Home and Away: Reflections on Long-term Care in the UK and Australia

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HOME AND AWAY

REFLECTIONS ON LONG-TERM CARE IN THE UK AND AUSTRALIA

by Melanie Henwood

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Tony Eardley
Editor

Abstract

The challenges posed by an ageing population are major preoccupations of governments throughout the developed world. There are many dimensions to such challenges, and this paper focuses on issues relating to long-term care in old age. The debate around such matters has been similar in the UK and in Australia. In both countries, a history of incrementalism and poorly presented policy reform has contributed to widespread public mistrust, and a sense of injustice at the extension of means-testing or user pays principles.

This paper examines the analysis and conclusions of a Royal Commission in the UK, set up to explore options for the finance and structure of long-term care. A fundamental principle advanced by the Commission is that the risk of needing long-term care should be shared by all citizens, rather than borne by those who have the misfortune to need such care. A separation of the personal care costs of long-term care from the living and housing costs components has been proposed as the most equitable way of sharing costs between individuals and the state.

Major reforms to the structure community care in the early 1990s in the UK (and similar developments in Australia) were concerned largely with improving management and accountability of local services and with promoting community rather than residential-based models of care. These failed to address the larger underlying question about the balance of responsibilities between individuals and the state and how to achieve a sustainable model for funding long-term care. The proposals by the Royal Commission in the UK can be seen to offer one such model. It is not without flaws and a cautious initial political response is evident. Nonetheless, the model has an immediate appeal in the simplicity of its argument, and in the prospect of offering improved individual security and enhanced social cohesion.

1 Introduction

The need to introduce sweeping reforms in the finance, structure and organisation of long-term care has been a distinguishing feature of social policy debate through the 1980s and 1990s in the UK, in Australia, and in many other countries struggling with the challenges of an ageing population. This paper explores the background to this debate in the UK, and the likely developments into the next millennium, while also reflecting on parallel developments in Australia, and considering the scope for learning from such experiences.

Any consideration of the UK typically begins the main story by stepping back to the not so distant past of 1989, and the publication of the Government's White Paper containing proposals for reorganising community care (Secretaries of State, 1989). Those proposals subsequently provided the foundation for the 1990 NHS and Community Care Act which largely took effect from April 1993. The six key objectives of the White Paper are summarised below:

- 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 proper assessment of need and good case 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; and
- to secure better value for taxpayers' money by introducing a new funding structure for social care.

In a review of progress against each of these objectives undertaken for the Royal Commission on Long Term Care, Henwood and Wistow (1999)

concluded that the evidence points to a 'reasonable degree of achievement in a number of different areas'. In particular,

> ... the new funding and assessment processes have successfully enabled the development of service patterns broadly in keeping with the White Paper's objective of enabling more people to remain in their own homes. This achievement is particularly noteworthy since it represents a reversal of the historic pattern in which care home places grew more rapidly than home care services. (Henwood and Wistow, 1999: 21)

Despite this evident progress and success, however, various caveats must also be introduced to this overall evaluation, which indicate incomplete implementation:

> First, the inadequacy of financial resources in relation to the extent of need and the ambition of service improvement goals; second, the insufficient development of policy objectives and service models to support independent living; and third, the absence of continuing organisational development and other implementation support mechanisms once the immediate implementation hurdle had been successfully negotiated in 1993. (Henwood and Wistow, 1999: 22)

Moreover, in revisiting the objectives of *Caring for People*, what is particularly striking is what the reforms did *not* address, as well as what they did. It is important to recall the particular context of the time, and the concerns which had prompted the establishment first of an independent enquiry by Sir Roy Griffiths (1988), and which had subsequently seen the publication of the 1989 White Paper. The *primary objective* of the community care reforms was to cap a runaway social security budget which had provided a notorious 'perverse incentive' in favour of residential and nursing home care, and to transfer this element of the social security budget to local authorities and make them responsible for the purchase of services, promoting - wherever possible - the use of alternative community-based packages of care. The focusing of attention on such matters can be readily

understood. The availability of social security funding for residential and nursing home placements, available without a test of need for care, saw expenditure rise from £350m in 1985 to £2.5bn in 1993-94, 'driven by what could be paid for rather than what people needed' (Royal Commission on Long Term Care, 1999, para 4.24).

The question of 'better value for taxpayers' money', and the approach to 'a new funding structure for social care', were therefore both defined simply in terms of switching from an open-ended budget to a cash limited one that would be tightly managed by making access to publicly funded care conditional on assessment of need. Significantly, the reforms *did not* address the fundamental question of the balance of funding responsibilities between the individual and the state. In retrospect this omission may appear puzzling. Certainly there had been considerable disquiet evident for some time about an apparent shift in the balance of such responsibilities. However, at the time this was evidently *not* the main consideration to be addressed by the reforms. Nonetheless, the failure to do so inevitably meant that further reform would be necessary.

The community care reforms of 1993 were essentially concerned with improving the *management and accountability* of publicly funded care services on the one hand, and with *promoting a community rather than residential-based model of care,* on the other. It is important to understand both of these dimensions. Thus, the reforms were not merely addressing an administrative problem, although cost control was the driving motivation. Over and above this, the reforms can also be seen to have reflected some clear principles and values which were largely following the example of best practice on the ground and seeking to promote a more widespread adoption of such models. *Caring for People* sought to enable people to lead as 'normal a life as possible', and spoke of enabling people to achieve 'maximum possible independence', and having 'a greater individual say in how they live their lives'. Indeed, maximising choice and promoting independence were presented as the key principles underpinning all the other objectives.

This introductory section has provided a brief overview of some of the background to the debate on long-term care. The community care reforms which were introduced in 1993 were concerned primarily with improving the care system and enabling people to remain in the community, whilst simultaneously (and overwhelmingly) 'introducing a capped budget and

shutting off what had been a financial safety valve provided through the uncapped social security system' (Henwood and Wistow, 1999: 22). This failed to address the compatibility of these two components, or to consider how needs led services would be aligned with a capped budget. Other limitations of the reforms have been identified by other commentators in terms of insufficient development of policy objectives, particularly around principles of independent living, and how these might find expression in service shape and content (Harding, 1999).

In addition to the immediate policy background to the long-term care debate, other factors can also be identified which are crucial to understanding the specific context. A number of such factors might be included, but two elements would appear to be especially important. These are:

- alarm over demographic pressures; and
- changing health and social care service boundaries, and an associated growing disquiet over long-term care.

