Choices, Policy Logics and Problems in the Design of Long-term Care Systems

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Abstract

Establishing a public, comprehensive, independent, mainly community-based long-term care system, separate from medical care and social services, can lead to the provision of more effective and consumer-oriented services, and also to a more appropriate mix of public/private financing. Of the two main approaches to financing long-term care (LTC), a tax-based model is more flexible in providing benefits according to the individual’s need, since income levels and the family’s ability to provide care will be taken into consideration, while a social insurance model is more rigid because the individual’s rights are more explicitly defined. The latter system is likely to provide more opportunities for choice, including decisions about the mix of health and social services. Policy-makers must decide which approach to take after weighing the positive and negative aspects of each, and the existing organizational infrastructure. Decisions must also be made on the practical issues of coverage, fairness, form of benefits, service delivery patterns, relationship with medical and social services, and controlling costs. With increasing pressure to contain public sector expenditures and improve efficiency, the focus of care will gradually shift from medical care to LTC, and within LTC, from institutions to housing. How to make this process proactive and planned, instead of ad hoc and reactive, is the challenge for public policy.

Keywords

Long-term care; Social insurance; Entitlement

Basic Issues

Although long-term care (LTC) has been rising on the policy agenda of many nations, we have noticed that it is usually discussed rather narrowly in the context of a particular nation. Lacking is a broad, generic framework of how LTC could be financed and delivered. In this paper, we will provide a rationale for establishing an independent LTC system and discuss several practical issues that must be addressed in its design. It is useful to begin by quoting the Institute of Medicine’s (1986) definition of LTC as: “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 or friends as well as formal services provided by professionals or agencies". A careful reading of this brief explanation provides us with some hints as to why it has been difficult to establish LTC as an integral part of social security.

Why LTC is difficult

We note first the difficulty of defining the proper line between public and private responsibility. It is easy to agree that care for an old lady who is alone, impoverished, and frail should be a public responsibility. But what if her husband is alive and fairly healthy? Or what if there is money in the bank, or an asset like a house or car, should she still be eligible? If so, should her children inherit those assets? What if the children are well-off, should they contribute? Or if nearby children could provide hands-on care? In fact, most hands-on care for frail older people in the community is provided by family members, in all countries (OECD 1996). If formal services were provided, would families withdraw? Worries and conflicting views on these issues make LTC policy hard to think about.

A second problem is that LTC requires “a variety of ongoing health and social services”. As is well known, health and social services professionals have very different goals and working styles (Kane 1996). In general, health professionals try to be objective and are focused on change, so that they usually tend to lose interest if no improvement is likely. On the other hand, social services professionals try to be empathetic and are geared to the present so that they tend to pay insufficient attention to the possibilities of improvement with medical treatment. These differences in their education and training make it difficult for members of the two professions to work together in teams. Differences in how medical and social services are organized and financed make cooperation even harder to develop and sustain at the organizational level.

The third and perhaps most crucial reason for the reluctance to think seriously about expanding LTC is simply cost. The governments of all the industrialized nations are worried about the increasing burdens of population ageing on their pension and health care systems. In that context, taking on LTC as a new, costly entitlement programme looks foolhardy.

Why do it?

Given these formidable obstacles, why have several nations decided to recognize long-term care as an integral part of their social security systems? The answer is that establishing a new LTC system, daunting as the prospect might be, has appeared to be the best or only solution to major social policy issues.

Population ageing itself is certainly at the core. As the number of old (especially old-old) people goes up, so will the number of those who cannot
lead a decent life without assistance. Traditional sources of care are declining. Changes in family patterns mean that fewer (and older) spouses and children will be available to help. An increasing proportion of women in middle life are employed outside of their homes (Jensen and Jacobzone 2000).

Increasing LTC burdens cause distortions and fiscal strains in programmes designed for other purposes, such as medical care, social welfare, and housing. The strains may fall particularly on the medical care system because its services are available on a universal basis, in contrast to the restrictive means-testing in social welfare.

