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LONG-TERM CARE FOR THE ELDERLY: THE EXPERIENCE OF FOUR NATIONS

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Abstract. Providing long-term care for growing elderly populations is a major concern in many industrialized countries. Germany, Japan, Canada, and the United Kingdom address long-term care issues in various ways. A comparison of these differing approaches may help inform U.S. policy makers as they face challenges presented by the retirement of the baby boom generation and the growing number of older persons.

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Summary

Providing long-term care for growing elderly populations is a major concern in many industrialized countries. Germany, Japan, Canada, and the United Kingdom address long-term care issues in various ways. A comparison of these differing approaches may help inform U.S. policy makers as they face challenges presented by the retirement of the baby boom generation and the growing number of older persons.

There are some common policy themes across each of the four countries. Projections about the increasing share that the elderly will represent in the coming decades have spurred policymakers to review and improve existing financing and service delivery systems. Each country is striving to create greater incentives for home and community-based care, and in some cases, to correct incentives that favor more costly institutional care. Each country recognizes the important role of unpaid care provided by family and friends to assist older persons with functional and/or cognitive disabilities. The role of women in providing unpaid care is especially salient. Countries differ in their financing methods although each requires contributions from beneficiaries, either through deductions of insurance premiums from wages (Germany), premiums for social insurance (Japan), or fees and contributions for services received (United Kingdom and Canada).

Germany established mandatory long-term care insurance in 1994. This social insurance approach provides for pre-determined services or cash allowances to eligible individuals based on their level of need. The insurance program is financed through a 1.7% levy on wages shared equally by employers and employees.

Japan's challenge of providing for their elderly is magnified by changing family roles, with more women entering the workforce and unavailable to care for the frail elderly. Japan's "New Gold Plan" of 1994 laid the foundation for a long-term care insurance system that was enacted into law in December 1997 and was implemented in April 2000.

In *Canada*, there is no national system for providing or insuring long-term care. Instead, provinces are responsible for providing services resulting in variability in eligibility criteria and services across the country. The federal government provides a block grant for health care, social programs and post-secondary education. Provinces may use a portion of the federal contribution for home and community-based care.

In 1990, the National Health Service (NHS) and Community Care Act was enacted in the *United Kingdom*. Its goal was to control growth in spending for institutional care, consolidate accountability for services at the local level, and lessen the bias toward institutional care through greater incentives for home and community-based care. A Royal Commission on Long-Term Care was appointed in 1997 to examine the current system and make recommendations for improvement. It reported far-reaching recommendations in 1999.

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Introduction

As the U.S. prepares for an aging society and the retirement of the baby-boom generation beginning in 2008, policy makers will increasingly be called upon to focus on issues related to providing and financing long-term care. Other industrialized countries face similar challenges and are planning or already taking steps to change their long-term care systems. This report provides a description and comparison of approaches taken by Canada, Germany, Japan, and the United Kingdom.

The programs in all four nations seek to enhance the quality of life for the frail elderly population. During the 1990s, three countries, Germany, Japan, and the United Kingdom, each enacted major legislation to redesign their systems of long-term care for the frail elderly. In 1994, Germany created an employer mandated insurance program where employer and employee share equally in a 1.7% levy on wages to pay for long-term care services. Japan enacted major legislation to establish a public long-term care insurance system which was implemented in April 2000.

In 1990, the United Kingdom enacted major legislation to transfer funds from the central government to local governmental authorities to be used for home and community-based services and to correct a financial bias that favors institutional care. More recently, in 1999, the Royal Commission on Long-Term Care made far reaching recommendations to the British Parliament regarding changes in the current system.

In Canada, there is no national system of long-term care. The provincial and territorial governments have the primary responsibility for both health and social services as they affect long-term care. They have individually taken measures to reorganize and refinance their systems. The federal government's role in these areas is through its constitutional spending power, its ability to generate revenues and to spend such money in ways that do not infringe on provincial powers.

Similarities in the four countries include the following:

- Projections of the increasing share that the elderly will represent in the coming decades have spurred policymakers to review and revise existing financing and service delivery systems.
- Each of the countries is striving to create greater incentives for home and community-based care, and in some cases, to correct incentives that favor institutional care. In some cases, the desire to control costs of institutional care has propelled policymakers to expand home and community-based care.