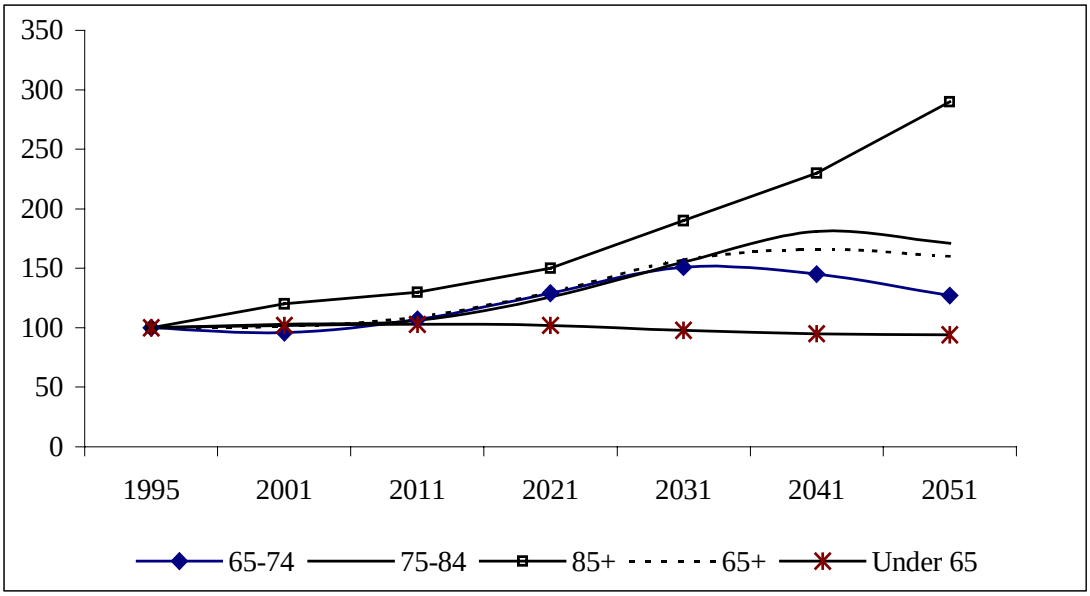
It is worth briefly exploring each of these dimensions.

Demographic Alarm

The structure of the UK population has, in common with that in all other advanced countries, been ageing throughout the century. The total older population is continuing to grow, but the largest relative growth is among the oldest cohorts (those aged at least 85). Figure 1 below summarises these trends from 1995 through to 2051, and demonstrates clearly the projected growth of the oldest cohorts.

Much of the political and popular response to these demographic trends in the UK has, over the last decade or so, been a negative and alarmist one. Thus the 'demographic time bomb' has become a much used (and abused) sound bite. In fact, most demographers and commentators now emphasise that the UK has already been through the most rapid growth of the older population, and the future is deemed to be more manageable. Certainly, the scale of the demographic challenges in the UK is of considerably less magnitude than that expected in the non-European industrialised world.

Figure 1: Population Projections Indexed on 1995 (100)



While the population aged at least 80 is expected to increase threefold in most Northern European countries over the period 1960-2040, the increases are expected to be in the magnitude of 900 per cent in Australia and Canada, and of 1300 per cent in Japan (Royal Commission, 1999). The scale of the demographic challenge in Australia may in part account for a similar use of hyperbolic terminology to describe the ageing of the population which has been tagged by some as the 'real millennium bug' of the next century.

The size of the elderly population is a very crude indicator of the likely need for long-term care. Of much greater relevance is the issue of the health status of older people. A longstanding and world-wide debate has been on-going since the early 1980s over the question of whether people are living longer and doing so in poorer health, or whether the extra years gained are at the price of more years of poor health and dependency. The vital importance of extending not only life expectancy but also *health expectancy* is reflected in the World Health Organisation's twin objectives of adding both years to life, and life to years.

The evidence in the UK is inconclusive (hampered, in part, by the absence of longitudinal data on the health status of older people). Analysis of available data (based on snapshot surveys of activities of daily living and the presence of limiting longstanding illness) suggests an overall improvement in health expectancy, and some indication of a compression of morbidity in

relation to severe disability, but contradictory trends at lower levels of impairment. On the basis of such trends it is expected that the years spent free of disability will remain roughly constant in proportion to total life expectancy.

The projected increases in the elderly population, and in the health status of that population, can be seen as representing the demand side of the demographic equation. Against this, other trends must also be considered, particularly those affecting the supply side of informal care. It is now well understood (and documented) that informal (generally family) care takes place on a scale which far outweighs support from formal health and social care services. The latest data indicate that nationally in the UK there are about 5.7 million carers (approximately 14 per cent of the adult population), with an estimated 1.75 - 2 million being 'heavily involved' in providing personal or physical care (Parker, 1998). The largest group of carers are those providing help to parents or parents-in-law. However, spouses (or partners) are the most important source of help with domestic and personal care.

The future availability of informal care cannot be projected with certainty. There are a number of variables which could reduce availability including: changing patterns of marriage and divorce, and the trend towards less stable family structures; smaller and more mobile families; women's increased labour market participation; and possible reductions in intergenerational links and obligations. Increasing female economic activity does not appear, in practice, to be reducing the supply of informal care. Women generally juggle the demands of paid and unpaid work, but the costs of so doing may become progressively greater. The importance of recognising the implications of caring responsibilities within employment policy and practice is in its early days. However, the recent cross-departmental National Carers Strategy launched by the UK Government represents one attempt to begin to address such issues.

Some variables can be predicted with greater certainty than others. The next cohort of elderly women will be more likely than previous ones to have been (and still be) married, and to have had children. For subsequent generations, this will not be the case, and there will be a reduced likelihood of either being married (reflecting trends in divorce and in cohabitation), or of having children (indicating reduced fertility patterns).