Perceptions of unfairness are growing among the public, whether centred on older people forced into poor-quality nursing homes, family caregivers facing intolerable burdens, or even potential heirs who resent “spend-downs” or the family home being sold off.

Governments of all advanced nations are aware of these trends, which have led to many policy experiments and new programmes aimed variously at lessening burdens, rationalizing programme structures, and holding down costs. Most such initiatives try to emphasize “community-based” services rather than institutional care, with varying success. The growing concern led the OECD nations in 1998 to agree on trying “to co-ordinate the roles of health and social care systems so they provide appropriate and integrated care for those with long-term needs”.

These goals can be met by adopting a public, comprehensive, mainly community-based, independent system to provide long-term care for frail older people. “Public” because voluntary private LTC insurance cannot work for reasons of adverse selection, moral hazard and so forth. “Comprehensive” because the common practice of adding incremental programmes to fix this or that problem as it appears often increases inequities and irrational cross-subsidization. “Mainly community-based” because even frail older people should be able to live as close to normal lives as is feasible. “Independent” rather than integrated into other social policies because LTC has a logic of its own.

Why not as part of health care?

Since in many countries long-term care is generally regarded as part of the health care system, the reasons why this is not appropriate should be clearly stated. First, despite the fact that an increasing share of health expenditure is being spent on managing chronic diseases, such as hypertension and diabetes, doctors are still oriented toward curing acute illness. Putting doctors in charge of long-term care could lead to both over-medicalization (such as in terminal stages) and under-medicalization (such as in rehabilitation). Second, a doctor’s professional opinion is vital for medical care, but is not as important in choosing among LTC alternatives, or evaluating their quality. If professional help is needed, it is more advice and assistance, where the doctor’s self-confidence and the patient’s deference would be a minus. Third, in practical operation, including LTC within the health care system runs the risk of it being infected by inherently high-cost practices on the one hand,
or having its resources leached away by more powerful actors in the acute care sector on the other.

The fourth reason is still more fundamental. Medical care is notoriously hard to ration explicitly because withholding a treatment may be a life-or-death matter. The tendency is to do whatever is medically necessary in the individual case, even at high cost. Outcomes thus cannot be related to the ability to pay. In long-term care, the issue at stake is more a matter of degrees of comfort and unpleasantness than life vs. death. In many respects LTC is part of daily life. The idea that everyone is entitled to some minimum level of care, but those with more money will be able to live more comfortably, is far more acceptable in LTC than in curative treatment. Thus, reaching a consensus on the degree of public/private mix in financing would be much more feasible in LTC.

Thus, for reasons of both principle and practicality, a public, comprehensive, independent system of long-term care is appropriate in advanced nations. The goals of the programme should be to improve the quantity and quality of care available to frail older people; to mitigate the financial, physical, and emotional burdens on their families; and to minimize the costs of LTC borne by society as a whole by a judicious expansion of public responsibility.

Can we afford it?

The OECD has estimated that total costs for long-term care, not including informal care, will run to about 1.5 per cent of GDP in a typical advanced nation. This figure will be affected by population and morbidity trends, and more by the extent to which formal care is provided—in Sweden, with a relatively old population and very high provision of formal care, total LTC expenditures are 3.2 per cent of GDP (1999) (Karlsson 2002). Even if the present trend in the compression of morbidity continues, there is likely to be a decrease in the amount of informal care that is readily available because of the social trends mentioned above. The question then is what share of those costs will be “socialized” or covered from public sources rather than privately by the individual or family affected.

In most advanced nations, public LTC expenditures run from 0.6 to 1.0 per cent of GDP. Although substantial improvements would require new public spending, they are not likely to be overwhelming, and should be easier to control, as would later be explained. The point to keep in mind is that many of these costs are already being borne somewhere: in the public sector as inappropriate and expensive substitutes in medical care and social services, or in the private sector as substandard care, burdens on informal caregivers, and spend-down of a lifetime of savings or paying the cost of “estate management.” Thus, the proper question for public policy is whether overall efficiency and fairness would be sufficiently enhanced by establishing a comprehensive, independent, public system for long-term care.

