. The people are expected to make provision for their current health and care needs and their future needs in old age. They are expected to co-pay part of all services and to pay more if they want a higher level of service. Older Singaporeans, especially, are also expected to be involved in community activities to help support others beyond their own families. The Government subsidises most services, especially basic care services.

Hence, services for the elderly are financed by a combination of taxes, employee benefits, compulsory savings, insurance, and out-of-pocket payments. The Government sponsored schemes that make up the financing framework are the Central Provident Fund, Medisave, Medishield, ElderShield, Medifund, and the ElderCare Fund. Some private insurance companies also offer long term care insurance. From the perspective of the individual or family, such financing arrangements are complex and fragmented.

This financing philosophy is illustrated by the fact that in 2000 Singapore spent S$4.8 billion or three per cent of GDP on health care. Of this, Government expenditure on health services was S$1.2 billion or 0.8 per cent of GDP (MOH 2003a).

Demographics

Singapore is a city state constrained by its geographical size – just 659.1 square kilometres – and lack of natural resources. The island's main asset is her people.

Singapore's total population was 4.1 million as at June 2001: 3.3 million residents and 0.8 million non-residents. While the population grew by 2.8 per cent in 2001, this was largely due to growth in non-residents which has been encouraged by the Government to increase the skilled and unskilled workforce. Over time, a high level of migration has led to an ethnically mixed population with 76.0 per cent being Chinese, 14.0 per cent Malay, and 7.7 per cent Indian (Statistics Singapore 2003; see also Lip 2002).[1] Many languages are spoken and many religions practised (Mehta 2001).

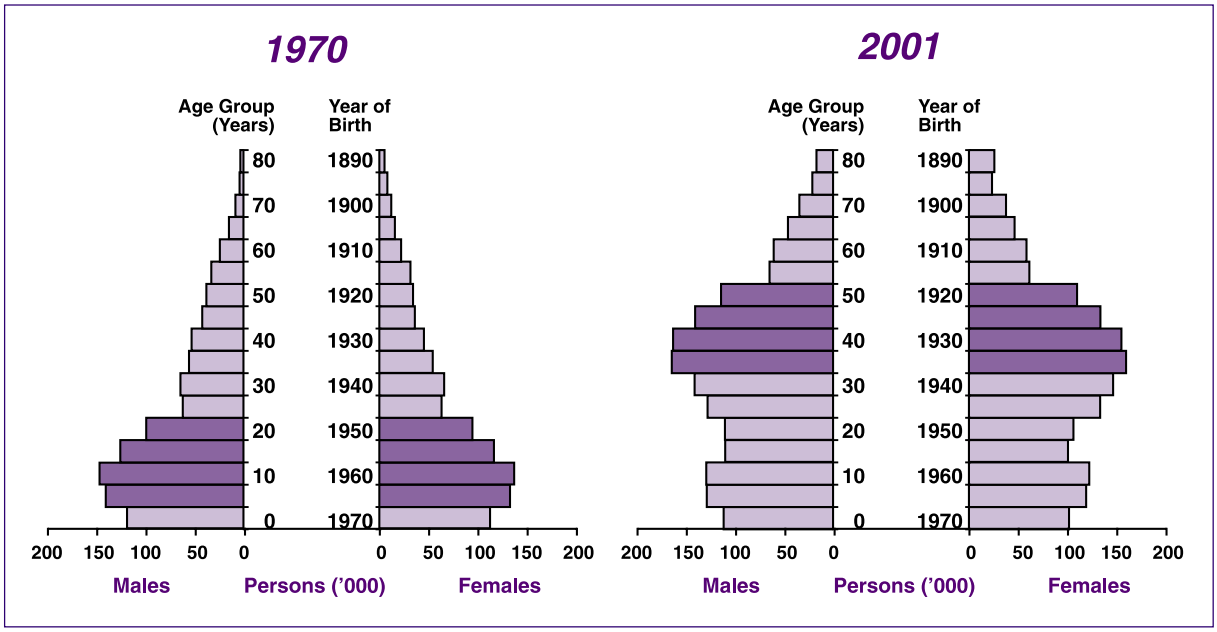
1 Unless otherwise indicated, the demographics section is based on information available on the Statistics Singapore Website at www.singstat.gov.sg

In comparison with the other countries discussed in this paper, Singapore's population is 'middle aged' rather than 'old' with the median age of the resident population in 2001 being 35 years, having risen from 20 years in 1970 (see Figure S 1). Even so, persons aged 65 and over have increased to 7.4 per cent of the resident population in 2001 (up from 6.0 per cent in 1990) and the elderly dependency rate has risen to ten per hundred working age residents.

The ageing of the population has also influenced marital status distribution. In 2001, 61 per cent of residents were married, compared with 57 per cent in 1990. While the overall share of singles in the population decreased from 36 per cent in 1990 to 31 per cent in 2001, the male:female ratio differed according to age group. At age 30-34 more males than females were single. However, because females tended to outlive males, more older females than males were widowed. Most of Singapore's elderly live with family members but 6.6 per cent lived alone in 2000.

In 2001, the total fertility rate was at an historic low of 1.41 children per woman, lower than the previous low of 1.43 in 1986. The fertility rate has been below the replacement level of 2.1 since 1997. Family size has become smaller with the average being 2.5 children in 2001 as compared with 2.8 in 1990. At the same time, the infant mortality rate had reached an historic low of 2.2 infant deaths per thousand resident live births in 2001, and life expectancy at birth and at aged 65 years had increased from 75.3 to 78.4 years and from 15.7 years to 17.2 years respectively between 1990 and 2001.

Figure S 1: Age pyramid of resident population



Source: Lip, 2002.

The old-old in Singapore

Based on data for 1999, Long and Lee (2002) note that Singapore's old-old lived through two world wars (including surviving the Japanese occupation) and experienced the struggles leading to Singapore's self-government. There are now some 16 000 old-old residents, those who are aged 85 and over, including 150 centenarians. They comprise just 0.5 per cent of the population but the increase in the old-old has been far more rapid than the increase in the overall elderly population with males joining their ranks at a faster rate than females (growth of 6.4 and 5.7 per cent between 1990 and 1999 respectively). By 2020 the number of old-old is projected to be double that in 1999.

Of the old-old, the majority are widowed females with relatively little education who came to Singapore as migrants. Mostly they live in 'reasonably comfortable' homes with other family members, but 8.0 per cent live alone.

Evolution of long term care in Singapore

Singapore's strategies for coping with the increasing number of elderly citizens build on the Central Provident Fund (CPF) which was set up in 1950 as a universal, compulsory savings scheme designed to provide for workers in their retirement.

A Public Assistance scheme was developed to complement the CPF by providing for destitute, frail and disabled elderly citizens. Later approaches to financing health and long term care were developed within this overall old age security system (Hong 2001). Table S 1 summarises the various arrangements that enable the funding of long term care.

Policy development looked to reinforce self-provision, the care of the elderly within the family and greater involvement of Voluntary Welfare Organisations (VWO)[2] in providing services for the elderly.

Almost 20 years ago Singapore realised that more would need to be done to cope with the impact ageing would have on the society. The Government set up an Inter-Ministerial Population Committee in 1984, the first of a continuing series of committees responsible for developing policies to meet the challenges of a rapidly ageing population.

2 A Voluntary Welfare Organisation: is voluntarily set-up and governed by an elected volunteer board; is non-profit making; promotes and provides social and community services in financial, emotional, educational, health and social aid and support; caters for those in need, distress or at-risk and helps the disadvantaged and disabled to be independent; is driven by a strong spirit of volunteerism and works with volunteers, government authorities, public and private organisations and the community. VWOs must be registered with the Registry of Societies. All VWOs are charitable organisations: provided they spend 80 per cent of their income (including donations) on 'charitable works', they are exempted from tax. Through the National Council of Social Service (NCOSS) they may also receive tax deductible donations (NCOSS 2002).

The current Inter-Ministerial Committee is chaired by the Minister for National Development and includes the Minister for Community Development and Sports and the Minister of State for Health, together with representatives from ministries, statutory boards and non-government agencies. This cross-sector representation has been a standard feature of the Singapore government's problem solving approach, one which has been accompanied by wide public discussion of the issues (Hong 2001; IMC 2002).

Table S 1: Health and long term care financing in Singapore

Compulsory national employee savings schemes	**Central Provident Fund** — a universal, compulsory savings scheme designed to provide for workers in their retirement **Medisave** — operates under the Central Provident Fund — helps meet the cost of hospitalisation, day surgery and some outpatient expenses for the worker and his/her immediate family — employee's plus employer's contributions — contributions are: capped in keeping with level of income, tax free, earn interest and remain part of an individual's estate
Health and long term care insurance schemes	**MediShield** — operates under the Central Provident Fund — catastrophic illness insurance to help meet medical expenses from major or prolonged illness that member's Medisave savings are not sufficient to cover **ElderShield** — managed by two contracted private insurance companies — designed to assist with expenses associated with severe disability **Private Insurance** — Medishield and Medisave members may choose a Medisave approved medical insurance scheme offered by private insurers
National endowment funds	**Medifund** — Capital remains untouched — Interest used to cover costs of poor patients in public hospitals **ElderCare fund** — Capital remains untouched — Contributes to Government's operating subsidies for VWO nursing homes; will be extended to subsidies for private nursing homes and other step-down care services as interest increases
Consumer co-payments and/or gap payments	Apply to all health, nursing home and other step down services, and to community-based eldercare services

Source: Summary based on sources cited in this section.

Among the recommendations of the National Advisory Council on the Aged set up in 1988 were proposals to assess the feasibility of providing health and medical services for the frail elderly in their own homes, and to make nursing homes more viable. To address the shortage and high cost of land in Singapore, land was made available to voluntary organisations so that they could afford to set up homes for older people. Subsequent initiatives included the provision of housing-related incentives to increase the proportion of elderly people living with family and the introduction of the *Maintenance of Parents Act 1994*. This Act aims to prevent elder abuse and poses a legal obligation on children to look after their parents (Hong 2001; Lee 1999).

The three Ms: Medisave, MediShield and Medifund

In April 1984, to help Singaporeans save for paying their health and medical expenses, the Government introduced medical savings accounts under the national medical savings scheme, *Medisave*. Medisave helps meet the cost of hospitalisation, day surgery and some outpatient expenses for the worker and his/her immediate family – older women in particular are dependent on their children's Medisave accounts.

Under Medisave every person in the paid workforce is required by law to contribute six to eight per cent of his/her income to a personal, but government managed, savings account. Employer's contributions are added (Ham 2001; Mehta 2001). Contributions are capped in keeping with level of income. They are tax free, earn interest and remain part of an individual's estate after death. (Ministry of Health 2003a; Barr 2001). Even with a Medisave account, all patients are still responsible for a sizeable portion of costs directly out-of-pocket (Hsiao 2001).

Medisave has been augmented by MediShield and Medifund. Medisave and MediShield operate within the broader compulsory savings scheme, the Central Provident Fund. Medifund operates separately.

MediShield was introduced in 1990 to facilitate a low cost catastrophic illness insurance scheme. Upgraded versions, MediShield Plus A and B were introduced in 1994. Run by the Central Provident Fund, this insurance is designed to help members meet the medical expenses flowing from major or prolonged illness that their Medisave savings would not be sufficient to cover. Even so, patients may still have to cover out of pocket some part of the cost. People aged seventy and over are excluded from MediShield (Ministry of Health 2003a; Hsiao 2001).

Apart from MediShield, Medisave members may choose a Medisave approved medical insurance scheme offered by private insurers. These include NTUC (the National Trade Union

Congress) and Great Eastern, the two companies contracted to provide long-term care insurance under ElderShield (see below).

Medifund, a national endowment fund, was established in 1993 to help the very poor pay their medical expenses. The capital from this fund remains untouched while the interest is used to provide a safety net scheme to cover the costs of poor patients in public hospitals. In 2002, accrued capital was S$800 million.

Providing for long term care

Comparable to Medifund, a new national endowment fund, the *ElderCare Fund,* was established in March 2000, under the *Medical and Elderly Care Endowment Schemes Act 2000.* The ElderCare Fund aims to 'help secure the future affordability of nursing home care for households of low- and lower-middle income'. An initial capital injection of S$200 million has been increased to S$1 billion through top-ups from the Central Provident Fund and Budget surpluses. The goal is to reach a capital sum of S$2.5 billion by 2010. In the short term, interest from the ElderCare Fund contributes to funding operating subsidies for VWO nursing homes. In the longer term, it is planned to extend to use of the interest to fund subsidies for other step-down care services such as community hospitals, hospices and community based services such as day rehabilitation, and home medical and home nursing (MOH 2000b; Perspective 2001; Ministry of Finance 2002; MOH 2003a; MOH 2003c).

The need for setting up such an endowment fund was summed up by the Ministry of Health as follows:

> …an ageing population means a shrinking tax base where a smaller working population will find it harder to pay for health care subsidies consumed by a larger retired population. In an increasingly globalised economy, countries will find it more and more difficult to raise taxes, and it would be difficult to preserve our economic competitiveness if we continually rely on taxpayers to pay for the subsidies to our nursing homes. By anticipating future needs and putting aside funds now while we can still afford it, our subsidies to the elderly future (sic) can be secured upon a more robust financial footing (MOH 2000b).