1.2 Changing Health and Social Care Boundaries and Growing Disquiet

Ever since the postwar foundation of the welfare state in the UK, there has been a line drawn between services provided by the NHS, free at the point of use, and those provided via local authorities which entail a means test. However, the boundary between these services has shifted over time. While the growth of the independent residential and nursing home sector was fuelled during the 1980s by the availability of the social security budget, this also served as an incentive for cost shunting, particularly from the NHS to local authorities (who, in turn, were able to pass some of these on to the social security system). As the Health Select Committee observed, a consequence of the shift in responsibilities in paying for long-term care meant that:

> ... many people who are now cared for in nursing homes on a means-tested basis would in previous decades have been cared for by the NHS without charge. (Health Committee, 1996: Iix, para 12)

An analysis of the current funding system for long-term care demonstrates why this is problematic. When a person is assessed by a Local Authority as needing care in a residential or nursing home (whether in homes which are owned by the Local Authority, or in homes with which it has contracts which are owned by the independent sector), the local authority is *legally obliged* to assess what contribution should be made by the individual towards the cost of their care. There is a standard assessment of means (taking account of both income and capital assets) which is applied nationally. Anyone with capital assets of more than £16 000 (which includes the value of their home) *is responsible for paying the full cost of any home fees.* People with assets of less than £16 000 must make a contribution based on the calculation of a tariff income assumed to be generated by their capital. Only when assets are less than £10 000 are they disregarded, and the fees paid by the state. Average weekly fees are £242 for residential homes, and £337 for nursing homes (respectively Australian $605, and $843).

This is the nub of the issue with paying for long-term care. The value of people's homes essentially determines whether or not they are entitled to state help with their care needs. Moreover, this is widely perceived to be

both ‘unfair’, and to represent a covert change in the rules. There is a double betrayal in evidence. First, home ownership has been promoted in the postwar period as an ideal to which all should aspire. The sale of council houses with substantial discounts to tenants was a reflection of such ambition, and indeed, buying a home has come to be seen almost as a *right of citizenship*. The pre-election Manifesto set out by the Conservative Party in 1992, for example observed:

> The opportunity to own a home and pass it on is one of the most important rights that an individual has in a free society. Conservatives have extended that right. It lies at the heart of our philosophy. We want to see wealth and security being passed down from generation to generation. (Conservative Central Office, 1992: 33)

Being obliged to sell the family home to pay for care somewhat undermines the viability of allowing capital to cascade down the generations. The second area in which a betrayal is felt by many older people concerns charging for long-term care at all. The distinction between ‘free’ and means-tested care has not only become more blurred, but because the NHS has largely withdrawn from providing long-term care, most people needing such care will find that it is viewed as ‘social’ rather than ‘health’ care and therefore will be means tested. Care from the ‘cradle to the grave’ was the foundation stone of the NHS, and many people believe that they have paid into this system throughout their working lives via the National Insurance Scheme, only to find that the care they had thought would be free must in fact be paid for from assets collected over a lifetime.

The increasing recognition that the approach to the funding of long-term care was creating a growing discontent among a home-owning electorate was addressed by some interim measures by the last Conservative Government. The capital limit on individual responsibility for long-term care fees was raised to £16 000 (previously it had been £8000), which eased the problems, but did not address them fundamentally. In 1996, a discussion document was issued on the development of partnership schemes in long term care insurance (Secretary of State for Health, 1996). Partnership schemes would allow protection of individual assets through alleviating the means test for those who had taken out private long-term care insurance. Insurers calculated that such policies would be of most benefit to people with assets

of between £60 000 - £120 000, but these people might have insufficient income to buy insurance policies. It was anticipated that the discussion document would be followed by policy proposals and a White Paper. However, the costliness of partnership arrangements, and the doubts over their viability, together with the imminence of the 1997 General Election no doubt encouraged some caution in this highly controversial area, and no such proposals were published. The Labour Party, on the other hand made an Election Manifesto commitment to establish a Royal Commission on Long Term Care if elected to Government.

The Labour Party took office on 1 May 1997 and announced the establishment of the Royal Commission in December of that year, with terms of reference summarised below.

> To examine 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, within 12 months, to recommend how, and in what circumstances, the cost of such care should be apportioned between public funds and individuals, having regard to:
>
> - the number of people likely to require various kinds of Long Term Care both in the present and through the first half of the next century, and their likely income and capital over their life-time;
>
> - the expectations of elderly people for dignity and security in the way in which their Long Term Care needs are met, taking account of the need for this to be secured in the most cost-effective manner;
>
> - the strengths and weaknesses of the current arrangements;
>
> - fair and efficient ways for individuals to make any contribution required of them;
>
> - constraints on public funds; and

- earlier work done by various bodies on this issue. (Royal Commission on Long Term Care, 1999, Introduction)

2 The Proposals of the Royal Commission

One of the most striking features of the approach of the Royal Commission on Long Term Care was the clear statement of a values-based approach. The Commission rejected the perspective of old age as a problem, urging instead that it should be viewed as an opportunity. A statement of values which the Commission regarded as informing 'all its work and recommendations' appears below.

- Older people are a *valuable* part of society and should be *valued as such.*
- Old age will come to increasing numbers of the population and this should be seen as a natural part of life and not as a burden.
- Old age represents an opportunity - for intellectual fulfilment and for the achievement of ambitions put on hold during working lives. Those who are involved in Government, or who provide and develop products and services should work to make available to old people the tools to enjoy education, leisure and their day to day lives.
- To compartmentalise old age and to describe old people as a problem is intolerable - morally and practically.
- A more positive and inclusive climate should be created and nurtured, so ensuring the development of more opportunities which can be taken up by older people.
- The whole approach to long-term care should be to view the management of older peoples' needs as a set of positive actions over time which help people to lead the kind of fulfilling lives they want to lead - and to be able to continue to contribute to society in a positive way - both economically and intellectually - and not as a management of decline.

- The funding system for long-term care should provide the widest possible opportunity for older people to lead the lives they want, whether it be in their own homes or in other settings.

- In improving the recognition of the importance of old age, the funding system must also strengthen the links between generations and spread the financial responsibility. (Royal Commission on Long Term Care, 1999: 5)

The institutionalised ageism of society continues to reflect negative images of old age, and this is reinforced, the Commission suggested, even in current political rhetoric which stresses the focus of New Labour on a new, young, modern and go-ahead Britain, which 'might (unintentionally) seem to exclude older people' (Royal Commission, 1999, para 1.12)

The Demand for Long-term Care

As noted previously, part of the basis for much negativity in the view of old age has been the belief that the elderly population is increasing exponentially and will make overwhelming demands on younger generations. A major concern of the Commission was therefore to examine the likely demands for long-term care, and to distinguish the facts from fiction and speculation. The projections and assumptions used by the Commission were all grounded on a model developed by the Personal Social Services Research Unit (Wittenberg et al., 1998). The five most important factors affecting the future demand for and costs of long-term care were identified by the Commission in terms of: demography; health expectancy; supply of unpaid (informal) care; use of services, and care costs.