Two models for expanding LTC

Long-term care is provided and financed through a great variety of institutional mechanisms around the world (Royal Commission 1999). However,
when policy-makers and the general public are considering a major expansion, it is helpful to think in terms of two “ideal types”. One is to build on the social welfare system, with services paid by taxes. The other is the creation of a new social insurance programme for LTC. Although hybrids are possible—for example, in the Netherlands provision is the former and financing the latter—characteristics of these two models tend to cluster together.

Tax-based models of long-term care, such as in Scandinavia and the United Kingdom, have developed incrementally from earlier systems of welfare or social services aimed mainly at poor people, by expanding the kind of services needed by frail old people (particularly community-based services) and relaxing the means test. The client applies to a local agency, a case-worker decides what services are needed, and the services are usually delivered by a monopoly provider, either a government agency or by contract with non-profit or for-profit organizations. Eligibility criteria are flexible, and can operate by comparing each individual’s need relative to the rest of the population covered, including availability of informal support. Thus, an individual does not have an explicit entitlement to be provided with services at all, much less any specific type or quantity of services.

The social insurance model, in one sense, can also be developed incrementally by expanding health insurance (as in France and to some extent Austria). However, for the reasons noted above, there is a strong logic for establishing an independent system such as has been done in Germany (1997) and Japan (2000) (Campbell and Ikegami 2000). Public, mandatory LTC insurance is financed completely or in part by designated insurance premiums. The major difference from the tax-based model is that the benefits are an explicit entitlement to individuals, with their eligibility decided according to objective criteria based on the extent of physical or mental disability. Income and availability of informal care are not taken into account. Choice of services and providers is in principle up to the consumer since benefits are in cash or (in effect) vouchers.

The advantages of the tax-based model are that it can be expanded or contracted incrementally depending on the fiscal situation, that money is not “wasted” on people with higher incomes or with informal support available, and that monitoring the quantity and quality of care at the individual and macro levels is easier. There are also some likely disadvantages. Monopoly providers—public, voluntary or private—tend to be run for the convenience of the organization and its staff with little incentive for better performance. Except in Scandinavia, where the norm of entitlement by right seems to be well developed, the stigma of means-testing may linger and inhibit both participation and support from the middle class. Also, bureaucratic provision is hard to integrate with informal or self-financed care. Finally, the problems arising from the differences in the entitlement criteria and the charges made to client between the health and social services are likely to increase as the two components become integrated. These disadvantages could be overcome by using direct payments to purchase integrated care (Glendinning et al. 2000), which would entail the development of an independent LTC system.
The advantages of the social insurance model rest on making LTC an explicit and uniform entitlement for everyone. Complicated and demeaning social and financial eligibility rules and arbitrary bureaucratic decisions are eliminated. Letting consumers decide what services they want meets their preferences (including the mix of health and social services), and also ameliorates turf battles and encourages competition over quality and (possibly) price. Disadvantages include the “waste” of resources or “dead-weight cost” of covering people who could rely on their own funds or family without public support, and the difficulty of monitoring the appropriateness of services.

As a practical matter, the choice between the two models is usually less a question of philosophical preferences than institutional legacies. It is not a coincidence that the tax-based model (Scandinavia, the UK, Canada, Australia and New Zealand) is found in nations where medical care is also financed from taxes or de facto taxes, while the LTC insurance approach has been taken by Israel, Germany, Austria and Japan, where medical care is provided through social insurance. One reason is that LTC requires a substantial infrastructure, which can be developed more easily from an existing system (note both Germany and Japan rely on existing health insurance organizations to collect premiums). Another is that policy-makers and citizens are likely to think in accustomed channels even about new issues.