The most recent component of the financing framework is *ElderShield*. Introduced in 2001, ElderShield is designed to assist with expenses associated with severe disability. For the purposes of ElderShield, disability is regarded as inability to perform three or more Activities of Daily Living (ADLs): mobility, feeding, dressing, bathing, toileting and transferring – the ability to move between a bed and a chair or wheelchair (MOH 2003a; MOH 2003e).

All Medisave account holders who reach age 40 years automatically become part of ElderShield unless they opt out.

The premiums for ElderShield may be paid with the funds from an individual's MediSave account or the account of a family member – this can be through an automatic deduction by the insurance company (Barr 2001; Ministry of Health 2003b; Great Eastern Life 2003). Premiums (based on the age at which the policy holder joins) are payable to age 65 but the policy holder is covered for life. They are higher for women on the grounds that they have higher claims risk due to longer life (MOH 2003e).

While ElderShield provides lifetime coverage, claims are strictly capped and must not exceed (in total over time) 60 months. Cash benefits up to S$300 per month (paid monthly) may be used to pay for nursing home care, home care, day rehabilitation, or other expenses associated with care in the home including medical bills or household expenses (MOH 2003a; Great Eastern Life 2003; NTUC 2002; MOH 2003e).

People not eligible to take out ElderShield insurance (disabled or aged 70+ before 30 September 2002), are covered by the fully Government funded Interim Disability Assistance Programme for the Elderly. Eligibility for benefits is the same as for ElderShield, but means tested and with benefits limited to S$150 per month or S$100 per month up to 60 months (MOH 2003a; MOH 2003e).

Although Government sponsored, the provision of insurance under ElderShield has been contracted out to two major insurance companies: NTUC Income, and Great Eastern Life which claims to be the largest insurer in South-east Asia with an asset base of S$26.9 billion (Great Eastern Life 2003; NTUC 2002). Under this arrangement, NTUC and Great Eastern are committed to freezing premiums for the first five years, after which premium adjustments are subject to Ministry of Health approval and must not be more than 20 per cent of the previous premiums (MOH 2003e; Lim 2002). NTUC Income has also been engaged by the Government to administer the Interim Disability Assistance Programme (IDAPE) for the Elderly (MOH 2003e).

Hong concludes that despite Singapore's consistent and integrated planning over the last 50 years since the CPF was introduced, the present generation of the elderly still lacks financial security:

> … it has been estimated that, of those reaching age 60 in 2000, one in five men and one in three women have no CPF coverage, while about one in four of those who are covered will not have a balance sufficient to provide adequate retirement income. Further, there are still sections of the workforce that are not covered by the formal systems, and these include the self-employed, family employers, casual workers, and others who work outside of permanent employment (Hong 2001; see also Lee 1999).

Policy development

Following a broad audit of policies and programs concerning ageing matters and older people, the Inter-Ministerial Committee on the Ageing Population recommended in March 1999 that six IMC Working Groups report in detail on policy issues. The Working Groups covered: the social integration of the elderly; health care; housing and land use policies; employment and employability; financial security; and cohesion and conflict in an ageing society.

The Working Group on Health Care took into account the work of the Inter-Ministerial Committee on Health Care for the Elderly which had considered the adequacy of policies and strategies for the provision of health care for the elderly, and the affordability of long term care. The Working Group recommended:

- setting up integrated multi-service centres
- care management services for elderly people with multiple needs
- that service providers be allowed some flexibility in service delivery to achieve higher efficiency
- that support services for informal carers should be more easily available (IMC 1999).

It also recommended that the roles of the VWOs and the private sector should be better defined and their services improved. Strategies for bringing this about included:

- VWOs should provide services for the poor and lower income groups
- VWOs should strengthen their management and service delivery capacities through better costing, accounting and management information systems, and co-location and the pooling of resources for common needs and services
- VWOs should be networked in clusters so that the expertise of experienced personnel is more widely available
- private sector operators should provide services for the middle an high income groups.

The Working Group also found that while health and social services policies would be central to meeting the needs of the elderly, coordination and integration across these policies and with such areas as housing, land use, transportation, town planning, employment and financing would also be critical. It recommended that:

> …land should be zoned for health care purposes and commercial operators allowed to tender and develop nursing homes and other facilities. In order to remove the uncertainties inhibiting such investments and the upgrading of facilities, extended tenancy and lease terms should be given. Also, the WG recommends that

> Government develop nursing homes and lease them out to private operators. Similar incentives could also be given to co-operatives to enter this sector (IMC 1999).

In April 2001, the Ministry for Community Development and Sports launched a Five-Year Eldercare Master Plan (2001-2005) with funding of S$93 million. The plan proposed a comprehensive network of community-based support services and programs to enable people to continue to live in the community and to support families in caring for their elderly members (Mah Bow Tan 2001b; Mathi 2001).

The ElderCare Master Plan also aims to reduce disincentives for VWOs to raise their 50 per cent share of funding for community services. In the past, if a VWO raised more than 50 per cent of its operational costs, the Ministry would reduce its contribution (Mathi 2001).

Policy positioning within government

Two Ministers have major responsibilities relating to long-term care – the Minister of State for Health and the Environment, and the Minister of State for Community Development and Sports. Both Ministers participate in the Inter-Ministerial Committee on the Ageing Population which is chaired by the Minister for National Development.

Residential care for the aged broadly comprises nursing homes and sheltered community homes (equivalent to hostels in Australia). Nursing homes come under the purview of the Ministry of Health while sheltered homes are the responsibility of the Ministry of Community Development and Sports (MOH 2003f).

The Ministers of Manpower and Transport also have responsibilities that contribute to the health and well-being of the elderly.

In the Ministry of Health, the Division of the Elderly and Continuing Care oversees the provision of health care services for the elderly, the disbursement of funding to VWOs, and is in charge of continuing care services for the terminally and chronically mentally ill. The Division is responsible to the Director of Medical Services (MOH 2001; MOH 2003).

In the Ministry for Community Development and Sport, the Elderly Development Division leads in formulating and driving the implementation of the Government's response to the challenges of an ageing population. The Division serves as the Secretariat to the Inter-Ministerial Committee on the Ageing Population. It develops, monitors and reviews community-based programs and residential (non-nursing) care services for the elderly. It also regulates sheltered homes for the aged (MCDS 2003).

Arrangements for long term care

While Singapore is acutely aware of planning for the impact of the ageing population, there appears to be no overall national policy statement on long term care for the aged. Policies focus on eldercare services in the community and on health care (including long term nursing home care).

The Five-Year Eldercare Master Plan announced by the Ministry of Community Development and Sports in January 2001 set out some broad directions largely for elder care services in the community (Tarmugi 2001; IMC 2001; Mehta 2001). The IMC Working Group paper on the Social Integration on Ageing Population also provides a framework that would foster an integrated approach to elder care. It states that:

> We want to foster a society where older people are valued as contributing members and are actively engaged in society. We also want to ensure that older people are supported by a strong network of services that aids their integration into their families and communities (IMC 1999).

The Working Group sees as critical to achieving these outcomes the integrated development of:

- heartware – shaping individual and society attitudes towards ageing and the elderly
- software – developing social infrastructure and program provision that meet the needs not just of the frail and/or low income families but those of the over 93 per cent of Singaporeans who are reasonably fit, independent and capable of contributing to society
- hardware – developing the built environment, housing infrastructure and transport system so that the elderly can remain in the community and have relatively easy access to developmental activities and supportive services. This includes siting elder care services in co-located facilities and in close proximity to the homes of the elderly.

The principles for eldercare services that may be drawn from the Working Group's paper include:

- shifting mindsets from seeing older people as 'contributors' not just 'receivers'
- elderly people remaining as integral members of strong and caring families supported by a network of eldercare services – which requires integrated development of policies, regulation, planning and implementation
- putting in place a seamless service delivery system and enabling consumers to make more informed choices about their service needs

- improving gatekeeper arrangements to guard against over-consumption of services (eg, through case management)
- recognising the care-giving roles of family members (eg, through augmenting domiciliary support services and providing incentives for family care)
- reorienting services to cater for all who need services, regardless of income (eg through reviewing subsidy policies)
- encouraging commercial providers to play a larger role in providing services, catering for the paying market at affordable prices. Middle class Singaporeans in particular have found difficulty in accessing services. They are morally bound to provide for ageing parents and often cannot afford the costs of private services but are ineligible for subsidised services (IMC 1999; Mehta 2001).

Nursing home care

The Minister of State for Health and the Environment has summed up the Singaporean approach to the provision of health services for the elderly (including nursing home care) as follows:

> My Ministry has taken a multi-sectoral approach in meeting these challenges, working with other Ministries, agencies and voluntary and private organisations. Our aim is to provide good and affordable care to the elderly for the whole continuum of health care, from promotive and preventive programmes, such as health screening, to primary and acute institutional care, and long term care. …
>
> New approaches to long term care of the elderly involve a shift from institutional models to those based in the community with supportive services such as day centres and home care. …
>
> Nursing homes help to free some of the beds in acute hospitals by accommodating the elderly who require primarily nursing care. With the increasing number of elderly in Singapore, we have to ensure that there are adequate residential facilities to meet the needs of those who genuinely require long-term institutional nursing care (Sadasivan 2002).

Nursing homes provide care for people who require regular nursing care and/or assistance with activities in daily living, and who are not able to be cared for in their own homes. Nursing homes are run either by voluntary welfare organisations or by private nursing home operators. In 2002 there were 50 nursing homes in Singapore with about 6 200 beds and it is estimated that a further 3 500 beds will be needed by 2010 (MOH 2000a; Sadasivan 2002). All nursing homes are required to be licensed and accredited under the *Private Hospitals and Medical Clinics Act 2000* (MOH 2001). Some homes provide dementia care; others provide respite care or care for the mentally ill (MOH 2003c).

The Ministry of Health has recently articulated a two-tier nursing home policy. The VWOs should cater for lower income groups providing them with basic nursing care, and private providers will be encouraged to cater for the needs of those who can pay for more comfortable services. Government incentives to providers are premised on this division of client groups. Currently, only 25 per cent of nursing home beds are provided by the private sector. The aim is to achieve a ratio of 60 per cent VWO: 40 per cent Private. VWOs may take private patients but not more than ten per cent of their total patients. From 1 April 2003, private providers may apply for a subsidy to provide care for a small number of less affluent patients (see further below). Hence, the Government as purchaser of subsidised nursing care will purchase care from private providers or VWOs as long as the operator is willing to provide care of appropriate standard and at the price offered (MOH 2000a; Sadasivan 2002; MOH 2003f).

Voluntary Welfare Organisation Nursing Homes

In 2002, half of the homes were run by VWOs, including four new homes which made available 900 more beds. A further three new VWO homes were expected to be operational within two years. Overall, VWOs provide around two thirds of nursing home beds. The government is committed to assisting the VWOs to increase nursing home capacity for severely disabled lower income people with an expectation that they will cater for up to 60 per cent of the 2010 national requirement (Sadasivan 2002; MOH 2000a).

Placement of the elderly in VWOs is managed by the Integrated Care Services (ICS) following an application by a doctor, health worker or medical social worker. Applications may not be made direct to a nursing home. To be eligible for nursing home care the elderly 'must be semi-ambulant, wheel-chair bound or bed bound' or have a medical condition that requires nursing (eg, stroke, diabetes mellitus with complications, head or spinal injury).

In accordance with the principle of user pays, VWOs receive fees from patients who pay according to their means. In the future, this may include drawing on their Eldershield insurance. Those with very low incomes or on public assistance receive Government subsidies towards the cost of care ranging from 50 per cent to 75 per cent. Following a recommendation by the Inter-Ministerial Committee on the Ageing Population a new level of subsidy (25 per cent) was introduced in July 2000 for the highest income earners in the low-income target group which will result in higher Government funding for VWOs (see Table S 2). Government subsidies are in part paid from the interest from the Eldercare Fund and in the future it is intended that they should be fully paid from this source. They are paid direct to the VWO provider as a recurrent operational grant.[3]

3 Means tested subsidies are available for care in all Government funded institutions (MOH 2003c).

Table S 2: Levels of Government subsidies to low-income residents

Per Capita Family Income	Subsidy Level
S$0 – $300 (including Public Assistance patients)	75%
S$301 – $700	50%
S$701 – $1,000	25%
Above $1,000	0%

Source: Ministry of Health, 2003f.

Access to these subsidies (and hence to VWO nursing care) is means tested. Assessments conducted by the VWOs take into account the income of the immediate family, and the number of people dependent on the income and the person's assets. People with private property are not likely to receive a subsidy and the income for those with a spare room in their public housing flat will be deemed to include imputed rental (MOH 2000a; MOH 2003c).

