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AGEING HORIZONS

Policies for ageing societies

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Long-term care and ageing populations

In the USA older people are often surprised to discover that although some of the long-term care services they need are paid for through Medicare, there are other kinds of care which they must purchase out of their own resources (including private insurance if they have any) or apply to Medicaid for means-tested public assistance. The experience of older people in the United Kingdom is in some respects similar, though they may perhaps be less confused about their entitlements. Some of their long-term care needs will be met by the National Health Service and paid for out of the NHS budget, so there will be no user fees. For other needs they will have to apply to their local authority, which manages the social care budget and provides publicly subsidised care only on the basis of a means-test. In this case, many people do have to pay user fees, which can be very high if what is needed is residential or institutional care. The situation in the UK is in fact even more complicated than the comparison with the USA might suggest – since in some circumstances the kind of care which is usually provided through the local authority may in other circumstances form part of a larger care package which is provided by the NHS.

What lies behind these particular administrative boundaries – apart from their peculiar institutional histories – is the fact that older people who need long-term care because of a long-standing medical condition or disability usually have complex care needs. They may have a long-term need for regular medical care *and* regular nursing care *and* regular help with some of the essential activities of daily living. In their 2005 report on long-term care for older people, the OECD follows what is, however, standard practice in choosing to define long-term care services in a way which sets them apart from health care services. Long-term care services provide the kind of help that people need when they are dependent on others for assistance with some of the essential activities of daily living. The OECD also follows standard practice in distinguishing between more severely disabled people who need help with ‘personal care’ (e.g. toileting and bathing) and less severely disabled people who need help

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Policies for ageing societies

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with a range of activities that are necessary for what the Americans call 'homekeeping'.

The possibility of receiving help with homekeeping activities indicates the extent to which publicly subsidised long-term services have changed across the entire *developed* world over the last thirty years or so: they are no longer provided *only* in institutional settings. This shift towards the provision of long-term care services which enable people to continue to live 'in the community' has also brought with it (besides a whole host of organisational problems) an increased awareness of the importance of what is now almost universally called 'informal' care – long-term care that is provided usually by family members at home. Not only is it generally accepted that the bulk of long-term care in developed countries is provided informally by family members (at no cost to the taxpayer), but it is also widely accepted that in recent years the burden of care on families has been growing steadily. Older people with the kinds of care need that would previously have triggered a move to institutional care are increasingly being looked after by family members at home.

This issue of Ageing Horizons deals with some of the difficult challenges that arise in attempting to provide solutions to the policy problems posed for long-term care services by the interaction between population ageing and those various changes in the family which limit its capacity to provide informal care. Although the publication last year of a ground-breaking review of 'social care' services by Derek Wanless has given the issue a strong UK focus, the innovative methodology of the Wanless review, as Bleddyn Davies argues in his article, is such that it deserves to have an influence as well as a readership outside the UK.

Long-term Care Policy: The Difficulties of Taking a Global View

Kenneth Howse, Oxford Institute of Ageing

Abstract

What should governments do about the provision of long-term care for frail elderly people in ageing societies? This paper considers some of the difficulties of taking a global view on this matter. It examines differences and similarities in policy context between developing and developed countries, and asks to what extent and in what way the problems of policy-making for long-term care are problems of fairness.

Introduction

What should governments do about the provision of long-term care for frail elderly people in ageing societies? Although the question seems straightforward enough, it does invite us to consider ageing societies *en bloc*, and this is perhaps an invitation we should resist, especially if we are thinking of generalising across both developed and developing countries. The difficulties of taking a global view on this matter are the subject of this paper.

In 2003 the World Health Organization published a report which laid out a ‘conceptual framework’ for the analysis and development of long term care strategies, and it drew a firm line between the more industrialized developed world and the developing world.

We should emphasize that this analysis rests primarily on the experience of industrialized countries. The conditions in the developing world and their initial experience in developing long-term care systems are quite different. Thus, not only the resolution of the basic long-term care design issues, but even the strategy for defining and analysing those strategies must be different.

Brodsky *et al.*, 2003, p.269

A very similar line is being drawn by the authors of a discussion of key issues in the design of long-term care systems when they argue that ‘for reasons both of principle and practicality, a public, comprehensive, independent system of long-term care is appropriate *in advanced countries*’ (Ikegami and Campbell, 2002, p.22; my italics). It is not just that different social and economic conditions might call for different policies, but rather that social and economic conditions are *so* different in the developed and developing world that policies have to be selected from a quite different set of options with different criteria guiding the choice between them. Even if we insist on the essentially global nature of the demographic and socio-cultural trends that are exerting so much of the pressure for change

in existing provisions for the care of the frail elderly both inside and outside the OECD, there is really little point in trying to generalise across countries that are as different as, say, Sri Lanka and Germany. Were we to try to characterise the policy challenge that these pressures create in such a way that both governments can be seen to confront the *same* policy challenge, we would almost certainly come up with something rather bland and uninteresting – such as ‘how to increase both the quantity and quality of formal long-term care provision for elderly people’. It is not easy, in other words, to say anything that would be of much interest to policy-makers without incorporating some assessment of the magnitude or urgency of this challenge, and of the way in which it is shaped and framed by an institutional context. How can we even begin to debate appropriate policy responses without taking account of the existing state of formal provision – the service infrastructure – as well as competing social priorities and the level of resources available to meet them?

If, however, we are uncertain about the value of looking for common ground in the challenges for long-term care policy in Sri Lanka and Germany, why should we not be at least cautious about the value of looking for common ground in the challenges for long-term care policy in, say, Germany and Sweden? The fact that Germany and Sweden have more in common than Germany and Sri Lanka is arguably beside the point if we suppose that policy makers concerned with long-term care have to resolve challenges that are shaped by the impact of socio-demographic pressures on highly particularized institutional contexts. What has to be decided is how to remedy or mitigate the defects and problems that the pressures of population ageing will disclose in a specific set of institutional arrangements. We are assessing the case for doing something differently, for changing these arrangements, and this case must surely start from an interpretation of the requirements of the present situation, and the failings and inadequacies of the relevant institutions. Perhaps then we should be wary of making *any* really useful generalisations about the policy challenges facing long-term care services even in ageing societies that share as much as do Germany and Sweden.

Wary, perhaps, but it is surely wrong to suggest that policy analysts and researchers in one country would be wasting their time if they tried to learn something from the policy successes and failures of other countries. It is not uncommon, for example, for British or American commentators to make unfavourable comparisons between the public provision of formal services in their own countries and what is

available in the Scandinavian countries. Are they entirely mistaken in supposing that there are lessons to be learnt in making the judgement that one country is 'doing better' in this respect than another? At the very least these comparisons require us to sharpen our formulations of the standards by which we judge of success and failure in long-term care policy. And surely it makes sense for the same researchers to ask about the advantages and disadvantages of different forms of public subsidy for long-term care (such as the social insurance systems in Germany or Japan); or the advantages and disadvantages of different ways of managing the interface between health care and social care or social services (see, e.g. Harrington *et al.*, 2002). Comparisons between countries help to clarify and systematize *both* the range of policy options available to any given country, *and* the methods of evaluating them.

In what follows I will sketch a few of the many diagnoses that have been made in recent papers on the policy challenges of long-term care in a small selection of OECD countries before going on to consider, firstly, how these challenges look from the points of view of an equally small selection of middle-income countries, and secondly, some of the attempts to generalise about the key issues that underlie these policy challenges. It has to be emphasised that the particular diagnoses that have been selected for inclusion here are not always uncontroversial, certainly when it comes to the OECD countries. The point they illustrate is that policy problems and challenges are framed in terms of what is usually a contestable diagnosis of the defects and failings of a very *specific* set of institutional arrangements. There are often substantial differences of opinion about the nature of the failings and defects of the institutional arrangements within any given country, and furthermore, these arrangements differ considerably from country to country and have their own particular histories. What should also be clear is that very different (and often incompatible) political commitments and principles have helped to shape these diagnoses – ranging from the free-market conservatism of the Cato Institute in the USA to egalitarian social democracy in Sweden.

Diagnosing problems and challenges for long-term care systems in selected OECD countries

USA

For several US commentators (Kaplan, 2005; Johnson, 2005; Moses, 2005; Mulvey, 2005) who have written recently on the theme of long-term care policy the central problem is a financial one: *who* is to pay for the additional formal long-term care (LTC) services that are going to be required as a result of population ageing? There may indeed be a problem, in the USA as elsewhere, with both the quality and appropriateness of care services that are provided for the most part by the private sector (Eaton, 2005), but for these particular commentators it is the increasing reliance of middle-income Americans on *Medicaid* that underpins the case for reforming existing arrangements for the provision of formal LTC services in the USA. Most Americans cannot

readily pay 'out-of-pocket' for LTC services, especially when these services involve placement in a nursing home¹; and only a small minority of Americans take out private LTC insurance (less than 10 per cent of people aged 55+ in 2002). Medicare, which pays for the medical care of almost all Americans aged over 65, does not as a general rule cover the long-term needs for non-medical care that often arise as a result of chronic disabling illness; and Medicaid, the health component in the USA's means-tested public assistance programmes, pays for the long-term care only of those people who are judged to be sufficiently poor to require welfare support.²

The main source of the political pressure for reform is the fact that the costs of paying for LTC services are making themselves increasingly felt, both on Medicaid budgets (CBO, 2004; GAO, 2005) and on the financial resources of middle-income Americans, most of whom appear to have no real choice but to 'spend down' their own resources until they become eligible for Medicaid.³ The fact that many people in these circumstances accelerate their Medicaid eligibility by what is generally known as 'Medicaid planning' or 'Medicaid estate planning' – they transfer their assets to someone else – complicates the picture, however. It is not clear (or is anyway open to dispute) whether the system is resulting in a widespread and catastrophic spend-down of assets (which is Kaplan's view), or whether the manipulation of loopholes in the eligibility rules is so widespread that the programme no longer functions as a safety net for people who have spent down into impoverishment; but rather is fast becoming the principal payer of long-term care fees for everyone except the very well-off (which is Moses' view). Either way, an increasing proportion of older Americans are becoming reliant on what was originally conceived as a 'poverty programme' to pay for their long-term care, which is not only inappropriate, but seriously threatens the ability of the programme to do what it is meant to do. What is not in dispute for these analysts is that *both* Medicaid *and* the market for private LTC insurance should be reformed so that fewer people will be reliant on Medicaid and more people will take out LTC insurance. The development of the market for private LTC insurance is regarded in other words as an essential part of the solution to the problem of increasing the supply of formal long-term services.⁴ The 'marketplace' (properly regulated) will supply the additional formal LTC services required as a result of population ageing and the declining availability of informal care; the problem is that most Americans lack the resources to pay for these services 'out-of-pocket', not that they altogether lack the resources to pay for them.

Germany

In 1994 the German Parliament passed into law measures which established a social insurance scheme for long-term care similar in nature to the country's existing schemes for health care, pensions and unemployment. The costs of providing long-term care services are met, in other words, by mandatory contributions from both employees and employers (with children and non-employed married part-

ners being co-insured at no extra cost)⁵, and the scheme is financed furthermore on a 'pay-as-you-go' basis: the costs of providing benefits to current beneficiaries are to be covered by current contributions.⁶ Although the actual administration of the scheme is in the hands of about 250 separate long-term care insurance funds – affiliated to the health care insurance funds – contribution rates, eligibility criteria for benefits and level of benefits themselves are all fixed by law. Entitlements have been set at levels that very often require beneficiaries to make quite substantial out-of-pocket payments to cover the full cost of their care package. Individuals who are unable to make these supplementary payments out of their own income do not have the full cost of their care met from the scheme. The government uses instead its general tax revenue to make up the difference with a form of means-tested income support.

Eligibility for benefits under the insurance scheme is determined on the basis of an assessment of need which takes no account of either family or financial circumstances. What matters is whether or not individuals require help in performing basic activities of daily living as a result of disability. If individuals are judged to need 'considerable care' they are entitled to benefits – and if they need more intensive care, they are entitled to a higher level of benefits.

So what's the problem? It looks as though the introduction of social LTC insurance in Germany resolved a similar problem to that which now worries commentators in the USA: excessive dependence on public welfare assistance to pay for a kind of care need that was generally excluded from the provisions of health care insurance. The sharp reduction in the number of older people in Germany claiming public assistance to pay for institutional care does indeed suggest that this problem has been resolved. Public attention and debate is now focused, however, on the projected rise in contribution rates that an unreformed system would require over the next 45 years (Arntz *et al.*, 2007) – with estimates ranging between about 80% and over 200%. The scheme is in fact rapidly running down reserves that it built up in its first few years of operation and is projected to go into deficit within the kind of time horizon that tends to exercise governments even more than these long-term projections. It is built into the very nature of the scheme therefore that something has to be done in the near future – and the predictability of the coming demographic shock makes it sensible to consider how to reform the scheme in such a way as to withstand it. What makes this an issue so soon after the introduction of a social insurance scheme is the belief that contribution rates should not be allowed to rise by the amount that many analysts think would be required to balance the books. The worry here lies in the fact that contributions to the scheme are shared by employee *and* employer – and there are serious concerns about the effects on employment of increasing non-wage costs for employers. As in the USA then, the problem centres on the *incidence* of the increasing costs of providing formal long-term care, but its contours are quite different, not least because of the degree of public support that exists for a

social insurance scheme (Arntz *et al.*, 2007). The choice appears to lie between reducing the generosity of scheme – so that beneficiaries meet even more of the costs of care through out-of-pocket payments – or reforming its financing in a way that will allow it to maintain its present match between care needs and entitlements to publicly subsidized care.

United Kingdom

In 1996, three years before a government Royal Commission published its final conclusions on what should be done about long-term care, the Joseph Rowntree Trust published its own report advocating the adoption of social (i.e. mandatory) insurance for long-term care in the UK. Now, ten years later, the Trust has revisited the policy challenges of long-term care in a discussion document (Hirsch, 2005). The government's decision not to implement some of the more controversial recommendations of the Commission left many issues unresolved, and the Joseph Rowntree Trust is not alone in thinking that something has to be done – and sooner rather than later – about the public provision of long-term care in the UK.⁷ The Trust's earlier proposal for a *funded* care insurance scheme has been shelved, partly because of what happened subsequently to equity values in financial markets and partly because of declining confidence in financial institutions.⁸ In its place, we find a discussion which is more concerned to specify the nature of the policy challenges than select any particular solution. What matters is that we understand what we are trying to do in choosing between the available options.

The starting point for this discussion is that the over long-term the UK will not be able to avoid paying more for long-term care. 'Doing nothing is not an option. Sooner or later, we will have to pay for the care that many of us will need as we grow older' (Hirsch, 2005, p.32). 'The main question is whether we can do so under a system that is fairer, and seen to be fairer, than the present arrangements' (*ibid.*, p.1). There is no crisis in long-term care at the moment, but if decisions are put off until a crisis occurs, there is a serious risk that the necessary changes will be made in messy and inequitable way. Act now, and it should be possible 'to make choices about how to make resources available on a fair and rational basis' (*ibid.*, p.32). One of the main conditions of a fair and rational allocation of resources is a system of provision that strikes the right balance between what is provided by the State and what is paid for by individuals or their families out of their own resources – and this balance, argues the Rowntree report, has to take proper account of public perceptions of the fairness and consistency of the institutional structures that treat different types of care need in different ways.

The underlying problem for the UK is that we have not fully made up our mind to what extent long-term care, like health treatment, should be part of 'universal' public provision or, like housing, be paid for by private individuals except for those who cannot afford to do so.

Hirsch, 2005, p.11

In other words, the terms of the problem (and note that the UK is importantly different from the USA in this respect) are set by the contrast between the way in which health care services are provided to those who need them and the way in which non-health care services are provided to those with long-term care needs.

Sweden

Budgetary constraints on the public provision of formal long-term care are nothing new in Sweden. The level of targeting and rationing of services has been ratcheted up considerably since the late 1980s, and it is the use of tax financing rather than social insurance that has enabled service providers to focus resources more carefully and narrowly on those older people whose needs are greatest. This marks an important contrast with the German system, which has virtually no room for provider discretion in the targeting of resources. Since the eligibility criteria for benefits are specified in the law which enacted the social insurance scheme in the first place, any decision to raise the threshold at which people are judged to be in need of care is shifted from the realm of administration to the realm of politics.

The Swedish home help services that are now more tightly rationed than were previously are still, however, provided either free of charge or *heavily* subsidised to those people who are judged to need them. Although many users do make some out-of-pocket payments for the care they receive, they are quite a lot lower than those in Germany (Karlsson *et al.*, 2007). In other words, the Swedish system is more generous in the way it matches entitlements to care needs. Eligibility for publicly-provided long-term care services depends, however, not only on the presence of need (as in Germany) but also on the inability to meet these needs 'by other means'. What matters for these decisions in Sweden are not financial means (as in the UK or the USA), but the availability of close family; and there is a clear expectation that spouses – though *not* adult children – should provide some degree of care, assuming of course that they themselves are not prevented from doing so by ill-health or disability.

And for the future? There is, according to Mats Thorslund (2004), considerable public consensus in Sweden about the importance of the core values and principles which have characterised the country's welfare arrangements since the 1950s, and it is this which sets the terms of the policy challenge for the country's system of providing formal LTC services to the frail elderly. Although it seems likely that the pressures for change will be much less severe in Sweden than in other parts of Europe – Germany say – they are nonetheless real enough. The challenge, therefore, is to adapt arrangements for the provision of formal LTC services to changing socio-demographic conditions without sacrificing values and principles that have been given definite form by popular institutions. The need for adaptation only arises of course if we suppose that the volume of provision cannot be allowed to expand in line with increas-

ing demand – on the grounds that this would place too great a strain on the already highly-taxed Swedish economy. If, on the other hand, we quarrel with this supposition, there is no need to accept the socio-demographic case for cost-containment, and the 'adaptations' it implies. The challenge, on this view, is not how to adapt formal LTC services to changing socio-demographic conditions but how to obviate the need for adaptation – how to ensure that the economy continues to generate the resources that are required to pay for the welfare services that the public wants. The country stands, therefore, at a kind of crossroads: it can choose either to try and resist the pressures for adaptation or it can go along with them by providing a service with reduced ambitions. Thorslund's view is that the country will choose the second route – and furthermore that it will do so not simply in response to economic constraints but also because of 'new ideas about the appropriate way forward' (p.126).

What does this mean in practical terms? The very least it means is that future cohorts of older people in Sweden will have to cross a higher need-threshold in order to be entitled to support from public services (Sundström *et al.*, 2006). For Thorslund, as I have said, the policy challenge is not so much to avoid this outcome as to reconcile whatever 'adaptations' are made to the system with the core values and principles which have so far characterised the country's welfare arrangements. Although he does not spell out exactly what this means, it seems likely that the kind of problem he has in mind is that of getting the balance right between more rationing and increased user charges. How does the government share out the costs of *reducing* the ambitions of its publicly subsidised provision?

And from outside the OECD

Detailed analysis of the policy challenges that the provision of long-term care presents for middle- or low-income countries is much harder to find than it is for high-income countries. No doubt there are many reasons why this should be so. One reason that stands out, however, from the middle-income country 'case studies' compiled by the World Health Organization in 2003 is that what counts as a distinct policy challenge in most OECD countries tends to be subsumed under – and not merely overshadowed by – two other looming social protection issues in most non-OECD countries: inadequate pension coverage and lack of access to appropriate health care (Brodsky *et al.*, 2003b). Researchers in OECD countries frequently make the point that families are the main source of *daily life care* for older people who require help with essential activities as a result of physical or mental disability. At least part of the rationale for distinguishing this particular role as one that the family continues to fulfil even in the wealthiest of countries is the fact that it is no longer the main source of other forms of old-age care and support.⁹

The lack of availability of appropriate health care provision for people with chronic disease and disability in many middle- or low-income countries means that family care-

givers will usually be the main source of both *daily life care* and *illness care*.¹⁰ This is partly because of the sectoral and/or geographical concentration of health care resources; and partly because of the high costs that individuals frequently have to bear in order to purchase the health care they need. Health care resources are as a rule *much* more thinly spread in rural areas than in urban areas, and they are often very much concentrated on the acute care sector. In Mexico, for example, about 10% of the population lack regular access to basic health care facilities; and the publicly subsidised health care that is received by about 40% of the population¹¹ is firmly based in the hospital sector. Although the country *is* developing home-based or community-based alternatives to hospital care, it is still very much at the beginning of this process (Knaul *et al.*, 2003).

Very substantial proportions of the populations in most of these countries have to meet all (or most) of the costs of care in user fees, which they pay 'out-of-pocket'. The proportion who find themselves in this position varies considerably of course from country to country, but even in those countries which aim to guarantee universal coverage for health care services, there are may still be various kinds of medical care that are not covered as well as relatively high out-of-pocket payments to be made. Prior to 2001 about 40% of the Thai population were not covered by any health insurance scheme and had to pay user fees whether they went to public or private health care facilities. Since 2001 coverage has been extended to the whole population. It remains, however, an open question what kinds of non-acute care (e.g. home-based care) might be included within the new collective health financing scheme (Chunsharas, 2003).

Contrast this with the situation in China, which is marked, firstly, by enormous disparities in both pension and health coverage between urban and rural areas, and secondly, by extraordinarily high levels of internal migration from rural areas to cities (with most migrants having no pension and health coverage¹²). Some cities in China, such as Shanghai, offer a home-bed medical service for people who are permanently housebound *and* include financial support for this service in their medical insurance scheme. Not all conurbations offer such extensive medical insurance coverage, however – and even where the 'home-bed' service exists and is affordable, there tends to be a lack of public confidence in its quality (Hua, 2003). Outside the conurbations, in rural areas, people are much less likely to have *any* health insurance, and notwithstanding the existence of an extensive network of public hospitals and clinics, out-of-pocket payments make up a much greater proportion of total health care spending in rural than in urban areas. In 2002 Chinese households paid 58% of health care expenses out-of-pocket – and that figure will be much higher in the countryside than in the cities (Howe and Jackson, 2004).

In circumstances such as these the policy relevance of the distinction between (i) the institutional arrangements for meeting the long-term needs for medical and nursing care

that arise as a result of chronic disabling illness and (ii) the arrangements for meeting the long-term needs for daily life care that often arise as a result of the same conditions must be quite different from what it is in most developed countries. Perhaps the main relevance of this distinction for policy-makers in developing countries is that it provides the context for an analysis of priorities, for decisions about the nature of the *additional* formal provision that is likely to make the most difference to the well-being of the older people with complex care needs. Given that older people with chronic ill-health or disabilities may well need regular medical care, regular nursing care, *and* regular daily life care, it is important to be able to decide what mix of additional formal services is likely to yield the most benefit. The point to note here is *not* that one kind of care – that which depends on professionally trained physicians and nurses as well as the technologies they are able to utilise – is relatively scarce whilst that which requires no such skills is relatively easy to obtain through the family. The problem that population ageing poses for many developing countries is that the supply of family-based daily life care is diminishing at the same time as health care services are having to adjust to the very sharp rise in the prevalence of chronic illness and disability. The point therefore is that the limited availability (and affordability) of *any* kind of formal provision of services (whether medical or non-medical, institutional or community-based) for long-term care needs that result from chronic disabling disease is clearly an essential part of the context for formulating and assessing policy options; and it is this fact to which the analysts writing in the WHO report insistently draw attention.