Still, an institutional legacy is not a predetermined fate. Many nations including the United States have experience with both types of social policy, and have the ability to mix the two (as in the Netherlands) or to choose based on conscious preferences. Japan is one such example: it was headed towards a tax-based system but changed course and decided on social insurance. Moreover, whichever basic system is chosen, many important choices remain when deciding how to design and manage a public, comprehensive, independent LTC system.

**Practical Issues in Organizing LTC**

**Coverage**

In any LTC system, benefits are restricted to people who need assistance to lead a decent life, however that may be defined and ascertained. There are many advantages to having that as the sole criterion for eligibility. However, to restrain costs, various additional criteria may be added. Restricting benefits to when informal care is not available or to those with low incomes is common in tax-based systems, as noted. Sometimes eligibility is restricted only to certain favoured categories of people—even the United States provides long-term care to war veterans who meet certain conditions, as well as to people with low incomes and assets.

Limiting the system only to the elderly takes care of the most pressing problems at somewhat lower cost while avoiding troublesome demands on the system (for example, younger disabled people may demand employment subsidies or provision of high levels of mobility that would not be so important for frail older people). On the other hand, age-based criteria may invite intergenerational resentments, particularly since it will be the younger
people who will bear much of the cost. In general, the principle of “universality” has many advantages in diffusing feelings of unfairness.

Fairness

Transparency and perceived fairness are critical to sustaining the system. In a tax-based system, since the amount is determined according to the relative need of each individual, there must be implicit trust in the competence and integrity of the local officials or “care managers” who will actually be making the decisions. The extent to which the government’s guidelines are explicit and/or binding, and the appropriate balance between flexibility in interpreting need and consistency in following prescribed standards would differ according to each country. However, the individual’s physical and mental status should be objectively assessed, and if income level and the amount of informal care available are to be part of the criteria, the degree to which these factors impact on the provision of formal services should also be made explicit and disclosed.

In a social insurance system, the assessment process, limited to the individual’s physical and mental status, is more important since the amount of benefits will be explicitly set by eligibility levels. A classification system must be developed to place each applicant into the appropriate eligibility level. This would be based on the standard care time that is needed for that level of disability (Ikegami 1997). The extent to which this process would follow a sophisticated algorithm would depend in part on how much trust the public has in the integrity of the assessor—for example, in Germany doctors employed by the sickness funds play this role and the criteria for assignment are not explicit.

In both types of system, there must be mechanisms for monitoring the eligibility process and for appealing adverse decisions. It is important that applicants are confident they will get a fair hearing in a different venue from that of the initial adverse decision. However, relying on the judicial system should be a last resort: the extreme situation that prevailed in the American disability insurance programme in the 1980s, when eligibility was denied and then reinstated by court appeal in a great many cases, is clearly undesirable (Mashaw 1998). Those already in the system need an advocate of some sort, such as the client’s own care manager or an active ombudsman.

Form of benefits

Long-term care is usually divided into (1) institutional care, including medical and rehabilitation services for chronic illness and disability; (2) in-home services, generally including “body” or hands-on care (such as bathing and toileting), nursing and possibly rehabilitation, homemaking, and various aids to family caregivers; (3) institutional services for clients living in the community such as day-care and “night-care” (temporary “respite” placements in a nursing home); and (4) material supports such as wheelchairs or other devices and reconstruction of the home. These benefits may be offered as directly provided in-kind services, as cash, or as “vouchers” with
which the client can purchase services. Each form has advantages and disadvantages.

An in-kind benefits system is normal in medical care, where in principle there is no limitation on the quantity of treatments, only professionals can decide what is needed, and purchase of additional services out-of-pocket is legally restricted. In long-term care, it is perhaps the easiest method for either very small or very large programmes. When eligibility is restricted to the poor by a strict means test, services will be provided without charge, and it is generally seen as acceptable for a local government official to decide both how much of what kind of services is needed and how they should be provided to each individual. At the other extreme, if a government’s policy is to offer virtually any service that any citizen wants at public expense (a hypothetical situation that seemed to be approximated in Sweden in the 1970s—Karlsson 2002), simply providing the service on demand by public or contracted-out agencies is the most direct way to do it.