However, currently set-up costs are largely provided by the Government and VWOs receive other subsidies towards operating costs:

- *capital grant* – financial support of up to S$40 000 per nursing home bed is given to VWOs for the capital expenditure of setting up health care facilities, in either purpose-built or renovated premises
- *pre-operating grant* – a one-off grant to help VWOs set up new health care services during start-up
- *recurrent grant: rental* – 100 per cent rental subvention during construction and when in operation given to VWOs occupying state land or government buildings; the amount is pegged to percentage of subsidised residents/patients
- *cyclical maintenance grant* – up to 90 per cent of the cost for repairs and maintenance of VWO premises will be paid generally after every five years (MOH 2003c; MOH 2003f).

Eight new VWO homes have been completed in the past three years. The Ministry has decided that no further new ones will be built with the likely phasing out of access to capital funding (MOH 2003f).

Private Nursing Homes

Private organisations operate the balance of the nursing homes largely for Singaporeans who are capable of paying for more comfortable surroundings. Two new homes with around 300 beds were being built in 2002 and at least two more were in planning stages (MOH 2000a). Most private providers have small operations, running one home with less than 200 beds. They claim to have limited access to capital. Only one operator, Econ Healthcare Ltd is public listed: it runs five homes with 553 beds (MOH 2003f; Phillip Securities Research 2002).

As noted above, the Government had identified a range of problems impeding the expansion of private nursing homes, in particular the availability and cost of land. As there was no land zoning for private nursing home development, operators have been utilising private residential land or commercial properties or leased vacant government premises on short-term leases. Hence, they have been reluctant to invest in improving the facilities. To help remove these disincentives, the Ministry of Health will help existing operators using leased buildings to secure longer tenancy and tag new sites for tender by private operators to develop purpose-built nursing homes (MOH 2000a). It was envisaged that most of these sites would be in or near Housing Development Board towns (MOH 2001). Five sites have been tendered out and it is expected that about 1 250 new private beds will be operational within three years (MOH 2003f).

From 1 April 2003, Government subsidies will be extended to private nursing home patients whose per capita family income is less than S$1 000 per month (see Box S 1). The Ministry's objectives in extending the subsidies to private nursing homes are

Box S 1: Extension of subsidies for Singaporean private nursing home patients

Under the new scheme:

- Private nursing homes may apply to be approved providers of nursing home and home care (home medical and home nursing care) services. To be an approved provider, private nursing homes must meet requirements on the:
  - — Adequacy and standards of their physical facility, staff and services; and
  - — Availability of medical and other support services (eg, physiotherapy, special diets).
- Eligibility for the subsidy will be means tested against the same subsidy framework used for VWO patients: 75 per cent, 50 per cent and 25 per cent, with the highest subsidy being given to those with the least ability to pay. This is to ensure objective and equitable distribution of subsidy according to patients' family income.
- To ensure that private providers do not over-charge their patients, the Ministry has established the norm cost for services (see below), based on the cost of basic services, and will impose a revenue cap on fees of subsidised patients. The norm cost comprises operational and fixed (capital) costs.

Category III	S$36 per day	Home medical	S$120 per visit
Category IV	S$50 per day	Home nursing	S$55 per visit

- As with public hospitals, approved providers' revenue from subsidised patients will be capped, to ensure that private nursing homes do not over-charge subsidised patients and that Government subsidies are passed on to these patients. This means that if the total revenue, comprising patients' charges and subsidy from the Government, collected from subsidised patients is greater than the aggregated norm cost, the excess will be returned to the Ministry.

Source: Ministry of Health, 2003f.

to help 'level the playing field' between the VWO and private sectors, and to provide incentives to raise the standard of nursing home care and bring down the cost of services, while offering greater choices for patients. In addition, an imputed land and building cost will be included in the subsidy to assist operators to better maintain and improve their facilities (MOH 2003f).

Residential nursing home care is regarded as part of a broader group of 'step-down' health care services for the elderly:

- community hospitals providing intermediate health care and rehabilitation for the convalescent for up to three months
  - — patients may be discharged to a nursing home
  - — Medisave benefits may be used towards fees in approved facilities; government subsidies are available for low-income families
- day rehabilitation centres (including senior citizens health care centres and multi-service centres) to assist the elderly regain functional capabilities following, for example stroke or fracture
  - — Medisave benefits may be used towards fees in approved facilities; government subsidies are available for low-income families
- dementia day care centres providing care for people with dementia (following diagnosis by a physician) and respite for their carers
- home medical and nursing services. Home medical services are provided by general practitioners and VWOs with VWOs generally servicing clients who need long-term and repeated medical care but who face great difficulty leaving their homes. Nursing services include wound dressing, injections, stoma care, checking blood pressure and other procedures
- in-patient, day or home hospice care providing palliative care and respite for family carers. Home hospice care is backed up by 24-hour medical and nursing coverage for advice, and home visits during crises.
  - — Medisave benefits may be used towards fees in approved facilities; government subsidies are available for low-income families.

Step-down care is designed for people discharged from hospital but requiring further treatment or care in a residential facility or through a service in or near their home. Patients may also enter step-down care when needed without being hospitalised. For low income families, subsidies the same as those for nursing homes are available with the subsidy going direct to the service provider to help offset the bill. Step-down services (including nursing homes) are organised into three geographical zones around an acute regional hospital with a geriatric department providing leadership in step-down care (MOH 2001; MOH 2003c).

Currently, Government subsidies for step-down care are paid directly out of the Government's annual budget. The aim is to have operating subsidies fully financed by the interest income generated from the Eldercare Fund (MOH 2003f).

Community-based Eldercare Services

In addition to the step-down services funded by the Ministry of Health, a range of other services have been put in place to allow the frail elderly to continue to live in a familiar environment with their loved ones. They also provide support to the family and caregivers in caring for their elderly members. Services include:

- Day Care Centres for Senior Citizens: these offer help for the frail elderly while their family members are at work. The centres run activities such as maintenance exercises, social and recreational activities to keep the elderly meaningfully occupied. These may be planned as part of congregate housing developments and located on the void deck of the facilities.
- Home Help Service: provides supports to the frail elderly in their own homes by providing a range of services that include meal delivery, laundry service, housekeeping, help in personal care hygiene, help in running simple errands, transport and escort service to hospitals and clinics.
- Counselling on family relationships, psychological and emotional problems, as well as information and referral assistance to the elderly and their caregivers.
- Sheltered Homes licensed under *The Homes for the Aged Act* (Cap 126A): cater primarily for the accommodation needs of the destitute aged and low-income elderly persons who are unable to live with their family because of breakdown in relationships. They do not provide nursing/medical care (MCDS 2003).

For active elderly who need social contacts to keep them active and integrated in the community, there are other avenues, programs and activities such as the Mutual Help Scheme, Senior Citizens' Club, Seniors Activity Centres/Neighbourhood Links, Befriender Service and the Active Seniors Program (MCDS 2003).

Issues

The following issues have been raised by researchers and commentators, or identified by the Government for future consideration:

- The undersupply of long-term accommodation: there is a need to increase the supply of nursing home beds and to decrease waiting lists for sheltered homes and nursing homes. Waiting times are causing high levels of stress within families (Sadasivan 2002; Mehta 2001).

- Medisave, MediShield and ElderShield provide strictly limited entitlements over a lifetime. Many Singaporeans fail to recognise that they need to use Medisave and ElderShield sparingly if they are still to have entitlements in their 'accounts' over the long term (Mehta 2001).
  - ElderShield which was designed to provide for long-term disablement, provides a maximum of S$300 per month for a maximum period of five years. Beyond five years, families must cover all costs including by drawing where possible on other savings or insurance sources.
  - The capping of Medisave accounts means that they are not likely to be sufficient for the expenses incurred by elderly people with chronic diseases or in need of surgery. Further, allowing individuals to withdraw a portion of their savings at age fifty-five further reduces their capacity to cover costs (Hsiao 2001).
- Case-mix funding is being introduced to public sector hospitals adopting the Australian classification system (AN-DRG). There is a continuing problem with acute beds being occupied by patients who no longer need acute care but for whom alternative accommodation is not available. Case mix is being promoted as an incentive for better planning for the continuing care of such patients (MOH 2003d).
- The availability of home medical and home nursing care and other supporting services are seen as a pre-requisite for elderly people continuing to live in the community. The Minister for Health has acknowledged that the availability of such services needs building up substantially; and there is a need for more training for home carers (Lim Hng Kian 2001; Mehta 2001).
- Despite the wide scope of policy initiatives, services have been characterised by fragmentation impeding accessibility both within community services and between health and community services. This has been recognised by the Five Year ElderCare MasterPlan developed by the Ministry for Community Development and Sports. An objective of the Plan is the development of Multi-Service Centres where all community services will be available under one roof, but with the extension of services into the community through Neighbourhood Links. Such centres will also have the advantage of more economical land use (IMC 2001; Mehta 2001; Mathi 2001).
- An adequate supply of health care staff for the elderly continues to be a challenge. New training courses have been introduced aimed at upgrading the skills of nursing aides from non-traditional sources in nursing homes (Mah Bow Tan 2001b).

- Women (wives, daughters, sisters, and daughter-in-laws) provide the majority of care for the older generation often to the detriment of their capacity to provide for themselves as they get older.
  - — Savings are expected to be used for the care of family members (not just the individual). For example, a single woman may spend a large part of her (finite) Medisave entitlements on her parents leaving little to cover her needs in future years (Mehta 2001).
  - — Eldershield premiums for women are expected to be 28 to 41 per cent higher because they live longer.
  - — There are no 'appreciation' payments for family members who provide care as there are in Germany or Australia.
- There is a shortage of Home Help service providers. A relatively new program, few organisations have undertaken to offer it, and in general female Singaporeans prefer office or factory jobs to housework. The recent economic downturn has made such work more attractive. Some families employ foreign maids to provide care and in such cases language barriers may impede the quality of care (Mehta 2001).
- Consumers have identified a need for greater ethnic sensitivity. Singapore is a multi-racial country with many languages and religions. The Government has developed comprehensive online information about services, consumer responsibilities and entitlements. However, the elderly do not necessarily have the language, skills or confidence to access this information and hence are unaware of the services available to them, for example, only nine per cent were aware of social day care centres (Mehta 2001).

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New Zealand

Communication, collaboration, co-operation

NEW ZEALAND

Communication, collaboration, co-operation

After a long period in which New Zealanders could expect a universal and comprehensive welfare system to provide support when needed throughout life, the 1990s brought a decade of change. Concern about slow economic growth and rising public debt saw the encouragement of a more market-oriented approach to social policy, and the introduction of a purchaser/provider split with a view to increasing competition between the public and private sectors.

By 1996, widespread public dissatisfaction with instability in the health and long term care system saw a shift in emphasis from competition and commercial profit objectives to principles of public service. The Labour Government, which came into power in 1999, continued this trend with greater emphasis being placed on 'communication, collaboration, and co-operation'.

Elected District Health Boards are now responsible for protecting, promoting and improving the health of a geographically defined population. Each funds, provides or ensures the provision of services for its population. Policy and funding responsibilities for aged care and disability support services which currently rest with the Ministry of Health will be devolved to the District Health Boards from 1 October 2003.

The aim is to ensure that the 'right services are provided at the right time in the right place by the right provider'. Older New Zealanders may access long term care through residential care in licensed resthomes, continuing care hospitals, or through a wide range of home based support services. These types of services have operated for some time however emphasis now is on 'an integrated continuum of care' with flexibility and the capacity to meet people's individual needs and preferences, while recognising that these may change over time. Many facilities are already enabling a continuum of care.

Financing of long term care is shared between the Government, residents and providers and the capital market. Around NZ$500 million per year of government funding is provided for some 19 000 state-subsidised residents in 894 homes for the elderly or retirement homes with care provided. A further 13 000 people pay their own costs of care. The Government has announced that it will progressively remove asset testing of older people in long-term residential care from 1 July 2005.

Demographics

The number of older people in New Zealand is growing both in numbers and as a percentage of the total population. At the end of March 2002 there were 457 000 people aged 65 and over living in New Zealand. By 2051, it is projected that there will be 1.18 million people aged 65 and over (26 per cent of the population), 708 000 (15 per cent) aged 75 and over, and 292 000 (5.3 per cent) aged 85 and over.

The most rapid growth over the period to 2051 will be in the number of people aged 85 which is projected to increase by 485 per cent compared with the population overall which is estimated to increase by only 20 per cent. It is this rapid growth in the number of very old people that will significantly change demand for health and long term care services but it is only one of the factors affecting demand (NZ Government 2002).

The older population

Because women have longer life expectancy than men, they make up the majority of the older population and their predominance increases with age. In March 2002, women accounted for 56 per cent of all those aged 65 and over varying from 52 per cent among 65-74 year olds, to 70 per cent among those aged 85 and over. The gender imbalance will lessen in future because males have made greater gains in longevity than females in the last two decades.