It has to be remembered also that in some middle-income and many low-income countries, the majority of the older population receive no old-age pension of any kind, and hence they have to rely either on their own current earnings (or their personal capital if they have any) or their family for their material support.¹³ In this case, older people are quite likely to co-reside with adult children in a multi-generational household; and here they become part of the overall economy of the household.¹⁴ They are very often major contributors as well as beneficiaries within a complex web of reciprocal intergenerational exchanges. Even if they are prevented by chronic-ill-health or disability from working outside the household they may still be able (and expected) to help with domestic chores and care of grandchildren. Once they lose the ability to make these kinds of contribution to the household, they then become dependent – in the widest and strongest sense – on their family for support and care: they rely on them to provide for their basic needs without having anything to offer in return. A very considerable proportion of the people who need help to prepare the food they eat will not have enough income of their own to purchase it – and in such circumstances it may seem pointless to make much of the distinction between the help that the family provides with *daily life care* and the support it provides for *material well-being*, i.e. food and lodging. Certainly from the point of view of the adult children who provide support for their elderly parents, these

two kinds of need merge into each other (see, e.g. Zhang and Goza, 2006). As with the distinction between daily life care and illness care, however, it does provide policy-makers with a context for the analysis of priorities. Decisions about how best to help families bear the strains that population ageing imposes on informal systems of old-age care and support have to take into account the fact that many relatively poor families are likely to be giving up income as well as time and labour to look after their older members.

A problem of justice?

The problem of care is a complicated logistical problem for any society. It is also, most emphatically, an ethical problem, a problem that must be addressed not only with resourceful policy thinking but also with the best normative thinking that we can muster. All too often, economic thought addressing this problem proceeds as if it is only a matter of efficiency, and not as well as matter of justice and equity. The first step in addressing this problem is to recognise that it is an ethical problem, a problem of justice.

Nussbaum, 2004, p.34

Nussbaum, a moral philosopher, is perhaps too dismissive here of the “logistical problems” involved in matching resources to needs in any system of publicly subsidised long-term care. It is surely possible, however, to concede that it is extraordinarily difficult to allocate such resources *efficiently*, to make sure, in other words, that they go to the people who will gain most benefit from them (Baldock, 1997); and yet still agree with Nussbaum that some of the fundamental issues that societies have to decide in settling on any set of public arrangements for the provision of long-term care turn on questions of fairness rather than questions of allocative efficiency.

Certainly if we suppose that the basic issue to be settled is the balance of public and private responsibility in the provision of help with daily life care, then we are very likely to agree with Nussbaum on this point. The policy choices we make will reflect our judgements about the extent to which – as well as the way in which – the burden of care *should* be shared through public institutions and collective arrangements. Since, even in OECD countries, the major part of this burden takes the form of unpaid work undertaken by the families of people who need help with daily life care, this decision must incorporate some sort of view about the share of the burden of providing long-term care that families may be fairly expected to shoulder in this form. And since the help with daily life care that is not provided by unpaid labour has to be purchased, it also has to be decided to what extent the financial costs of purchasing long-term care should be born by the individuals who need it. These issues, though evidently connected, are clearly distinct. It could be argued, for example, that the full costs of purchasing care for someone who needs it should be shared amongst people who do not themselves need care (mostly the active working population) – which is quite compatible with the

view that the amount or kind of care which is purchased should take some account of the availability of family caregivers to provide unpaid care. And similarly, the view that nothing in the way of unpaid work should be expected of the close family of someone who needs care is compatible with the advocacy of financing arrangements that require most people who need care to bear a considerable portion of the costs of purchasing it.

The role of families in the provision of care

In most OECD countries it is now widely accepted that families cannot be expected to supply in the form of unpaid work whatever additional help with daily life care is likely to be needed as a result of population ageing. Although this is partly a matter of realism – not only will the sharp decline in fertility reduce the ‘capacity’ of the family to provide help in this form, but most of the countries are actively pursuing labour market policies that will further reduce the potential supply of family-based care – there also has to be taken into account a strong weight of opinion in favour of ‘voluntarism’ in family caregiving. The argument here is not just that families cannot be expected in all fairness to do more in the way of unpaid work than they are doing now. The point is rather that it is unfair of the wider community to expect or require anything of family members in the way of unpaid care.¹⁵ Potential family caregivers should be able to choose whether or not to provide care (Nussbaum, 2004)¹⁶ – *and* (ideally) whether or not to be reimbursed for the care they choose to provide.

Many policy-makers in advanced industrialised countries are clearly reluctant to acknowledge voluntarism as a basis for reforming the public provision of long-term care because of ‘the public expenditure consequences of reimbursing what was previously a gift relationship’ (Pearson and Martin, 2005, p.30). The worry is that any additional funding intended as a response to population ageing might be used to purchase what was previously provided free rather than to increase the total supply of care. For some analysts this particular concern helps to define the policy problem that is posed by the increasing strains that demographic and socio-cultural change are placing on traditional mechanisms of care: how can the arrangements for public provision be improved so as to relieve these strains without adding to the pressures which are likely to reduce the supply of unpaid care?

It has already been noted (see above) that the long-term care regime in Sweden, which is one of the most generous in the world, appears to reject what we might call ‘unrestricted’ voluntarism. There is a clear expectation that spouses – though *not* adult children – should provide *some* degree of unpaid care. It seems reasonable to suppose that the basis for this distinction is that marriage – unlike the relationship between adult children and their parents – is contracted voluntarily. In other words, what justifies the wider community in expecting spouses to fulfil their obligations to each other is not merely the peculiarly intimate nature of the relationship, but also the fact that it has been entered into voluntarily.

Means-testing and universalism

The corollary of accepting that families cannot be expected *in all fairness* to do more in the way of unpaid work than they are doing now is not just that a great deal more care has to be purchased – but that the financial costs of purchasing a much larger volume of services have to be shared out fairly between the people who need care and those who do not. For some developed countries (such as the UK and the USA), this issue has raised the question of whether or not *existing* arrangements for sharing the costs of purchasing care across the wider community are fair – quite apart from any additional costs expected as a result of population ageing. Is the balance of public and private responsibility more or less right *as things now stand*? For others (such as Sweden), where there appears to be a broad consensus about the fairness of existing arrangements, the focus of the policy problem is how to *maintain fairness* under conditions of population ageing.

The choice whether or not to extend the reach of social solidarity in meeting the costs of purchasing care to include everyone who needs it and not just those people who lack the financial means to buy it for themselves is likely to be an important focus for disagreement in those countries where the fairness of existing arrangements is still a live issue (as in the UK and USA). Should access to publicly subsidised care be means-tested or not? The main argument for extending social solidarity beyond what are usually regarded as the *minimum* requirements of justice is familiar, namely that the need for care, and hence the cost of the care that is needed, is highly variable and uncertain. Not everyone needs care in old age and the amount of care that people need varies enormously, with a substantial minority requiring very expensive institutional care – at a cost which may exhaust not only their personal income but also whatever personal wealth they may possess. There is therefore a kind of lottery in the distribution of the cost burden associated with the need for long-term care; and even if no-one is reduced to poverty as a result of paying for it, some people will find that their financial resources are depleted much more than others (see, e.g. Kemper *et al.*, 2005). Whether or not it is the business of government to protect people against this risk (rather than encouraging them to protect themselves) is of course a matter on which free-market conservatives and social democrats will profoundly disagree.¹⁷

Inside and outside the OECD

The balance of public and private responsibility in the matter of long-term care is tipped most heavily towards social solidarity in burden-sharing when it is accepted (i) that nothing in the way of unpaid work should be expected of the close family of someone who needs care and (ii) that the *full* costs of purchasing care for someone who needs it should be shared amongst people who are not themselves currently in need of care (mostly the active working population). It is not easy, however, to find an OECD country where this particular combination of views underlies the arrangements for publicly subsidised long-term care

(Denmark perhaps?). There seems rather to be a convergence towards the view that (i) universal programmes can justify some measure of cost-sharing in the form of user charges (OECD, 2005), and (ii) the commitment to voluntarism is hard to sustain.

What about the middle-income countries discussed above? They all take a ‘minimalist’ approach to burden-sharing by the wider community: it will meet the costs of purchasing help with daily life care only for people who have no family to look after them and who are too poor to pay for it themselves. Rather more than this, however, needs to be said, if we want to distinguish their position from that of the OECD countries. Certainly their reluctance to replace means-tested programmes with universal programmes is shared by at least some OECD countries.

Just as any system of publicly subsidised long-term care has to decide *how much* (and what kind of) paid care of should be provided to the people who are entitled to it, so too any system that expects something from potential family caregivers in the way of unpaid care is faced with the problem of deciding *how much* it is reasonable to expect of families in this way. And what seems to distinguishes the middle-income countries from the OECD countries in this respect is not that they reject ‘voluntarism’ (so do many OECD countries) – nor indeed that they reject the contractualist view of personal obligation which appear to underlie the Swedish system (so do some OECD countries)¹⁸ – but rather how much they expect of families. In China and Thailand, for example, there is not really much prospect of bringing *any* paid help with daily life care into households where there is an older person who already receives unpaid care from close family. Nor is it likely that publicly subsidised institutional care will be made available to older people with families unless they require a considerable amount of regular medical or nursing care *as well as* help with daily life care. The policy response to population ageing looks quite different, therefore, inside and outside the OECD: the less affluent countries are much less willing to accept that families cannot be expected in all fairness to do more in the way of unpaid work than they are doing now. Perhaps we could say that the guiding objective of reform in these countries is not to lift off from the shoulders of the family the additional strains that demographic and socio-cultural change will impose on them as providers of unpaid care – but rather to put systems into place that will help the family bear the additional strains that it will almost certainly have to carry. They are staking their medium-term future on the willingness and capacity of the family to bear these additional strains – which is not really the case in the more developed countries.

Concluding remarks: resource constraints and development paths

Ultimately what differentiates developed societies with ageing populations from developing societies with ageing populations is their prosperity. There is a handful of

countries, especially in Asia, that used to be counted as part of the developing world but have now already grown rich and are also growing old very fast indeed. And then there are some other countries, most notably perhaps China, that have a chance of growing rich before they grow old – but may well grow old before they become rich (Howe and Jackson, 2004). Decisions about the extension of public benefits for the care and support of the older population clearly have to be seen in the context of resource constraints determined in part by the development path on which the country is set. In a country such as China the perceived threat of demographic ageing is that they will grow old before they grow rich – which will seriously hobble them in their efforts to become rich – and this perception is bound to influence the view that government takes on the best balance between investment for economic growth and consumption for present needs.

Should this have any implications for the way in which we think about the ‘requirements of justice’ in sharing the burden of long-term care in developing as opposed to developed countries? The question is large and difficult, and all that can be done here is gesture towards some of the issues it raises. We would have to clarify, for example, the reasoning behind the ‘contractualist’ view of family obligation as it appears in the Swedish LTC system. Nor is it possible to ignore the feminist concerns that are so important for Nussbaum’s argument. In other words, we are bound to consider the implications of choosing to rely on *intergenerational* solidarity as a major source of unpaid care for the position of women in the household and the wider society. And finally we would have to articulate criteria for deciding on the *limits* of what it is reasonable to expect from families in the way of unpaid care – and see how they should be applied in countries that are as different as Sweden and China.

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Notes

- ¹ According to Johnson and Uccello (2005) about 40% of Americans spend some time in a nursing home before they die.
- ² Though most states allow applicants to subtract medical and LTC expenses from income before determining eligibility.
- ³ Since Medicaid rules still make it difficult for frail older people to receive public support for home-based care, the system also seriously distorts the choice between home-based care and institutionally-provided care.
- ⁴ A great deal of American analysis of the challenges for long-term care policy focuses on the 'problem' of the lack of demand for private long-term care insurance. For a useful overview, see Johnson and Uccello (2005).
- ⁵ There is an earnings ceiling above which employees are not enrolled into the scheme, and about 9% of the German population have private LTC insurance cover (Arntz *et al.*, 2007).
- ⁶ Pensioners also pay contributions, and now do so entirely from their own pockets. Prior to 2004 they received a special contribution subsidy from the pension funds.
- ⁷ England and Wales are in a different position in this matter from Scotland, where it was decided that the 'personal care' element in LTC should be free.
- ⁸ This stands in marked contrast to the opening up of debate on the use of capital funding for mandatory LTC insurance in Germany (Arntz *et al.*, 2007).
- ⁹ The assertion is usually intended to reassure us that social change is not undermining the willingness of families in advanced industrial countries to provide care and support for their older members; and also to remind policy-makers of the importance of informal sources of this kind of long-term care – and hence of the importance of helping families to provide this care when their ability to do so is threatened or impaired.
- ¹⁰ The terminology comes from the WHO report on China, which makes the point that most caregivers are female and usually provide both *daily life care* and *illness care*.
- ¹¹ The rest have some form of private health insurance.
- ¹² See e.g. Xu *et al.*, 2007.
- ¹³ In China, for example, about three-quarters of the workforce have no pension coverage at all (Howe and Jackson, 2004). See, also Peng and Phillips (2004) and Heller (2006) for brief summaries of the availability of old-age pensions in China. Older people, and this applies not only to China of course, who have neither pension nor close family are clearly at serious risk of destitution once they lose the ability to support themselves through employment. If they are also in need of help with daily life care, then their position is even worse. All of the countries examined in the WHO report provide some kind of publicly subsidised care for older people who have no family to look after them and insufficient income to support themselves. In other words, they provide a limited amount of institutional care as part of their basic welfare programmes, and this will often include help with daily life care.
- ¹³ As ever, we should be wary of generalisations, but to take China again as an example, according to the 2001 census, 64% of elders aged 65 years or more live with their children (usually a son); and they receive most of their income from the same source (Howe and Jackson, 2004).
- ¹⁵ Which means not merely that there should be no legal compulsion in the matter, but also that decisions about entitlements to publicly subsidized care should take no account of the availability of unpaid family care, i.e. they should be 'carer-blind' (Pickard, 2001).
- ¹⁶ For Nussbaum one of the most powerful arguments for the unfairness of requiring anything of families in the way of unpaid care is that familial obligations to provide unpaid care typically bind women to the household.
- ¹⁷ Consider, for example, the very different views that have been expressed about the role of LTC insurance for middle-income families with assets to bequeath. Whereas Moses (2005) is clearly unhappy with the idea that it is the business of government to provide "inheritance insurance for the baby boomers and their children", the Joseph Rowntree Foundation (1996) appealed to the role of LTC insurance in protecting heritable assets as an argument in favour of their proposal for a social insurance scheme.
- ¹⁸ Since this line of reasoning explicitly absolves adult children from any responsibility to help their parents with daily life care, it would almost certainly be rejected by many developing countries with rapidly ageing populations.

Securing Good Care for Older People: Taking a Long-term View

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Abstract

The paper aims to explain and evaluate two key features of *Securing Good Care for Older People*, the Wanless Report on alternative mechanisms for funding long-term care of older people. One is the new elements of the methodology for evaluating the alternatives (section 1.1). The paper argues that more successfully than previously and analyses in other countries, these elements focus attention on what are really the core issues: the means and ends which are the unique foci of long-term care, and estimates of the consequences of alternatives for them. By doing so, the report faces the politicians and policy analysis and research communities with a formidable challenge, to master and contribute to the development of the new framework and evidence. Failure to meet the challenge will increase the risk that the policy system will reinforce rather than weaken causes of gross inequity and inefficiency caused by the under-funding of long-term care seemingly unanswerably demonstrated by the report. The second key feature is the type of funding model the Report recommends given expected changes in the balance between demands and public expenditure. Section 1.2 argues that the report's analysis as successfully transforms the state of the argument about this as much as about the framework, methodology and evidence for evaluating alternatives, demonstrating the relative weakness of models widely advocated a decade ago. Part 2 discusses how to build on the Report. Section 2.1 discusses the framing of issues and the analysis of evidence for each of the key foci of the report's main contribution to evaluation methodology. Section 2.2 discusses whether the recommended model would be the wisest choice given the environment likely during the next few decades.

Introduction

In every generation, a few reports redefine issues of current moment in a way which could set the framework for evidence-based discourse, often for a long period. This is so of the report of the Wanless team's review (hereafter WR) (Wanless *et al.*, 2006). It will have less impact than it should unless this is widely enough recognised not just in academe but far beyond. And its most important contributions are precisely those whose application in other countries could advance their discourse also.

In particular, it engages the means and ends which are really at the heart of long-term care debate. Starting with quantified descriptions of what levels, balance and incidence of outcomes are most valued by citizens (and are the declared aims of policy intervention), and how they can be most fairly and efficiently produced, it works back to

resources and costs and who would pay how much for what value of benefit given each of a set of exemplar funding models. It shows that some model types could not sufficiently satisfy enough of the general criteria to play anything more than a supporting role, if that. The patterns of benefit differ from one another and so confer varying ratios of benefits to costs to groups though much the same in effectiveness judged by the most general of the WR criteria, but likely to attract different advocates. As the models have been designed and parameterised by WR, the 'partnership model' has the edge, it argues.

It provides this key insight without neglecting the many criteria which recent analyses recognise should affect judgments about systems in policy and political processes, from the broadest principles to the most focussed analyses of costs and benefits by subgroups of the population. Analyses of the properties of model types, indeed of multiple exemplars of parameterised models of each of several types (as with the analysis of costs and the incidence of costs and benefits on groups defined in various ways), have been transformed in their sophistication and detail. But it is the WR which is the first internationally to fill the key gap: to provide a methodology for evaluating alternative funding mechanisms starting from quantitative evidence about citizen's valuations for the specific benefits which are the *raison d'être* of long term care policy and quantitative knowledge about how to produce them most efficiently. Think of the alternative: without this WR methodology, we are doomed to asking partially irrelevant questions and providing only partially relevant evidence to answer them, not the ones directly about the ends and means which the policy process has honed in its long learning experience. Without it, we should be able to compare funding models by their outcomes for the income, educational, cultural minority, gender, social class, and many other relevant distributions of costs to public and private funds and the monetary costs of services received. But we should be unable to compare their distributions of public and private costs and the value of the net benefits of care as these are perceived by potential beneficiaries for groups defined by the need criteria of long-term care in general, and the policy paradigm for social care in particular.

The application of this new methodology makes WR's case a formidable challenge. The WR framework assembles key new components, some the basis of publications only during the last decade or so. Although the argument it bases on them is itself sophisticated, and based on complex models and detailed analysis of large amounts of evidence, above

all it suggests the great practical benefits from strengthening the knowledge base. It is all the more a challenge to those seeking to create the knowledge it needs because crossing boundaries between intellectual communities is difficult, uncomfortable and risky, and it is dangerous to narrow readerships by using argument whose basis is analysis which many cannot follow: gurus chant KISS – Keep it Simple and Sequential. But in this field the public interest demands that we do the opposite. And requisite engagement of the complexity is a challenge not just to those advancing knowledge but also to the higher official with many other concerns than this, the policy analyst in a pressure group, the specialist journalist, and politicians.

It would greatly handicap policy development were insufficient policy leaders, analysts and others to learn to understand and use the new frameworks and methods. What would be tragic would be for people not to attempt to contribute to the new argument. Hence the form and content of the paper. It is to help the reader understand some essentials of the WR framework and argument and how to improve it and discuss how the momentum can be maintained.

1. Analytic framework and evaluation methodology

The Wanless team's key methodological contribution to the evaluation of alternative funding models has been to combine quantified knowledge about the levels and mixes of outcomes from mixes of services with citizen valuations of the levels of outcomes. WR did so in two stages of the analysis, each a breakthrough for the discussion of the WR topic. The first was to develop a methodology for setting a *threshold level for the outcomes obtained from an increment of cost to public funds above which subsidy should be made*. The second was to provide a methodology for comparing the *relative benefits given costs from alternative models* (weighting benefits by older people's valuations of them). That methodology was key to the final stage of the evaluation of funding mechanisms.

1.1 Threshold value above which subsidise

The threshold is based on the selection of a value of the increase in benefit obtained from the service obtained using an increment of subsidy; that is, an incremental benefit/cost ratio.¹ The selection is based on incremental benefit/cost ratios in competing policy areas, reflecting estimates of the threshold beyond citizens would not be willing to pay for additional gain.

ADLAY: a generic measure of the value of outcomes. The value of the benefit is a generic indicator of welfare of the kinds which social care is intended to produce. WR's generic indicator is the value of outcomes of services intended to compensate for limitations in activities of daily living due to disability, either physical or mental. The estimate of benefits is for the year. So the Report calls the generic indicator the ADLAY, the ADL-adjusted year.

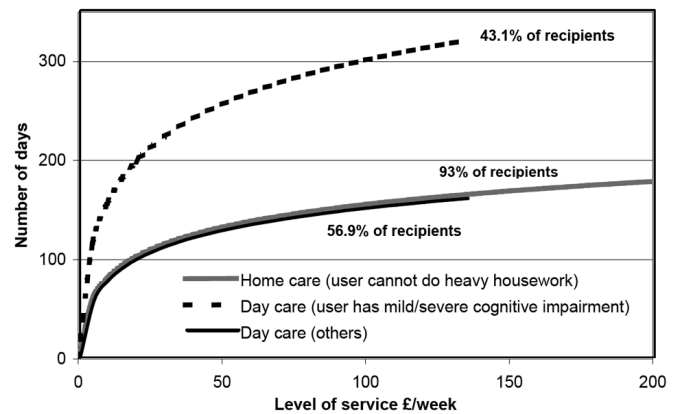


Figure 1: Effects of home care and day care on the extra time an older person remains in the community

The estimation of incremental benefit/cost ratios requires both a) knowledge about how outcomes differ given variation in the costs of inputs, other things being equal – what economists call the ‘production function’, and b) valuations of outcome levels to use as weights to compute the overall value of benefits.