In-kind benefits are more problematical, however, when the programme is supposed to be broad but not unlimited, and adequate care, cost-control and fairness are all highly valued. Middle-class clients are likely to demand more say in deciding what services they want and whether they like what they are getting. The proper amounts for co-payments are hard to determine (particularly if they are on a sliding scale depending on income), and the distribution of services easily becomes irrational and unfair (e.g. if the pool of home helpers is completely occupied, there is a tendency to refuse new clients rather than reduce services to current clients even if their need is less). It is also difficult to integrate the directly provided services with additional services to be paid out-of-pocket, if the client wants more than the minimum.

At the other extreme, cash benefits provide the greatest freedom of choice to consumers, and typically support family caregiving, often the type most preferred by clients. In low-income households the cash benefit can raise the standard of living for the entire family. All those who are eligible would apply and would receive immediate benefits: they would not have to wait until the LTC delivery system has fully developed. In Germany, most people have chosen cash benefits over direct services. Cash benefits for informal care appear natural in a social insurance system but they can be approximated in tax-based systems as well, as by an agency “hiring” a relative as a service provider.14

On the other hand, there is the worry that cash payments would be absorbed into family budgets with little real improvement in the situation of the older person or of the informal caregiver. Note also that cash benefits give more of an incentive to cheat on eligibility. Offering cash can save money in one sense—in Germany a client chooses between a cash allowance or roughly double its worth in services—but would initially cost more, and possibly in the future too, because the beneficiaries would not be limited to those who really need the services.

Vouchers can avoid many of these problems. They allow a high degree of choice within a (presumably long) list of approved services and providers. There is little risk of inappropriate use. It is easy to top-off services purchased by the voucher by paying out-of-pocket. Although services may not be
immediately available, the demand created by vouchers should bring their rapid development, and lead to adjustment of supply and demand on market principles. Thus, expenditures will increase as the programme matures, but this is only to be expected as the previously unmet demand will be satisfied by making LTC services an entitlement.

Service delivery

The three key variables in considering how services should be delivered are the ownership of providers (public, voluntary, commercial), the scope of services offered by individual providers (integrated to specialized), and the extent of competition.

With respect to ownership, the trend in most nations is away from direct government provision—often because costs are high due to civil service rules and unions. Commercial firms are often thought to be more efficient, and can be created quickly by mobilizing private capital. Non-profits may be able to draw on more community support (including volunteers) and coordinate better with informal care. In tax-based systems, local authorities may contract out to commercial firms or established non-profits, typically monopoly providers for a given area, or a care manager may negotiate a mix of services for individual clients from various providers. Under a social insurance system, the client may choose freely. In any case, information about providers’ services and how they measure on quality should be made available to the local government or consumers so that intelligent choices can be made (Ikegami et al. 2002).

Services can be offered by integrated agencies that provide the full comprehensive range as a package, or they may be delivered from several independent, specialized providers. Integration of health and social components of LTC could be achieved through top-down government directives, butressed by joint financing and more flexible organizational arrangements in tax-based systems (Glendinning 2002), or through the bottom-up development of new services and mergers of providers in social insurance systems. Very integrated systems run the risk of individual clients becoming so enmeshed that they have little effective power, while clients picking and choosing among narrow providers may not have access to good information or effective coordination. Regardless of how providers are organized, integration of care by a team at the grassroots level would be facilitated by having a uniform assessment form, a common care-planning instrument, and cross-training of staff (Ikegami et al. 2002).¹⁵