As outlined in Section 1, analysis of demographic trends indicates that the UK has already experienced the most significant increases in the elderly population earlier this century, and 'the future is much more manageable' (Royal Commission, 1999, para 2.18). Since 1900, the numbers aged over 65 have risen by 400 per cent, and have doubled since 1931. In general, the upward trend is expected to continue until around 2030, but the population will then stop growing because of low birth rates in the past. However, it is not just total numbers which are the issue, but the relative size of different cohorts of older people, and the population aged at least 85 is expected to be three times more numerous by 2050.

In terms of the likely health expectancy of the aged population, the Commission followed other analyses, and concluded:

> The best evidence we can find about the United Kingdom suggests that the factors which are causing us to live longer are also resulting in the extra years of life being free from severe disability. (Royal Commission, 1999, para 2.23)

Despite some grounds for optimism, the Commission also recognised the need for caution in interpreting the findings. As noted in Section 1, analysis is limited by the absence of any longitudinal survey of health status in the UK, and indeed the Commission recommended the establishment of just such a national survey in order to reliably monitor trends in health expectancy.

2.1 '... the Current System is Failing'

In analysing the current system for long-term care, the Commission used its values as a basis for an evaluative framework having regard to:

- fairness;
- maximum choice, dignity and independence;
- security, sustainability and adaptability; and
- quality and best value.

The current system of paying for long-term care is financed through general taxation on a pay as you go basis (current taxation pays for those currently in the system). As was outlined earlier in this paper, there are a number of shortcomings believed to reside in the funding system. Indeed, the Royal Commission observed that 'confusion and uncertainty exist as an intrinsic part of the current system'. The system is perceived as unfair. The impact of the means test on those who are homeowners or who have savings is felt to be a tax on thrift. Such feelings have been articulated in much of the evidence submitted to the Royal Commission, and are well documented in a range of research. For example:

> There seems to be no point in saving for old age because you are going to be penalised for it; whilst those who have never done a day's work in their life get it all.
>
> I don't like to think that the house that I worked for all my life can just go and my children won't benefit. (quoted in Henwood and Waddington, 1998: 12)

This sense of 'unfairness' in the operation of the current system was addressed by the Commission:

> The current system clearly does not fulfil the reasonable expectations of old people. They feel that they have paid into a system through the National Insurance Scheme which they were led to believe would look after them in later life whatever their needs were. At a key point in peoples' lives they find that they are expected to pay for themselves out of assets they have accumulated over a lifetime for care they had previously expected would be free. We do not say this belief is logical: that it exists is a fact, and the sense of betrayal cannot be denied. (Royal Commission, 1999, para 4.36)

Moreover:

> The system at the moment helps people who are poor, demands that people of modest means make themselves poor before it will help, and affects people to a lesser degree the richer they are and the better able to afford the sums required. This seems strangely inconsistent ... The lack of consistency causes much distress to the public, particularly those who have modest assets which can be eaten up very quickly when care is required. (Royal Commission, 1999, para 4.16)

The fact that the current funding system developed haphazardly and incrementally over a number of years can be seen as the cause of much of the confusion. With the use of the Social Security system to fund a large expansion of residential and nursing home care in the 1980s, the boundaries

between free and mean-tested services shifted, but did so in the absence of any public debate or consent. If this change had been made explicit, the Commission suggested, it would be clear to people 'that only the poor are currently meant to receive state support and that a large part of the population is not entitled to any help'. People would have had better information and would have been able to use this to plan accordingly. The lack of an explicit statement of the respective responsibilities of individuals and the state can be seen to have 'contributed massively to the uncertainty and bitterness felt by large numbers of people at the present time and the lack of preparedness of many' (Royal Commission, 1999, para 4.23).

Other flaws can also be identified in the current funding system. The Commission highlighted the lack of dignity and choice, and the fact that there remains a financial bias towards supporting residential care which militates against independence. The net cost to local authorities in making residential placements is *less* than the cost of providing intensive packages of domiciliary support. Under such conditions, the Commission believed that securing the most appropriate care for an individual is 'precarious'. Furthermore, they argue, residential and nursing home admissions are often made at a time of crisis because the system fails to allow time for recovery. Such conclusions are supported by other analyses. In considering the extent to which the 1993 community care reforms have succeeded in enabling older people to remain in their own homes, Harding (1999) has observed that the verdict is very mixed:

> The conclusion must be that, while there has undoubtedly been an increase in personal care to some older people, there are grave doubts about the quality of life that has resulted from this. Meanwhile, many older people have ended up in residential or nursing home care due to low cost ceilings on the provision of domiciliary care and the lack of rehabilitation facilities and intensive short-term support to enable them to return home from hospital. In parallel, less intensive forms of home-based care, which may well have been sustaining the independence of many thousands of older people, have been lost, with unknown and unexplored

> consequences for increased dependency. (Harding, 1999: 42)

In terms of the security, sustainability and adaptability of the existing system, the Commission was similarly critical. Given the level of anxiety and concern expressed by older people about 'what will happen to them', the system cannot be seen to provide a sense of security. The system is not adaptable, and contains no incentives to encourage the development of new and more responsive services which would better meet people's needs. The continued bias towards residential care also fails the test of 'best value'. Other inefficiencies are evident and standards are highly variable, and 'what people get depends very much on where they live and the state of local budgets'.

Considered overall, the Commission concluded that the current system is failing, and in clear need of reform:

> ... there are too many flows of funds which have been designed for different purposes and what the individual does or does not get out of it depends on a number of complex decisions which are out of their control. People have no idea what to expect. The tendency of the system to *require* impoverishment - and its proof - before it will help leads to despair which in our judgement is unacceptable. Modestly prudent people risk losing their dignity, partly as a result of their condition and partly because of how the system deals with it. People have no choice but to receive services for which all but the poorest have no further choice but to pay. (Royal Commission, 1999, para 4.50)

On the basis of their analysis, the Commission concluded that a new funding system was required which would 'define a new and clearer relationship between state provision on the one hand and personal responsibility on the other'. In considering the requirements of a new system, the Commission began with 'first principles' by examining long-term care 'in terms of the kind of risk it comprises both for the individual and the state'. The risks of needing long term residential care are presently estimated at one in five for men aged 65 and over, and one in three for women of this age. In this

respect, the Commission argued strongly that the risk of needing long-term care is quite unlike other risks in old age - such as for a pension.