Production functions. Figure 1 reproduces WR's illustration of a (‘reduced form’ of the) production function for one outcome and one service, for the contribution of home care to ‘producing’ extra time supported in the community, from the ECCEP study which estimated production relations for 19 outcomes of value in their own right (Davies, Fernandez and Nomer, 2000). The figure illustrates the shape of the mathematical form most commonly describing the effects of variations in service levels on outcomes.² The effects of increments of input are smaller as input levels increase.³ The figure also illustrates that the effects of the services depend greatly on circumstances of users and carers, a result consonant with the predictability of outcomes from risk factors. The patterns confirm the importance of using production function techniques, incorporating equation forms which allow theoretically likely complex forms to reveal themselves.⁴ Estimates for social care do indeed have several of these features, illustrating why attempts to estimate the relations between service levels and mixes (and costs) and outcomes often yield absurd results.⁵

Outcome dimensions. WR used OPUS as a tool for outcome measurement and the value weighting of outcomes (Netten *et al.*, 2005). The outcome domains used in the WR analysis were: personal care and comfort; social participation and involvement; control over daily life; meals and nutrition; safety; accommodation; employment and occupation; role support (as carer or parent), and being in their own home.⁶

The selection of OPUS was politically shrewd, because OPUS was originally influenced by the assumptive worlds of those faced with balancing needs and the allocation of public spending of a period which was more pessimistic

about the balance between needs and resources than that of earlier classifications of outcome and their indicators.⁷ What is key for avoiding biased estimates and a balanced description is that it should include all important outcomes. Some to which the attention of some in the policy world wavered as spending grew more slowly than demands was user morale, the probability and severity of the sub-clinical and clinical depression which between them are so prevalent in the population at risk (Davenand *et al.*, 1996; Livingston *et al.*, 1996, Saunders *et al.*, 1993, and their carers (Buck *et al.*, 2002). Improvements in them are outcomes valued in their own right.⁸ Some early British argument was that the production of morale effects for many (as means, ends or by-products) were hallmarks of high quality and efficient systems, with enhanced user influence on the prioritisation of ends and choice of means being important in the causal process (Davies and Challis, 1986; Davies and Missiakoulis, 1988). More recent research differentiates good from bad commissioning and service quality by referring to related causal processes (Patmore, 2006; Sinclair *et al.*, 2000). More directly, modelling research on substantial data from a variety of areas suggest that during the nineties, the reforms caused services to produce substantial outcomes for morale and depression-associated variables.⁹

The same (or co-produced and highly correlated) effects are once again highly valued in policy statements. Despite fiscal stringency¹⁰ whose effects at the local level has been well documented by user, professional and local government interest groups and others (Health and Care News, 2007; CSCI, 2006), the green paper of 2005 (DH, 2005) courageously made a political commitment to goals related to morale, wellbeing and associated concepts: courageously – because it thereby made the widening gap between aspirations and achievements the focus of public attention – including the consequences of the targeting consequences of stringency that the Commission for Social Care Inspection [CSCI] has promised to ‘focus on in its report for 2006–07’ (Carson, 2006; CSCI, 2006c, LGA, 2006, 2007). So these goals now have a higher policy priority during the mid00s than such goals had among hard-pressed managers at the end of the previous decade, giving them an importance closer to that in some other leading countries from the mid 1980s.¹¹

In this respect, the new policy statements of the mid-00s are closer to the articulation of the social care paradigm in 1989 and 1990 in *Caring for People*, the associated guidance papers (especially those for field managers and workers; DH, 1990a, b), and the literature which first included morale, wellbeing, and life satisfaction as outcome criteria.¹³ The green paper *Independence Wellbeing and Choice* (DH, 2005) made much of the wellbeing agenda and specified a key role for Directors of Adult Social Care. The outcome goals from the Green Paper were reflected in criteria of quality developed by the CSCI (2006). One of the outcome domains is ‘Quality of Life’, another ‘Improved Health and Emotional Wellbeing’. The latter was elaborated with, *inter alia*, the statement that that ‘emotional and

mental health needs are responded to and appropriately addressed’ (CSCI 2006, pp.7–10).

The WR methodology is being rapidly developed. Though OPUS does not have the equivalent of a morale dimension *per se*, its developers are ‘committed to seeking to cover all the consequences of the impairment disability or handicap due to all causes (physical, cognitive impairment, other mental health problem) for the performance of key personal care and ‘instrumental acts of daily living in the circumstances of users and carers.’ Therefore work is in progress to develop a morale dimension, and as far as statistically possible to map existing OPUS dimensions onto all CSCI domains. WR applied both the narrower ‘core business’ concept and a broader concept attempting to cover wellbeing. But by presenting estimates for stringently defined core business alone as well as the broader concept, WR could not be accused of Utopian optimism about the ease with which allocations of public spending to social care could be raised.

Valuation of outcome dimensions. The relative value of increments of each output must be weighted to derive the total value of outcomes required for broad allocation judgements. The valuations used by WR were derived for a sample of older citizens, only some of whom were users. A sample of older people was selected partly because it was assumed that they would be aware of the issues. Results showed that preferences were associated with user and carer circumstances; and in particular, with whether they had actually had experience of the services.

Selecting the threshold to equalise costs of values across policy votes. It would strengthen the basis for allocations across policy areas competing for a share of the same budget to be able to compare the benefit/cost ratios for each area’s marginal expenditures. The invention of the ADLAY does this. The QALY, an analogous generic indicator for health outcomes is widely applied. Most famously, it is used by NICE, the National Institute for Clinical Excellence, in the evaluation of new pharmaceuticals and treatments. WR set the threshold maximum cost per ADLAY at £20 thousand. The Chair of NICE recently commented that ‘anything around about £20,000 per QALY is likely to be regarded as cost-effective. Beyond about £30,000 per QALY, we wouldn’t necessarily say ‘no’, but you’ve got to have



Figure 2: Outcome gains from home care services

better . . . reasons for saying “yes” (Rawlins, 2007). He related these thresholds to estimates of approximately £32,000 for the value of a lost life because of a road accident averted by public spending. He described how there were exceptional circumstances in which NICE had approved pharmaceuticals whose costs per QALY were much greater: for instance, Riluzol, which ‘avoids the need for tracheotomy for about six months for victims of Motor Neurone Disease... [because] people with tracheotomy say it’s almost worse than death’, and for which NICE’s estimate of the costs per QALY was approximately £38,000.¹³

WR was shrewd to base the threshold on an ADLAY concept and to choose £20,000 per ADLAY as the threshold. The subsidy to social care being paid from the vote of the DH, NHS heads are adult social care’s closest competitors in the budgeting process. The ADLAY is designed to be a close analogue of the QALY, and the QALY is the accepted generic indicator of the value of health care outcomes. Given that NICE would almost take for granted that additional public expenditures yielding a QALY for £20,000 would be cost-effective, it would seem difficult for government to deny special funding approval for forms of social care expenditure with a cost per ADLAY considerably exceeding £20,000 in circumstances in which it would relieve situations judged to be ‘almost worse than death’. What about some manifestations and stages of dementia about which *The Guardian* (2007) wrote ‘for those directly afflicted, the unremitting erosion of independence can resemble torture’?¹⁴

Of course, for this argument to hold, it has to be broadly accepted that an ADLAY is roughly equivalent in value to a QALY, and that estimates of costs per ADLAY and per QALY are valid and reliable enough to provide a useful if crude guide. Results of the research mapping QALY and other generic indicators for health on ADLAY will provide evidence. A more formidable obstacle to the comparison is that generic outcome indicators have not been applied systematically to health policy areas. Kind and Williams (2004, 1) wrote: ‘It is remarkable that we know so little about the health improvements brought about by the enormous array of activities provided by the NHS, but in recent years some piecemeal attempts have been made to rectify the situation’. They recommend the systematic application of EQ-5D to all areas of health services; a major step towards comprehensive and systematic QALY analysis. One of its five dimensions is Anxiety and Depression, possibly close enough to be mapped onto a social care morale and wellbeing dimension.

1.2 Comparing funding options

Selection of funding options. WR designed funding model types, and undertook a general evaluation of model exemplars of eight of the types chosen to provide variety.¹⁵ The types were ‘free personal care’, ‘social insurance’, ‘means-tested public funding’, ‘the partnership model’, ‘limited liability’ (a version of the American Connecticut Partnership

and its descendants, including the Conservative ‘partnership’ model: DHSS (1997), Care Savings Account, and private insurance.

Space does not permit a description of the first stage of the evaluation at which model types were systematically scored by the general criteria developed in the literature. The first stage dismissed some runners which had been thought potential winners a decade ago, indeed later (Brodsky *et al.*, 2003; Gibson *et al.*, 2003; OECD, 2005); and are still promoted in some countries. Some of the types offering more universal cover like German long term care (social) insurance, and by implication treated by some as if important elements (if not the entire model) could well be applied in England, did not score highly when all the criteria were taken into account. That the UK’s social care paradigm uses a much wider and more subtle range of criteria for the evaluation of policy success in long-term care than those for which evidence is available for countries which have adopted the social insurance route is relevant because policy-makers tend to look for models elsewhere which work better by their paradigm’s criteria (Rose, 1991). Perhaps also some recent history of the schemes contributed to their lower ratings: crude reliance on risk factors not welfare shortfalls in the implicit definition of eligibility and allocations; inefficiencies in the production of welfare outcomes; inflexibilities in response to worsening balances of demands and income flows in two of the best known long-term care insurance systems; the replacement of the well established Dutch arrangements by some more like those in Sweden and England.¹⁶

WR concluded that two exemplars of the eight families best met the general criteria. These were ‘free personal care’ of which a variant had been implemented in Scotland, and ‘the partnership model’, in which the state would finance ‘a basic, minimum level of care’, and would match private payments above that up to a maximum package cost ‘set in line with available resources’ (WR 2006, p.231). The partnership model satisfied the WR effectiveness-equity-efficiency criteria somewhat better: ‘a more sophisticated and less costly mechanism’ WR commented. They were compared with a re-parameterised version of the existing means-testing model. Although a means-testing model with substantially different values set for all its parameters could yield greatly improved performance compared with the present, its basic features interferes with equalizing the incremental benefit/cost ratios of what users would actually consume, a prerequisite for optimal achievement of the goal implicit in the policy goals. Some distortions would be basically similar to those of the present system, re-parameterisation reducing but not removing them. There is no escaping the fundamental truth. Poor Law mechanisms were designed for another age. Perhaps only argument based on the slow adaptation of cultures behaviours and supply systems or a value shift more thoroughly subordinating social policy to the requirements of an age of ferocious global competition could make them acceptable; and in the former case, only temporarily. We return to the theme below.

2. Discussion

2.1. Issue framing and evidence analysis

WR has shifted the discourse enough to make some comfortable intellectual habits more difficult to square with the public interest. That is illustrated in three areas where by the use of new (and more technically demanding) methodologies, WR has shifted the framework for discourse.

Advancing knowledge about how resource inputs affect valued outcomes. This is the most formidable challenge – to understand how and in what way through time events and circumstances affect the impact of resource: user and carer circumstances, values and cultures underlying expectations, behaviour and preferences; supply-side cultures, policies, processes and practice, endowments, circumstances affecting the pattern of productivities of service. So easy to write, so difficult for the research world to achieve, it requires the use of a wide enough range of social science in designing collections and their analysis, recognition of the connection between what they are finding and the broad framework of policy discourse. For what proportion of the time of what proportion of our working lives are we researchers happily hacking our way through the wood without understanding the importance of those twigs and leaves for understanding a world of great and subtle variations in what counts and what affects its individuals?

Valuing outcomes. The history has been too short for there to have been time to explore the forms of interrelatedness of preferences and their dependence on circumstances and characteristics: the equivalent in utility analysis of data collection designs and the equation forms which allow complicated joint supply, non-linearities and non-monotonicities, substitution and complementarity effects (many already themes of utility theory) to show themselves – the interdependence of utilities of persons within a network, the dependence of the marginal valuation for one outcome on the level of another achieved, circumstances in which mechanisms which distort perceptions and expressions of preference work in what way. Already there is evidence that preferences are associated with users', carers' and other citizens' circumstances; and in particular, and predictably, whether they have actually experienced of services.¹⁷ There are other issues which are tricky in other ways also.^{18 19} Whose valuations should be sought? The Pareto principle on which much normative economics is based might suggest the most relevant preferences would be the user and carer populations and those most at risk, though sensitivity of valuations to the degree of unmet seem often to be reduced by psychological adaptation to their position. However the general citizen would be expected to foot the subsidy bill. Should their preferences should be altogether discounted if they do not agree to it? The issue has long been recognized. Alan Williams wrote in 1974 that at 'the heart of the matter ... is a societal judgment as to who shall play what role according to what rules' (p.71), clearly still one factor underlying differences in arguments about policy and funding models today.

Projecting costs, outcome values and their incidence.

Like all reports since the Royal Commission on Long-Term Care, WR uses more elaborate simulation modelling methodologies to project consequences over its time horizon to 2026. Indeed, continuity in the discourse has been helped by them all using the same model and its descendants and elaborations. Again, the challenge is the same: to cross subject and topic boundaries, to recognise the development of the knowledge base for projecting the consequences of alternative funding mechanism as something to which an apparently unrelated analysis of data base can contribute. Because some societies have potential for suggesting trends in structures and cultures in others and anticipation of scenario evolution is the key, add the information for the imaginative basis for the models from other societies. Again, there are the same obstacles: those who have investigated the right areas have not thought it useful to ask the questions the answers to which would best develop the WR-type framework. Perhaps it will help that more states will come to develop WR-type argument. When they do so, we can expect a greater variety in assumptions and so in the architecture of projection models: a great stimulus to intellectual progress.

The mushroom growth of climate change theory illustrates why. Projection of demand and supply of long-term care has some characteristics in common with the projection of climate change and its consequences – a relatively new area with a rapid increase in understanding, great sensitivity in estimates to assumptions about trends²⁰, the potential for differences in the fundamental architecture of the causal models implicit in the projections models, deep uncertainty and so the need to attempt to attach probabilities to scenarios, differences in perspectives and interest in what should be a transparent and pluralist discourse about alternative policies and so a preference for different position on the probability distributions of greatest interest to the participant.

The Stern Report suggests how the subject might develop. Projections are summarised in Figure 3. As in long-term care projections – for instance the plotting of the funnel of doubt in Wittenberg *et al.* (1998) and Hancock, Wittenberg *et al.* (2006, Figure 26) - the differences between low and high base case projections for each type of model are much greater than the differences in projections between models. (The large number of independent models is not of relevance for long-term care: it would be fanciful to imagine more than one or a few for each country.) Such figures help to focus discussion. Finance ministries would no doubt have a concern for the costs to public funds and press for a solution with a probability of 90 per cent that it would not exceed a certain proportion of the GDP, while consumer interest groups would be interested *inter alia* in the threshold benefit: cost ratio, and would press for parameterisation of a model yielding not less than a 90 per cent probability that those whose interests they promote would actually receive benefits of at least a particular threshold level.

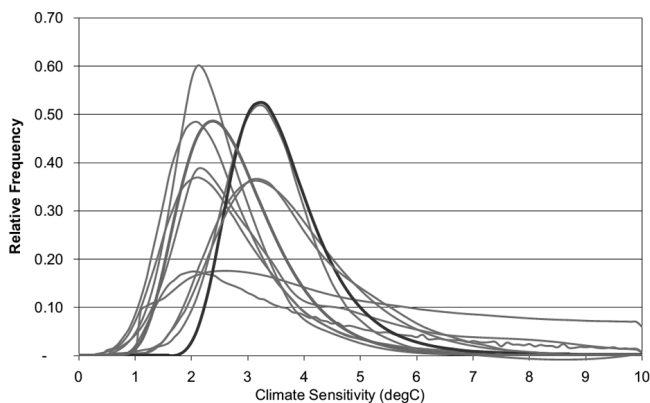


Figure 3: Probability distributions of an outcome given probability-weighted scenario variations in each of a variety of projection models; source: Meinshausen (2006) in Stern (2007)²¹

To conclude: great though the contributions of the WR analysis are, it and others on which it draws rely too much on early cost/time-limited evidence analysed. There are implications

- Social science sometimes needs ‘bigger’ (if certainly anything but ‘big’) research by natural science standards. Bigger research is risky and with long collection periods and vast collection effort, of apparently low productivity. Too often, it has paid better to keep clear of it save as hitch-hiker. But it can produce uniquely important evidence.
- There should be more research collaborations across disciplines and groups *as long as* much of the work is integrated rather than in parallel. Disciplinary associations can provide the frameworks for working groups seeking to establish such work. The flexibility demanded in such working should be better reflected in education and training of researchers and the courses and professional settings from which they are recruited. Many would agree that the principles are mainly honoured in the breach, suggesting that the challenges to actual performance are not trivial.
- Research funders can helpfully remember that one quality that makes applied research reliable enough to use is its theoretical strength, barely visible though that may be to the research user.
- The pressure group, manager or politician can helpfully remind themselves that the useful generalities are only likely to have the validity their plausibility suggests when based on hard detailed work often requiring technical skill and repeated and costly collection and analysis of evidence. Academe must assert the importance of time horizons and the time and resources to think around issues and others must not be so foolish as to denigrate it for doing so.

2.2. WR policy alternatives

WR logic depended on analysis of the properties of types at least as much as on the more detailed quantitative analy-

sis of exemplars. Would each possible member of a type share the properties of evaluative significance to a greater degree with other members of the type than with almost any member of other types? Could it be that the properties for types running in tandem – or hybrids – could be greatly different? Would the partnership type be the best of those so far considered whatever economic weather the changing climate throws at us? Since the immediate future will be a difficult time to commit to a radical change – a low maximum achievable allocation for public expenditure at least in the near future; as always, a slower rate of change in the capacity to cope of the kind of vulnerable people who would be losers by the changes than optimists trying to pursue new visions in the policy world assume; and likewise a slower and more geographically unequal pace of adaptability of service commissioning and supply systems – can we expect a better time later? If so, should we now choose a second best solution, but one which will ease the adoption of the partnership model later?

Within- and between-type variations in model properties. No doubt, the Treasury-led committee to develop alternatives are examining more variants within families, though there is not yet a comparison and synthesis of the pattern of outcomes from even from the published work. There are questions galore to ask of the quantitative analysis of the patterns. What WR-found patterns can be most relied upon? There might be more sensitivity at the second than at the first stage in the WR analyses, even of costs and outcomes and their incidence. But it is difficult to imagine that some key differences between the serious contenders would be removed if the comparison was with some new variant of a rival; other than a variant which is so exotic as to resemble nothing seen in real life if only because some of its special features would conflict too much with the national values for that type to be chosen.²²

Definitely the partnership model come what may? The partnership model could work well for balance of ideas about ends and means within the range of mainstream British discourse, given time to adjust and some minimum of public spending. A high enough level for the unmatched element of the state contribution would virtually avoid losers. So what the minimum would be would depend on the design of the implementation plan, about which no clues are available. What factors would affect the minimum? Could the policy system deliver that minimum?

The capacity to cope of vulnerable people likely to lose by model change is a factor suggesting that there exists a minimum. Changes in expectations and capacities of successive cohorts to manage change are easy to over-estimate. Circumstances making it more difficult to cope are well established: many least affected by transformed life chances and roles as proactive consumers; many with a lifetime trapped by the absence of opportunities and skills, and have family members who are similarly constrained; most at high risk too old to be baby-boomers;²³ many hit by health accidents which at least for a considerable period greatly

limits their capacities to self-manage, often causing a gestalt switch in assumption and morale to an expectation of decline and death; many with debilitating clinical and sub-clinical depression and cognitive impairment (Pavlou and Lachs, 2006). DH initiatives and CSCI policies developing more detailed policy attempting to combine choice and empowerment with avoiding excessive danger and risk reflect dilemmas more clearly than the policy papers stating policy argument and proposals at their most general level (CSCI, 2006a, 2006b; DH, 2006²⁴).²⁵

A slow and geographically uneven rate of adaptation and effectiveness/efficiency improvement of local commissioning and care systems would be a second factor suggesting a minimum. The performance of the social care system in England and Wales was in important respects transformed during the decade between the late eighties and nineties. Can the system respond as greatly to the requirements of the policies in the green and white papers? During the nineties there was in one respect a happy coincidence of wants. Prioritising user independence in the sense of enabling more users to be supported longer in their own homes was something which managers at all levels and field professionals could and did accept as the highest priority (Davies and Challis, 2000) because it fitted long-term aspirations and values of the social care paradigm, and was mainly (not wholly) strengthened by incentives from the financing arrangements after 1993.²⁶

National priorities then changed. Coordination with health services at various levels in Leutz's (1999) typology became the top priority. Rewards and sharp sanctions for adult social care were made more dependent on performance indicators of the social care contribution to achieving health system priorities. Health care received large funding increases while social care authorities continued to suffer severe fiscal stress, though it was widely believed that social care (home and community services as well as care homes) was substantially reducing the demand for acute beds.²⁷ Unsurprisingly, the gap between some national policy goals and the reality has seemed increasingly widen as a result (McNally *et al.*, 2003).²⁸ For instance, the proportion of areas in which only the two highest Fair Access to Care Services (FACS) (DH, 2001) priority classification of cases actually received services was increasing well before the most recent cuts (CSCI, 2006; Jones, 2006).

The green paper (DH, 2005) reasserted and reworked retainable values and policy principles of the social care paradigm while redefining it as part of a broader health and well being paradigm. But it redefined the issues in a way which made tackling them more complex at the same time as proclaiming a context of changing expectations and – most directly tackled by WR – a worsening resource balance. Re-engineering and substitution were major themes, but its argument was that to cope with the changed balance of demands and public budgets, many of the substitutions would replace resources financed from the adult social care budgets of 'councils with responsibilities for social services' [CSSRs]

by others; for instance by substituting universal services not financed from the social care budget for mainstream social care services, leveraging effort from the Voluntary and Community Sector, and other sources of care in the community. Directors of Adult Services were to play a leading role in promoting 'local wellbeing agenda': a task whose precise aims and form would vary greatly from place to place and from time to time, including the quantitative precision of links between means and ends. There were exhortations to develop new forms of governance to match the need to negotiate ends and means in the context of multiple interests and uncertainty. That is the Green Paper stressed the development of interventions whose contexts would necessarily make their creation and management generate more 'wicked' issues than the mainstream services (Rittel and Webber, 1973) more than, for instance, the white paper of 1998, and to recommend governance arrangements accordingly.²⁹ The complexity and uncertainty of the contexts and processes in which they would be established and the novel elements in their inputs, logics, cultures and prioritisation of effects, would create a low degree of technological determinacy at least until relationships and understandings had been fully established and trust in their continuation created. Experience has shown that when these preconditions for achieving a practically useful degree of technological determinacy are established at all, it usually takes much longer than optimistic managers expect and implicitly promise.

Paradoxically, the Green Paper argued that the system should also continue to cultivate the virtuous consequences of using tools of which some assume a practically useful degree of technological determinacy (Davies *et al.*, 2000), including what white papers called consistency (mentioned in 1989 and a main theme in 1998). The reforms of the period during which technological determinacy was most emphasised certainly delivered the then prioritised goals much more effectively by the later nineties. The proportions of losses of some prioritised dimensions of welfare predicted from risk factors were by then being offset by up to a remarkable 25 per cent on average among users and principal carers, and there were effects for a wide range of the dimensions of evaluative importance in the social care paradigm.

The greater consistency in the relations between means and ends by the late nineties sharpens the dilemmas of simultaneously pressing the exploitation of the benefits of technological determinacy and increased reliance on new 'wicked' ways of producing welfare for which the uncertainty of outcomes is great. The opportunity costs of relying more on wicked ways have been increased by the greater clarity and consensus about the prioritisation of goals, high risk offset proportions, clearer patterns of service substitution and complementarity, and the dependence of these on user and carer circumstances. Greater losses of other valued benefits than before would be caused by changing the prioritisation of goals, particularly by giving the highest priority to outcomes for which the relations between means

and the end are unclear to the key field and lower management actors.³⁰ A more determinate technology and greater consistency in its application imply less reducible inefficiency, and so larger opportunity costs if priorities are changed or efficiency savings are imposed. That would be still more powerfully the case if demand were diverted from health to social care as the NHS is put under increasing pressure during the coming CSR period, if more social care resources were absorbed by NHS-led schemes with different targeting priorities and objectives, and if the resource balance in social care worsened.

The dangers are obvious. Putting great effort and resources into developing those new ways of tapping resources to produce welfare which create the uncertainties and complexities of policy areas which are wicked may distract councils from achieving highly valued outcomes which have been increasingly effectively delivered with policies based largely on assuming a practically useful degree of technological determinacy. It may be more difficult for CSCI's successor to monitor commissioners and providers to the best effect. Perhaps it would be safer to err towards minimising the reliance on wicked ways of producing welfare than *vice versa*.