Good performance should be encouraged by competition, whether between two or three large, integrated providers or among many specialized organizations. In tax-based systems, although local governments may contract out services (with periodic bidding, among non-profit or for-profit organizations), since providers tend to have a monopoly within the local area, clients will have little real choice and would not directly benefit from competition. In social insurance systems, clients would have freedom of choice in theory, but the actual extent would depend on the services available—probably restricted in rural areas or if there are barriers on entry to the market.
Incidentally, the term “care manager” is often heard in connection with LTC. The care manager’s role is to help clients choose among options and to coordinate among providers. Tax-based systems require care managers (though the term may not be used) to allocate limited resources on behalf of the community, and this creates a potential conflict of interest since clients may wish for more services. Care managers are optional in social insurance systems: in Germany, the client or her family directly purchases services and a simple care plan is written up by the service provider. However, Japanese policy-makers were worried that clients would have a hard time choosing and coordinating services, and so care managers were introduced when the LTC insurance was implemented. Most of these care managers are employed by service providers and clients can freely change their care manager. Care managers in various countries differ greatly in their qualification requirements, status and employment arrangements—an indication of the diversity of approaches to LTC.

Relationships with other sectors

Long-term care services overlap substantially with other elements of social policy. At the level of formal organizations, the interfaces with medical care, social services, and housing are particularly important and difficult to manage. Still more vital is the relationship of LTC programmes to the family.

First, medical care. Assuming that LTC management and financing are separate, the key questions are functional differentiation on the one hand, and effective integration where appropriate on the other. The relationship is frequently troublesome—for example, in Sweden, Germany and other nations, medical and LTC organizations have tried to dump expensive patients on to the other side. Of course, serious acute problems should be handled via the regular medical care system (i.e. in a hospital, paid by medical care funds), but what about minor acute problems, complex chronic care, and hospice care? Moreover, post-acute care, including rehabilitation, that used to be provided in hospitals, has been increasingly turned over to nursing homes and community care agencies. Since medical needs have a higher profile, there is a risk that post-acute care will take priority over personal care for the frail and chronically ill elderly, as has been the case in Canada (Chappell 1998).

The last issue could be solved by making the entitlement to personal care explicit so that those who meet the eligibility criteria would be assured of these services, in principle irrespective of the budgetary situation and the demands placed on the LTC system. The more general issue concerning the extent to which medical care should be provided within the LTC system will depend on two factors. One is the sophistication of the payment mechanism. If LTC providers could be appropriately compensated for the higher costs of medically complex cases, then the LTC system would be better placed to meet this growing demand. The other is how the professional staff is paid. If employed by the provider, then it would be inefficient to dichotomize care rigidly into “medical” and “non-medical” within the same organization, and pay separately from different funding sources. This can be avoided: in Dutch
nursing homes, doctors work full-time and their services are included in the facility’s budget.17 On the other hand, if the doctor is not paid by the LTC provider, as is the norm in community settings, then the medical services, including medication, should continue to be funded by the medical care system.

The most difficult relationship with the social service sector occurs when regular LTC benefits do not cover a high proportion of the real cost of care, in which case many LTC recipients will be forced into public assistance (as is true for at least half of the nursing home residents in Germany, for example). Otherwise, people whose level of disability is not very high, but who cannot get by on their own due to low income or a lack of social supports, are a difficult problem, particularly when starting up a new social insurance system since they may lose the care they had been receiving. The solution would be to provide regular LTC services on a universal basis, but continue to make available additional means-tested social services for those in need.

Third, skilful use of housing policy can make LTC policy much easier. Sheltered housing, even with a low level of service, can be adequate for many moderately frail older people, and more intensive LTC services can then be added gradually as needed. In several countries, as LTC services become available, the division between “institution” and “home” has faded. “Ageing in place” replaces physically moving people as they get more frail. Scandinavian nations have used grants to improve people’s own houses, as well as to construct innovative group housing (e.g. for Alzheimer’s patients), in combination with extensive community-based services to provide good care at reasonable cost. In Denmark many nursing homes have been converted into housing facilities. For middle-class elderly people, publicly provided basic LTC services can be conveniently supplemented by out-of-pocket purchase of quite comfortable housing (a possible future path even for the United States, which has extensive assisted-living facilities of various sorts).