> Everyone reaching pensionable age expects to start drawing a pension for their later years. The pension is something which people hope they can rely on for an old age which they would like to be comfortable, and for which many have optimistic expectations. Paying for long term care on the other hand involves making provision in one way or another against catastrophic and, in principle, unforeseeable costs. (Royal Commission, 1999, para 3.2)

The sums involved in paying for long-term care are considerable. The Commission calculated that a married couple would need £85 000 (approx Australian $212 500) to be sure of meeting the average cost of a residential home for three years. Being able to make such provision from private income is simply not an option for most people. Moreover, the Commission argued that the need for long-term care is not primarily because people are simply *old*, 'but because their health has been undermined by a disabling disease such as Alzheimer's disease, other forms of dementia or a stroke'. This is a fundamentally important conceptual issue. If it is accepted that long-term care is analogous to health care, the arguments for sharing the risks of needing such care in a comparable way become more compelling.

How might the risks of long-term care be tackled? The Commission explored three possible funding routes:

- leave people to decide whether or not to take out private insurance;
- *compel* people to insure themselves (with the state taking responsibility for those unable to afford insurance or refused cover); or
- collective provision or insurance on the grounds of the universality of the risk; the unequal ability of people to make provision for themselves; and the inability of the insurance industry to produce universally affordable or effective products.

The market for long-term care insurance cannot be relied upon as a solution. Certainly the experience to-date indicates that in the UK there has been relatively little interest in taking out private long-term care insurance. Private Long Term Care Insurance was first introduced in Britain in 1991. Since then, 14 companies have offered similar schemes, but it is estimated that only 23 000 policies have been sold. The insurance market will not provide cover for everyone at risk, and voluntary private insurance is unlikely to work. The Commission concluded that some model of universal risk pooling is essential:

> This views the risk of needing long term care as, in practical, moral and social terms, the same kind of exceptional risk of having a heart attack or contracting cancer. It requires provision that pools the risks in a similar way. The overall solution here should have regard to what will benefit the majority of citizens at the lowest cost to the nation overall, and remove from as many people as possible fear of the costs of needing to be cared for at the end of their lives. Ideally also, the solution should be one under which people contribute according to their means. (Royal Commission, 1999, para 3.16)

Major Restructuring of the Funding System

As other analyses (notably that of the Rowntree Foundation in 1996) have also observed, long-term care incorporates a number of different components which are not separately identified within the current system. The Commission disaggregated these into the following elements:

- living costs (food, clothing, heating, amenities etc.);
- housing costs (the equivalent of rent, mortgage etc.); and
- personal care costs (the additional costs of being looked after because of frailty or disability).

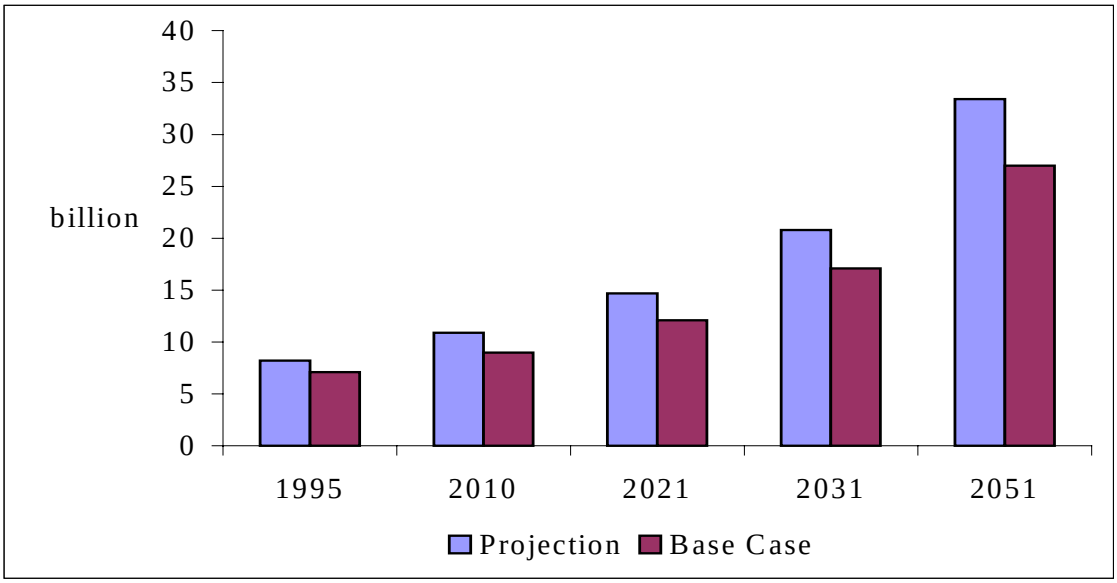
The Commission argued that people should be responsible for living and housing costs (subject to a means test if needing help), but that the costs of personal care should be treated as something 'quite different'.

> These are the costs which unpredictably and through no fault of their own, old people have to incur when unfortunately they can no longer be looked after at home or cannot be sent home after hospital treatment. They reflect the true risk and 'catastrophic' nature of needing long term care. In our judgement it is right for the state to exempt personal care from means-testing altogether. This is our key recommendation. (Royal Commission, 1999, para 6.32)

This proposal would extend universality and a collective approach to personal care, in place of the 'arbitrariness and practical problems of rigorous means testing, the market failures of private insurance and the uncertainty of relying on peoples' private incomes or savings'. Personal care costs would therefore be taken out of the means-tested system altogether, while means testing *would* be applied to living and housing costs. The Commission estimates that the cost of personal care are £122 a week in residential care (approx. half the total average costs), and £217 a week in nursing home care (approx. two-thirds the average weekly cost), leaving a living costs element in both cases of £120. The same principle would apply to the provision of care at home, with personal care provided free of charge. The cost of introducing this change is estimated at between £800 million and £1.2 billion a year. Figure 2 shows the projected costs of making personal care free in both residential and domiciliary settings, compared with the estimated baseline costs of long term care if the system remained as presently structured.