Fortunately, most of the most important new ways need not be wicked indefinitely, though conversion will require time, effort and resources. The analyses which were the basis of the concept of the 'wicked problem' distinguished between contexts in which the wicked characteristics could be temporary from those in which wickedness was irredeemably permanent (Rittel and Webber, 1973; Wood, 1944).³¹ But conversion from wickedness will require the skilful, gradual, committed, continuing and well-focused management of change, supported by sufficient, well-grounded and continuing investment in human, organisational and physical capital and investment to create stability and trust, preconditions for cooperation and collaboration between people and organisations.³² Perhaps then in the longer run the forms of intervention which are by nature irredeemably wicked will consume too low a proportion of the resources for their opportunity costs massively to reduce welfare. It is in that longer run that the demands for public financing will be greatest.

Could it be that making this optimistic scenario a reality could be helped by processes parallel to those observed in the urban regeneration programme (Whitehead, 2007)? The WR findings are key for putting the issues into perspective. The Green Paper developed the substitution and innovation argument substantially because without such substitutions and innovation, likely public funding would be insufficient to meet the demands with the then policies. A systematic shift in resources substantially reducing the vast underfunding shown by the WR in time to contribute when the innovations are at their most technologically indeterminate could transform the degree to which ambitions could be achieved in the long run.

What then is the lowest WR threshold which would keep

down the collateral damage of the most vulnerable losers to an acceptable degree? WR estimates suggest under-spending on social care compared with the NHS by approximately one fifth if the threshold is set in terms of core personal care business alone, two fifths including well-being. And budgeting makes no allowance for transitional costs. Only modelling of costs and the value of outcomes with allowance for transitional costs given realistic assumptions about the kinds of difficulty discussed above could give a quantitative feel for the answer. Presumably this is a focus of the activity of the Treasury-led team.

How likely is it that the government will deliver the minimum in the medium term? The room for manoeuvre in the triennium of the CSR08 (Comprehensive Spending Review) is presumably strictly limited, whatever the marginal rates of return on different forms of spending. What effort should government make in the longer run? The focus should be on the health vote and on the transfer of Attendance and Disability Living allowances from the social security budget.

The latter is easier to discuss partly for the bad reason that we have less knowledge on which to base estimates of the opportunity costs in terms of lost welfare of reducing these benefits. Would it be fair to apply to those British benefits the same scepticism about their impacts on our prioritised subtle but well-defined British social care outcomes as we apply to the German benefit in cash because government until recently has not demanded to know? The evidence is old and slight. Davies, Fernandez and Saunders (1998) did not find that Attendance Allowance receipt reduced the probability of admission to institutions for long-term care during the eighties. They estimated that the French ACTP was more successful. WR reasonably bases its suggestions on what is known. In several OECD countries disability and related policy areas are in question. And some of these are not traditionally tied in level and eligibility to the other elements in the wider social security system. It is difficult to deny the WR argument that substantial redistribution to the social care budget would add to the sum of human welfare, as indeed was suggested thirty years ago (Davies and Challis, 1986). But there should surely be transitional compensation for the losers, and the many who will be unable to adjust without great loss of welfare because of the nature of their disabilities – many more than the most obvious examples like socially isolated victims of autism with personality difficulties and substantial learning difficulties, for instance. Those transitional arrangements should continue over an indefinite period in the absence of a more efficient and welfare-improving alternative.

WR creates an extremely strong case about the direction, and order of magnitude for the redistribution from health votes that would maximise welfare. Highly respected experts suspect there to be little evidence that there is anything like the same marginal rate of return being achieved in many areas of the NHS. However, NICE recommendations have so far affected only a very small

percentage of the total NHS spend. Appleby (2007, p.50) argues that such evaluation should be carried out 'at another level' than NICE precisely in order to contribute to setting limits on NHS budgets, a theme parallel with that of the paper by Kind and Williams (2004). Appleby suggests that 'from the limited data that does exist, it is hard to demonstrate that the NHS is on the steepest part of the curve where the health returns from additional spending are high. In no area among those reviewed are there major identifiable health gains that can be attributed to extra health spending alone. This is even true of the diseases such as cancer and coronary heart disease (CHD) on which the government has focused extra resources . . . Gains are being achieved in such areas as convenience and process benefits (for example, the changes that have led to shorter waiting times within hospital accident and emergency departments). Some of these may lead to better health outcomes, but the main argument used by the government for setting targets such as these derives from the perception that 'expectations' of service performance are rising and that people want choice of when and where to be treated and easier access to whatever services they choose . . . While this is intuitively convincing, in fact there is very little hard evidence about the *value* placed on benefits of these kinds, nor indeed of the costs of providing these benefits' (Appleby, 2007, p.53). That is, the gains are more comparable with the wellbeing and morale gains from social care quality of life, but unlike the gains from additional social care, at the margin they are probably are likely to be at much higher cost than the NICE threshold.

So in a rational and just world, the minimum would be provided, even if not immediately. But it is one thing to speak truth to power, another for power so much as to acknowledge it, and yet another for government to act to remedy the inequity and inefficiency. The low expected increase in the adult social care budget for the CSR08 triennium has been repeatedly proclaimed. With a low CSR settlement not just for this but for subsequent triennia, the partnership model would have to be designed to incorporate an extremely high incremental benefit/cost ratio, a very low proportions of that set as the limit for the state entitlement, and/or a low state match to consumer payments. Given the threshold, the lower the state entitlement, and the lower the State match, the bigger the gap left to be covered by co-payments.

As a contingency plan, should we envisage garnering whatever additional budget is available for less costly attempts to soften the edges of the means-tested system during the medium term? There is a historical precedent. After all, except for shifting skilled nursing care to the NHS, making incremental changes to the system was how the government acted in response to the Royal Commission report of 1999 (DH, 2000). The literature has already explored various combinations of changing upper and lower limits of capital disregards and of income for either or both

residential or home care, reducing the tariff rate, or abolishing the assets element (JRF, 2006; Hirsch, 2005; Hancock, Wittenberg *et al.*, 2006; Royal Commission, 1999, pp.58–62).

How long would the medium run last? Certainly longer than one or two CSR triennia. Space does not allow an analysis of factors influencing its duration. Since the key constraint is surely what level of public spending will be forthcoming, the key precondition for a successful bid will be what growth in per capita GDP will follow from our performance in the global economy. For what it is worth, not until between 2035 and 2040 are the total and old age dependency ratios projected to stabilise.³³ Hancock, Wittenberg *et al.* (2006, Table 6) projections until 2051 of the demands and supply of long-term care of older people (with current policies) suggest diminishing rates of growth of public spending decade on decade after 2012, with a decline in the percentage increase by 20 per cent during the decade beginning in 2041. The pattern may not be very different for several model types. Radical change would still be an expensive undertaking, slightly less to the degree that the means-testing model were upgraded in the interim. Perhaps the conclusion is that there will not be an ideal period for a change to a model shifting responsibilities to the state unless the long run is defined so as to satisfy Keynes' observation that it is the period in which we are all dead.³⁴

The focus of WR was selecting main funding mechanisms. Whatever is chosen will create opportunities for 'niche' models to make a contribution when policy is sufficiently in place to create a more stable policy environment. It will then be important for the State to identify and publicise market failures, by that means helping to spot niches for which supplementary models would be useful. Government should publish its appraisal of proposals like that reported in WR by Kent County Council to continue work on the BRITSMO model (Davies and Challis, 1986) for which support in experimental implementation was first recommended in the Griffiths Report in 1987 (Griffiths, 1987; Wanless *et al.*, 2006, pp. 246–250).

3. Conclusions

WR has provided England with a clear direction for policy development based on evidence about what could most equitably and efficiently produce the benefits sought by means of long-term care policy. In the new real economy of care produced in the nineties, attempts to cope with additional demand and to increase quality will require higher spending because much of the system's inefficiency has been squeezed out by years of lower rates of increase in social care spending in relation to demands and relative price effects. Without the higher spending, even arguably efficiency-improving innovations would be financed largely by robbing Peter to pay Paul.

WR results confirm large under-funding of this Cinderella

of the DH family. The WR estimates carry all the more conviction because they applied conservative assumptions: the low ceiling spend per ADLAY compared with actual NICE practice as described by its chair, the calculation of under-funding by approximately one fifth for a narrow 'core business' concept of outcomes, much larger assuming a concept including wellbeing effects. This underfunding has been long and often argued from other evidence. The underfunding worsened during most of the reform period. It distorted the implementation of key policies, particularly in care management and service commissioning and development, seriously weakening the outcome-affecting processes on whose outcome effects the logic of the reforms was argued. The continuation of gross underfunding would similarly distort and weaken the outcome-producing process and practice of the new models promoted in current policy – particularly for the outcomes prioritised throughout the period, because the earlier models were designed exclusively for their production, the new models being little different in their values and arrangements for producing those outcomes but adding new and often conflicting objectives.

Several things would help the policy process to correct the under-funding.

One is to continue and involve more people and groups in policy debate making use of the Wanless framework and the type of evidence it uses. It requires that more of the interested parties should tool themselves to participate in its deepening and development. That would help to create a coincidence between spending allocations which would best improve human welfare and those which would most gain electoral support. It would substantially reduce the

undue influence of established but partially erroneous assumptions, unbalanced formulations of issues and arguments, and so in effect the interests of some actors and groups.

A second is to ensure the continuing influence of the social care paradigm with field reorganisations and the amalgamation of the agencies for quality assurance and improvement for health and social care. The national quality improvement body has a degree of constitutional independence of the day to day pressures on the politicians and the executive. The danger most discussed in the international literature is 'capture': excessively frequent surrender to external interests in the effort to contribute to consensus.³⁵ Reorganisation at the field level has tended to place those most influenced by the social care paradigm into the organisational authority structures of paradigms dominated by other ends and means. When circumstances are difficult, outright confrontation with the strong may not seem to them to be the most effective way to make what limited progress may be possible.

A third is to ensure that the policy of devolution to lower level governments and independent agencies, and extending citizen empowerment in return for risk and responsibility, is accompanied by increasingly extensive and rigorous evaluation. WR illustrates how powerful can be the evidence produced from it. But again there is a danger of capture when such a high proportion of the money for big and continuing research collections and analysis on long-term care is provided by such few sources. If so, can we envisage creating institutional arrangements which would reduce it? The question has been put many times before and will no doubt be put many times in the future.

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Notes

¹ It reflects the development of the interpretation of one use of the concept 'need' as equitable and efficient allocation. Feldstein (1963) wrote that the many advocated 'meeting needs' when 'it would make for clearer analysis if they talked about "optimising the use of resources"'. During the seventies, York economists led and others followed in developing the cost-benefit concept of need (Culyer, Lavers, and Williams, 1971), a step in the development of what Culyer (2006) identifies as a theme in the development of 'extra-welfarist' theory better fitted to inform policy-makers than the more reductionist approaches in theoretical welfare economics (Culyer, 2006). A stream of papers followed using the cost-benefit concept to analyse policy argument, the rationale of methodologies for developing social indicators, and structures and processes by which resources were allocated using concepts like the policy paradigm. For instance, Williams (1974, p.65) used it to dismiss its then common use as what he called 'need as quasi-supply concept' where 'need' was defined as existing over the whole range of marginal productivities between the current level of welfare and the point at which they ceased add to the value of outputs because, first, that led to an overstatement of under-funding – and, secondly, not there argued, for different outcomes, the ratio of areas under the productivity curves in the range between the actual level and the optimal need threshold on the one hand to the area in the range from the optimal threshold to the top of the curve on the other, is likely to differ greatly between commodities, thus biasing estimation if the quasi-supply concept were the basis of indicators in models; Davies (1974) applied the cost-benefit need concept in conditions

of technical determinacy to the design of indicators in the context of the theory of standards-setting and to the measurement of need as welfare shortfall defined in relation to the cost-benefit need threshold, the range which Netten *et al.* (2005) define as measuring a concept akin to Sen's capability; Davies (1975a; 1977a) applied it to the discussion of needs indicators implicit in policy paradigms as one element in the theory of variations in local policy outputs; Davies (1976a, b) to the rationale for a new design for need-compensating central government grants to local authorities; Davies (1977b) to the discussion of its relevance to the empirical measurement and valuation of outcomes and production function studies using techniques applied in transport studies and studies using a human capital theory framework; and Davies (1985) the different weighting of dimensions for aggregating data into an indicator of supply-side non-resource inputs (weightings to leave outputs unchanged) and into an indicator of outcomes (valuation weights for the range between the observed and threshold cost-benefit need level).

² The analysis depends on a classification of 'services' assumed to have the same balance of content across local systems save to the degree that differences are controlled for by other variables in the estimation models. For practical purposes of interpretation and application, the assumption is that differences in content between systems in each 'service' are small compared with differences between services. Of course, as such studies have long emphasised and as national policy has increasingly pressed, it is important to engineer services around local system contexts. Models for areas whose services have different contents would of course have different classifications of services, and yield at least

slightly different patterns of substitution, complementarity, economies of scale, etc.; that is models must be interpreted in the context of their purpose and geographical scope.

³ Situations with linear relationships were often characterised by a scarcity of the service in question: less of the service with constrained supply was consumed than would have been desired or would have been efficient.

⁴ See Davies, Fernandez, and Nomer (2000) for such equation forms. To estimate the substitution and complementarity effects, it is necessary for the outcome indicators to be general to all inputs. If the raw information ties the outcome to each individual indicator separately – frequently done in all countries, the sum of the effects will exceed the true overall effect. Also the outcome variables for each domain must include questions worded to make it clear to users, carers and other respondents that what is being asked about are the overall effects of services, as well as questions about achieving service goals and process quality narrowly defined.

⁵ Particularly

- The ‘productivities’ of services are highly contingent on risk factors and other circumstances. We discuss the effects of low morale and its correlates below. Low morale is associated with greater disability, so that failure to allow adequately for it can yield what are oxymoronic negative estimates of marginal productivities or costs in conditions of tight service rationing.
- Most services affect several outcome dimensions but to different degrees, with the impacts depending on the mix of inputs and outcomes and supply side factors. Therefore it is key for efficiency and effectiveness to mix services in a way which best exploits the relationship between service productivities and service prices (or marginal costs) given the other factors.
- Levels of one outcome affect the ‘marginal productivities’ of services in the production of other outcomes. For instance, morale and depression at sub-clinical as well as clinical levels affect the costs of improving other care outcomes by whomsoever rated. In part, this is because users and carers themselves necessarily ‘co-produce’ some outcomes and can contribute to the co-production of others, and do so less if paralysed by low morale or clinical depression. Also some outcomes are user or carer perceptions, and the effects of low morale should be included.

⁶ The WR production function for it, estimated from ECCEP data, predicted the service inputs required to bring the perceived burden of caring of principal informal caregivers down to a threshold level established by mapping onto the ECCEP’s main indicator of carer burden a threshold from another ECCEP indicator for which an appropriate threshold had been established in the American literature. The ECCEP project included triadic design elements for the collection of data for users, principal informal caregivers and care managers, thus permitting analysis of the interdependence of utility functions and of differences in perception of situations and outcomes.

⁷ OPUS was the product of government-sponsored research. It worked to, and was helped by a reference group who usefully reflected the dilemmas of policy and practice affecting resource allocation at the time. Central government officials and local managers were powerfully represented on the reference group. Their experience and views were powerfully reflected in the domain structure and the wording of instruments.

⁸ Morale change (and associated indicators) were used as an outcome in some streams of the British literature since Mattilda Goldberg’s path-breaking experiment (1970), and indicators for much the same domain were used in major American experiments like channelling (Wooldridge *et al* 1986).

⁹ Examples are the influence of reduced carer stress on reducing the marginal cost of extending user stays at home and improving user satisfaction with services, and substantial levels of ROPPs (Risk Offset Proportion from Productivity effects, measuring the proportion of the predicted effects of risk factors offset by service inputs; Davies *et al.*, 2000, p.170) for indicators of reduced felt burden of caregiving and improved locus of control among users of 25 per cent and affecting 90 per cent of carers, improved satisfaction with life development (18 per cent affecting 40 per cent of users), and the general Philadelphia

Geriatric Center morale scale (Lawton, 1975), 12 per cent and 72 per cent (Davies, Fernandez, and Nomer, 2000, Figures 11.2 and 12.1). Social care inputs clearly increased morale and related variables for substantial proportions of users – just as they improved users’ feelings of empowerment over their own life, ‘locus of control’ (24 and 54 per cent).

¹⁰ It will be remembered that the rate of diversion of more disabled users to social from health care accelerated from the end of the decade. National government set performance targets in ways which focused social care more on a narrower (and different) clientele in seeking to prioritise the reduction of demands on acute beds and aspects of need traditionally the foci of health care: not the imposition of the ‘medical model’, but an important refocusing away from some core elements of the social care paradigm and its outcome and targeting priorities nonetheless. Fiscal pressure continues. One reason is that the new health-orientated priorities for the social care services, including servicing new branches of NHS-led community activities for health policy purposes, have to be financed from social service budgets which are only modestly growing. Local authorities have been complaining about the difference in growth rates between social care and NHS expenditures. ‘Support for services such as social care through the general grant has increased by just 14 per cent in real terms since 1997/98. This is in stark contrast to the NHS, which has seen a 90 per cent rise over the same period. Half of local authorities with social care responsibilities received a government grant increase below inflation this year’ (LGA, 2006). The LGA survey of February 2007 again raised the consequences of NHS resource pressures for cost-shunting to social care, though suggesting that a lower proportion of authorities were intending (or contemplating) a step change between FACS levels in the minimum eligibility criterion, though substantial proportions suggesting other effects which would reduce the effectiveness and efficiency of service, including diminished preventive effects (LGA, 2007).

¹¹ In response to the LGA finance survey in March 2006, 77 per cent of the respondents suggested that they would raise the eligibility floor during the coming year. Carson (2006) reported that one third of the councils responding to a Counsel and Care survey had tightened eligibility criteria in the past year and two-thirds now only offer care to older people with ‘critical’ and ‘substantial’ risk levels. It was reported that Hampshire planned to raise the threshold to the topmost (‘critical’) level of the fourfold FACS classification.

¹² Central government promoted a new priority to wellbeing as an outcome in Modernising Local Government (1998), which proposed a duty ‘to promote economic social and environmental wellbeing (para. 8.8) to be supported by a ‘discretionary power to enable councils to take steps which will promote the wellbeing of their area and those who live in it . . . provided that’ their policies would not prejudice the performance of other functions and those of other statutory agencies (para. 8.11). The logic was reflected in the Better Government for Older People initiative, and later in the 2005 green paper.

¹³ For Interferon, it was estimated to be ‘up to £900,000’ per QALY.

¹⁴ The issue arises irrespective of how the eligibility for NHS continuing care funding is defined, because there can be conditions in which the victim consumes no health resources.

¹⁵ Variety was sought with respect to eight characteristics, two in particular: the degree of risk pooling (and so risk reduction and cost), and the balance of State and individual responsibility. Other characteristics were the balance between entitlement and budget dominance; degree of redistribution; indemnity benefit versus needs-meeting; national or local determination of benefit levels and eligibility criteria; citizen choice of contribution and benefit levels; reliance on informal care.

¹⁶ One feature which at first sight seemed attractive was the national standardisation, simplicity, transparency, and so greater comprehensibility to citizens and beneficiaries/users of eligibility criteria and their relationship to levels of benefit in cash or kind. However, the subsequent development of some of the models seems to be weakening precisely these elements to some degree in the pursuit of new effectiveness and efficiency goals. For instance, Dutch legislation in 1986 signals the abandonment of

the AWBZ insurance mechanism, creating municipally subsidised and managed models. Reacting to dissatisfaction with the way the new system was working, and in particular to inadequate case management and the supply side unresponsiveness to users' wishes to which some partly attributed the fact that a high proportion of users chose cash not services, the Germans launched a major multi-site demonstration of a model in which the entitlement is viewed as a 'person-bound' (individual) budget with a professional case manager to help beneficiaries make their choices of provision, and also coordinate with medical care, increasing the likelihood of producing more welfare with the resources by taking into account a wider and more subtle range of circumstances and preferences, so lessening the clumsiness of the social insurance arrangement by which benefits based on crude individual and straightforward criteria are used in a user-unresponsive system of provision. Whereas, early French discourse had been substantially in the language of insurance - 'fourth social risk' and other metaphors, building on a standard national evaluation instrument, with almost complete reliance (for needs assessment) on the standard national tool, the AGGIR, in the second and third stages of development from the use of the disability benefit, the *Allocation Compensatrice pour Tierce Personne*, to a benefit for older people culminating with the introduction of the *Allocation Personnalisée d'Autonomie* likewise introduced assessment and care management by multi-disciplinary teams (Davies, Fernandez, and Saunders' 1988; le Bihan and Martin, 2006). What was interesting about German long-term care insurance was that it introduced benefits in kind into an insurance framework with its assumptions that benefits would be in cash. (Appropriate for their argument, some Anglo-Saxon observers instead treated payment of the benefit in cash as being what was interesting.) France too shifted some way from the focus on cash benefits. The influential sociologist Claudine Attias-Donfut had criticized the system thus: '*il y une conception très individualiste de la protection sociale. On aide des individus isolés, indépendamment de leurs contextes*'. Indeed, a French historian of the process (writing for French readers) summed up the French development as a shift from benefits in cash to services in kind matching resources to needs; 'The abandonment of *prêt-à-porter* for tailored benefits' (Frinault, 2005). Secondly, as experience has accumulated, it became evident that transparency carried with it the disadvantages accompanying simplicity and inflexibility of contributions and benefit structures and inflexibility of the regulatory structure. That made it more difficult to maintain effectiveness efficiency and equity by other criteria as the balance of pressures of demands and resources worsened. The political difficulties in raising more contributions (particularly from employers) in Germany caused benefits to lag increasingly behind costs, causing increasing recourse to the means-tested social assistance again, the escape from which for users and for the sub-national funding bodies alike was a major impetus for the introduction of long term care insurance. In Japan, a similar situation was responded to by changes in eligibility rules removing a substantial proportion of those who would previously have been eligible, and by the introduction of user co-payments for hotel costs in care homes (Ikegami, 2007). A priori, it seems more difficult to achieve effectiveness, equity and efficiency by the key outcome criteria of the social care paradigm, as reflected for instance in the new WR criterion, with a social insurance philosophy aimed to provide a contingency benefit to cover crude risk factors than with some of the alternative models.

¹⁷ For instance, already Ryan *et al.* (2006) have shown that there are associations with routine variables like age, living circumstances, and reporting both some impairment and currently receiving services. People aged 85 and over were more concerned about food and nutrition and less concerned about social contact than younger recipients. Disabled people in receipt of services ranked food and nutrition highest, followed by social participation. (See Table 5.7) As they stand, these patterns are Rorschach tests. The literature on valuation illustrates many interpretations with quite different practical implications for the analysis. Progress depends on teasing them out.

¹⁸ More work is needed to investigate the most appropriate ways to investigate differences in perceptions, to incorporate objective

risks and sense of safety and to identify utility weights with nationally representative samples. Specific investigations into groups of interest, such as ethnic minorities, would also both potentially provide alternative utility indexes reflecting the perspectives of these groups.