With the development of group homes and continuing care communities, the need for institutional care as it is now understood may decrease to a point when it will be reserved to those with severe problems, particularly dementia (Wiener et al. 1994), or post-acute or chronic cases that require extensive medical supervision. This direction would not only relieve pressures on public financing, but also offer greater opportunities for individual choice and autonomy. Also, by reclassifying the majority of nursing homes as “housing”, “hotel” charges could be levied on the residents if public assistance programmes for those who are unable to pay were to be made available.

Finally, a question that often comes up in discussions of LTC is whether increased formal services will simply substitute for family care. From a strict cost-cutting perspective, a government would clearly prefer uncompensated family caregiving either to a cash subsidy or to formal services provided as an entitlement. However, it could be argued that if relatives are relieved of the heaviest burdens of care, relationships within the family will improve and more emotional support will become available. Moreover, in many cases the quality of the care may be higher from the point of view of the client—for example, day care with its combination of rehabilitation and social
participation cannot be provided by families very easily (and indeed is unlikely to develop as a private market). Cash allowances may also improve family relationships, but would neither necessarily relieve the actual burdens of caregiving very much, nor ensure high-quality care.

Controlling costs

A nation that establishes an independent, comprehensive LTC system has presumably already decided to go beyond providing minimal, residual benefits. Either social insurance or tax-based systems can be very lavish and expensive or relatively modest, depending on the coverage in terms of numbers of people, kinds of disability, and extent of comfort guaranteed. For example, in the tax-based Scandinavian countries, the safety net is placed quite high so that individuals will be provided with services that are more generous than under the German social-insurance model. On the other hand, the German system is more generous than the English tax-based system.

Both initial expenditures and the rate of increase depend on how the system is designed. A social insurance approach that includes cash will attract all eligible people right away, so that the initial expenditures would be high but the rate of increase slow, as is the case for Germany. In a tax-based system or a social insurance system limited to direct services, initial spending may be relatively low because many potential clients will continue to prefer family care (at least in part and at least initially) but the growth rate would be greater as people become more conscious of their rights. Initial spending and benefit levels must be set taking these factors into consideration. Delicate judgement is needed because if set so low that the situation of many older people or their caregivers is not markedly improved, the programme will be seen as a sham. If too high, the economic or political effects of high taxes or premiums will cause trouble, and benefits once granted will be hard to reduce.

However, certainly compared with medical care, LTC expenditures should be relatively predictable and controllable at both the individual and the system levels because policy-makers can set eligibility criteria. Also, “managing care” is also easier in LTC since levels of need do not change as rapidly, life-or-death interventions and high-cost technology are not as important, and organizational routines rather than independent professionals can control more of the decision-making.

Budgetary measures such as pooling funds for institutional and community care and imposing global caps have been effective in shrinking tax-based programmes in England and Sweden. The German LTC insurance system has effective controls at the individual level (insurers manage eligibility determination) and overall (total expenditures are restricted to premium revenues; benefit increases require new legislation) (Schneider 1999). Although German expenditures have increased gradually, the proportion of GDP has remained stable at 0.8 per cent, indicating that spending can be controlled. In Japan, excess demand has been contained by imposing a 10 per cent co-payment (with a lower rate for those with low income) to the voucher that
has contributed to surplus in the LTC insurance funds in the initial year of its implementation.

At the same time, the fact that costs are more controllable in LTC implies that policy-makers will be held more accountable for setting the limits of public responsibility. Since the relationship between spending and services is more explicit in LTC, politicians would have to declare how they stand, and the electorate would have to take the consequence of how they have voted.