The initial difference in annual costs would be £1.1 bn, rising to an additional £2.6 bn by 2021 and £6.4 bn by 2051. It is estimated that 2.2 per cent of taxes from earnings, pensions and investments is currently spent on long-term care in residential settings and in people's own homes. The changes proposed would add a projected 0.3 per cent, rising to 0.4 per cent by the middle of the next century. The changes would represent a shift from 1.2 per

Figure 2: Projection of Long-term Care Costs and Comparison with Base Costs



cent of GDP to 1.4 per cent. The Commission rejects the argument that making personal care free will result in a deluge of demand for two reasons. First, personal care is not a desirable consumer good in itself; it is only desirable when people have needs for it. Secondly, that need will be determined on the basis of assessment.

The precise funding mechanism for this model would need to be determined: whether it should be pre-funded in some way or on a pay as you go basis, and whether through general or hypothecated tax. The Commission's preference is for a pay as you go system (comparable to the approach with the state retirement pension). They argue against a hypothecated model in favour of sticking with an approach to the use of general taxation which is familiar, progressive, cheap to administer, generally accepted and transparent. Moreover, they suggest that:

> The Government would have an opportunity to re-establish a degree of faith in the tax system and to strengthen the public's willingness to pay for public services, assuming that the money is spent well and efficiently and people can see that this is so. (Royal Commission, 1999, para 6.71)

Despite some major similarities with the approach adopted by the Rowntree Foundation, the Royal Commission advocated a different model. The

Rowntree Inquiry distinguished between the need to deal with immediate funding issues, and those arising in the longer term. Like the Royal Commission, the Rowntree Inquiry had also seen the necessity of separating housing and care costs. In dealing with the longer term, and the unpredictability of that future, the Rowntree Inquiry believed that 'it is too risky just to hope for the best', and that a national care insurance scheme should be established in order to 'throw forward' at least some of the resources required for care in future (Joseph Rowntree Foundation, 1996).

The Rowntree model advocated the establishment of a Long Term Care Insurance Fund, with compulsory contributions. This would provide a 'national investment' and create a pool which would allow monies to be drawn down to meet future care costs, providing the funding base for long-term care, with a reduced burden on general taxation. This apparently simple model nonetheless becomes more complex on closer examination with the Rowntree Foundation envisaging the possible use of the fund to purchase actual long-term care insurance policies. The administrative costs of such a scheme would be correspondingly greater. The logic for the Rowntree approach was argued in these terms:

> By making regular payments throughout their working lives, today's generation would ease the costs on the next generation of taxpayers. This, we believe, is a much safer and more sensible option than hoping the problem will go away or that the electorate tomorrow will be content to pick up a much larger bill than today. (Joseph Rowntree Foundation, 1996: 72)

Why, then, did the Royal Commission reach such different conclusions? The Commission considered the issue of pre-funding which 'offers an appearance of security in that the fund will pay out as required, providing enough is paid in'. But this 'appearance' may be illusory. Pre-funding does *not* necessarily buy security given that the funds can be 'raided' by future generations, and that the funding base could prove to be inadequate. Moreover, there is a major difficulty with 'double funding'. That is, the current generation would be caught in the transition from one system to the other; it would continue to pay through taxation for the care of current cohorts needing long-term care, while also having to find additional contributions to pay into a long-term care

fund for its own future. The Commission concluded that this would 'place an unacceptable burden' on the transitional generation.

In the light of such concerns, the Commission favoured a 'pay as you go' model. Some might argue that the long-term care component of taxation should be hypothecated in order to increase visibility and inspire trust in the system. Against this, hypothecation is viewed as 'inconsistent with the approach of successive Governments to funding public services' (in other words, it is most un-British). As well as being a break with tradition, hypothecation can be seen as a model which reduces flexibility in the use of resources, and *could* expose this area of funding to the risk of cuts (because of its visibility). General taxation, on the other hand, offers certain advantages:

> ... it provides a generally progressively based source of revenue which can be attributed according to the decisions of democratically elected and accountable politicians. If there are problems in the economy the level of funding of long term care has a broader base of support than a single levy. Funding long term care in this way would seem more familiar in the UK system. (Royal Commission, 1999: 73)

There is clearly no problem-free method of publicly funding long-term care. Pre-funded systems are vulnerable and costly; pay as you go models are cheaper and simpler. *Any* model is reliant on the continued readiness of future generations to make the payments demanded. If the pooling of risk is largely to be met through general taxation, the Commission concluded that 'some other visible safeguard is needed for people to have confidence in the system'. Such a device is envisaged in the establishment of an independent body as a National Care Commission. This would be responsible for looking at the care system strategically, stewarding the interests of people receiving services, and reporting to Government and Parliament on spending on long-term care.

Does the Royal Commission Offer an Acceptable Blueprint?

The problems with long-term care which the Royal Commission set out to address were several. In particular, the following can be identified:

- a fear of the future and alarm over the affordability of an ageing population;
- a widespread sense of public dissatisfaction and distrust of the current system;
- a need to address the relative balance of individual and state responsibilities;
- a need to establish a model which offers a new contract for security in old age; and
- a need to develop a system which supports appropriate models of care and encourages independence.

The Commission was quite clear in its conclusion that in the UK there is no problem with a demographic timebomb, and therefore 'the costs of care will be affordable'. The major breakthrough achieved by the Commission can be argued in its conceptualisation of long-term care as a risk which is best met by some degree of risk pooling. While simple in its essence, this is a substantial departure from the existing system which treats the risk of long-term care largely as a matter either of individual luck or misfortune, and which offers limited support to individuals in need of such care on the basis of their financial hardship, rather than because of their need for *care*. Personal care was viewed by the Commission as equivalent to the need for health care. We can all expect to grow old; we do not all expect to need personal care; it is 'a contingency, not a probability'. The chances of needing such care fall in many ways randomly, and the costs of this have to-date been allowed largely to lie where they fall.

What the Royal Commission can be said to have offered is a new clarity in setting out the respective rights and responsibilities of the individual citizen and the state. Whereas the current system is characterised by lack of clarity, uncertainty, fear and confusion, this alternative model offers a degree of simplicity and transparency.