¹⁹ That creates problems of interpretation. For some it is because of the probability of cognitive dissonance among people responding to great distress, adjustment of their reference group to those with similar need-related circumstances, or other forms of psychological adaptation to cope with their situation. For others, it is that they are being asked to evaluate purely hypothetical situations whose effects they cannot easily envisage. Opinion differs whether valuation compression (by which those with experience give responses which distinguish between levels of unmet need less - in this study case, to a degree sufficient to remove statistical significance in some analyses) makes the valuations of the experienced more or less valid than the weightings of others. Perhaps the judgment must depend on whether it is the users' own psychological interpretation which should count the most. If so, there is a double danger that the estimates may exaggerate the value of meeting unmet needs: first the estimates are based on willingness to spend rather than willingness to pay, and secondly, because the value weights are more heavily weighted with the perceptions of the general population than of service recipients. These influences from all levels of illumination and irrationality down to the sub-conscious influence individuals to differing degrees. Most perhaps are to some degree potentially predictable from other data, so eventually allowing the correction of the resulting biases in estimates to a practically useful degree. They usefully warn the reductive modeller against the hubris of imagining that all the precise calculations provide are crude orders of magnitude and monochrome sketches of complex polychrome patterns.

²⁰ One reason for the insistence of the designers of the projection models from their earliest publications that it should be focused primarily on examining the sensitivity of outcomes to scenario variations, however inevitable the reliance of the policy world on its best guess case projections. See Wittenberg *et al.* (1998).

²¹ Reproduced under PCI license no.C2007000684.

²² For instance, Hancock and Wittenberg (2006, tables 8 and 15) illustrate how the incidence on public and private expenditure can vary almost as greatly between current and the alternative reforms of asset means tests investigated as between current means tests and three variants of free personal care. But with the free personal care options, the share of public spending is in all versions lower, and the differences established early are projected to be continued in the long run to 2051. Another example: tipping the balance towards more formulaically weighted allocation judgments based on general risk factor into broad levels of care (as with social insurance) between now and mid-century rather than towards allocation by a wide range of factors, some complex and subjective, evaluated and weighted in a context-sensitive judgment within broad guidelines (closer to the Single Assessment Process philosophy) is likely to have more certain effects on the distribution of welfare than projections for 2051 from alternative variants of our current funding model.

²³ Someone borne in 1946 will not reach eighty until the end of the WR time horizon, almost twenty years hence.

²⁴ For instance, with respect to self-assessment and the allocation of a provisional budget for self-administration, a key aspect of one model of the commendable individual budgets model: 'Enabling individuals to self-assess the threats to their own independence/health is a complicated issue as there are potential risks around inappropriate service delivery and failure to identify some needs. . . . However, we believe that there are probably areas where self-assessment could be used, for example in assessments for some items of low-level, community equipment and for other low-level services' (DH 2006, p.38).

²⁵ Response to risk of diswelfares of various kinds is core to the language and logic of the Fair Access policy for eligibility determination and prioritisation: allocations to the four bands being based on the 'seriousness of the risk to independence or other consequences if needs are not addressed' (DH, 2003a, 2003b), and establishing this risk can require professional interpretation of the situation: 'needs assessment and risk

- evaluation rely for their quality on person-centred conversations with individuals seeking help carried out by competent professionals prepared to exercise their judgment . . . Frameworks, case examples and the like can only ever support the exercise of person-centred, competent judgment (DH, 2003b). Although some documents for models which require self-management and risk tend to contain little discussion about how hard it is to handle the dilemmas, scoring systems in self-assessment forms give heavy weights to safety and risk domains (Duffy and Waters, 2005; In Control, 2005), and some leading the implementation of the models have argued the importance of adapting policy and practice to recognise the dilemmas: ‘there is a risk that a focus on enabling disabled people will lead to services failing to identify those individuals where it is genuinely too risky to hand over leadership to the person. There will need to be a much greater onus on human services identifying people at risk and authorising named individuals to take responsibility for their services. At the moment the presumption of provider control masks the possible options available, but there will be no room for uncertainty in systems that seek to minimise central control’ (Duffy, 2004).
- ²⁶ The remarkable correspondence of rankings by workers at all levels in authorities and this top national priority was described in Davies and Fernandez (2000). Restoring the bulk of the costs of the public subsidisation of care home costs to the social care budget created the conditions for the generalisation of what were becoming the policies of leading authorities before the budgetary responsibility was in effect transferred by the creation of the Board and Lodging Allowance in 1980. So the development of alternatives to residential care in the new policy logic of 1989 fitted the dominant values at all levels and in most groups in social services departments. After a first year of relative plenty in 1993, the growth of demand in excess of public budgets sharpened the incentives both to find less costly home care alternatives, and also to strike hard bargains with home care providers – leading eventually to under-supply and pressure on quality, as the theory of the nursing home market of the eighties predicted (Davies, 1986, 1989; Davies and Knapp, 1988).
- ²⁷ The evaluation of a vaunted NHS nursing-led model, Evercare, the model from which the community matron stream of NHS schemes was to descend, had little if any effect on what it was designed to produce, diversion of demand from acute beds (Boaden *et al.*, 2005; 2006). In contrast, estimates of the effects of inter-personal variations in utilisation of home and community services suggested that home care had large effects on the utilisation of acute beds over a period of two years (Fernandez and Davies, 2004). Perhaps the excess demand for acute beds have been reduced more had the money been spent by the social services departments on the users they would anyhow have targeted (Fernandez and Forder, 2007 forthcoming).
- ²⁸ That is illustrated by their account of pressure at the front line: ‘our research [in three areas] points to a Catch 22 situation . . . [there is] so much incoming work that social services practitioners (as lead agents . . .) have often struggled to take any single referral beyond the initial stages of assessment and care planning. On the other hand, the inability first to integrate the monitoring and review stages and second to provide a comprehensive, multi-disciplinary approach (where appropriate) almost certainly helps explain the very high re-referral rates and subsequent work overload. This suggests that focusing on procedures for joint working and honing the existing system, as advocated in the single assessment guidance, will not address the root cause of the problem. This lies in case loads which demand the processing of clients and patients as quickly and efficiently as possible and overstretched practitioners who simply do not have time to act as ‘care managers’ coordinating care and the various ‘specialist assessments’ of other agencies and professionals. As noted earlier, social services departments are often expected to operate increasingly close to breaking point.’ Of course, there has always been great variation – and volatility, for instance in response to budget changes in related agencies and changes in grant settlements – in the balance between needs and resources at the local level, but it is likely that this has been and remains a fair picture of the situation of a substantial proportion of field areas at any time (McNally *et al.*, 2003, pp.21–2). See also Sinclair *et al.*, 1998.
- ²⁹ Ritter and Webber argued that the planning context in which they invented the concept of wickedness was characterised by extreme technological indeterminacy – social heterogeneity is incompatible great precision of goals, causality is unclear and so therefore are the means to achieve goals,
- ³⁰ The most highly prioritised goals have been shifted from some which are well culturally embedded and so pursued with little prompting by all participants and structurally embedded in field organisations dominated by them, to goals which are less directly open to social care influence increasingly in field settings requiring accommodation to culturally alien values and assumptions about ends and means. That is likely to weaken consistency in the relations between resources and outcomes.
- ³¹ Indeed, there seems to have been a tendency among both policy-makers and academics to have a preoccupation with ‘wickedness’ that would do justice to the devout Massachusetts colonists: to perceive and pursue it in policy contexts whose symptoms of wickedness and its causes pale into insignificance compared with the policy areas for which the wickedness argument was originally developed. That may have both led to misleading policy judgment and to the unintended creation of alibis for under-performance. For instance, more welfare may be produced if the context is acted upon as if it is substantially technologically determinate than technologically indeterminate when there is the evidence that it is the former to a practically useful degree.
- ³² The great diversion of resources and attention to improving the integration of health and social care had only mixed success partly because assumptions about time and other preconditions were too optimistic, the literature suggests. In some cases, like some of the NHS-led models seeking to reduce acute bed use among those at high risk using considerable amounts of spending on social services for older people by CSSRs, it will also require more effective learning from the experience from CSSR experience of care management.
- ³³ The older population is projected to be much more evenly distributed across the age range. Therefore there will be higher proportions in the older age group in 2051, with an increase of two thirds or more in the number of persons aged 85 and over during the previous two decades (DWP, 2004; Turner, 2004).
- ³⁴ Funding reforms were among those advocated for the period when the window of opportunity was last open, the nineties. The OECD projected that continuation of the whole range of current public policies would actually reduce public spending by 2 per cent over the decade. An academic suggested: ‘failure to find the resources to make the investment could be . . . an opportunity to improve the quality of our national life permanently lost’ (Davies *et al.*, 1990, pp.399; OECD, 1988). Policy makers had an alibi: as in several other countries, they were too busy developing and managing reforms to tackle issues with which the policy world is most familiar and for which it can most readily put tools in place, only later engaging other issues, often by modifying the newly created mechanisms: in the British case, supply side reforms; in the German and Japanese, a social insurance funding mechanism. It can be debated whether an important opportunity was lost by not also experimenting with models incorporating innovations in financing mechanisms with feature to improve equity, effectiveness and efficiency in the publicly subsidized real economy of care.
- ³⁵ In its official response to the DH consultation on its plans to merge the quality assurance regulators for health and social care, the CSCI suggested that the new remit was so broad that care would have to be taken to ensure health issues did not dominate official focus (Care and Health News, 2007). The announcement was made by Gordon Brown ahead of the 2005 election in the context of his battle to reduce red tape.

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Financing Long-term Care for Older People in England

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Abstract

During a decade of debate on how best to fund long-term care, British analysts have focused more on policy developments in other countries than ever before. Discussing criteria for appraising options, the paper argues that the objectives of the financing system must be considered in the light of the objectives for the long-term care system as a whole. The types of funding mechanisms discussed are private insurance, including private/public partnerships, tax-funded and social insurance models. The differences between tax-funded and social insurance models are discussed. Social insurance with hypothecation of funds is no longer part of the current debate, which now focuses on the three types of options whose properties are described in the paper: free personal care (adopted in Scotland), the retention of means-tested arrangements in some form, and a partnership model as recommended in the Wanless report. The paper agrees with the Wanless Report that all three have strengths and weaknesses. Decision-makers have a window of opportunity to make reforms before the baby-boomers reach late old age.

Introduction

The recent report (Wanless *et al.*, 2006) has re-kindled the debate about the financing of long-term care in England. The debate started to smoulder before the establishment of the Royal Commission on Long Term Care (Royal Commission, 1999) and much more visibly since the publication of its report and of the Government response (Secretary of State for Health, 2000). The key issue has been who is eligible for what publicly funded care and with what user contributions if any. Underlying the debate are concerns both about the future affordability of long-term care and about the fairness of the current funding system. The debate has sharpened the criteria for the evaluation of funding systems and mobilised evidence about a wider range of policy options.

The Royal Commission's key recommendation was that the nursing and personal care components of the fees of care homes and home-based personal care should be met by the state, without a means test, and financed out of general taxation (Royal Commission, 1999). Means-testing would remain for the accommodation and ordinary living costs ('hotel' costs) covered by residential fees and for help with domestic tasks. The Government accepted many of the Royal Commission's recommendations but only removed the means test for nursing care in nursing homes (Secretary of State for Health, 2000). Similar decisions were adopted by the National Assembly for Wales and the Northern Ireland

Assembly. The Scottish Executive, however, decided that it would make personal care free of charge as well (Care Development Group, 2001).

The debate on how best to fund long-term care has continued. The Joseph Rowntree Foundation (JRF) has suggested a number of ways in which the funding system could be improved (JRF, 2006; Hirsch, 2005) and the Wanless Social Care Review has proposed a partnership arrangement (Wanless *et al.*, 2006). The JRF and Wanless proposals are both based on analyses of long-term care systems internationally (Glendinning *et al.*, 2004; Poole, 2006), with an awareness that "other countries have taken major steps to secure sustainable and stable funding systems" (JRF, 2006, p.2). British analysts have become more interested in policy developments in other countries than ever before.

Criteria for Appraising Options

The purpose of long-term care provision is to promote the welfare of users and carers, including outcomes such as improved health, improved quality of life, making a positive contribution, exercise of choice and control, freedom from discrimination or harassment, economic well-being, personal dignity (Department of Health, 2005; 2006). These are broad well-being goals, which can be regarded as outcomes-based objectives for the Welfare State more generally. Financing long-term care needs to be seen in the context of wider developments in the Welfare State, particularly family policies, as so much care is provided by unpaid carers, health care policies and pensions policies.

The function of financing mechanisms is to contribute to the achievement of policy goals using the means and accepting the constraints prescribed by policy. The objectives of the financing system need, therefore, to be considered in the context of the objectives of the whole long-term care system. The overall system covers ways in which revenues are raised to fund care and ways in which those revenues are allocated to service users. The former include the balance between private and public sources of funding and between different public sources of funding. The latter include eligibility criteria, patterns of care and the balance between cash and care. Although this paper concentrates on the former set of issues, issues concerning revenue raising cannot be divorced from issues concerning allocation of resources.

Glendinning *et al.* (2004) proposed four criteria for assessing long-term care financing systems: equity; promotion of

dignity, choice and independence; efficiency and effectiveness; economic and political sustainability. The Wanless Review (Wanless *et al.*, 2006, p.11) used six similar criteria: fairness; economic efficiency; choice; physical resource development; clarity; sustainability/acceptability.

Efficiency and effectiveness are key criteria in economic analyses. Effectiveness refers to the achievement of a policy's stated objectives. Efficiency may be regarded as the achievement of maximum output, in terms of quantity and quality, for a given level of expenditure. In the context of long-term care, it is not ultimately service outputs that are valued but outcomes for users and carers. Achieving efficiency may, however, in practice be impeded by unsatisfactory incentives. For example, fragmented funding streams generate incentives and opportunities for cost-shifting agencies: where the costs of care are shared between agencies, the agency responsible for assessing care needs may not appreciate the true resource costs of different types of care.

Another key criterion has been equity or fairness. Equity is affected both by the ways that revenues are raised and how those resources are allocated. Equity considerations include equity of access; equity in level and mix of services relative to needs; and equity of outcomes. In the context of long-term care a key concern is horizontal equity – the provision of equal care for equal needs (Glendinning, 2004). The issue of what constitutes equity is clearly normative. Generalised perceptions of fairness may influence political judgements about balancing criteria as indicators of degrees of inequity of different kinds.

Independence, dignity and choice have been increasingly highlighted as objectives of community care policy generally (RCLTC, 1999) In the context of evaluating approaches to funding, key concerns may be to ensure that arrangements do not unduly limit older people's choice of care; distort preferences through unsatisfactory incentives; or create stigma or social exclusion.

Affordability and sustainability are important criteria and are also increasingly stated explicitly as evaluation criteria (e.g. House of Commons Health Committee, 1996). As there is much uncertainty about future demand for long-term care, and the resources required to meet that demand, funding arrangements need to be flexible and include effective cost control mechanisms. Political sustainability and acceptability is also important.

Funding mechanisms: private

Long-term care for most older people in England is provided or so supported by informal carers as to be in effect financed by them. They carry costs in terms of lost remuneration for employment opportunities foregone; leisure time foregone; direct care-related costs; psychic and health-related costs; and welfare costs of attention diverted from other family responsibilities. In respect of formal care services,

costs may be incurred through user charges for publicly subsidised care; direct private purchase of services; and, possibly, premiums for private long-term care insurance.

Older people with the resources to do so could fund long-term care from their income and/or savings (including the value of their home). If necessary they could release resources invested in their home through equity release schemes (JRF, 2006). The use of savings does not, however, seem efficient. Since not everyone will need long term care, it is not necessary for everyone to save sufficient to meet the average cost of care, let alone the maximum likely life-time cost. Risk pooling through insurance seems more efficient than saving for long-term care needs. Moreover, it would also redistribute from those with lesser to those with greater care needs.

Private insurance is not, however, always feasible (Barr, 1993). Insurance for long-term care faces serious problems of market failure. These include problems about adverse selection, uncertainty concerning future risks, insurance-induced demand, and potential changes in dependency rates across the population. There are also difficulties about consumer knowledge and affordability (Glennister, 1997; Wiener *et al.*, 1994). Pricing of long-term care insurance seems to be especially problematic. A key reason is that there is neither past experience of claims nor quality UK data with which to estimate the size of the lifetime risks involved. Measures to counteract these problems – for example, through exclusions, limitations, co-payments and higher premiums – tend to reduce the affordability and/or attractiveness of policies.

The attractiveness and affordability of long-term care insurance constitutes a significant problem. Only a minority of the population could reasonably afford long-term care insurance unless purchased early in life (or possibly through home equity release). Yet early in life people have other priorities and may be poorly informed about the risk of long term care and about the arrangements for public funding of long term care. Private long term care insurance, voluntarily purchased, therefore seems most unlikely to become widespread in England, as the Wanless review acknowledged (Wanless *et al.*, 2006, p.287). The recent exit of all but one provider from the long-term care insurance market in the UK lends weight to this view.

In principle, public support for private insurance could address some of these problems. Tax concessions or subsidies could reduce the cost to enrolees of insurance premiums, although the impact on demand for insurance would be uncertain. The public sector could reduce the cost of private long term care insurance by effectively taking part of the risk. Such partnership schemes which have been introduced by some US states have this effect. Those who purchase private insurance offering benefits of a specified minimum amount are treated more favourably under a means test, should they later exhaust their insurance benefits and seek public funding for their care. Such policies

could have lower premiums than policies with unlimited cover, because the public sector takes part of the risk. Nevertheless, the uptake of partnership policies in the USA has proved low.

Finally, the public sector could intervene to the extent of making long term care insurance compulsory. This could reduce adverse selection and other informational problems and improve affordability. Such an arrangement would, however, be regressive in comparison with social insurance: while payments for social insurance tend to be based on earnings or other forms of income, premiums for private insurance are based on individual risk, not income. The public sector could in principle address such distributional concerns by subsidising premiums on a means tested basis. This would, however, raise the issue of whether a compulsory, subsidised private sector insurance system would be preferable to a public sector system.

Funding mechanisms: public

The primary rationale for a public sector scheme is that it would allow both efficiency (through risk pooling) and equity (through redistribution) objectives to be achieved (Glendinning, 2004). A public sector scheme could range from a safety net with a substantial means test as in the UK and USA to a universal scheme for the whole population as in Germany and Japan. The main sources of public funding for long-term care are general taxation, as in the UK, Australia and Scandinavian countries; social insurance as in Germany and Netherlands; or a combination of both, as in Japan.

The difference between a tax-funded scheme and a social insurance scheme does not lie in insurance, since a tax-funded scheme also involves risk-pooling, but in the following features:

- hypothecation of revenues, that is contributions that are dedicated to long-term care;
- a link between contributions and benefits, but the link may be weak where there are credits for spells of unemployment, etc.;
- national, enforceable eligibility criteria;
- absence of a means-test but insurance can incorporate non-means-tested co-payments and deductibles.

Hypothecation has been advocated (JRF, 1996) as a means of ensuring that a specified level of resources is guaranteed for a specified purpose. Hypothecated funds for long-term care, such as in Germany, would mean that these resources would no longer compete directly with funding for other NHS or local authority services. Hypothecation has also been advocated as a means to raise more revenue for an important or popular purpose: it might be more acceptable to the public than an increase in general taxation, but this seems uncertain. Hypothecation is not without drawbacks. One problem is that the revenues raised through contribu-

tions based on earnings in any year would be affected by the economic cycle. Supplementation from general tax revenues or borrowing might be needed in some years.

A social insurance approach with hypothecated funding has, however, ceased to be part of the current debate. The debate now centres around three options (Wanless *et al.*, 2006):

- introduction of free personal care, on the lines of Scotland, under which there is no means-test for care costs;
- retention of the current means-tested arrangements, possibly with reforms such as those recommended by the JRF and/or with limit liability, such as a limit to the number of years for which the users are required to fund their care;
- implementation of the Wanless recommendation for a partnership funding scheme, as described below.

Bell and Bowes (2005) have reviewed the introduction of free personal care in Scotland. The Scottish system involves non-means-tested personal care at home and a flat rate non-means-tested contribution to nursing and personal care costs in care homes but not to 'hotel costs'. They found that the main beneficiaries have been people with dementia and people with modest means. Free personal care has not been accompanied by a major shift from informal to formal care. It has, however, proved more costly than expected and the costs are set to rise because of demographic pressures and rising home ownership.

Hancock *et al.* (2005) estimated that the introduction of free personal care throughout the UK would cost between £1.3 billion and £1.8 billion in additional public expenditure for 2002 and would take public expenditure to between 2.15% and 2.40% of GDP in 2051 or more if there were an impact on demand for care. Free personal care would benefit home-owners more than non-owners and would benefit older people in the higher quintiles of the income distribution. If financed by an increase in the higher rate of income tax, however, the net gain would be greatest for the middle income quintile of the whole population and top income quintile would be net losers.

There are a variety of ways in which the current means tested system could be reformed. These include:

- amending the capital limits by raising them, abolishing the upper limit above which service users are ineligible for any public (as in pension credit) or disregarding housing assets completely;
- increasing the personal expenses allowance for those in residential care and/or relaxing the treatment of income for those receiving home care;
- limiting liability to fund care privately by setting a life-time limit to private payments defined in terms of years of payment or total private outlay.

Hancock *et al.* (2006) found that such options for reforming

the means-test would each cost between £250 million and £1,000 million in 2002 in additional public expenditure and would take public expenditure on long-term care for older people to around 2.25% of GDP in 2051 rather than to 1.95% under the current funding system. These options mostly favour home owners and higher income groups, with the exception of raising the personal expenses allowance. Hancock *et al.* (2006) also considered a limited liability model with a lifetime maximum payment of £100,000 for residential care. The beneficiaries from this option would mostly be home owners with gains concentrated in the highest income group; the cost would be around £250 million.

The Wanless review favoured a partnership arrangement 'characterised by combining a publicly funded entitlement to a guaranteed level of care, with a variable component made up of contributions from individuals matched at a given rate by contributions from the state' (Wanless *et al.*, p.278). Wanless proposed that the publicly funded entitlement should be two-thirds of the benchmark level of care. Users could choose whether they wanted the remaining third, with the costs being met half by the user and half by the state. The benchmark level of care is the level that is cost-effective given a cost-effectiveness threshold of £20,000 per ADLAY (that is the gain for one year of life of having core activities of daily living (ADL) needs improved from being entirely unmet to being fully met). A partnership arrangement on these lines would require an increase in public expenditure of some £3.5 billion.

The Wanless report compares a partnership arrangement with free personal care or a means-tested system as follows:

- the partnership model is efficient: it produces the highest ratio of outcomes (ADLAYS) to costs of the

three funding systems (p.270);

- it has strengths and weaknesses in regard to equity and fairness: 'for the guaranteed element, support is based entirely on need and not ability to pay, but the converse is largely the case for the matched element. . . ' (p.269);
- it scores well on choice, as individuals will be able to choose the level of care they receive above the guaranteed level, albeit subject to co-payment;
- it scores as well as free personal care on dignity as no means-testing would be required within the care system;
- it is not as strong as a means-tested system on economic sustainability, but if necessary 'the guaranteed entitlement can be scaled back to reduce costs. . . or the matching contribution can be reduced' (p.271); and more options for dealing with sustainability could be added.