The older population is less ethnically diverse than the population aged under 65 however future cohorts of older people will have significant increases in Maori, Pacific and Asian peoples. The ethnic composition of the older population has been shaped by patterns of migration in past decades as well as ethnic differences in life expectancy. In all, 29 per cent of older people counted at the 2001 Census were born overseas (compared with 22 per cent of the population aged under 65):

- 93 per cent of people aged 65 and over affiliated with European ethnic groups
- Maori comprised 4 per cent (approximately 18 000 people) of those aged over 65: this is expected to rise to approximately 10 per cent by 2051
- 1.6 per cent identified as Pacific peoples, some 7 600 people which has doubled over the decade to 2001 and is expected to reach 11 per cent by 2051
- 3.3 per cent reported Asian ethnicity of which 93 per cent were born overseas.

In 2002, 18 people aged 65 and over were dependent upon every 100 people aged 15 to 64 years. By 2011, this dependency ratio

is expected to be 21 per 100, and rise rapidly thereafter to reach 38 per 100 in 2031. Over the next decade increased aged dependency will be partially offset by falling youth dependency. From 2011, however, rising dependency at the older ages will increase the overall dependency within the population. This ratio is then expected to rise from 50 to 67 per 100 by the year 2031. If only those people in the labour force are included in the population on whom the older population is potentially dependent, the ratio rises to 25 per 100 in 2011 and 45 per 100 in 2031 (NZ Government 2002).

Retirement income and superannuation

The cornerstone of New Zealand's retirement income policy has been the New Zealand Superannuation (NZS) scheme, funded from general revenue on a 'pay as you go' basis.

Over the decade from 1992, eligibility was raised from 60 to 65 years. NZS is neither income nor asset tested and all New Zealand residents aged 65 and over are eligible. Rates for most people are set at not less than 65 per cent of the average ordinary time weekly wage, adjusted annually in line with the Consumer Price Index. The National Government had reduced the rate for a married couple from 65 per cent to 60 per cent. However, the current Labour Government has taken it back to 65 per cent while making it clear that the state should not try to replicate in retirement the incomes people earned during working life.

At the same time the Government has put in place legislation to set up the New Zealand Superannuation Fund as a mechanism to accumulate sufficient savings to partially pre-fund future payments from the NZS. The Government considers that the fund will allow them to maintain the NZS level after the baby boomers retire and the numbers over 65 double. In the 2002 Budget, an initial contribution of NZ$600 million was made to the fund, with assumed transfers for the next three years of NZ$1.2 billion, NZ$1.8 billion and NZ$2.5 billion respectively. It is estimated that at 30 June 2006 the Fund will comprise NZ$8.9 billion or 6.3 per cent of GDP.

Despite these recent initiatives, debate about the most appropriate long-term arrangements for retirement income is inconclusive and continuing.

A large majority (76 per cent) of senior citizens owned their own homes at the time of the 2001 Census, a decrease since the 1996. Home ownership is regarded as a key source of personal and financial security and an asset to hand on to their children.

The proportion of people aged between 60 and 64 continuing to work has doubled between 1992 and 2002, with 55 per cent of

men and 21 per cent of women of this age in full time work. The number of people over 65 years who continue in paid employment has also doubled with 11 per cent of this group being employed in 2001. These increases are despite there still being some barriers discouraging older people from working (NZ Government 2002).

Evolution of the New Zealand long term care system

The 1990s saw a decade of change in the provision of health and aged care following a long period in which New Zealanders could expect a universal and comprehensive welfare system to provide support when needed throughout life. Concern about slow economic growth and rising public debt saw the encouragement of a more market oriented approach to social policy and moves to improve the efficiency and accountability of government funded services.

A more market oriented approach

In 1993, the Government introduced a purchaser/provider split and established four regional health authorities as regional purchasing agencies, with a view to increasing competition between the public and private sectors. By 1996, under these authorities most of the public funds for health, long-term care, and home support services were managed as a single funding stream. In view of widespread public dissatisfaction with instability in the health system, in 1996 the incoming coalition Government replaced the regional health authorities by a single funding agency, the Health Funding Authority, and emphasised that competition and commercial profit objectives would be replaced by principles of public service (Ashton 2000).

In December 1999, a new Labour-led coalition Government introduced further changes. Greater emphasis was placed on 'communication, collaboration, and co-operation' and the Health Funding Authority was replaced with elected District Health Boards from January 2000. District Health Boards are responsible for protecting, promoting and improving the health of a geographically defined population. Each funds, provides or ensures the provision of services for its population. In the 2002 Budget, the basis of funding was changed to provide a 'three-year health funding path' so that District Health Boards, together with the sector, can plan for service delivery in a more strategic way. Boards must keep within their indicative funding path (Ashton 2000; New Zealand Treasury 2002).

The three-year funding path will assist District Health Boards to develop an integrated continuum of care for older people. The

continuum of care approach aims to maintain close links between the health professionals individuals see initially, their families and carers, the specialists, the hospital, home support services, and rest home care (including respite care) which may follow. Two District Health Boards are leading the way in developing the continuum of care approach with other Boards to follow (Dyson 2002a; Dyson 2003b).

Asset testing was introduced in 1993. In the context of the last election, Labour undertook to introduce legislation to remove asset testing on those in long term care (Cullen 2002; see further below).

Towards an integrated continuum of care

The Associate Minister for Health summarised the Government's vision for health and support services for older people, a vision to be achieved through developing an integrated continuum of care focused on promoting positive ageing (see Box NZ 1).

Box NZ 1: Vision for health and support services for older New Zealanders

By 2010 the scene will look like this:

- Health promotion and disease prevention will be at the forefront of services.
- Older people will have access to a range of living options and support services to assist them to age positively.
- There will be well-developed specialist health services for older people.
- Older people with high needs will have access to timely and comprehensive assessment, and appropriate treatment, rehabilitation and support.
- Services will respond flexibly to the diverse needs of older people.
- There will be culturally appropriate services for the increasing numbers of older Maori and Pacific peoples, as well as for older people in other ethnic groups.
- Support services will work with caregivers to strengthen informal support and support networks.
- Older people will receive a range of services through a coordinated package of care.
- There will be smooth transition between services when an older person's needs change.

Source: Dyson, 2002a.

Specific actions to be undertaken by the Ministry of Health and District Health Boards over the next two years towards fully implementing these changes by 2010 include:

- advice on the removal of asset testing and the future funding of long-term care
- development of guidelines for comprehensive, multi-disciplinary needs assessment, treatment and rehabilitation of older people in a variety of settings
- a review of specialist health and mental health services for older people
- an assessment of the options for intermediate-level care between hospital treatment and home-based support
- development of an expanded role for primary health care, with a greater emphasis on health promotion and preventative care, the role of the community and the need to involve a range of professionals
- a report on the health workforce needs of the ageing population, including the community and home-based workforce
- development of specific standards for dementia units and for home-based rehabilitation and home support services
- development of District Health Boards' ability to implement the strategy.

From 2002-03 each District Health Board will include in its annual plan its broad approach to services for older people and milestones for implementing the Health for Older People Strategy. Plans are to be informed by consultations with the community, aged care providers and consumer groups, and an analysis of the district's health and support needs.

Policy positioning within government

The Minister for Health has overall responsibility for health and disability services for older people and for the 21 District Health Boards that purchase and/or provide health services for their local populations.

The Minister is assisted by four Associate Ministers each with Ministerial responsibilities relevant to the aged, including Health, Women's Affairs, Disability Issues, Social Services and Employment, Community and Voluntary Sector, Housing, Maori Affairs, Rural Affairs, and Immigration. In addition, the Minister for Senior Citizens has responsibility for advocating for older people in policy forums across the broad scope of positive ageing, health, retirement income, housing, security, transport and other issues. In doing so, the Minister takes into account the potential impacts of policy decisions on future generations of older people. Long term care for older people is funded from within Disability Support Services.

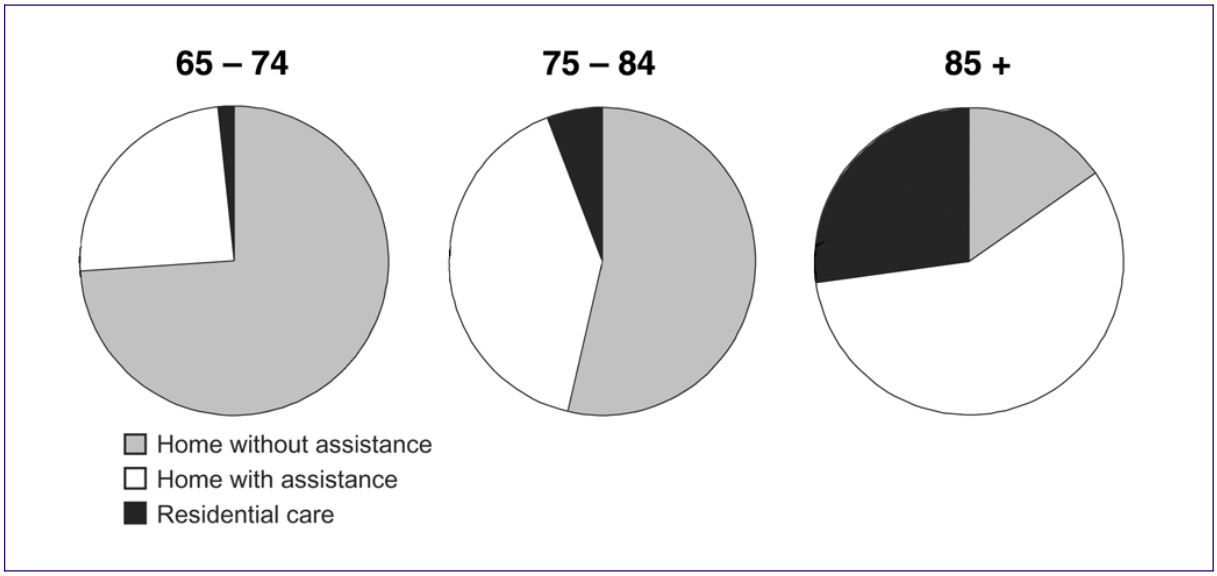
The Ministry of Health provides Ministers with strategic policy advice, manages the public health and disability system and is responsible for ensuring that the system works for New Zealanders. Policy and funding responsibility for aged care and disability support services currently resting with the Ministry of Health will be devolved to the District Health Boards from 1 October 2003, provided the Minister for Health and the Minister for Disability Issues are satisfied that each has developed the necessary capacity. This will increase their ability to provide a continuum of care for individuals as well as using residential care facilities in more flexible ways.

The Ministry of Social Development also plays a role in aged care services. It administers the 'income and asset' test that determines whether an individual has income and assets over the threshold that entitles the individual to subsidised care. The Ministry also places (and lifts) caveats over the homes of people who use the Residential Care Loans scheme, but the Ministry of Health administers the loans scheme (NZ Government 2002).

Arrangements for long term aged care

By far the majority of older New Zealanders prefer to remain in their own homes. In 2001, 74 per cent of people aged 65–74 were living at home without assistance, while 54 per cent of 75–84 year-olds also managed without assistance (see Figure NZ 1; Ministry of Health 2002a).

Figure NZ 1: Residential distribution of people aged 65 and over, by level of disability and age group, 2001



Note: Home with assistance includes people needing assistance or specialist equipment either daily or less frequently.
Source: Ministry of Health, 2002a.

Services: the 'right services provided at the right time in the right place by the right provider'

Of people aged 85 and over, 15 per cent were living at home without assistance and 57 per cent were living at home with assistance. People aged 85 and over were also more likely to be living in residential care than the other two age groups (27 per cent compared to 5.9 per cent of people aged 75–84 and 1.8 per cent of people aged 65–74).

Long term care for older New Zealanders is provided through residential care in licensed resthomes, continuing care hospitals, and home based support services. Other services available to older people include home-based support services, and palliative care. While these types of services have operated for some time, emphasis now is on 'an integrated continuum of care' with flexibility and the capacity to meet people's individual needs and preferences, recognising that these may change over time. The aim is to ensure that 'right services are provided at the right time in the right place by the right provider' (Dyson 2002b).

Recently, the Associate Minister for Health indicated that New Zealand seems to have 'a more-than-adequate supply of residential care beds', especially when compared with England where only one per cent of the population aged 65 to 74 is living in a nursing home or receiving long-stay hospital care. In New Zealand the equivalent figure in nearly five per cent. The Minister stressed that the point she was making:

> …is that there is no 'right' level of residential care services that should be available for a given population. It depends on a number of factors, not least being the availability of alternative support services. …
>
> Despite the popular desire to remain at home, the growth in the number of people in residential care has been in excess of the growth in the population turning 75 over the past 4-5 years – though it has slowed over the past few years. There will always be a place for residential care. But no one should be entering residential care simply because they have no other options (Dyson 2002a).

Residential care in resthomes and continuing care hospitals

In April 2003, around 31 000 people were living in long term residential care, equivalent to seven per cent of those aged 65 years and over. Around 19 000 people receive State subsidies. On average, residents are older and more frail than they were 15 years ago but their average stay is shorter (Dyson 2003a; Ministry of Health 2001b; NZ Government 2002).