The implementation difficulties which can be anticipated were, nonetheless, evident in the fact that the Commission failed to secure a unanimous report. Two members signed a note of dissent (within which they also disagreed with each other). Their main concern was with the central recommendation

that personal care should be provided free of charge, paid for out of general taxation and delivered on the basis of an assessment of need (Joffe and Lipsey, 1999). The note of dissent argued that there is a tension in attempting to improve services for those who cannot afford to provide for themselves, and easing the burden on those of moderate means. While not arguing for a pure free market approach, Joffe and Lipsey do not wish to see a universalist welfare model take root:

> It is not enough merely to focus on public activity in this field. We believe that there is also dignity that comes from providing for oneself in old age if one can afford to do so ... Universal welfare provision discourages thrift and self-reliance. (Joffe and Lipsey, 1999: 116)

Joffe and Lipsey contend that the Commission's main recommendation fails to take account of the irresistible demand for higher standards of provision. If these costs were to be met privately, this would not be a problem ('If they want better long term care they will just have to spend less on other things they could buy, and save the money for their old age'). However, if funding of long-term care is to be provided by the state, Joffe and Lipsey believe this to be more problematic:

> There, spending on care will have to compete against other desirable objects of increased public spending; and against the natural desire of taxpayers to keep taxes low. While it is relatively easy to justify spending on minimal provision, it is harder to argue for it for less spartan standards. (Joffe and Lipsey, 1999: 118)

The projected costs offered by the Commission are viewed as 'alarming', and Joffe and Lipsey believe that making personal care free would lead to a major increase in demand. Moreover, they argue that the main beneficiaries of the changes would not be the worst off:

> Most of the beneficiaries, it is true, are not by any standard rich, though the rich will also benefit. But the priority for state support should be those least able to fend for themselves. Even relatively well-off older

> people would not be the true beneficiaries. The true beneficiaries would be their heirs, rich or poor ... The effect of the free personal care proposal on poor people will not stop there. We live in the real world of limited financial resources, including resources for the care of elderly people. If more of these are absorbed by making personal care free, this is likely to mean less spending on services for poorer elderly people. (Joffe and Lipsey, 1999: 119)

In short, the counter-argument to the Commission's central proposal utterly rejects the idea of universal provision against the risk of long-term care. Joffe and Lipsey believe that the current situation presents people with certain choices:

> They can insure themselves privately. They can accumulate savings to pay for their care. They can rely on running down their assets, particularly their housing assets. Or they can do nothing. The argument for moving beyond such individual responsibility to collective provision is weak. (Joffe and Lipsey, 1999: 120)

The views set out by Joffe and Lipsey are unlikely to find widespread support. Many of the concerns reflected in evidence to the Commission, and to previous inquiries on long term care, indicate the genuine sense of injustice and inequity which Joffe and Lipsey's critique fails to address. However, there *are* elements of their argument which are likely to find some resonance. First is the point that the Commission's proposals *would* benefit some better off people at the expense of some poorer, and second is the argument that universalism is very much out of favour, and the whole trend (including under New Labour) has been away from the expansion of universal benefits and accompanying high taxation and towards low taxation and selective welfare provision.

Political Response

The political reaction to the Commission's proposals has been initially cautious. As the Secretary of State for Health (Frank Dobson) told the House of Commons,

> This is a complex issue. And none of the options is easy. We have to get this right ... I hope that the Royal Commission's report and the debate that it will stimulate will help us to find a way of ensuring that people have access to high quality long term care that is fair to both individuals and the taxpayer. I hope that it will be founded on a consensus that will stand the test of time: a dependable contract across the generations. (Dobson, 1999)

In view of the highly controversial nature of the long-term care debate, it is surely right to believe that any alternative must be one that 'broadly speaking, commands the support of all the parties in the country, and of the people of this country' (Dobson, 1999). However, in the absence of an immediate endorsement from the Government, there is some concern that further procrastination will mean that the proposals stand little chance of being adopted prior to the next General Election, or that some of the cheaper options might be adopted which would ameliorate the situation but would not deal with the fundamental question of respective rights and responsibilities. On the other hand, the facts that the Labour Party was so critical of the Conservative's handling of long-term care, that once in government they moved to establish the Commission, and have now received its report, creates some climate of expectation. As the Royal Commission itself observed, doing nothing is not an option. In his introduction to the report, the Commission's Chairman, Sir Stewart Sutherland provided further reasons to believe that 'doing nothing' would be difficult for the Government:

> ... in the case of funding long term care for older people we have a unique combination of a subject to which there is no obvious answer but one for which, in the UK, something needed to be done quickly. By agreement in advance our timescale was set at around one year. This is because it was quite clear that the

> present unsatisfactory state of affairs should not be allowed to continue, and that the Government's clear willingness to formulate policy and to act should be informed by the Commission's Report. (Royal Commission, 1999: x)

3 The Australian Experience

It is not proposed to provide a detailed analysis of long-term care in Australia. Nonetheless, there are some parallel developments which are of particular relevance, and which should provide some cautionary tales for those embarked on major structural change to the UK system. 'The Nursing Homes Debacle' is the shorthand which refers to the 1997 proposed policy reforms to the system of paying for nursing home care. The furore which greeted their introduction hastened a swift climb down by the Prime Minister in the face of a public outcry which threatened to cost the Government's re-election. The main controversy was over the introduction of a nursing home entry fee in the form of an accommodation bond. While such a bond had long been an accepted feature of hostel accommodation, it had not previously been a component of nursing home care. In parallel with the health and social care divide in the UK, in Australia hostel accommodation has been seen very much as a lifestyle choice for people with lower level care needs, while nursing home care is that which is necessitated because of people's frailty and ill health (with some 60 per cent of admissions being made directly from hospitals). The accommodation bonds were developed primarily as a mechanism to provide a pool of funds to assist with the capital upgrading requirements of nursing homes.

The public outcry which greeted the accommodation bond reflected a number of concerns. Just as people in the UK have felt that they have worked and paid taxes all their lives to pay for their care in old age, and then find themselves confronted with the need to pay again, so too in Australia was there outrage. The prospect of having to sell the family home to pay large bonds to nursing home proprietors was not welcome, albeit that the bond system would effectively represent an interest free capital loan to the providers. Unlike the system in the UK which necessitates the spending down of capital assets, the proposals in Australia would have seen the majority of the bond eventually repaid to the estate of nursing home

residents. The Prime Minister's surprise backdown on the changes scrapped the accommodation bond for nursing homes, although introducing a new system of accommodation and care charges.