Conclusion

The debate about how best to finance long-term care for older people in England continues. The recent Wanless report and JRF report have highlighted a choice between three broad approaches for change: free personal care, reform of the current means-tested system or partnership arrangement. As Wanless concluded, 'all have strengths and all have weaknesses' (p.284). Policy-makers have a window of opportunity to consider these approaches before demographic pressures accelerate when the baby-boom cohorts reach late old age. Decisions will need to reflect the chosen balance between the different criteria for appraising options. They will also need to be consistent with developments in other areas of public policy such as health care and pensions.

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Distributional Effects of Reform in Long-term Care

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Abstract

Population ageing will intensify the distributional dilemmas related to provision and funding of long-term care (LTC) services. Several OECD countries have recently reformed their LTC systems, but as yet there is a paucity of evidence on how different reform options affect the financial position of different socioeconomic groups. Another neglected issue is how individuals adapt to changes as a result of LTC policy reform. One complication in the analysis of LTC reform is the great uncertainty in projections. This is largely due to the long planning horizon needed, and also the nature of LTC services themselves. The aim of this paper is to review two recent contributions to the literature: Hancock *et al.* (2006) and Karlsson *et al.* (2007). Particular emphasis is placed on the policy implications of these findings, but we also identify key issues for future research.

1. Background

The subject of long-term care (LTC) is receiving increasing attention both in the research community and in the governments of various countries due to the belief that an ageing population will greatly swell the demand for LTC services and create a huge public expense. One of the pressing issues is to determine by how much the demand for LTC will increase. Since all LTC systems by necessity entail a great degree of redistribution – over the life-cycle, from the young to the old, and between generations – another pressing issue is to address distributional concerns. It is the objective of this article to review recent research findings concerning these two issues.

1.1 Dependency and Ageing

LTC is administered to people who have reached a stage in life in which they are dependent on others for social, personal and medical needs. It is usually associated with the very old but, in fact, it could begin at any age depending on the reasons for the disability (perhaps, a road accident, a mental or a congenital condition). The age gradient in disability does however become very clear in Figure 1. The latter depicts a survival curve for males and females based on English Life Tables 15 (ONS, 1997). A life table does not represent the actual population but what the population would look like if age-specific mortality were to apply to a synthetic population, usually, 100,000 people. The light shaded area of the figure represents the proportion of the surviving population that is disabled.

The average 'stock' of the disabled of a given age and the duration of their disability are represented by the vertical

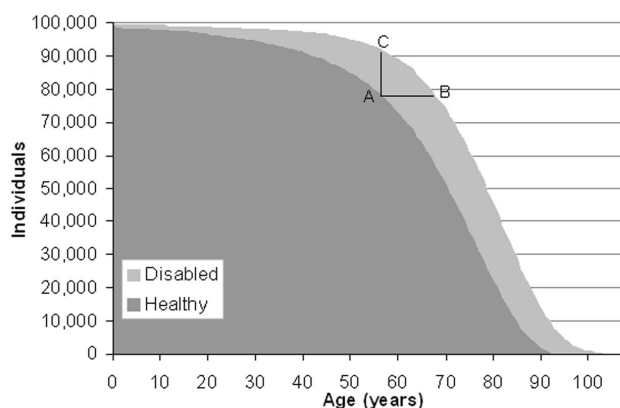


Figure 1: Survival curve based on English Life Tables 15 (ONS, 1997)

line A-C and horizontal line A-B, respectively. It is striking that the duration of disability tends to be constant if it begins in older ages but it is significantly longer if it begins in younger ages, say, between 40 and 50 years. The overall average is 9.91 years. If we were to construct the same diagram for the most severely disabled only, the light shaded area would be much narrower. It would represent those who are likely to be in need of intensive nursing or palliative care. For this group, the duration of severe disability averages 1.48 years.

1.2 Systems for funding and providing LTC

As yet, there is little by way of comparative analysis to help governments decide which approach to the provision and funding of LTC strikes the right balance between the various objectives of public policy. To date, the main focus has been on aggregate costs, but the policy-maker also needs to be concerned with economic efficiency as well as intra- and intergenerational equity. This in turn requires a careful analysis of the distributional effects of the various funding regimes for LTC, which is the topic of this paper.

There is a wide variety of LTC systems at work in the developed world. Countries have generally chosen very different paths and reforms have normally borrowed inspiration more from national traditions in the realms of health care and public pensions, than from other countries' models (cf. Scheil-Adlung, 1995). LTC systems may be evaluated in many dimensions and there is thus a multitude of possibilities for public policy. As suggested by Wittenberg *et al.* (2002), the most important decisions that policy-makers and society as a whole have to consider are:

- the boundary between LTC and health care;
- the role of the family in provision and financing of LTC;
- the balance between residential and home-based services;
- the provider roles of public and private bodies;
- the form of the public subsidy.

These differences in the role of the state have implications for the aggregate costs. In Sweden, total public expenditure on LTC for elderly comes to 3.0 per cent of GDP (Socialstyrelsen, 2006). This is several times more than in Southern Europe, where total expenditure – public and private – falls short of one per cent of GDP (cf. Comas-Herrera *et al.*, 2006). Most countries lie somewhere in between. For instance, in the UK around 1 per cent of GDP is contributed from the public purse each year. It is clear in Figure 2 that these differences between countries are not entirely attributable to different demographic situations. For example, Italy has a relatively high proportion (4.0 per cent) of very old people, but spends only 0.6 per cent of GDP on LTC. In the Netherlands, on the other hand, the very old are a smaller group (3.2 per cent of the population) and yet LTC costs are much higher (2.5 per cent of GDP).

Given that the projection of needs of and costs for LTC is complicated by several uncertainties, a formal assessment of the various LTC funding regimes displayed in Figure 2 is difficult. Moreover, analysis of intergenerational equity will typically need to involve very long time spans – which further aggravates the problems related to uncertainties. This means that projections and analyses of LTC costs have to be interpreted with more caution than, for example, pension projections.

1.3 Uncertainties in trends

Various uncertainties concerning future LTC costs appear on the demand as well as on the supply side. On the supply side, the main issues are whether relative wages of care workers change in the long term (possibly, but

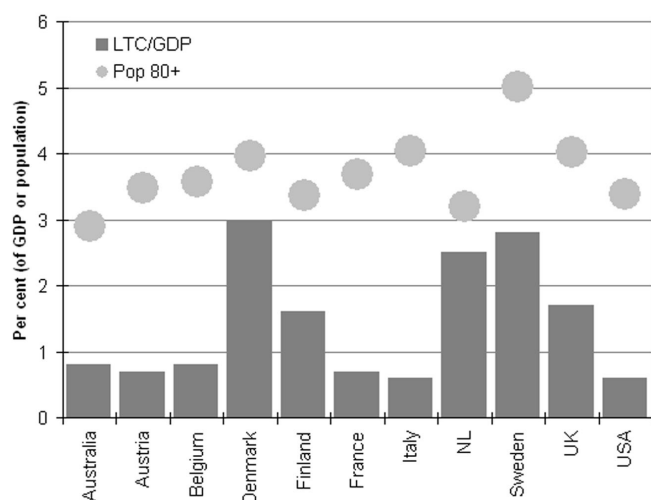


Figure 2: Public Expenditure on Long-Term Care and Demographic Situation; adaptation from Casey (2003)

not only, as an effect of the surge in demand for LTC services) and whether technological improvements allow for increased efficiency in provision. Furthermore, the availability of informal carers is a key issue also as far as formal services are concerned, due to the high degree of substitutability between the two types of services. In this part, there seem to be countervailing trends, the relative importance of which is difficult to assess at present. Trends in supply seem to depend on who provides the care. Care provided by children can be expected to decrease in the future. Although reduction in supply due to increased female labour market participation could be compensated by the growing pool of fit younger retirees, changes in social norms and geographical distances between generations seem to be a growing barrier to intergenerational care. Spouses, on the other hand, can be expected to take on greater responsibilities in the future (Pickard *et al.*, 2000). Hence, the overall supply of informal care remains an open issue. There seems to be a widespread agreement, however, that the availability of informal carers is unlikely to keep up with the need for care (cf. Karlsson *et al.*, 2006).

On the demand side, there is uncertainty concerning the future income and asset distribution of older people, but the main uncertainty is of course related to the future development of morbidity. Over the past 30 years, there has been an intense academic debate on the implications for healthy life expectancy (HLE) of falling mortality rates. Three competing hypotheses have been proposed. The most optimistic one, suggesting a compression of morbidity, was proposed by Fries (1980). According to this perspective, adult life expectancy is approaching its biological limit so that if disability spells can be postponed to higher ages the result will be an overall reduction in the time spent disabled. By contrast, Gruenberg (1977) suggested an expansion of morbidity based on the argument that the observed decline in mortality was mainly due to falling accident rates. The third hypothesis was proposed by Manton (1987) according to whom the development in mortality and morbidity is a combination of the two, which could lead to an expansion of the time spent in good health as well as the time spent in disability.

There is, however, not yet enough empirical evidence available to draw a definite conclusion on how the gap between healthy life expectancy and total life expectancy is behaving in all countries. Concerning the UK, the estimates based on the General Household Survey suggest that the prevailing trend largely depends on the definition of disability. Hence, there is relatively strong evidence of a contraction of the time spent in severe disability as a proportion of total life expectancy. For moderate disability, trends are less clear and partly dependent on the definition of disability used (Bone *et al.*, 1995; Bebbington and Darton, 1996; Bebbington and Comas-Herrera, 2000).

1.4. LTC Projections

How to treat the ambiguity concerning future morbidity has been one of the main challenges of previous projection models. Existing models for projections of future needs for LTC are either cell based macrosimulation models or microsimulation models (cf. Nuttall *et al.*, 1994; Wittenberg *et al.*, 2006; Richards *et al.*, 1996; Hancock *et al.*, 2003). Microsimulation has two main advantages. Firstly, since it deals with the entire distribution of certain variables in the population, it allows for a very detailed analysis of various aspects of policy changes – such as, for example, their implications for spend-down of care recipient's assets. Secondly, microsimulation also allows for modelling behavioural responses – such as responses in demand to changes in public subsidies (O'Donoghue, 2001). To date, however, it has been common to assume that there are no such behavioural changes. The main downside of microsimulation is that there are severe limitations to the interactions between variables which microsimulation analysis can take into account due to either a lack of rich datasets or computing constraints. Hence, microsimulation runs the risk of giving an illusion of realism that may, in fact, be unfounded.

One of the first rigorous reports on the future costs of long term care was provided by Nuttall *et al.* (1994). The projection was based on a multi-state model of disability, where the three states are assumed to be healthy, disabled and dead. Separate series of models were built to incorporate the severity of disability in which no recovery was allowed once the particular disabled state has been reached. The 1980s OPCS study (Martin *et al.*, 1988) of disability provided the basis for prevalence rates (with the implicit assumption that prevalence rates by age had remained constant between 1986 and 1991, the base year). The study projected a rapid increase in the demand for long term care from 2011 onwards. In order to estimate the future costs of LTC, it was assumed that LTC costs remain constant in terms of GNP (alternative scenarios with changing relative prices were also considered). According to the central projection, LTC costs as a share of GNP would increase by 47 per cent (from 7.3 per cent to 10.8 per cent).

More recent projections have been provided by the PSSRU (Wittenberg *et al.*, 1998; see Wittenberg *et al.*, 2006 for the most recent version). The PSSRU model, originally developed for the Royal Commission on Long-Term Care (1999), assumes that dependency rates by age and sex remain constant over the projection period and uses a cell-based model to project the future demand for LTC services and the implied costs. The dependency measure used in the PSSRU model is based on Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) failed by the individual. Sensitivity analysis allows for different assumptions concerning trends in life expectancy and disability. Karlsson *et al.* (2006), on the other hand, use continuing improvement in prevalence of disability as their baseline assumption, and then consider constant disability rates as a “pessimistic” scenario.

Most developed countries use some kind of projection model to assess future costs of long-term care. In Germany, it has been suggested that the current social insurance arrangement is untenable in the long term, since projections suggest that contribution rates will explode in the future (SVR, 2004). For Sweden, on the other hand, a projection model based on longitudinal data suggests that the demography-driven increases in LTC spending might be almost completely offset by improvements in morbidity (Lagergren, 2005). In a study commissioned by the European Commission, finally, projection models for Germany, Spain, Italy and the UK were compared, showing that projections for Southern European countries are more sensitive to changes in policy (Comas-Herrera and Wittenberg, 2003; Comas-Herrera *et al.*, 2006).

2. The Redistributive effects of LTC systems

Aggregate cost projections for long-term care have received considerable attention in media and in the policy debate, whereas the distributional impact of various reforms to the funding formula have largely been neglected. Nevertheless, there are clear indications that the system currently operating in England and Wales is not perceived as ‘fair’ (Hirsch, 2005) and there seems to be “widespread dissatisfaction with the current means-tested funding arrangements” (Wanless, 2006). Besides, the great diversity in long-term systems among OECD countries (Karlsson *et al.*, 2004) suggests that it is far from obvious which is the most equitable system for funding and provision of long-term care.

2.1 Equity in Long-Term Care

Discussions of equity normally make the distinction between horizontal and vertical equity – where horizontal equity requires that equal cases be treated equally, and vertical equity requires different cases to be treated differently. Concerning long-term care, however, there are several dimensions of such ‘vertical’ equity which have to be taken into account. The most important dimension is, of course, the distribution between people in need of care and others. However, distributive justice also requires the system to strike a fair balance between the young and the old, the poor and the rich, and between men and women. Furthermore, there have been some concerns in the UK that the current system fails to deliver ‘horizontal equity’ as well – such as the ‘diagnostic inequities’ identified by Hancock *et al.* (2006). ‘Diagnostic inequities’ are due to the fact that people suffering from illnesses for which treatments exist get personal care free of charge within the NHS, whereas those who suffer from conditions for which no treatments exist (such as Alzheimer's disease) do not. Similarly, there have been concerns that the decentralised system for LTC in Sweden leads to unacceptable regional variation in eligibility criteria (Karlsson *et al.*, 2004). In summary, equity in the funding and provision of LTC is a complex issue.

Moreover, even if we had a clear concept of distributional fairness, the formal analysis of different funding formulae

faces several methodological challenges. For instance, in the presence of behavioural responses on the part of the individuals affected, any policy analysis will face the difficulty of determining the appropriate baseline scenario (cf. Bergh, 2005). Besides, the long time perspectives complicate the analysis of distributional effects somewhat – for instance, in the presence of systematic differences in life expectancy, it is unclear whether total lifetime redistribution is the appropriate measure.

Two recent contributions have analysed the distributional effects of changing the system for funding LTC in the United Kingdom: the PSSRU-CARESIM model (Hancock *et al.*, 2006; Malley *et al.*, 2006; see Hancock *et al.* 2006b for a summary) and the model by Karlsson *et al.* (2007). Both models take the current system as their starting point and analyse the effects of different alterations to this system. The techniques used are very different, however. The PSSRU-CARESIM model uses microsimulation techniques and focus mainly on the distribution within the group of older people. Karlsson *et al.* (2007) use a simpler approach to analyse the distributional impact of different regimes, but are able to do the analysis in a life cycle perspective.

2.2 The PSSRU-CARESIM Model

The PSSRU-CARESIM model was used to assess the cost implications of the Wanless Review (Malley *et al.*, 2006). In this article, however, we focus on the distributional analysis undertaken in Hancock *et al.* (2006). The paper uses the already mentioned PSSRU model (Wittenberg *et al.*, 2006) to project future needs for long-term care, and the CARESIM model (Hancock, 2000) for the distribution of incomes and assets in the older population. The main advantage of the CARESIM model is that it allows taking into account the non-linearities in the means testing formula and the spend-down of assets that is bound to happen in such a system. In the means testing formula operating in the UK, personal assets are treated differently depending on whether they exceed £21,000 (in which case the individual has to cover the full care costs out of pocket), fall between £12,500 and £21,000 (in which case an income is imputed) or are below £12,500 (in which case they are disregarded altogether in the means test). The value of the recipient's home is disregarded for three months – and longer if a close relative is still living there. The CARESIM model uses the British Family Resources Survey to derive the joint distribution of incomes and assets among older people, and can thus assess the eligibility to a public subsidy under various regimes and the implied total costs.

Hancock *et al.* (2006) consider a host of different reform scenarios. Most of them are to do with the means testing formula for capital mentioned above. The authors allow for four different types of reform:

- An increase of the capital threshold from £21,000 to £150,000. The amount was chosen so as to correspond to the average value of homes owned by older people.

This reform scenario would benefit people with assets between £21,000 and £150,000 – a group which pays all LTC costs out of pocket in the current regime.

- Increases in the upper and lower capital thresholds to £50,000 and £150,000 respectively. This option would benefit all care recipients with assets between £12,500 and £150,000.
- Abolishing the upper capital threshold, and changing the imputed income from capital from £1 per £250 to £1 per £500. This reform scenario would benefit most care recipients with assets above £21,000.
- Full and permanent disregard of housing wealth.

Furthermore, the authors analyse two reforms to the funding of residential care:

- An increase in the Personal Expenses Allowance – the income that every care home resident is allowed to retain for personal needs – from £18.05 to £73.10 per week. This reform option is likely to benefit residents on lower incomes. The new allowance was chosen so as to achieve equivalence, from a public expenditure point of view, with offering free personal care.
- A lifetime limit on the amount an individual is required to pay towards institutional care costs. An overall limit of £100,000 is considered. This reform option is believed to promote the market for private long-term care insurance, since it removes some of the less insurable risks related to LTC – such as cost inflation and the risk of catastrophic care needs.

Finally, the paper also analyses the implications of offering free personal care in institutions. This was one of the reforms suggested by the Royal Commission (1999). It was later dismissed by the government in the 2001 *Health and Social Care Act* since it was expected to benefit relatively well-off older people. The Scottish Executive, however, did introduce free personal care in Scotland. The paper analyses two different methods of indexation for the personal care subsidy, and assumes that the costs are to be covered by an increase in marginal tax rates for high earners.

The paper by Hancock *et al.* delivers two types of results: estimates of aggregate costs and of distributional effects. Concerning the aggregate costs, the various reform options are expressed as percentage of GDP devoted to long-term care. Since there are no behavioural changes in the model, total costs are the same for each scenario (but vary over time) whereas the distribution between public and private spending is different in the different scenarios. According to these estimates, total costs devoted to LTC will increase by around 20–25 per cent between 2002 and 2022, irrespective of reform scenario.

If implemented, the different reform options studied would lead to increases in public spending on LTC of between 3 and 20 per cent, depending on scenario. The most costly reform option is to provide free personal care, as already practiced in Scotland. Such a change

would increase aggregate costs from 0.96 per cent of GDP to around 1.1 per cent of GDP. In the long term, that reform option would cost as much as 1.3 per cent of GDP. Conversely, the cheapest reform option by far is to introduce a lifetime limit on LTC costs, which would increase costs only marginally compared with keeping the current funding formula. This finding is expected since only relatively few people with very high LTC costs would be affected by the change.

Concerning the *distributive* effects of the reform, the paper focuses on the short-term gainers and losers from changes in the public benefits – whereas the revenue side is largely ignored. In general, it seems to be difficult to rank the different options according to their “progressiveness”, since the gains or losses from some changes are concentrated in both tails of the income distribution. For example, the proposal to disregard all housing assets has the gainers concentrated in the middle classes whereas the poor (who are unlikely to own their houses) and the rich (who have enough non-housing assets to be exempt from public funding) stand to gain less. Raising the upper capital limit to £150,000, on the other hand, benefits low earners disproportionately – presumably because their assets tend to be below that amount. The most striking distributive effect, however, is that all reform proposals concerning means testing of assets imply tremendous gains to home owners compared with non-owners.

For the two scenarios specific to residential care – increasing the personal expenses allowance or introducing a lifetime limit on contributions, the gains are relatively unevenly distributed, as illustrated in Figure 3. The figure shows how the relative gains from the reform are distributed over different income quintiles – as well as between home owners and non-owners. An increase in the personal expenses allowance is more favourable to low earners, since these are more likely to be affected by it. Home owners, however, only get 64 per cent of the average gain.

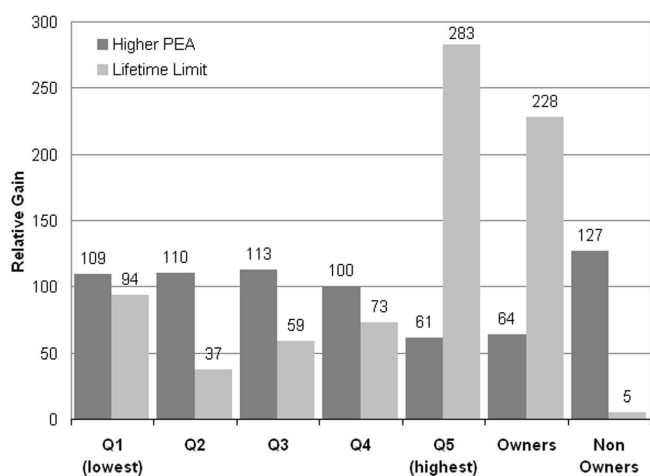


Figure 3: Relative gain from scenarios specific to residential care: recipients of residential care aged 85+, 2002

Concerning *free personal care*, the authors consider three different variants which have very similar implications. If the revenue side is ignored, introducing free personal care is clearly a regressive reform, since high earners stand to gain disproportionately. If the reform is financed from an increase in income taxes on higher incomes, however, the gains are instead concentrated in the middle of the income distribution.

2.3 The model by Karlsson et al.

The study of Hancock *et al.* (2006) can be contrasted with a study by Karlsson *et al.* (2007). The issues discussed in the two studies are very similar, but the methodological approaches differ substantially. Karlsson *et al.* (2007) use a projection model based on the OPCS disability survey from the 1980s (Martin *et al.*, 1988) to estimate the life cycle redistribution implied by various reform options. Using data from the OPCS survey, the model has been calibrated so as to replicate official population projections from the Government’s Actuary Department. The OPCS uses a 10-graded scale of disability which is slightly different from the ADL and IADL measures which form the basis of the PSSRU model used by Hancock *et al.* (2006).

The main advantage of the model of Karlsson *et al.* (2007) is that it is based on a so-called multiple state model and hence allows tracing an individual over the entire life course (details of the underlying disability model are provided in Karlsson *et al.*, 2006). This way, individual contributions to, and benefits from, the public LTC system can be measured in a life cycle perspective. The main limitation of the model is, however, that it does not allow for analysis of the entire distribution of assets and incomes in the population. Hence, the authors restrict themselves to analysing a set of ‘stylised individuals’, which differ in various dimensions, such as

- sex and the generation they were born;
- their earnings potential (low/middle/high).

In contrast to Hancock *et al.*, this model does not focus on the UK debate concerning funding of long-term care, but instead analyses the implications of introducing LTC systems as practiced in other OECD countries into the UK. The current system for financing LTC is contrasted with three different alternatives:

- One scenario similar to the *German* model for LTC. This includes a mandatory social insurance scheme (from which high earners can opt out), covering roughly half of actual costs in the various care settings. Furthermore, people with insufficient resources to cover remaining costs get income support financed through general taxation.
- One scenario similar to the *Japanese* model for LTC. This includes a universal social insurance which covers roughly 90 per cent of long-term care costs in any care setting. The social insurance benefits are financed in equal shares from contributions from

people aged 40 and over and general income taxes.

- One scenario similar to the *Swedish* system for LTC. This includes small but income-related out of pocket-payments in residential care. The public subsidy is financed out of proportional income taxes.