Concluding Remarks

Establishing an independent, comprehensive system for LTC is preferable to leaving it in an ambiguous status within the medical and social service systems. To the extent policies have clear objectives, defined targets, logical criteria, and well-thought out mechanisms, public expenditures would be easier to control. With increasing pressure to contain public sector expenditures and improve efficiency, the focus of care will gradually shift from hospital care to LTC, and within LTC, from institutions to housing, with a commensurate increase in the share of private financing. How to make this process proactive and planned, instead of ad hoc and reactive, is the challenge for public policy.

Notes

1. Some argue that medical and lifestyle advances will produce a “compression of morbidity” and reduce the rate of increase in demand for long-term care (Jacobzone et al. 1998). Manton and Gu (2001) argue that even absolute numbers of elderly needing institutionalization are declining in the United States, and that the rate of “compression” is accelerating, but Baltes and Mayer (1999) have shown that while investment in health care may have improved the status for the young-old, similar improvement is not likely to occur in the “fourth age” (old-olds).

2. In this paper, the term “medical care” is used to refer to the services provided by health care professionals that are not under the LTC system.


4. It appears that only in the United States is there much belief in private LTC insurance as an important solution. See Wiener et al. (1994); OECD (1996); Royal Commission (1999).

5. In contrast, efforts to explicitly deny public funding of specific medical treatment have not met with much success. See Maynard and Bloor (1998) for the problems that arise for rationing health care.


7. This figure may also be high because after the Adel Reform in 1992, LTC and rehabilitation hospitals were turned over to the communes and accounted as LTC expenditures. Expenditure levels in real terms may have been higher in the 1970s. Survey data show that formal care decreased and family care increased in the 1990s for Swedes aged 75+ (Sundstrom et al. 2002).


9. In the United States, the setting up of trusts to avoid spend-downs has become a feature of LTC, although only a minority who would actually benefit appear to have done so (Taylor et al. 1999).
10. For example, the charitable organizations that provided community-based services in Germany before it initiated Pflegeversicherung were famous for not working evenings and weekends, a situation that changed quickly when the new system got started. Interviews suggest that similar problems occur even in high-provision nations like Sweden and the Netherlands, although in the former case political accountability via elected local officials can be an effective check (more so than contracting-out to private organizations, so long as those still keep a monopoly vis-à-vis consumers).

11. In England, each integrated LTC service tends to have different arrangements (Glendinning 2002). In Sweden, regional differences in what is available and charged have increased (Karlsson 2002).

12. Of course, some would argue that advocacy for autonomy is exactly what frail older people need, but others believe, for example, that Austria adopted cash benefits in its LTC insurance system in 1993 because of agitation from younger disabled people, while in-kind benefits would have worked better for the elderly (Royal Commission 1999, supp vol. I, ch. 6, p. 14).

13. One of the difficult tasks in designing eligibility criteria is evaluating the burden of caring for those with cognitive problems. Although 24-hour supervision may be required, there is less need for direct, hands-on care and some of the supervision could be regarded as a consequence of cohabiting with the spouse (Ikegami et al. 2001). Assessing this situation and providing a supplementary cash allowance to a relative might be the best way to achieve parity with those with only physical conditions.

14. The Netherlands has experimented with such programmes, which prevent illegal employment and allow training for informal caregivers (K. Okma, personal communication, 29 May 1999).

15. Without such investment, health and social service workers have difficulty in communicating because they have been trained to talk in different languages and have been taught different values.

16. In the United States’ Medicare payment for nursing homes, the higher costs of medically complex cases are reimbursed according to how the resident is grouped by the RUG-III (Resource Utilization Group, version III) (Fries et al. 1994).

17. Doctors working in Dutch nursing homes are recognized as a specialty and are skilled in working in teams so that there is little risk of the medical model dominating.

18. Although the German LTC insurance has been showing a deficit since 1999, that for 2001 was only 0.06 billion euros or 0.4 per cent of the expenditures (www.bmgesundheit.de/themen/pflege/finanz/ergebenisse.htm) and as a ratio of GDP 0.78 per cent (www.destatis.de/basis.d/vgr/vgrtabl1.htm). We thank Ulrike Schneider for the data source.

References


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