Residential care provides a 24-hour comprehensive service for those who have been assessed by a needs assessment coordinator as needing it. Facilities providing residential care services must be licensed under the *Disabled Persons'*

Community Welfare Act 1975 or subsequent legislation. Care is available through resthomes, or through dementia and hospital beds. Hospital beds may be either in specific hospital-level facilities (subject to a higher level of regulation) or they may be a 'bed' in an aged care facility although resthomes are generally only permitted to have one 'hospital bed' per facility unless they operate as a hospital. Hospital level care is provided in resthomes as a transition either into or out of hospital (NZ Treasury 2003).

Close to 900 facilities offer residential care, either homes for the elderly or retirement homes with care provided. The facilities range from small, owner-operated homes and not-for-profit religious and welfare homes, to large, multi-site for-profit providers, including some that are listed on the stock exchange (ANZSIC 2002; Ministry of Health 2001a; Statistics New Zealand 2001; NBR 2001).

Home based support services and informal care provided by family and friends

Services include home help services (cooking, cleaning, etc), personal care services such as bathing and showering, and assistance such as wheelchairs and aids, appliances and equipment that enable the person to remain in their own home. Home help services are free for holders of a Community Services Card assessed as requiring that assistance, but people without a Card are expected to pay. Recipients of personal care services are not subject to financial means testing. Consideration is being given to removing inconsistencies in access.

Where someone is cared for full-time by a partner, family member or any other person, carer relief is available to give the caregiver a break from their caring responsibilities (NZ Government 2002).

Other community supports

A wide range of formal and informal community-based organisations also provide services and support. Some services are organised at a national level while others are local initiatives. Some work independently while other work cooperatively with clinical and professional services (NZ Government 2002).

The Ministry of Social Development and the Ministry of Health are assessing the comprehensiveness and integration of policies to assist older people to live at home as long as they would wish, with a view to identifying and addressing gaps. Older people who can afford it may purchase an increasing range of home support services from private providers.

While not regarded as part of the provision of long term care, related initiatives are the growth in retirement villages and the provision of palliative care.

- A growing number of older people are choosing to live in retirement villages. In 2000 there were 303 retirement villages in New Zealand, a 13 per cent increase since the previous survey two years earlier. It is estimated that 4.66 per cent of the over-65 population (21 000 people) live in retirement villages. Concerns about financial and tenure risks affecting residents have prompted the drafting of a Retirement Villages Bill and a Code of Residents' Rights (NZ Government 2002; Dalzeil 2002).

- In 2000 the Ministry of Health, after widespread consultation, released the New Zealand Palliative Care Strategy and provided additional funding of NZ$7.5 million nationally. Palliative care may be provided by hospices or through palliative care beds in continuing care hospitals. Work is in progress around the interface between long term care and palliative care (Ministry of Health 2001a).

As noted above, the Government is encouraging providers to provide an integrated continuum of care involving well-maintained links with the health professionals people are used to, their families and carers, any specialists involved, the hospital, community support services, and the rest home care (including respite) that may follow. Some providers are offering such integrated packages of services; for example, retirement village and residential care services together with home carer support, day stay options, respite care and meals-on-wheels (Dyson 2002b).

Access to care

To access care services, people must be assessed by a needs assessment service with the aim of 'putting the person in need of support services at the centre of the equation, assessing their needs (as defined by themselves and their family) on an individual basis, and actively securing the best possible package of services to meet those needs'.

Assessment procedures for residential care are designed to ensure services are directed to those for whom there is no alternative. Even so, until recently demand had increased at a greater rate than the growth in the target older population prompting more stringent controls on access criteria and increased use of home support options to help keep demand within target population levels (Dyson 2003b; NZ Government 2002).

Financing

Financing of long term care is shared between the Government, residents and providers and the capital market. Around NZ$500 million per year of government funding is provided for

some 19 000 state-subsidised residents in 894 homes for the elderly or retirement homes with care provided. A further 13 000 people pay their own costs of care.

Government

Disability support services funding for older people is subsumed within Vote: Health funding. Total health expenditure has risen from 5.2 per cent of GDP in 1989-90 to 6.4 per cent in 1999-2000 and is expected to be 6.8 per cent in 2004-05, following significant additional funding in the 2002 Budget. As a proportion of government spending it is forecast to have gone from 13.9 per cent to 21 per cent over the same period (NZ Treasury 2002).

Funding was increased in the 2002-03 Budget for Vote: Health by NZ$12.5 million and is forecast to increase to NZ$35.2 million in 2004-05. The Disability Support Services component for 2002-03 is NZ$1.4 billion which is broadly split as follows:

— residential care	57 per cent
— assessment, treatment and rehabilitation	11 per cent
— home/care giver/respite	16 per cent
— environmental support	5 per cent
— other	11 per cent

However, the Disability Support Services budget funds disability services for the entire population (older people and those with disability support needs aged under 65), including both residential care facilities and services provided in the community. Hence it is not clear what proportions are for aged care services alone.

The Government provides operating funding to resthomes through two mechanisms:

- *directly* through the residential care subsidy, which varies depending on the level of care being provided and the extent to which individuals are already contributing to their own costs of care. There has been ongoing debate in the sector as to whether the subsidy levels are sufficient
- *indirectly* through the provision of the Residential Care Loan Scheme, whereby the Government provides interest free loans to people entering residential care facilities who are either unable or unwilling to sell their family home to realise their assets to pay for the costs of their care. Once a person's estate is settled, these loans are required to be paid back, but there is currently a 10 per cent default rate on the loans, and there is an opportunity cost of the scheme to Government that needs to be recognised. Reverse mortgages and similar products have not proved popular with New Zealanders (NZ Treasury 2003; NZ Government 2002; St John 2002).

Operating funding for resthomes is further controlled by other regulatory and quasi-regulatory arrangements.

With very few exceptions the Government provides no capital funding for residential aged care. Occasionally, the Government might provide capital funding for an isolated rural area where the only provider of residential care services is the local District Health Board.

Residents

Currently, once an individual has been assessed as needing residential care, they are income and asset tested to determine whether they are eligible for a Government subsidy for the costs of their care. If assets exceed NZ$150 000, the person is expected to contribute to the cost of care until the assets are reduced to NZ$150 000. The level of subsidy depends on their income. Those residents who receive a Government subsidy forfeit their publicly provided superannuation (around NZ$20 000 per annum), and in return receive a small weekly allowance (around NZ$30 per week) and an annual clothing allowance (around NZ$200).

Resident charges are to cover the total cost of care: health and care-related services including meals, accommodation and access to basic nursing and medical care. Where there are any additional costs, these are covered by the Government according to an agreed contract price, except where a resident requests a more costly optional item for which they would pay the differential cost. If a client has chosen not to be assessed for their care needs then they are required to meet the total cost of their residential aged care (NZ Government 2002).

The Government has announced that it will progressively remove asset testing of older people in long-term residential care from 1 July 2005:

> From 1 July 2005, single people and couples with both partners in care will be able to keep up to $150,000 in assets (including both property and savings) before their assets are used to contribute to the cost of their care, up from $15,000 and $30,000 respectively. Couples where one partner is in care will retain their current exemptions of a house and car, while their cash asset exemption will rise from $45,000 to $55,000.
>
> The exemption thresholds for all groups will then increase by $10,000 a year, progressively removing asset testing (Dyson 2003a).

This decision was taken to remove discrimination against older people and in light of human rights considerations: '…asset testing is unfair. People aged 65 and over are required to use up their assets to contribute to the cost of their care, whereas younger people are not'. In consequence, by 2005 a further 5 600 will be eligible for the Government subsidy so that around 70 per cent of people in care will be subsidised (Dyson 2003a).

Some facilities charge residents for 'add-ons' which can include higher quality facilities, access to some of the activities and services provided by the rest home, and higher level medical interventions (including, for example, incontinence devices). The Ministry of Health has been looking at some of these charging practices within its quality audit framework.

Providers

Private providers are largely responsible for capital funding for aged residential care facilities, both not-for-profit providers (including religious and welfare groups) and 'corporate' providers including some companies listed on, and raising capital via, the share market and some non-listed companies.

There has been some consolidation in recent years, with several larger corporate providers becoming more dominant players in the market. Corporate providers rely on 'graduated' care arrangements to fund Government subsidised residential care facilities. They sell either a licence to occupy or the title to self-contained units within their facilities, and rely on the profits from these activities to cross-subsidise the 'resthome' facilities.

By contrast, the religious and welfare sectors and other smaller private providers have not followed this approach and are less able to fund the operating and depreciation costs of their facilities solely from the Government-provided subsidies. Some religious and welfare providers are selling out to private providers. However, other religious and welfare providers are purchasing more facilities. In part this tends to depend on location.

The four large corporate providers dominating the market are ElderCare, Metlifecare, Ryman Health Care Ltd and Calan Healthcare Properties Trust. Even so, the performance of these companies has fluctuated.

ElderCare New Zealand's core operating assets are hospitals, nursing homes and clinical rehabilitation facilities. For the six months to the end of November 2000, ElderCare reported a loss of NZ$6.73 million; and for the year ending 31 May 2001 a net loss of NZ$8.18 million. It sought more than NZ$10 million in new equity from current shareholders and institutional investors; another NZ$2 million through a placement of 12.12 million shares to Alliance Capital Management NZ; and issued a NZ$5 million capital convertible note. The new money was to reduce debt and support acquisitions in the medical and health care sector (NBR 2001). As at 31 May 2002, ElderCare operated 13 hospitals and resthomes in New Zealand (Wright Investor Service 2003; National Business Review 2002b).

Metlifecare operates 13 villages and care facilities all of which provide independent living facilities, seven provide nursing home beds and four include hospital care (Metlifecare 2003). As at 31 December 2000, Metlifecare had earned $474 000 (compared with $1.53 million in the previous year) and showed a profit of $7.2 million for the full 2001 year. The Company reported a record net surplus of $10.4 million for 2002, up 44 per cent on the 2001 result (NBR 2001 and 2002a; Metlifecare 2002 and 2003).

Ryman Health Care Ltd operates 13 integrated locations each with independent living units and resthome care, with hospital beds available at five locations (2002b). Net profit for 2000 was NZ$12.56 million; NZ$14.1 million for 2001. In its half-year report to 30 September 2002 Ryman reported net surplus after tax of NZ$7.6 million, a new record in any half-year period and up 68 per cent on the same period the previous year. Net assets had increased by 71 per cent from NZ$67 million to NZ$116 million since listing on the New Zealand Stock Exchange in June 1999 (NBR 2001; Ryman 2002a).

Calan Healthcare Properties Trust does not operate the facilities it owns. Rather, it purchases or purpose-builds and leases health care facilities to specialist operators. Currently it owns three continuing care facilities (Calan 2003).

The increasing dominance of larger private providers is seen by the sector as a whole as both positive and negative. In urban areas, increased competition is seen as helping to improve quality and safety while in smaller rural areas this competition could drive out small local providers.

Contracting

Residential care contracts

Contracting arrangements and prices have been under review and debate for some time. Over time, the Ministry has established contracts with each service provider for the delivery of services resulting in four separate service specifications and over 500 different prices for essentially the same service.

The Ministry is seeking to the four service specifications into one nationally consistent specification for residential aged care and to agree a new nationally consistent price structure.

A pricing study was undertaken in 2000. This was followed in 2001 by Ministry consultations about the desirability of shifting from individual contracts to payments under section 88 of the *NZ Public Health and Disability Act 2000*, and a proposal to move towards new indicative prices over a number of years. The proposed indicative prices were a variation of those suggested by the pricing study. The Ministry has stated that its aim is to:

> …pay 'efficient' prices for aged care residential services. Consequently, the Ministry has used assumptions which reflect this stance … the Ministry wants to get best value for money, as a major (indeed majority) purchaser. Balancing this, the Ministry has a vested interest in seeing a strong market for aged care residential services. The Ministry wants to see financially secure providers who are providing quality care in sufficient numbers that older people have *reasonable* choice of provider (Ministry of Health 2001b).

The 2002 Budget signalled the provision of some additional funding for resthomes and dementia care and the introduction of new contracts (not under section 88). Negotiations are continuing around future service specifications and any increase in prices. The industry has commissioned further work on costs to update the earlier pricing study.

From 1 October 2003 responsibility for residential aged care contracts will rest with District Health Boards together with responsibility for achieving greater national consistency in pricing. These contracts account for around 65 per cent of the NZ$700 million being transferred to the Boards. Current services will be protected through existing contracts, some of which continue for up to three years (Dyson 2003b).

Other services

At the behest of the Minister for Health, in 2002 the Ministry worked with home care service providers, peak bodies, and the District Health Boards to develop a new, more inclusive approach to contracting. Future contracting should be based on continuing partnerships to achieve:

- high quality, reliable and secure services
- a stable workforce with appropriate training
- monitoring provisions which include client satisfaction
- open and informed complaints procedures …
- cooperation between government agencies on [the] provision of services
- constructive partnerships and working relationships between all parties – the ministry, providers, clients and caregivers (Dyson 2003b).