As in Hancock *et al.* (2006), the authors provide projections of the overall costs implied by the different regimes, as well as analysis of distributive effects. One main difference, however, is that the analysis of distributive effects takes contributions paid into the system into account, and also studies the entire life course of individuals. Due to the very long time perspectives involved when LTC is concerned, however, the authors study a period of transition from the current system to another one, and not how different ‘mature’ systems would fare in comparison. One consequence of this is that it makes little sense to compare the estimates of gains and losses within a certain scenario – as contributions already made to the current system are disregarded – whereas a systematic comparison of the different scenarios can be very informative.

Concerning overall costs, the authors find that all three of the alternative systems considered would imply increased public costs and thus increased taxes. In Table 1, the LTC costs expressed as a tax rate are set out for period 2000–2040 for the LTC systems used in Germany, Sweden, Japan and the UK.

*Table 1: Implied tax rates from different countries’ LTC systems**

Scenario	2000 (%)	2020 (%)	2040 (%)
UK	0.99	1.02	1.30
Sweden	2.40	2.45	3.11
Germany	<i>General</i> 0.50	0.50	0.63
	<i>Social insurance</i> 2.08	2.13	2.71
Japan	<i>General</i> 1.11	1.13	1.44
	<i>Social insurance</i> 3.00	2.89	3.60

* For the German and Japanese scenarios, ‘general’ refers to the tax rate paid on earnings by everybody, whereas ‘social insurance’ refers to total contributions (social insurance and tax) paid by non-high earners (Germany) or people aged 40+ (Japan).

It is clear that, despite the differences between the systems, the tax rates necessary to finance LTC will increase by roughly the same percentage regardless of which system is employed. The tax rate would increase by approximately 30 per cent by 2040 in all cases. The only exception is the Japanese scenario, where those making social insurance contributions benefit from the increase in the proportion of people aged 40 and over. As a result, the social insurance contribution rate needs to increase much less. However, general tax rates would still have to increase quite substantially over the period. This finding highlights a dilemma

the policy maker faces: the trade-off between comprehensiveness and cost control. A less comprehensive system, such as the Japanese one, is less sensitive to demographic changes, but it also allows for less redistribution and less mitigation of certain risks (e.g. health, longevity, or cost risks).

The model predictions could also be compared with projections made in the countries from which the scenarios have been borrowed. For example, a recent study by Lagergren (2005) shows that Swedish LTC costs can be expected to increase by 25 to 69 per cent between 2000 and 2030, depending on trends in health. A German projection, on the other hand, suggested that the social insurance contributions could amount to between 2 and 8 per cent in 2040, depending on how relative costs of care develop (SVR, 2004). This discrepancy is in part due to the adverse demographic situation in Germany, and in part due to more conservative assumptions concerning improvements in health.

Turning to the distributive aspects, Karlsson *et al.* provide a range of measures of how the different scenarios perform in various dimensions of equity. Since we are considering life cycle redistribution, there are at least two alternative measures available for this exercise: one is net contributions to the system (Net Present Value, NPV) and the other is the internal rate of return, measured as the ratio between benefits received and contributions paid to the system (i.e. Money’s Worth).

One important result is that, in monetary terms, all the systems considered are remarkably favourable to women. This is not a surprise in itself, but it is the differences between systems that are noteworthy. In net present value terms, the typical difference is between £3,000 (Germany) and £13,000 (Sweden), and in terms of ‘money’s worth’, women get between 91 pence (Germany) and £1.60 (Sweden) more in return for each pound spent on LTC than their male counterparts. These differences are mainly due to the fact that women are more likely to become disabled, and that they tend to be in more expensive care settings for a given disability severity level. Differences in income are of secondary importance.

For the rest, the results are quite as expected. A Swedish-style system would above all benefit low earners and old people, whereas a Japanese-style system is particularly favourable for young males. The ‘intergenerational’ profile of the different scenarios is summarised in Figure 4. Since we are studying a transition period, the age gradient in the net present values is hardly surprising. However, useful comparisons of relative effects between the different scenarios can still be made, since they give an indication of where a certain system puts its emphasis and what cohorts are particularly advantaged, in relative terms. In doing so, we note that young and middle-aged people would prefer the UK system, whereas relatively old people would prefer a Swedish-style system. On the other hand, the Swedish system is the worst for young people and the UK system

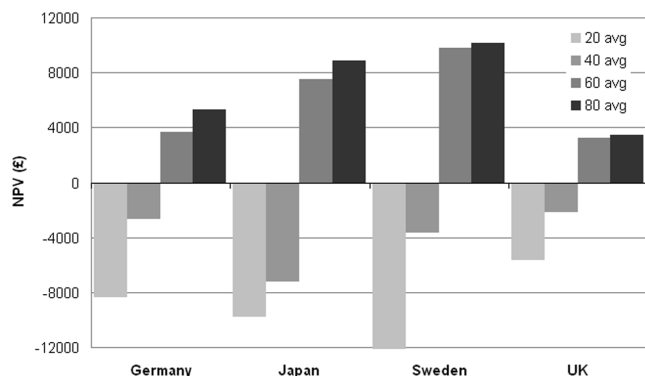


Figure 4: Net present value of public LTC benefits, by age

is the worst for old people. The Japanese system is the worst for 40-year olds, primarily due to the fact that they pay a considerable share of the costs without being entitled to many benefits. The German system falls in between, but is generally better for young than for old people.

2.4 Assessment

The two studies compared here address the same type of issues, but the approaches chosen are so different that it is scarcely possible to make meaningful comparisons between the two. Hancock *et al.* (2006) focus on short-term effects and largely disregard contributions paid to the system, whereas Karlsson *et al.* (2007) study the redistribution in a life cycle perspective. On the other hand, the PSSRU-CARESIM model allows for a more complete analysis of the entire distribution of income and assets in the elderly population. Hence, apart from the estimates of aggregate costs there is very little overlap between the two studies.

Concerning these aggregate costs, there is a striking difference between the two studies in the timing of the increase. According to Karlsson *et al.* (2007), LTC costs take off only after 2020, whereas Hancock *et al.* (2006) project a significant increase already by 2022. One reason is that the study by Karlsson *et al.* expresses aggregate costs as a proportion of total earnings in the economy, whereas the PSSRU model takes costs as a proportion of GDP. Since there is a growing group of pensioners – who earn income without contributing to the GDP – the two measures diverge. Furthermore, the model by Karlsson *et al.* (2006) allows for improvements in morbidity which are consistent with recent empirical evidence.

Concerning the distributional side, the issues studied and the time perspectives involved make direct comparison difficult. What both studies highlight, however, is that it is typically not possible to rank different reform options according to some simple criterion such as ‘progressiveness’. This is mainly due to the fact that when LTC is concerned, several dimensions of redistribution overlap – from men to women, from the young to the old, between home owners and non-home owners, and from the healthy to the ill. It follows – as was mentioned initially

– that the issue of equity in funding and provision of long-term care is very complex and needs to be analysed with great care.

3. Concluding Remarks

The existing models for projecting LTC costs are very sophisticated in some respects, but disregard other important aspects of LTC funding completely. Hence, there is a wide scope for future improvements in projection models for dependency and long-term care. In this section, we discuss the policy implications of the articles reviewed and then give a brief overview of possible future research developments.

Firstly, the research by Hancock *et al.* (2006) suggests that the widely discussed reform option of free personal care might not be the most efficient way to relieve care recipients in the middle income brackets. It is a very costly option – leading to an immediate ten per cent increase in public LTC costs – and yet it benefits many care recipients who are not really in need of public interventions. Changes to the means testing of capital, on the other hand, come at slightly lower cost, yet tend to benefit the middle income brackets much more. In conclusion, there might still be strong reasons to treat health care and long-term care differently, despite the perceived ‘diagnostic inequities’ inherent in such a system.

On the other hand, their research also shows that trends in the various factors determining the needs and ability to pay for LTC may change considerably over time. Although free personal care is the most expensive reform option in the short term, changes in home ownership could make the suggested reforms to means test of capital more expensive in the long term. It follows that it might be ill-advised to perform public policy by means of incremental changes, since these are likely to be too concerned with present-day issues. Conversely, a more far-reaching reform approach might be better at handling the long-term issues.

A related issue is the finding by Karlsson *et al.* (2006) that the long-term sustainability of different LTC systems varies somewhat with the distribution of public costs for long-term care. In a Japanese-style system, where a substantial part of the public LTC costs are borne by the older half of the population, contributions need not rise as much as in other funding regimes. This could in turn be seen as an argument for partly funded long-term care insurance, since such an arrangement insulates the public funding from demographic fluctuations. The case for funding of LTC might be stronger than for pensions, since, firstly, the costs might be more sensitive to demographic changes than pension costs, and secondly, they constitute a smaller share of total public expenditure and hence the transition would be less costly.

Thirdly, a distributional analysis needs to take the distribution between men and women into account. Due to systematic differences in earnings, assets, cohabitation patterns, health, life expectancy and provision of informal

care, men and women are bound to fare very differently in any funding regime, and this raises the issue as to whether the differences are perceived as 'fair'. Karlsson *et al.* (2006) show that the funding regimes practiced in different countries differ significantly in this respect; for example, changing to a Swedish-style system would increase average redistribution from men to women by around £10,000 over a life cycle. Interestingly, there seems to be no correlation between informal caregiving patterns – where women typically provide more – and the redistribution in the formal care system.

Most projection models are in effect extended population projections, and as such they tend to disregard systematic differences between different population strata. One reason, however, why the empirical evidence on trends in morbidity is so incomplete could be that different subgroups of the population are diverging over time. Hence, models of disability and LTC could benefit from allowing for more *heterogeneity* within the population. Introducing such heterogeneity would be useful from several points of view. Educational attainment, for example, is correlated with health and morbidity as well as with savings and income (and possibly also with preferences and behaviour). Thus, projections could and should be done separately for different educational groups – as well as for other subgroups of the population.

Another serious limitation of previous models is that they do not allow for *behavioural responses*. One example where policy reform could induce behavioural change is the popular suggestion of a tax on bequests (cf. Casey, 2003), in which case there is a risk that intra-family transfers will offset the tax at least partly. It is clear that incentives do matter, as the UK experience demonstrates: changes in the funding formula for residential care in the 1980s lead to a rapid expansion of care homes which could not at all be attributed to changes in demography or morbidity (cf. Howe and Healy, 2005). In fact, the system for LTC funding and benefits is likely to influence a wide range of decisions on the part of the individual, such as

- the choice between informal and formal care (cf. Pudney *et al.*, 2006), and between domiciliary and institutional care;
- the supply of informal care;

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- labour market decisions – how much to work, how long to work.

Given a lack of systematic studies, it is impossible to tell how important these possible changes in behaviour are.

Incentives clearly matter if individuals behave rationally. But do they? There are new developments in **behavioural finance** which suggest that individuals are bad at handling costly events which occur with a very low probability (cf. Mitchell and Utkus, 2003). This is probably particularly true for long term decisions as whether to make financial arrangements for LTC or not. On the other hand, it has been suggested that the low take-up of private long term care insurance is perfectly rational in the presence of a means tested public subsidy (Pauly, 1990). Further research should investigate to what extent and under which circumstances individuals can be expected to behave rationally in the face of future LTC risk – which is a precondition for any analysis of incentives and their effects. On the other hand, if individuals do *not* behave rationally, it is equally important to assess the implications of their misperceptions.

Finally, the *macroeconomic* assumptions of LTC models are particularly naïve. LTC unit costs are normally assumed to follow labour costs or the GDP per capita closely, and sensitivity analysis is undertaken to see what happens when LTC costs diverge in some direction. This approach is probably reasonable given that LTC services are very labour intensive and there is little potential for efficiency gains over time. Historical data, however, suggest that LTC costs in the UK have been growing at a slower pace than unit labour costs – despite the surge in demand for these services (Curtis and Netten, 2006). For the future, it could be argued that shortage of labour and increases in demand would push LTC costs upwards. On the other hand, trade liberalisation is believed to have put a downward pressure on unskilled worker's wages in rich countries (Wood, 1995). Hence, there is a considerable uncertainty regarding the future costs of care, and a more comprehensive model of the economy could provide some insights into this. Furthermore, to the extent that the funding of LTC affects savings and labour market behaviours, the funding formula will have repercussions in the macro-economy which should be taken into account. In summary, projections of LTC costs would benefit from more explicit macroeconomic modelling.

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A Journey through the Years: Ageing and Social Care

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Abstract

The paper analyses the history of English social care philosophy, policy, and institutions since the late seventies, and the challenges of today which they have helped to shape. Guiding principles changed in fundamental ways requiring and causing profound cultural and structural changes, not always with the intended mix of consequences. Changes in practice philosophy complemented changes in the philosophical bases of policy. They moved along a continuum of doing 'to' people (containing and controlling as well as caring), to doing 'for' (paternalistic but often also patronisingly assuming 'cosiness' in looking after people), to doing 'with' (partnership and participation), to offering more independence choice and control and doing 'by' themselves but with 'assistance' when needed. Since 1989, policy and institutions have been adapted to reduce the dependence on institutions, better match responses to individual circumstances and increase control and choice by shifting the balance of roles of authorities from direct provision to planning and purchasing more diverse services and supporting the development of a succession of new models for securing their fit to user wishes and circumstances. From 1998, policy was designed to accelerate and secure greater consistency in development based on the national policy principles through performance management including rewards and incentives. From 2005, the challenge was defined more in terms of improving the broad wellbeing of older people and finding new ways of contributing to it, particularly in ways which would reduce the subsequent need for services. Pressures on public budgets have throughout been and continue to be a major concern of field agencies.

It continues to be topical and timely although it also continues to be addressed with a degree of timidity reflecting the tensions it encapsulates. So, how should assistance be provided for people as they age with an increasing likelihood of deteriorating physical and cognitive capacity and with an increased potential for mental ill health, especially depression (see, for example, National Centre for Social Research, 2000)? With current and projected demography showing an overall significant ageing of the population, and with the balance across age groups skewing towards a higher proportion of much older people, social policy and social care practice has often adjusted itself to survive, rather than to support and sustain, an ageing population.

Setting the changing scene

A long-term perspective shows a move away from institutional care in the 1940s (in large geriatric hospitals and mental health asylums, often having been reincarnated from

former Poor Law workhouses), to the advent of smaller residential care and nursing homes from the 1960s, and with a greater emphasis on community care assisting people within their own homes from the 1980s, to a current policy to support people to live independently. The practice philosophy running alongside the policy changes has seen a move along a continuum of doing 'to' people (which was as much about containment and control as about care), to doing 'for' (with its paternalistic but also often patronising 'cosiness' of looking after people), and then doing 'with' (in partnership and with participation by older people), to an intention now that people should have more choice and control and be 'in charge' doing 'by' themselves but with 'assistance' rather than 'care'.

The change in practice philosophy is illustrated by changing terminology. Government initiatives about 'community care' have been replaced by initiatives about 'supporting people' and 'promoting independence'. But as well as reflecting positive changes in philosophy, with a movement away from segregation, institutional isolation, containment and negative discrimination, many older people experience benign neglect, with families having fragmented, been reconstituted and geographically more dispersed, and with the state rationing services more heavily.

There is also a two-tier experience of ageing. Those in good health and those with cash and resources within their own control (and they are likely to be the same people) have longer lives and continuing opportunity, and when they need assistance they can buy it (although its quality may still be limited). These are the older people with significant occupational pensions, available equity through home ownership and inherited wealth from a previous generation, all of which is increasing for the 'new elderly'. But for older people who need state support with income maintenance, housing and the provision of social care assistance there are more heavily rationed and reducing services, often purchased by the state more cheaply and of a lower specification and quality, and with waiting lists and delays before any help is provided. For some older people this means very damaging, unnecessary and too long hospital admissions, with the risks of secondary infections, deteriorating muscle tone, and reducing confidence, capacity and competence.

The danger of increased rationing of services, and a continuing heavy dependence on institutional services, was noted by the Audit Commission twenty years ago:

At best, there seems to be a shift from one pattern of residential care based on hospitals to an alternative supported in many cases by Supplementary Benefit Payments – missing out the more flexible and cost-effective forms of community care altogether. At worse, the shortfall in services will grow, with more vulnerable and disabled people left without care and at serious personal risk.

Audit Commission, 1986, p.2

The framework which has resulted is still overall one of 'less eligibility', a residue of the Poor Law, with bureaucratic procedures having been installed nationally to determine who will not be assisted as much as who should be helped. This is a residue which results from limitations in resources leading to an emphasis on rationing. But it also reflects the limited value which has been given to older people, who have been seen as a drain and strain and a cost for communities rather than as active participants and contributing citizens (see Office of the Deputy Prime Minister, 2006).

This contrasts with some other cultures known to the author, such as in The Gambia, where older people are seen to have experience and wisdom and the elders have status as advisors and decision-makers. It also contrasts with the very real position in the UK where it is often older people who are leading and sustaining community and voluntary organisations as well as being a resource as carers and confidants within their own families and neighbourhoods.

Our concept of 'being old' is also changing. No longer, in some respects, are women aged 60 and men aged 65 seen as 'elderly'. The age of admission to residential care is now in the high 80s rather than the mid 70s, and more people are maintaining active and independent lives well into their 90s. The special and unusual significance of reaching 100 is less now that more people are becoming centenarians. Service performance measures which used to focus on how many people aged over 65 years are receiving assistance have been replaced over time by measures of over 75s and then over 85s.

However, conversely, people aged 50 plus are being drawn into the concept of 'being elderly' as, very positively, they are encouraged to plan for their own ageing, and in particular about money, housing, health and activity. They are also, more generally, being engaged in planning the shape of future services, which is especially relevant as services being commissioned and designed now, and especially where they require a return on capital investment, are still likely to be what is available in twenty or thirty years time.

And the aspirations of someone who is now aged eighty, who would have been born in the mid 1920s, and would have grown up under the Poor Law, the depression of the 1930s and the post-war rationing in the late 1940s and early 1950s are likely to be quite different to someone who was born in 1950 (and who will be aged eighty in 2030) with an experience of the MacMillan 'never had it so good'

1950s, with an adolescence in the freedom decade of the 1960s, and with much of their adulthood amidst the consumerism and individualism of the Thatcher years, and all within the framework of the post 1946/1948 welfare state.

The accepting, largely undemanding and grateful (see Help the Aged, 2006) current older generation (who regularly rate services as good or better) will be replaced by a consumer-orientated, choice-expecting and quality-conscious generation who are likely to be more demanding and less acquiescent. For an increasing number they will have control of their lives as they use their own wealth to determine how they want to live. For a smaller number with no or limited financial resources, they could be, and are being, left stranded by a state which only sees the improvements within a majority who are more visible than an isolated, excluded and ghettoised minority.

Policy and practice: shaping or responding?

So, within this changing scenario of ageing and of older people what has happened within social policy and social care practice? To what extent has it shaped the context for older people and to what extent has it responded to changing contexts? The answer, of course, is that it is both. Policy and practice has an impact on experience and shapes expectations, but it also is a creature of its times, reflecting contemporary values and realities. And policy and practice are often rational responses to current and future issues, but there are also times when they generate their own unanticipated and unintended consequences. One such dynamic was a major driver in promoting the social care changes of the 1980s.

The growth of residential care

In the late 1970s, despite the national community care policy intention that more disabled and older people should be assisted to remain in their homes, a possibility was spotted of using the income support system to meet the majority of people's costs if they moved into residential or nursing home care:

... in contrast to Attendance Allowance and Invalid Care Allowance no test of disability is required for Supplementary Benefits payment for board and lodging unless the special rate for 'very dependent elderly' is claimed. Thus, anybody fulfilling the Supplementary Benefits rules (irrespective of extent of disability) who chooses to live in a residential home is entitled to allowances meeting their fees up to £125 or more a week ... in these circumstances the temptation must be strong for anyone trying to look after a relative at home to make use of the more generous, and far less stringent payments for board and lodgings, by placing them in residential care ... in short, the more residential the care, the easier it is to obtain benefits, and the greater the size of the payment. And Supplementary Benefit funding cannot be targeted towards those most in need of residential care. Nor are homes judged on whether they are giving value

for money within the care for which they are registered.
Audit Commission, 1986, p.44

This manoeuvre was not only followed up by disabled and older people themselves as an alternative to waiting for local authority funding to allow them to move to independent private and voluntary sector care homes, but was also encouraged (albeit often surreptitiously) by local councils as a means at a time of tight budget restrictions to shunt costs from local authorities to the Department for Social Security:

Local authorities are becoming increasingly aware that board and lodging payments can often meet the accommodation and care costs of those in independent homes who might previously have been sponsored by the local authority. In at least two of the authorities visited, a 'gain' of £1 million a year (each) had been received by transferring to Supplementary Benefits responsibility for people placed in voluntary sector residential accommodation.
Audit Commission, 1986, p.45

The consequences were an escalation in the social security spend on residential care from £10m in 1974 to £1bn by 1989 (Evandrou, Falkingham, and Glennester, 1991), the move into residential care of older people for whom there was (at least within local authority threshold judgements) no need for residential care, and a burgeoning private sector expansion of care homes, often run as small businesses. It was not at all unusual to find, for example, a local builder adapting properties to become care homes which were then managed by his wife and staffed by other family members or local doctors owning care and nursing homes. But at the same time that this unintended consequence of social policy (the opening up of the social security system to pay care home fees) was taking place, another counter initiative was being implemented.

Care management

The advent of 'care management' is a fascinating example of how national policy can grow from local initiatives (a further example below is about 'direct payments'). Indeed what is about to be illustrated here is how there is often a time-lag between a successful and well promoted local model and its adoption within national policy and legislation.

'Care (or case) management' in the UK was heavily promoted in Kent, starting with the Kent Community Care Project in Thanet in April 1976. Kent County Council took up, shaped and promoted a model designed at the Personal Social Services Research Unit (PSSRU) at the University of Kent at the end of 1974. PSSRU then evaluated its implementation and impact. In this well-structured evaluative study of care management with older people (and one of those too rare occasions where research can be seen to have influenced policy development) it was found that care management led to lower rates of admission to institutions, there were gains in

cost-efficiency, there was a closer match between resources used and the needs of the older people, and older people and their carers appeared to benefit more from the (care management) scheme than from the usual range of services, and "the reduction in admission to institutional care did not appear to be achieved at the expense of quality of life" (Challis and Davies, 1986).

Professionally and, especially, politically 'care management' found its moment in time, although in its wider roll-out some of the focus, professional social work skills base and sophistication of the initial model were lost. Professionally, the emphasis on care managers being beside disabled and older people helping them to choose how they wanted their needs to be met, and then making the arrangements on behalf of the disabled or older person, fitted well with a professional orientation focussed on assisting but not controlling or dominating people. Politically, care management fitted well with the Thatcherism philosophy of a mixed economy of care which would alter the balance away from a heavy reliance on local authority provided and managed services, with the market to drive the three 'Es' of greater economy, efficiency and effectiveness (but often forgetting a concern for 'equity' and a fairness between people and between areas), and where consumer choice would drive the re-shaping of services and promote quality.

Griffiths and the reform of community care

This was all then picked up by Sir Roy Griffiths in his report on the care of disabled and older people, with Griffiths noting the gap between policy rhetoric and reality:

At the centre, community care has been talked of for thirty years and in few areas can the gap between political rhetoric and policy on the other hand have been so great. To talk of policy in matters of care except in the context of available resources and timescales for action owes more to theology than to the purposeful delivery of a caring service.