The overall approach to long-term care in Australia is similar in many ways to that which has evolved in the UK. Despite similarities, there are also significant differences, particularly indicative of the different underlying political structures and the Australian federal system of government. Unlike the UK, the approach to planning and funding residential and nursing home care in Australia is highly centralised, with normative planning levels specified by the Federal Government covering the number of hostel places, nursing home beds, and Community Aged Care Packages (CACPs) to be provided per 1000 elderly population. The Home and Community Care (HACC) service, which is broadly comparable to local authority social services support in the UK, is decentralised to the state level.

Just as social security subsidies inadvertently distorted the community care terrain in the UK in the 1980s, with the availability of 'perverse incentives' for residential and nursing home care rather than for community-based support, similar developments also took place in Australia. The 1983 community care reforms introduced under a Conservative administration in the UK, which sought to cap the social security budget and introduce controlled access to residential and nursing home care, were very similar in focus to the Aged Care Reform Strategy introduced from 1983 by the Federal Labor Government in Australia. A series of reforms led to central control on the provision and use of nursing homes; tighter entry criteria and standardised assessment procedures through the development of multi-disciplinary Aged Care Assessment Teams (ACATs), and the introduction of differential subsidies for nursing home proprietors linked to the dependency level of residents (Fine, 1998). The net effect of these changes was to refocus policy and practice as follows:

> These measures saw a marked shift in Australian policy for aged care towards community support, with greater emphasis on assessment and targeting as a means of ensuring that individuals receive appropriate services while tight budgetary constraints were maintained. As a result of these changes, a gradual shift in expenditure

> in favour of community care took place. (Fine, 1999: 111)

Most recently, the focus of various initiatives and special projects in Australia has been on approaches which address support at the primary care level, and which focus on breaking down boundaries between hospital and home support (Fine, 1998). The Coordinated Care Trials, are one such example, and in the use of pooled budgets across hospital and community services, are of direct interest to initiatives signalled in the UK which seek to break down the so-called 'Berlin Wall' between health and social services and remove barriers to joint working by introducing new powers for the development of pooled budgets, lead commissioners arrangements and integrated provision (Department of Health, 1998). Fine has observed that it is not, as yet, possible to speak of an 'Australian model' for integrating care services across sectors because there is such diversity and no single 'best practice' model has yet been proved (Fine, 1998).

Just as in the UK, in Australia too, there is considerable debate over how long-term care should be paid for, with - as Howe has commented – 'the present focus on containing expenditure turning to considerations of raising revenue' (Howe, 1997). Options which have been examined include linking financing to retirement income and superannuation, on the one hand, or adopting an insurance-based approach on the other (Fine and Chalmers, 1998). Howe comments that without some comprehensive model of funding, the growth of means testing and user charges will continue. Moreover, it will be essential to involve the community in debate if:

> paying for aged care is to move beyond divisive argument about intergenerational transfers. A social insurance-based scheme would not only commit the community as a whole to providing for aged care, but, if combined with public health programs that reduced disability and the need for care, could yield a windfall for all. (Howe, 1997: 323)

Fine and Chalmers (1998) have advocated a social insurance model, perhaps linked into existing Medicare insurance. Exactly as in the model being proposed by the Royal Commission in the UK, this would aim to fund health care in any setting - home, hospital or residential facility, whilst individuals

would still be 'responsible for the payment of their costs of accommodation, food and other aspects of material support' (Fine and Chalmers, 1998: 46). It has not proved politically acceptable in Australia to generate additional revenue for aged care on the scale required simply by increasing charges and entry fees. The only other options, suggest Fine and Chalmers, are increases in general taxation or the development of a model of social insurance. Further development of how such models might operate in detail has been offered by other commentators (Howe and Sarjeant, 1999; McCallum, 1998; Swerissen, 1999).

4 Conclusions

In both the United Kingdom and Australia, as in the rest of the developed world, the challenges of paying for long-term care are substantial. In both countries too, much of the focus of political concern and intervention in the field of aged care since the early 1980s has been in relation to cost containment and management of the balance between community and residential-based options. Thus, the underlying objective has been to support people in the community wherever possible, and to ensure that admission to nursing home care is conditional on assessment of need and targeted on those with high level care needs. Whatever the success of this strategy, there is also recognition that this fails to address more fundamental questions of how to pay for long-term care in the future.

Even on the more optimistic scenarios of trends in disability and dependency, and assuming that some compression of morbidity *does* take place such that the period of high need is concentrated into a shorter period at the end of life, nonetheless the upward pressure of increased numbers of very elderly people will be profound. Decisions about whether and how the risks of needing care in later life should be shared between individuals and the state, and - crucially - between generations, must be the result of genuine public debate and the establishment of some measure of consensus. In both countries, the failures to initiate a proper debate, and attempts to introduce covert policy changes have resulted in widespread resentment and mistrust, among both the elderly electorate *and also* among younger generations of potential inheritors concerned at the loss (or reduction) of the assets they had been led to expect would flow to them.

In some respects, the debate about whether capital assets *should* be protected has diverted attention from the wider questions about collective responsibility and sharing of risks in aged care, and the anomalies which arise in treating these risks as different to the risks of ill health. Left to itself, the market will not solve the problem of paying for long-term care. Private insurance is unaffordable for many, and on a voluntary basis is unlikely to prove attractive. Increasing interest has been shown in various models of compulsory risk sharing, whether through a specific social insurance model (such as in the Netherlands, Israel and Germany), or through a general taxation revenue base, such as has been proposed by the Royal Commission on Long Term Care in the UK.

Without some form of explicit risk pooling for long-term care, it can be anticipated that the hybrid of public and private responsibility which currently typifies the model in both Australia and the UK will become increasingly stretched and discredited. The extension of user pays principles is both unpopular and apparently inequitable, and effectively represents further taxation of 'those individuals who have the misfortune to require aged care services' (Howe, 1997). The alternative of pooling risks and sharing costs (which might take place through various mechanisms) offers a way forward which has at least the prospect of improved individual security and enhanced social cohesion, in short:

> ... an opportunity for a new contract between Government and people and between all generations of society ... The nation will have demonstrated that it values its older citizens, and will have given them in large measure the best thing any society can offer - freedom from fear and a new security in old age. (Royal Commission, 1999, para 10.31)

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