Quality

Strategies to help ensure quality include initial assessment to determine needs and to match needs with appropriate services, and moving from a licensing and registration framework to certification (Dyson 2002d).

As noted above, access to residential care depends on assessment by a needs assessment service. The Associate Minister for Health recently acknowledged that, in practice, the needs assessment process has become increasingly unworkable.

Assessments have been inconsistent and the focus has shifted from the needs of the individual to use as a 'budget manager and rationing tool'. Hence she has directed that consideration be given to the development of evidence-based guidelines for needs assessment. The Associate Minister has also flagged other changes needed to improve assessment including: more funding in some areas; more trained staff; better integration of the roles of the various departments and agencies with related responsibilities; and ensuring that the right mix of services are available as the value of appropriate assessment is lost if there are no services to meet the needs identified (Dyson 2003b).

Certification was introduced under the *Health and Disability Services (Safety) Act 2001*. The purposes of the Act and related standards are to promote safe services with consistent standards and to improve the care for people in resthomes, hospitals and homes for people with disabilities. Before the new legislation was passed, health and disability services were either licensed or registered. Licensing and registration focused on such things as the building in which a service was provided with relatively limited focus on the quality of care.

Certification shifts the focus to the standard of care provided. It encourages providers to continually improve their services and to have those improvements acknowledged through certification. Requirements focus on safety, resident services and outcomes, and on continuing compliance with quality standards as determined by independent audit. Certification came into effect on 1 October 2002 and providers have two years to move from their current licence to certification. The first provider received certification (a rest home) in late November 2002 (Dyson 2002d).

Workforce

The *Health of Older People Strategy* recognises the need to strengthen the workforce to meet the needs of older people. Care givers (both nurses and the home care workforce) are seen as under valued, under paid and under trained: not surprisingly recruitment and retention rates are poor. District Health Boards offer nurses engaged in health services higher levels of pay than can be provided in the aged care sector.

In considering future employment, nursing students see the following issues as important: the availability of their preferred area of practice, the support provided for new graduates, remuneration, the location of the position, and support for continuing education. The Associate Minister for Health has requested that a report on workforce needs, and a plan for the future, be prepared by June 2004. Advice is being sought from the Department of Labour and Treasury 'on the best way to ensure that a qualification gain equates to a pay gain'. As an

interim measure, the Community Social Services Independent Training Organisation has been funded to develop a national training program for care givers, one that recognises the competencies needed in different care.

Initiatives relating to the home care workforce include the cooperative drafting of a 'Home and Community Sector Standard' under the *Health and Disability Services (Safety) Act.* It is intended to implement the standard within the next two years and to develop training modules and opportunities and settings for training (Ministry of Health 2002b; HWAC 2002; Dyson 2002b).

Issues

Cost

- There is ongoing debate about whether the current subsidy levels for individual beds are sufficient (Ministry of Health 2001b; NZ Treasury 2003).

Growth in private provision

- The sector sees the increasing dominance of larger private providers as both a negative and a positive. In urban areas, the increased competition is helping to improve quality and safety in the sector, while in smaller rural areas, the threat of this competition could drive smaller players out of business.

Workforce

- Care givers are seen as under valued, under paid and under trained: recruitment and retention rates are poor. The Minister for Health has requested that a report on workforce needs, and a plan for the future, be prepared by June 2004 (Dyson 2002b; SFWU 2001).

Quality

- Consideration is being given to the development of evidence-based guidelines for needs assessment. The process has become increasingly unworkable with inconsistent assessments and a focus on budget management and rationing, rather than the needs of the individual (Dyson 2002c).

Enduring power of attorney

- Enduring power of attorney (EPA) has been promoted in New Zealand as a way to protect the affairs of frail older people. Misuse of EPA has prompted the Law Commission to examine the actual protection provided and to propose amendments to Part IX of the *Protection of Personal and Property Rights Act 1988* (NZ Government 2002).

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Japan

‘Socialising’ long term care

JAPAN

'Socialising' long term care

The introduction of long term care insurance (LTCI) after ten years of debate and planning marks a radical shift in Japanese policy. It breaks with decades of social welfare programs limited largely to people on low incomes and/or without family support, by explicitly 'socialising' care and transferring much of the responsibility for care for the elderly from the children to society.

Before the introduction of LTCI, the Japanese social security system made no special provision for long term care. Families typically looked to the free services of family members to care for the elderly at home while the more frail and those with chronic illnesses often were admitted to long term care in hospitals. If no family carer was available, personal care services could be purchased from out-of-pocket expenditure.

Under the current system, consumers' premiums are pooled with contributions from the national and local governments with the national government providing around half of the pool from tax revenues. Pooled funds cover 90 per cent of the cost of services. Consumers assessed as needing care pay a further ten per cent co-payment. As yet the system is in its infancy.

Demographics

In 1947, average life expectancy was 50 years for men and 54 for women; by 1997, life expectancy had risen to 77 years for men and 84 for women. Average life expectancy in Japan is now the highest in the world. Further, Japan is the most rapidly ageing society in the world. People aged 65 and older have increased from 4.16 million in 1950 to 21.87 million in 2000, while those 75 and over increased even more sharply from 1.07 million to 7 million (Lai 2001; Makigami and Pynoos 2002). In comparison, it took France 115 years to double the proportion of its elderly population from seven per cent to just over 14 per cent (Ogawa 2001).

Since 1960, the proportion of elderly living with their children has dropped from over 85 per cent to around 50 per cent, single-person elderly households have increased from 5.4 per cent to 17 per cent in 2000, while a further 28 per cent were couples-only households (Lai 2001). The role of women has changed due to improved education and increased workforce participation but at the same time traditional expectations that families (ie, women)

will care for the elderly or disabled still continue to influence family life and women's career expectations (Eto 2001).

The parent support ratio (ie, the ratio of those aged 80 and over per 100 persons aged 50-64) is around 17 and is projected to reach 44 by 2025 (Brodsky, Habib and Mizrahi 2000).

The elderly in rural populations have traditionally been from agricultural backgrounds. In recent years rural communities have experienced two impacts associated with the ageing of the population: emigration of younger people leaving elderly parents in largely 'senior citizens communities'; and elder immigration to rural communities in search of retirement amenities (Ogawa 2001).

Evolution of long term care in Japan

The traditional Japanese value system, which emphasises filial piety and respect for older people, placed primary responsibility for the support of older people on families. These values continue to influence debate on health and welfare policies for the aged.

Social welfare and filial piety

In the late 1940s social welfare became an important national goal and initiatives in the 1950s improved the living conditions of the elderly. Universal public pension and health insurance schemes were established in 1961. The Law for the Welfare of the Aged was introduced in 1963 to provide home help, respite care and institutional care to elderly people with low incomes and no one to care for them. The Welfare Law (amended) continued to provide care, including long term care, up to the introduction of LTCI in April 2000 (Commonwealth of Australia 2000; Brodsky, Habib and Mizrahi 2000).

A system of free medical service, including hospital care, for older people was introduced in 1973. Cost sharing arrangements, together with co-payments by older patients, were adopted in 1983 to cope with increasing health care needs. The public pension system was restructured in 1985 to cater for the projected ageing of the population, and retirement benefits were rationalised.

Before 1988, long-term care was provided in welfare institutions, called Special Nursing Homes for the Aged, and in special geriatric hospitals and wards. Such care was typically limited to people with low incomes and/or no family support. In 1988, Health Care Facilities for the Aged, funded through the health insurance scheme, were established to meet rapidly expanding long-term care needs. These facilities provided for older people with chronic illnesses who needed intensive care and rehabilitation but not hospitalisation (Commonwealth of Australia 2000).

Before the introduction of LTCI, the Japanese social security system made no special provision for long term care. Families typically looked to the free services of family members to care for the elderly at home. If no family carer was available, personal care services could be purchased from out-of-pocket expenditure. People with chronic illnesses (but without real medical need) often found themselves in hospital with the consequence that hospitals were being extensively used for long term care (Brodsky, Habib and Mizrahi 2000).

Precursors to long term care insurance

Precursors to LTCI attempted to expand the range of services available for long term care but these were not accompanied by reforms to financing (Lai 2001). In 1989, the Gold Plan was established with the aim of better integrated development of health, medical care, and welfare for the elderly over a ten year period. In 1990, administration of welfare services was shifted to the 3 200 municipalities with mandatory requirements to develop health and welfare plans for the elderly.

Over the previous years, strong economic performance and substantial improvements in health, welfare and the quality of life had created a confidence in the Japanese occupation-based, labour-market financed welfare model. However, the economic crisis in the mid-1990s increased scrutiny of areas where the system had not kept pace with these social changes and was exposed by the extent to which social security was funded by general taxation vis-à-vis premiums paid by salaried workers in the occupation-based welfare system. In the late 1990s, employees' premiums for their pension schemes and health insurance was roughly equivalent to 25 per cent of their salaries or three months' wages each year, in addition to income and other taxes.

According to Lai's analysis, the financial implications of the taxation system for funding social expenditures are:

> First, the tax base and the volume of direct tax derived from salaried workers is relatively small; indirect taxes and the consumption tax thus have an important role to play for funding new programs. Second, for the majority of salaried households, the tax contribution is less than the social insurance contributions paid for pensions and health insurance, at a ratio of 1:1:3. Third, the balance between social insurance and taxation is inversely proportional to income; for lower-income households, the social insurance burden is high in proportion to the tax burden, which higher income households contribute more through taxes compared to social insurance contributions (Lai 2001).

Further, Japan was faced with a high-technology, high-cost medical system with the cost increased by longer stays in hospital in part because of the unclear separation of acute hospitals from

long stay and rehabilitation services. From 1963 to 1993, the number of hospitalised elderly people increased to the point where they occupied nearly half the hospital beds (referred to as 'social hospitalisation'; Lai 2001; Campbell and Ikegami 2000). Although health care accounted for a modest share of GDP compared with other OECD countries, the rate of increase was higher (six per cent in 1990 rising to 7.5 per cent in 2000). During the same period, per capita outlays increased by almost 40 per cent and internal transfers became critical to keeping the health insurance schemes afloat. Not surprisingly, by 1999 social security had become the second largest single item (19.7 per cent) in the government's total budget (Lai 2001). Hence, by the late 1990s the sustainability of the occupational welfare model was under threat and continues to be so (Watanabe 2002).

The *Nursing Care Insurance Act* was passed on 17 December 1997. Its structure is similar to those of the twelve major laws governing other welfare services. While the need for reforms across all social security programs was recognised, the first initiative has been the introduction of LTCI suggesting the priority attached to the care of the aged. Besides, introducing the new scheme may have been regarded as 'less difficult' than tackling the existing programs (Lai 2001).

Policy positioning within government

LTCI policy responsibility rests with the Minister for Health, Labour and Welfare. The Ministry of Health and Welfare and the Ministry of Labour have recently been amalgamated reflecting the interconnectedness of the matters. However, within the Ministry of Health, Labour and Welfare, there are separate policy bureaus for health, social welfare, health insurance, pensions, and for the health and welfare for the elderly. In addition, there is a Social Insurance Agency responsible for the operation of the national pension, employee's pension insurance, government-managed health insurance and seamen's insurance (MoHLW 2003).

While policy for LTCI is formulated at the national level, implementation is devolved to the 47 prefectures and municipal governments. All prefectures are also required by law to establish and run a national health insurance program.

Arrangements for long term aged care

Japan's mandatory long-term care social insurance scheme started in April 2000 following decades of debate and nearly ten years of planning. Despite this, it appears that there was relatively little analysis of immediate or long-term costs. This may have been because it was assumed that the substantial existing expenditure on long term care would be re-directed to cover LTCI

costs. Debate continued to the last minute with a compromise agreement resulting in over six months' premium payments for the elderly being paid from the national Budget, and the social conservatives finally getting agreement to cash benefits for family home care. The additional cost is to be covered by floating Treasury Bonds (Campbell and Ikegami 2000; Eto 2001).

The LTCI scheme is based on access to institutional or community-based services with consumer choice of services and providers. Benefits cover care costs (less a ten per cent co-payment) at six levels of need, as measured by objective tests. Revenues are from insurance contributions and taxes. The program costs about US$40 billion with costs expected to rise to about US$70 billion annually by 2010 as applications for services go up (Campbell and Ikegami 2003).

The new scheme covers a wide range of community care and institutional care services and is based on the concept of 'socialising' care. 'Socialising' care recognises that the care of the elderly should no longer be left solely to the family but should be supported by the entire society through an increase in services; and that social support for long term care is indispensable. This marks a radical shift in Japanese policy, reflecting wide-ranging changes in Japanese society including to demographic profile, family structure, the employment of women and attitudes to caring for aged parents (Eto 2001).

The aims of establishing long term care insurance

The new LTCI scheme has been separated from medical care insurance as a first step towards revising the overall structure of social security. In making the separation, consideration was given to any consequent inequalities in costs to users and to minimising 'social hospitalisation' including through revised medical care practices in hospitals.