Griffiths, 1988, p. iv

Griffiths noted the perverse incentive resulting from social security payments being available to fund a person's residential care but not their care at home, and saw the solution as making local authorities responsible for assessing whether someone needed residential care and what was a reasonable rate to pay for that care. But Griffiths also saw that giving local authorities this responsibility, and the control of the money for care services, would allow the ambitions of national policy care for more people in their own homes to be more easily attained:

The aim would be first, to preserve entitlements whilst putting the social services authority in a position of financial neutrality in deciding what form of care would be in the best interest of the individual and secondly to ensure that individuals are not placed in residential accommodation, when it is not in their best interest.

Griffiths, 1988, p. vii

The actions proposed in the Griffiths Report were that local councils should assess the community care needs of their area, set priorities and service plans, assess individual needs within this framework “taking full account of personal preferences” and “design packages of care best suited to enabling the consumer to live as normal a life as possible”, and then to arrange the delivery of the package of care, acting as “the designers, organisers and purchasers of non-health services, and not primarily as direct providers”.

At the time Griffiths was not totally ‘on message’ politically (see Baldock, 1994; Jones, 1994). Thatcher was uneasy about handing more money over to the control of local government whereas Griffiths’ view was that “to prescribe from the centre will be to shrivel the varied pattern of local activity”. But Griffiths did argue that there needed to be stronger national incentives and sanctions noting that “nothing could be more radical in the public sector than to spell out responsibilities, insist on performance and accountability and to evidence what action is being taken”. This is a message which was heard and then reflected in the increased management from the political centre introduced by New Labour in the late 1990s. Griffiths also went on to say that it would be “even more radical to match policy with appropriate resources and agreed timescales”, but even now twenty years on this can be seen to be a message which has still to be heard and continues to be debated, especially in terms of how much should people pay towards their own care (Royal Commission, 1999; Wanless and Forder, 2006).

It was by and large the recommendations of the Griffiths Report which were picked up in the 1990 NHS and Community Care Act (see also Department of Health, 1990). This legislation, which followed the ‘Caring for People’ (1989) white paper, gave the framework within which local authorities were to assume the responsibility for public funding of residential and nursing home care, with the government to transfer to local authorities during a transitional period of several years the social security spend which had seeped into funding care services. But through this manoeuvre the Government also intended to cap the public spend on care services (with social security spend being uncapped and rights-based whereas local authority budgets are cash-limited and discretionary), and to re-direct expenditure away from residential services to more investment to assist people in their own homes and in their own communities. How the government came to create further levers to promote and deliver this change is discussed below.

The Griffiths Report and the ‘Caring for People’ white paper also resulted in a flurry of reorganisation within local authority social services departments, with new organisational arrangements being established to separate care management and the purchasing of services from the provision and management of direct care services. There was also the requirement that “local authorities should set up independent inspection units, under the Director of Social Services, charged with inspecting and reporting on both

local authority and registerable independent residential care homes” to ensure that “common standards should apply across all sectors” (Caring for People, 1989). This inspection and regulation function was further expanded and shaped in the mid 1990s and with the inspection and regulation functions being taken outside of local councils to an independent inspectorate (see Burgner, 1996).

There was also a flurry of activity to create specialists and separate divisions within social services departments for the management of children’s services discrete from the management of social care services for disabled and older adults, and this partly reflected the increasingly separating legal frameworks for children’s services, through the 1989 Children Act and also the 1991 Criminal Justice Act, and for adult and disability services, through the 1990 NHS and Community Care Act. This is a separation which has now reached its conclusion in the mid 2000s with the requirement in England (but not in the three other UK administrations) that there be directors of children’s services separate from directors of adult social services (see Department of Health, 2005b) whereas previously every local authority with social services responsibilities had to have in post a director of social services. My own senior management career between 1987 and 2006 mirrors these changes where I went from being a divisional director of social services, to deputy director of social services, to senior assistant director (purchasing), to director of social services and then to director of adult and community services, and en route also had a year as chief executive setting up one of the new national organisations spawned in the early 2000s to promote the performance agenda.

The consequence of the community care changes heralded by the Griffiths Report, shaped by the ‘Caring for People’ white paper and encapsulated in the 1990 NHS and Community Care and the associated statutory regulations and guidance (see, for example, Caring for People, 1990) was that there was a levelling off and then a reduction in the numbers of older people moving into residential and nursing homes, and an increasing number of older people who were assisted, primarily through receiving home care services (see, for example, Audit Commission, 1996) but also day care, respite care and home meals services, to live in their own or family homes and this followed an existing trend:

There has been a gradual shift away in the balance of care from hospitals to the community. The numbers of people in long stay hospitals (whether elderly, mentally ill or disabled in some way) have been declining with the community expected to take the strain. People are discharged earlier from acute hospitals with average stays in geriatric beds halving over ten years. And with the increase in day treatments they may no longer even stay overnight. There are increasing demands for alternative options from childbirth to hospice at home; and many conditions such as asthma and diabetes are managed in the community where hospital would once have been the automatic focus.

Audit Commission, 1992

The most up-to-date picture of the re-patterning of community care services, which it was noted in 2004-2005 were provided to 1.7 million adults in England, is within the annual report of the Commission for Social Care Inspection which commented that:

There have been further increases in the number and proportion of people using intensive home care (households using more than 10 contact hours and 6 or more visits per week); in 2005, 98,240 households received intensive home care (an increase of 6% from 2004). Admissions to nursing and care homes have continued to decline reflecting government policy to support more people to live independently in their own homes. The number of people supported by councils to live in residential care decreased from 277,950 in 2003-04, to 267,240 in 2004-05.

Commission for Social Care Inspection, 2006

In essence, the changes reflected the community care policy intentions and the Association of Directors of Social Services commented one year after the implementation of the community care changes that:

It is clear that Social Services have delivered the objectives set for them in this first year. Assessment processes have been established, negotiations undertaken with the National Health Service, and arrangements made with the independent sector which – with very few exceptions – have proved to be effective and have considerably improved the pre-1993 situation.

ADSS, 1994

However, this 1994 ADSS report (with a foreword by Denise Platt, the then president of ADSS but later to become the chief inspector for social services in the Department of Health) also flagged up concerns about the uncertainty of roles and responsibilities across the NHS/ Social Services interface, the ‘planning blight’ resulting from the uncertainties of local government reorganization, the lack of clarity for engaging with housing authorities and providers and, in particular, about the resources which would be required to continue to successfully implement the community care reforms.

This concern about resources was emphasized in a number of reports at and around the time of the early 1990s community care reforms and was seen as a major threat to achieving the aspirations of the reforms:

The rate of growth allowed to social services by the government between 1978/79 and 1988/89 was 22.3% in real terms – an average annual increase of 2.3%, which is intended to allow for ‘demographic and other changes’ . . . Local authorities have been spending considerably more on social services than the figure the government thought necessary. Overall, their spending exceeded the government’s figure by 4.3% in 1987/88, rising to 13.9% in 1990/91. The difference was made up from local taxation. However, charge-capping has now forced spending down and more into line with government figures . . . In 1990/91, thirty two local authorities had reduced budgets for social

services, and many more had standstill budgets or reduced growth. This year the trend is even sharper, with half of all local authorities having reduced or standstill budgets to bring them closer to government figures. Government controls on local authority spending mean that the option of raising more money locally is no longer viable.

Harding, 1992

This scenario is echoed in a further report five years later:

Funding was transferred (from the social security budget to local authorities) in the form of a Special Transitional Grant (STG) which has increased Government funding on social services by 63% over the five years from 1992/93 to 1997/98. During this same period the basic Standard Spending Assessment (the amount the government thinks needs to be spent and on which it bases its formulae for giving money to local councils), without any additions for the STG, increased by only 8.5% in cash terms. Taking inflation into account, the basic amounts of Personal Social Services SSA have actually decreased by over six per cent in real terms . . . A number of authorities have introduced stringent limits on the number of placements they will make and the services they will provide. These have been introduced as emergency measures in response to budget shortfalls. A result is users waiting in hospital beds for placements which, due to their greater costs in comparison to residential care or nursing home beds, is not a cost effective use of resources. Such a policy also has implications for the choices available to users.

Edwards and Kenny, 1997

This financial scenario could be seen as another example of an unanticipated effect of policy (this time the trickle policy effect following the introduction of the ‘poll tax’, which was so unpopular that it became an overriding government concern, regardless of other social costs, to keep it low with minimal yearly increases), and it was a continuing concern four years later when the Audit Commission (1996) noted that in 1995/96 local councils were still spending on average 7% more on social services than the national government considered appropriate and that:

Overall, most authorities have given priority to community care with steadily increasing sums made available to deal with increased responsibilities. But whatever the framework set by central government or the budgets set by local government, financial commitments must be kept within these budgets. This calls for a number of measures starting with the careful management of the numbers receiving care.

Audit Commission, 1996

From provision to planning and purchasing

A further government policy intention at this time was to discourage local authorities from being direct providers of services. For residential care for older people there was a danger that by transferring the social security spend on care into local social services budgets that local councils would then use this money to spend on their own in-house

care homes. This national government unwanted policy outcome was avoided by restricting local authority capital expenditure on building and maintaining care homes, by still making available through the national social security system a 'residential care allowance' which could only be claimed by disabled and older people on low incomes who moved in to independent private and voluntary sector care homes (but not local authority homes), and through the 'choice directive', which was a statutory regulation enshrining the right of a person to choose which care home they entered (albeit if funded by the local authority within a price envelope set by the local council).

Local councils (see Edwards and Kenny, 1997) indeed increasingly transferred their existing care homes to the independent sectors (and often spawned local not-for-profit organisations, what might now be called 'social enterprises', to take on the care homes) as a means of being able to attain for the homes the capital investment they required. This was not only to cover general maintenance and refurbishment costs but also to meet the enhance standards now being set nationally before a home could be registered and operated. By transferring the homes local authorities also reduced their net revenue commitment to the homes as residents with limited income could claim the 'residential care allowance' to subsidise the costs of their placements and there was also an opportunity for increased cross-subsidy from full fee payers (who received no state support) as the fabric and environment of the homes was enhanced making the homes more attractive to self-funders. The new providers of the former local authority homes also reduced the unit costs of running the homes by reducing terms and conditions of employment (and especially pension entitlement) and management and staffing structures, and by focussed management often leading to higher occupancy rates and fewer voids (i.e. vacant beds).

At the same time, within the established independent care home sector there was considerable turbulence. The new registration standards (influenced by Avebury, 1984 and which continued to be enhanced; see Department of Health, 2000) meant the closure of some previously adapted small care homes, rising property prices meant it was possible in many areas for care home owners to cash in on a capital gain by selling the home (for conversion into apartments, private dwellings or guest houses and hotels), and the unit costs of, in particular, smaller care homes were higher than the weekly fee rates local authorities were willing or able to pay making the homes unviable, especially as the expanding flow of potential residents was curtailed by the shift to assisting more older people to remain, with support, in their own homes.

A consequence of all of this was a re-shaping of the care home market, which has become much more dominated by a smaller number of large national and international companies (which are often traded on) running larger homes. Whether this market-driven re-shaping will meet the expectations of the forthcoming generation of older people is

still to be seen as 80-100 place care homes are bound to be somewhat institutional.

An alternative has been, especially within the private sector, the growth of supported accommodation, through 'retirement apartments' and indeed 'retirement villages', where a whole range of activities and care is provided on-site to be bought off a menu of options as and when needed. At the same time, however, much 1960s and 1970s built local authority 'sheltered accommodation' for older people has become dated and poorly maintained and is difficult to let.

But overall the 1990s community care changes achieved the government's aspirations, which were largely shared by older people, social care workers and local councils, to stem the public spend on residential and nursing home care, to re-pattern services to support more disabled and older people within their own homes, to turn the focus of local authorities to strategic planning, commissioning and service purchasing rather than the direct management of service provision, and to stimulate choice for service users within a mixed economy of services. However, for those requiring public funding for their services their choice was increasingly limited by tight local authority budgets, which led to a heightening in the thresholds of need which had to be met before local authorities would fund a service.

This is a concern which is very current. The Commission for Social Care Inspection (CSCI) has noted that fifteen years ago councils provided home care to over 500,000 households (with each household on average having just over three hours of home care a week). Despite the growing and ageing population, and the policy of assisting more older people to live within their own homes, only 395,000 households were receiving a local authority funded home care service (albeit with an average of 10.1 hours per week) in 2004-2005. Some people may now be using their own resources to buy the services they want without seeking help from the local authority, but CSCI comments:

The continued increased intensity suggests that provision is actually focusing on people with the greatest need, providing a narrow range of people with a deep level of service. Whilst this is important, it poses questions about what happens to those people with considerable needs and those who may be prevented or delayed from seeking more expensive services by some timely, simple help.

Commission for Social Care Inspection, 2006

Direct payments and choice and control

For younger disabled people in particular, however, being a recipient of what were still local authority determined and arranged services was experienced as restrictive, limiting and intrusive. This was especially so when local authorities, especially as they continued to ration services heavily, continued to spend most of their social care budgets on residential care leaving limited choice for people with impairments with the options of little or no service or residential care. The residential care itself was experienced as

engulfing, leaving little space for individual life-style decision making, little privacy and little opportunity for any personal progress or change in the future.

It was disabled people themselves (see Morris, 1993; Campbell and Oliver, 1996; Oliver and Barnes, 1998; Barnes and Mercer, 2004) who developed and led the move towards more independent living in the community, with the disabled person in charge of the resources to acquire whatever assistance they needed when and how they wanted it. The then existing social care legislation did not give powers to local authorities to hand over money to disabled people so that they could purchase their own services (although social security disability benefits, such as attendance and mobility allowances, did to some extent provide this opportunity). Griffiths (1987) only dipped a toe into the water of direct cash payments suggesting that “there is no reason why, on a controlled basis, social services authorities should not experiment with vouchers or credits for particular levels of community care, allowing individuals to spend them on particular forms of domiciliary care and to choose between particular suppliers as they wish”.

But Griffiths was in danger of being behind the times. Local authorities were already using vouchers, for example, so that parents of disabled children could arrange respite care as, when and how they wanted and there was already pressure from disabled people themselves, first in Hampshire but then in a relatively small number of other areas, for disabled people to have control of the cash for the assistance they needed. Some local councils set up ‘third party’ schemes where a grant would be given to a another, often voluntary sector, organisation that would then, usually following still a care management assessment, make cash payments to the disabled person so that they could purchase and have more control over the assistance they needed. The popularity of these ‘indirect, third party’ payments was such that, with considerable canvassing from organisations of disabled people, but also with support from organisations such as the Association of Directors of Social Services, the government moved to introduce legislation, the 1996 Community Care (Direct Payments) Act.

The 1996 Act gave the power, although not initially the duty, to local authorities to give direct cash payments to disabled people who were “willing and able” to arrange and manage the assistance they required. At first this was limited to disabled adults aged between 18-64 years, but was then extended to all disabled adults aged over 18, including older people, to 16-17 year old disabled young people making the transition to adulthood and to carers. This was a win-win-win policy, supporting the aspirations of many disabled people to have more control within their lives, supporting the then Major government’s interest in moving services away from local authority control (as also happened, for example, with schools becoming grant maintained rather than immediately managed by local education authorities), and the incoming New Labour government’s agenda to promote consumer choice as a means of pushing forward

improvements in services and to break what was seen as the lethargy of the public sector and the paralysis of public sector bureaucracies.

However, the take up of direct payments was slow (see Commission for Social Care Inspection, 2004), partly because local authorities may not have heavily promoted them (and some where openly opposed to direct payments which might threaten the viability of in-house services, a concern also shared by public sector unions) and partly because, as now, there are limited numbers of disabled and older people and carers who want to take on the responsibility, pressure, tensions and workload of making their own service arrangements. One way around this conundrum of increased choice and control being set against increased stress and work is the introduction in the mid 2000s of ‘individual budgets’ where a sum of money is allocated to the service user, they can choose how it is spent, but the management of the money and the arranging of services may be undertaken by someone within the local authority, usually a social worker, or by a third party, such as a family, friend or advocate. But the take-up of direct payments is increasing from 14,000 people in March 2004 to 22,000 people in March 2005 to 32,000 in March 2006 (Commission for Social Care Inspection, 2006). No doubt this increase is prompted by local authorities having ‘direct payments’ as one of the key performance indicators on which they are externally measured and publicly assessed, but it also reflects a continuing change in professional and agency culture, confidence and competence in promoting direct payments.

Promoting performance

By the end of the 1990s, however, despite the community care framework from 1990 having been in place for ten years there were concerns about the limited pace of change and an expressed frustration by the in-a-hurry new Labour government from 1997 to want to make a difference and to be seen to be making a difference. In particular, Blair had a concern about the inertia within public services (see Sampson, 2004; Seldon, 2005). A new, and not seen before, phase of public policy was initiated. Right across the public sector there was a government crusade focussed on performance and quality and a number of levers were constructed to drive performance and quality improvements (see O’Neill, 2002). Similar techniques to drive change were applied in widely varying public services from health to education to housing to libraries to waste management, etc. and social care for disabled and older people experienced the full range of levers within this somewhat manic and certainly managerial agenda from central government.

The levers for change (Jones, 2004) included:

- “*management by machismo*”, achieving an impact through threat and intimidation (more prevalent in recent years in the NHS than social care), including being publicly “named and shamed” and “called in” to

see the chief inspector with jobs on the line;

- “*management by message*”, with the clusters of performance indicators showing where the government wants attention to be given and within national policy frameworks, such as the National Service Framework for Older People (Department of Health, 2001);
- “*management by measurement*”, on the basis of what gets measured gets done!
- “*management by motivation*”, with rewards (stars and honours) for achievements and punishment (more inspections or on monthly report) for failures;
- “*management by money*”, with specific grants from central government defining how resources can be used;
- “*management by mistake*”, which is to be avoided where possible but where there is an unintended consequence of striving to hit a target and with this undermining sensible policy (as with local authorities being measured on how much service they provide or purchase but not how much they invest in building community capacity to enhance life opportunities and experience more generally for older people).

The pulling of these levers had an impact. On the basis of what gets measured gets given attention, and that punishment will almost always be avoided and rewards will be chased, the performance targets set by central government did demonstrably lead to “gradual improvement and the modernisation of services” (CSCI, 2006, p.iii). Those people still seen as eligible for help received that help more quickly, the help provided was repatterned in line with national policy intentions (such as more home care and more community equipment to assist people to remain at home), and the views of samples of service users were sought each year to check on consumer satisfaction, which started relatively high and continued at similar levels but with quite considerable variation between local authorities.

But the focus on performance indicators which were largely agency and service focussed has its own limitations. Firstly, the indicators did not encourage the integration of services between, for example, health and social services, despite evidence that bringing health and social care together locally can improve access to, and speed of response of, services (see Brown, Tucker, and Domokos, 2002). Each public service sector had its own battery of indicators, focussed inwardly on its performance rating, and when the going got tough (especially about funding) would look after its own interests even if at the expense of its partners. This has been an intense experience in those areas where the NHS had set itself an unrealistic and damaging timetable to achieve financial balance after years of overspending. Secondly, for disabled and older people their quality of life is not only determined by the quality and quantity of services they receive. The services remain important but the service-focus misses the whole life-focus which is of importance to disabled and older people. The service focus primarily sees older people as service users and recipients of assistance, but not as active and contributing citizens with often unique aspirations.

The bigger and broader picture

It is this bigger and broader picture for disabled and older people which has most recently been painted by the government (see Department of Work and Pensions, 2005; Office of the Deputy Prime Minister, 2006), prompted by organisations for disabled people (see Help the Aged, 2004) and service and professional organisations (see LGA, 2004). It takes into account that older people, for example, are still citizens who within their communities are impacted by universal commercial and public services as well as specialist and secondary health and social care services. It also recognises that older people do not primarily define themselves in terms of the services they receive but still have a range of roles, and make a range of contributions, within their continuing capacity and commitment and reflecting their continuing ambitions and aspirations. For the public sector, therefore, a perspective is needed which sees older people more roundly in a bigger context which is not restrictively defined only in terms of services.

Focussing on this wider context can be a potential ally in seeking to address some of the difficulties heavily rationed public services have failed to adequately tackle. For example, high levels of depression in older people who use social care services (see, for example, Brown, Tucker, and Domokos, 2002) may be linked to a narrowing of friendship networks, to bereavement and loss of close family and friends, but also to some loss of capacity and physical and intellectual functioning. Opportunities for older people to remain socially active and engaged within their communities, with valued roles and status, and with social and intellectual stimulation, may contribute more to tackling depression than the array of health and social care services. It may also encourage continued physical activity, delaying or minimising the onset of physical deterioration and ill health.

It is local authorities (see, for example, DTLR, 2001) who have been given by central government a lead responsibility, through ‘local area agreements’ and ‘local public service agreements’, to bring together the sectors and interest groups right across communities to look to enhance the life experience and opportunities for everyone within the community. This might range from tackling crime and nuisance and the fear of crime, to the availability and access to transport, leisure and retail services, to safe and attractive environments with reasonable and appropriate housing, and with encouragement for communities to actively engage with all their citizens.

For agencies that have traditionally been service providers or, more recently service purchasers, they need to have a focus on community development as much as service development. This was a theme in the Seebohm Report (1968) on social services in England in the late 1960s, and twenty years on it was a part of the script for care managers and their organisations in the Griffiths Report in 1988 in developing more options to give more choice to disabled and

older people, and twenty years on again it has re-emerged as a major theme in social policy for older people.

Where now?

Chronology may influence but does not define or determine people and their needs. Being aged 75 does not require that someone must be in ill health and needing a range of health and social care services. Social care and health services are not provided to older people because of their age but because of their variable, but likely to be increasing, needs. And the experience of being aged 75 is not solely or, for most people, even primarily described and delimited by their health or social care status. This is the current challenge about the change in mind set which is required if people as they age are to be seen as more than dependent, and dependent, recipients of services.

There is also a challenge to move further away from the legacy of the Poor Law, with a Poor Law residue in our current policies which are focussed on determining who is not entitled to assistance (what was called under the Poor Law 'less eligibility'), with a continuing dependence on segregation in institutions (care homes), and with the 'parish rate' still alive and well through the council tax and territorial differences between local authorities in access to and standards of service and with disabled and older people

having to be re-assessed when they cross local authority (the new 'parish') boundaries.

An alternative would be, firstly, to move to a rights-based rather than discretion-based system of social care entitlement, maybe with disabled and older people receiving funding direct from national social security disability and income support benefits. This would, at a sweep, do away with the need for 'direct payments' and 'individual budgets', but would still require a framework of care arrangers, brokers or, as they were called in the Adult Social Care Green Paper (Department of Health, 2005a), 'care navigators' who would assist the disabled or older person to access and arrange the assistance they might need and want.

A second alternative would be to move towards enhancing the whole-life experience of disabled and older people, with universal services provided by all the sectors, including for example retail, transport and recreation, being more geared to the needs of disabled and older people (as is already happening to some extent with home-shopping services), and with more opportunities for disabled and older people to continue as active contributing and participating citizens. This would be a move away from a focus on services to a focus on experience, which is how strategic planners and commissioners ought to re-frame their attention.

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- Migrant careworkers
- The need for care and dementia
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Forthcoming issue – Fertility Decline



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