In deciding to establish a socialised care system that would respond to society's concerns about ageing and care problems, the Government was aware of the need to address the following problems:

- lengthening and seriousness of long-term care: one of every two bedridden[1] persons is bedridden for three years or more
- aging (sic) of care attendants: over 50 per cent of care attendants are 60 years or over
- declining percentage of elderly persons living with their children: this has declined to approximately 50 per cent
- increase in the number of working women

1 Bedridden: Refers to both people who require some assistance living indoors and spend most of the day in bed, sitting up and those who spend all day in bed and require assistance to urinate/defecate, and with meals and dressing.

- [the need to] build a stable system in which the relationship between benefits and costs is made clear, which can easily gain public understanding (MoHLW 2002).

The Government also identified the need for the efficient delivery of a user-centred, quality long-term care service system, one in which users could access services of their choice. To help ensure responsiveness to consumer needs the Government decided to promote the participation of a variety of independent enterprises (such as private companies, agricultural cooperatives and citizens' non-profit organisations). Services should be 'diverse and efficient' and integrated with other necessary welfare, health and medical services.

The aim was to make elderly people the policyholders and have them bear the cost of premiums where possible. In addition, the elderly would have to pay a fixed rate ten per cent charge for long term care services. The Government also sought to ensure that benefits would be fair nationwide and in accordance with required care certification standards for benefits (MoHLW 2002; Eto 2001).

Overall objectives for introducing the system are summarised in Box J 1 below:

Box J 1: Aims for introducing the LTCI system

To facilitate a system in which the society as a whole support those who are facing the need of long term care, society's major cause of concern in terms of becoming old.

To establish a system in which the relationship between benefits and burdens are made clear, by way of introducing a social insurance approach, which can easily gain public understanding.

To reconstruct the present vertically-divided system between health, medical and welfare services, and to establish a system by which service users can receive comprehensive services from a variety of institutions of their choice.

To separate long term care from coverage of health care insurance, and to establish a system which aims to decrease cases of "social hospitalization" as the first step toward restructuring the social security system as a whole.

Source: MoHLW, 2002.

Long term care insurance arrangements

Japan's LTCI system is summarised in Figure J 1. The scheme:

- is a compulsory insurance system applying to people 40 years and older

- derives half its funding from mandatory insurance and half from government expenditures with responsibility for these shared between central government (50 per cent) and the rest provided by the prefectural and municipal governments (see Figure J 2 next page)
- provides that all contributors aged 65 years and older (Category 1 insured) qualify for the insurance service while contributors aged 64 and younger (Category 2 insured) are not automatically entitled to services (see Table J 1, *The insured, beneficiaries, and premiums*)
- is managed by over 3 200 municipalities, each of which sets and collects premiums from Category 1 insured people according to the services it provides (premiums are deducted directly from pensions), while Category 2 insured pay according to a uniform premium rate for health insurance
- makes the municipalities responsible for assessment/ screening, without which there is no access to benefits
- encourages both public and private sectors (not-for-profit and for-profit) to provide services and ensures that there is a new contractual relationship between service providers and users, one that is governed by the LTCI law (MoHLW 2002).

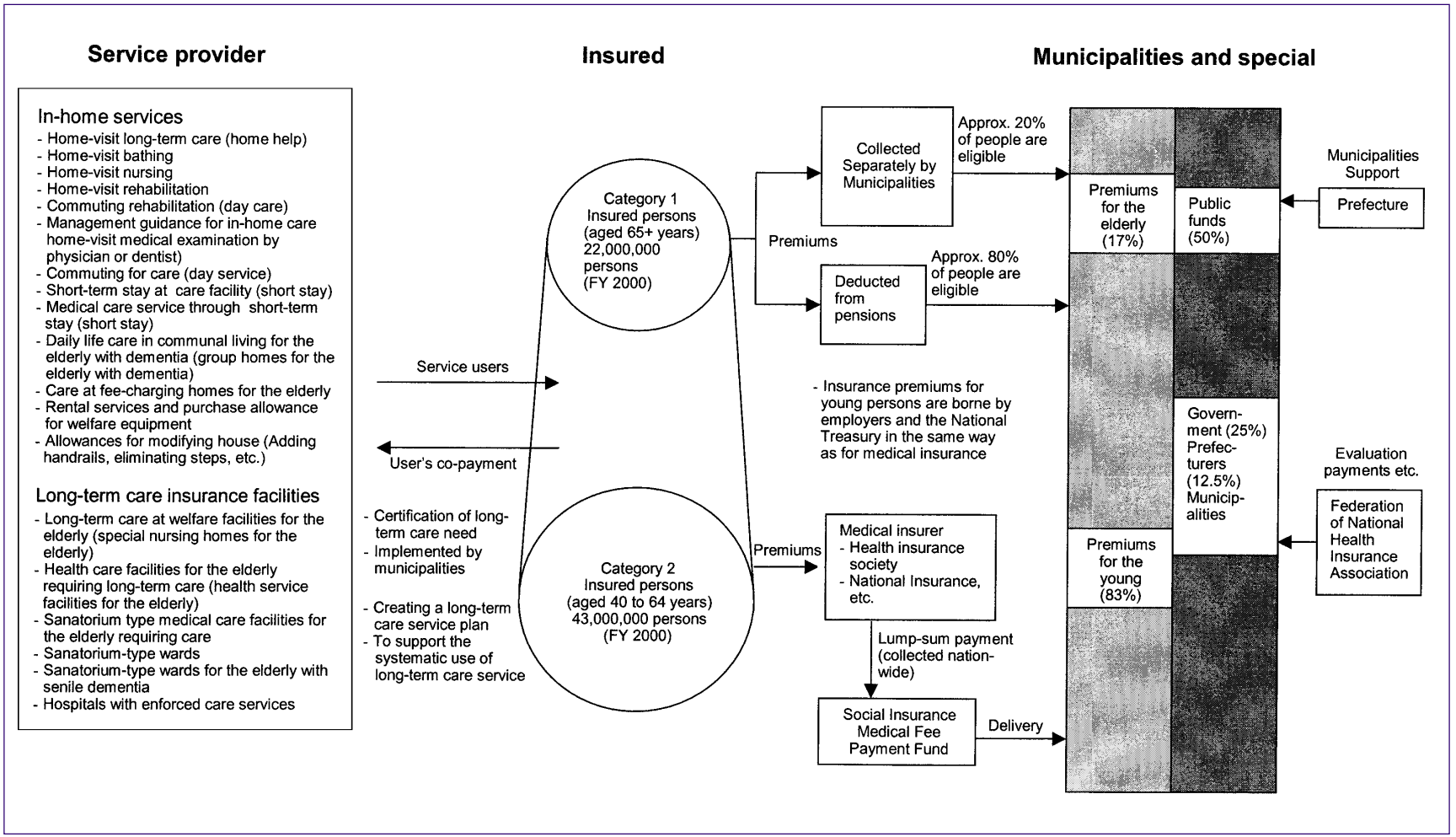
While called a social insurance system, it is not strictly 'insurance' based. The Japanese Government supplies half the funding though tax revenues and the other half comes from pooled premium contributions, with the method of levying premiums depending on the category of beneficiary, and with each municipality managing its own insurance scheme. Hence, in terms of funding, the arrangements may be seen as an amalgam of the German and British models (Okamoto 2001). Japanese LTCI premiums pay for current costs rather than providing for the future costs of individual premium payers. In addition, the Government has provided a 'stabilizing fund' to cope with increased demand on expenditure or to cover 'unpaid or non-recoverable premium contributions'. Each of the levels of government contributes to this fund (Lai 2001).

Arrangements for the insured, beneficiaries and premiums are summarised in Table J 1 below.

Role of prefectures and municipalities

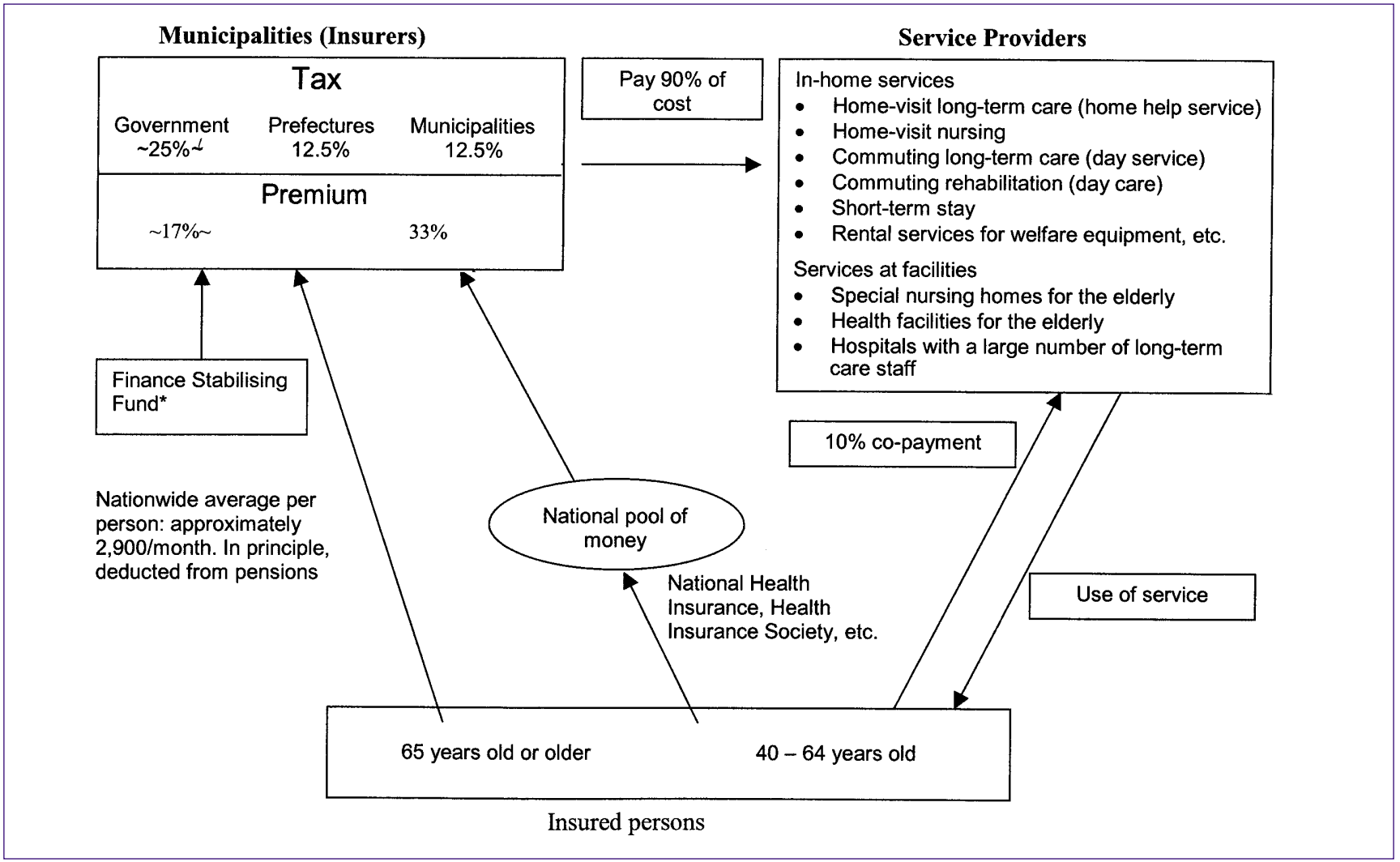
The national framework sets some conditions, such as the range of services to be covered by LTCI and the premiums to be paid by those aged 40 to 64 years, but each municipality or prefecture administers its own insurance scheme, deciding the premiums and the range of services included. Municipalities directly collect premiums from people over 65 years and are responsible for the assessment process through which beneficiaries gain access to services. If a municipality wants to provide more services it can

Figure J 1: Outline of the long-term care insurance system



Source: MoHLW, 2002.

Figure J 2: Outline of the long-term care insurance system – Financing



* Provides grants or loans to Prefectures to make good financial deficit caused by increased payments resulting from benefits surpassing estimates, and declined rates of premium payments.

Source: MoHLW,2002.

Table J 2: The insured, beneficiaries and premiums

	Category 1 insured	Category 2 insured
Eligible persons	• Persons aged 65 or over	• Persons aged 40 to 64 who are insured by health care insurance
Beneficiaries	• Persons requiring long term care (bed-ridden; dementia) • Frail persons requiring support	• Those who have become bed-ridden, dementia, and/or frail because of specific age-related diseases such as early-stage dementia, cerebro-vascular disorder etc*
Premiums	• Collected by municipalities	• Collected with premiums for health care insurance by health care insurers and paid in lump sums
Method of levying and collection	• Fixed premiums per income bracket (premiums reduced for people with low incomes) • Premiums deducted from pensions benefits above a given amount, otherwise collected directly by municipalities	• Employee's Health Insurance: premium based on standardised salary level multiplied by long term care premium rate (employers bear part cost) • National Health Insurance: premiums based on the amount of income as well as a fixed per-capita amount (government bears part cost)

* Public funds used to provide young disabled with long term care services in accordance with the Government's *Action Plan for Persons with Disabilities*

Source: MoHLW, 2002.

charge a higher premium (Okamato 2001; Campbell and Ikegami 2000). Premiums and services vary significantly across municipalities. For example, the home modification programs in some municipalities adhere strictly to LTCI criteria while other municipalities continue with the more comprehensive programs they had established before the introduction of LTCI (Watanabe and Lai 2001; Makigami and Pynoos 2002).

Statistics available at the end of March 2002 showed that in January 2002 close to 23.2 million people were insured with the municipalities as Category 1 insured persons, of which close to 3 million had been certified as requiring long term care or support. Over 1.6 million were receiving care or support in their homes and 670 000 in long term care facilities (MoHLW 2002).

The municipalities are each required under the LTCI law to have in place a five year strategic plan to ensure a sound actuarial basis for operation. The beneficiaries must be consulted regarding any proposed changes to the plan or to the services provided (MoHLW 2002).

Municipalities are highly dependent on the central government with most relying on central government for 70 per cent of their funding: hence the popular phrase '30 per cent autonomy'. This provides a strong incentive for municipalities to plan and administer

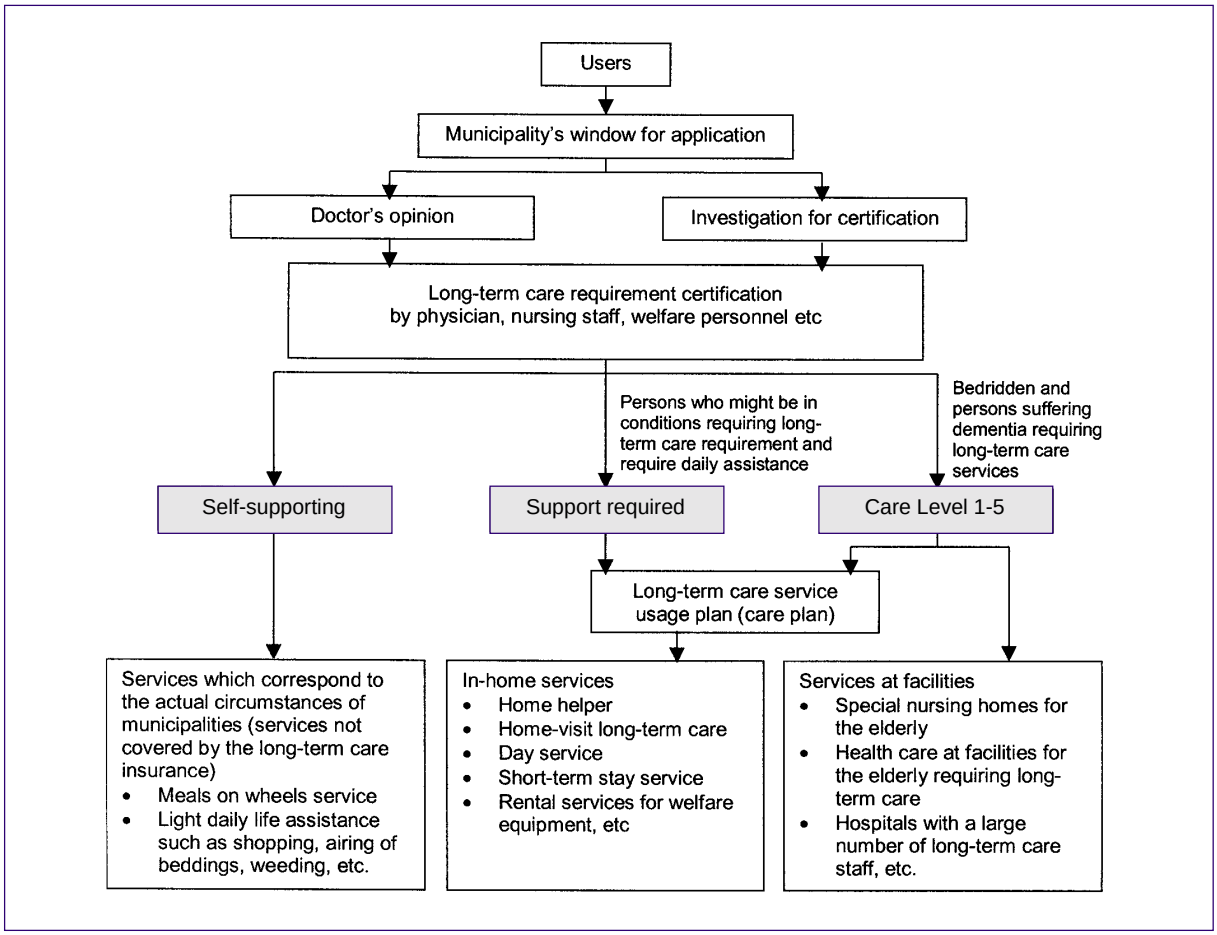
programs according to central government expectations (Eto 2001). At the same time, municipalities wanting to tailor services to the needs of their own regions can feel that this places restrictions on them.

Access to services

LTCI is generally called 'nursing care insurance' as the need for some level of nursing care is the fundamental eligibility criteria for access to the services covered by the scheme (Watanabe and Lai 2001). Paying premiums and being 'entitled' to benefits does not provide automatic access to services.

The process for accessing services is summarised in Figure J 3 (below). In short, consumers apply for services through a municipal screening and certification process which also involves a doctor's assessment. Assessments are made according to a uniform assessment tool consisting of 73 survey items to measure Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) and behaviours. Computer analysis of the survey

Figure J 3: Access to benefits and services



Source: MoHLW, 2002.

scores generates a preliminary assessment against six levels of care needs which is then considered by attending doctors and the needs assessment review committee appointed by the local mayor. An assessment is usually valid for only six months (Okamoto 2001; MoHLW 2002).

Once a consumer has been screened and certified, an accredited and qualified care manager develops a care plan and coordinates access to services within an allocated budget. The first care managers were accredited in 1998 either following a special examination or because they were professionals already possessing health or welfare related licenses and at least five years of clinical experience (Okamoto 2001).

Consumers are free to choose the provider and type of services they prefer (subject to entry eligibility and benefits category). They pay a ten per cent co-payment plus food costs. The other 90 per cent of the cost is paid from pooled premiums and government taxes (MoHLW 2002; Lai 2001 re food costs).

Clients are learning that they cannot afford to use highly priced services to satisfy service needs within the limit of the LTCI. Some are choosing to purchase only the cheaper services, instead of personal care services, or purchase services from non-profit organisations that tend to provide less expensive services (Wanatabe and Lai 2001).

Providers

Anticipation of the introduction of LTCI saw a 55 per cent increase in the total number of registered nursing care providers between March 2000 and the end of April 2000. The increase was largely due to an influx of private providers seeking to enter the nursing care market from which they, and voluntary groups, had largely been excluded. New players included: large-scale corporations already providing families with nursing services delivered by visiting nurses and home-helpers; large-scale corporations not previously involved in the field setting up networks of services or providing nursing care products and equipment; and existing not-for-profit organisations and small-scale businesses providing inexpensive home-help services. As many of the new players had little direct expertise in home care services, they faced difficulties in operating in the field unless they formed business alliances (Campbell and Ikegami 2000; Watanabe and Lai 2001; Saphir 2002; Marubeni 2000).

Providers clustered in four groups:

- the largest group, comprising medical, and allied health professionals based in clinics and hospitals which provide around 60 per cent of nursing and allied health care for aged people
- municipal sponsored and funded service providers which were expected to play a decreasing role

- incorporated welfare foundations[2] (eg, the council of Social Welfare); and volunteer organisations. In 1999, such foundations managed and operated more than 90 per cent of the special nursing homes for the elderly and 'custodial homes' for people with physical disabilities (MoHLW 1999); and
- private, for-profit businesses providing welfare services looking to gain a larger market share because of their corporate financing and aggressive marketing.

The Ministry's statistics for the first year of operation show that in-home service providers entering the market increased as did the total number of service facilities nation-wide. However, some of the new private providers withdrew from home-helper or care management services because they were not sufficiently profitable (including in rural areas) and because clients tended to choose the more familiar municipal-sponsored services (MoHLW 2002; see also Wanatabe and Lai 2001). In rural areas, agricultural cooperatives are expected to take up a greater role in facilitating care by training home-helpers; establishing nursing homes, health care facilities and day service centres; and delivering in-home services (Ogawa 2001).

Usage of community-based services (including day care and respite care) has steadily increased in the first two years of the program so that their share of total LTCI spending grew from 28 to 37 per cent in the first two years. Of the most used community-based services, home help was running at a small loss, partly due to so many clients electing the low-fee 'housekeeping' type. Day care (with or without rehabilitation) showed a surplus (Campbell and Ikegami 2003).

There was a short-fall in the expected number of beds in residential facilities with the Ministry reporting availability of around 119 000 beds in 'sanatorium type medical facilities' compared to approximately 179 000 as estimated in municipal service plans (MoHLW 2002).

In addition to direct service providers, the anticipated boom in home care has seen strong growth in companies manufacturing a wide range of products to support home care and rehabilitation: wheelchairs, beds and specially designed furniture; continence aids; electronic monitoring equipment; home elevators etc. Companies see new marketing opportunities dealing directly with the expected 170 000 home-helpers and 40 000 care managers instead of with local authorities. In the past, needs have largely been filled by expensive imports. Now, Japanese manufacturers are developing products more suitable for Japanese people and residences (Jetro Lyon 2002).

2 Social welfare foundations are non-profit charitable corporations established in accordance with the Social Welfare Service Law. They were created to enable expenditure of public funds on 'charitable activities' in face of the prohibition on such expenditure in Article 89 of the Constitution (MoHLW 1999).

Capital

Before the introduction of LTCI the Government had identified the Fiscal Investment and Loan Program (FILP) as an avenue for providing capital to support growth in the provision of care for the aged. Under the Fiscal Investment and Loan Program, the Social Welfare and Medical Service Corporation provides long-term loans with low interest rates to establish social welfare facilities, including special nursing homes for the elderly, and loans to establish medical treatment facilities for the elderly such as hospitals, clinics, and welfare institutions. To enable such loans the Corporation receives subsidies from the general accounts of the national Treasury as compensation for expenses including gaps in the interest rates for procurement and lending (Ministry of Finance 2000 and 2002a).

From 1990 to 1998, the Corporation provided loans for 88.6 per cent of the total number of special nursing homes for the elderly, welfare institutions for the elderly, and care houses that were established under the new Gold Plan. Despite the continuing difficult economic circumstances, the FY 2002 Budget increased investment in nursing homes for the elderly by 6.3 per cent (Ministry of Finance 2000 and 2002b).

Issues

The Ministry of Health, Labour and Welfare considers that the new system was introduced 'without any big confusion' and that there have been satisfactory increases in the number of service providers and the usage of services. LTCI is scheduled for full review after five years of operation including consideration of the quality and cost of the scheme.

As part of its implementation plan, the Ministry identified further work to be done and named the improvement of the quality of long term care services as one of the most pressing issues (MoHLW 2002/5). Measures to be developed include:

- research into dementia care and training to improve the care of dementia patients including the promotion of a 'no physical restraint campaign'. Little information is available on how the system currently provides for people with dementia. The Ministry has estimated that the number of elderly people with dementia is projected to rise from an estimated 1.6 million to reach 2.3 million by 2010
- an increase in the number of single rooms and group-care units at special nursing homes for the elderly
- the provision of further assistance for care managers.

Other matters to be tackled include increasing the construction of housing more appropriate to the needs of the elderly and expanding the role of for-profit companies through the use of the

Private Finance Initiative scheme; reviewing the insurance fee table and municipal planning for service provision; and undertaking a survey of the financial position of service providers (MoHLW 2002/5).

Issues identified by researchers and other commentators

- Concerns have been raised about the variable quality of care managers and care plans, the complexity and fairness of the assessment system causing including overlap of roles in screening for certification and care planning (Wanatabe and Lai 2001; Campbell and Ikegami 2003).
- LTCI was grafted on to existing medical, social welfare and community services infrastructure and at a time when the private sector was playing a larger role. One of the aims of LTCI is to better facilitate integrated care. The extent to which LTCI develops an appropriate 'fit' with the existing infrastructure remains to be seen (Campbell and Ikegami 2003).
- Expenditure in the first two years has been slightly below budget, partly because of fewer than expected transfers of institutional beds from health insurance to LTCI. If projections of demand for community-based care were realised, spending would rise to 8 trillion JPY or about US$70 billion a year in 2010. Provision does not seem to have been made for this possibility (Campbell and Ikegami 2003).
- Home modification programs existed in some 70 per cent of the municipalities before the introduction of LTCI. While all municipalities now cover modification programs within LTCI, the national program restricts benefits to the frail elderly. The program is reactive rather than enabling modification that would help prevent deterioration. Nor does it pay for more costly features such as lifts. Further, benefits are limited to up to 200 000 JPY in a lifetime which the ten per cent co-payment effectively reduces to 180 000 JPY (Makigami and Pynoos 2002).

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