- Each of the countries recognizes the important role of unpaid care provided by family and friends to assist older persons with functional and/or cognitive disabilities. The role of women in providing unpaid care in each country is especially salient. In Japan, particularly, which has traditionally relied almost exclusively on family care, the increased participation of women in the workforce is expected to have a profound effect on family care. The United Kingdom's Royal Commission on Long-Term care has proposed a major national initiative to assist caregivers.
- Responsibilities for administration are generally decentralized , either divided among federal and local (or provincial) authorities. Local governmental agencies or, in the case of Germany, insurance plans, are responsible for assessment of an individual's need for service and development of a care plan according to services available.
- Each of the countries requires individuals to pay for a portion of the cost of their care and in the case of Germany, a deduction is made from employee's income to pay for long-term care insurance.
- Each of the countries, except Germany which has a mandated employer-based insurance plan, relies on public funding to finance long-term care in varying degrees.

Table 1 compares major components of each system.

Table 1. Comparison of Selected Country Characteristics and Long-Term Care Systems

population % of 65+	**Germany**	**Japan**	**Canada**	**U.K.**
United States 12.7% (1998) 13.2% (2010) 20.3% (2040)	15.8% (1997) 20.5% (2010) 34.6% (2040)	15.7% (1997) 22.0% (2010) 31.0% (2040)	12.3% (1998) 14.1% (2011) 22.6% (2041)	15.7% (1998) 16.5% (2010) 26.6% (2040)
Financing	employer mandated insurance; 1.7% of wages, shared equally by employer and employees	public long-term care insurance plan; public subsidies; insurance premiums and copayments paid by beneficiaries	federal transfer payments; tax credits and deductions for individuals; client fees for some services imposed by provinces	pay as you go taxation; individual contributions toward cost of care; tax credits for caregivers
Eligibility	assessment of need for care by medical service department of health insurance fund; benefits granted on basis of care requirement and not financial resources	assessment of need for care by municipalities	assessment of unmet needs by case managers; each province has own long-term care plan, now commonly called continuing care; formal income testing exists in some provinces	assessment of need by local authorities; requires individuals to contribute toward the cost of care based on a fee schedule (called a "means test")
Services & benefits	pre-determined benefits according to three levels of care/need; beneficiaries able to choose a mix of cash or services	12 at-home care programs to choose from, three institutional care services; maximum benefits at fixed yen amounts based on care needs	wide range of institutional and home care benefits in varying amounts set by provinces	wide range of institutional and home care services in varying amounts
Problems	low fertility rate and growing elderly population	rapid growth in elderly population and decrease in number of potential caregivers; decline in family care	strained resources; lack of uniform services and eligibility criteria across provinces	bias toward institutional care; lack of uniform application of eligibility criteria; uneven quality and access

Germany

Summary

- In 1997, almost 13 million people, 16% of Germany's population, was 65 years of age or older. By 2050, this group will represent 36.0% of the total population. An estimated 1.75 million people, or 2% of the population, require long-term care in Germany today.
- In 1995, Germany established a mandatory, universal, employer-based long-term care insurance system. The system is financed through a 1.7% wage contribution, split equally between the employer and employee. The system provides both cash and services to the eligible population. As of January 1997, insured persons totaled 71.7 million, or 87% of the total population. At the end of 1997, 2.3% of the insured, had been beneficiaries of the program.
- Each of over 1,200 individual "sickness funds" (or health insurers) has a medical service department that assesses individuals to determine eligibility and extent of need for long-term care. Individuals in need of care are assigned to 1 of 3 levels of care which establishes the extent of benefits and/or cash allowances that a person may receive.
- While the mandatory long-term care insurance system is financed through employer-employee contributions, each German state (Länder) is responsible for providing and arranging care.

Background

The national health care system in Germany has century old beginnings. The year 1876 marks the foundation of the Health Office of the German Reich in Berlin. In 1883, statutory health insurance was enacted by the first chancellor of the German state, Otto von Bismarck. From those early beginnings, social welfare legislation was enacted throughout the next century contributing to the evolution of what was considered by many as a model social insurance health care system. What originally began as an insurance scheme for wage-earning laborers and their families, expanded to include other groups of workers.

Today, Germany's social insurance program for health covers more than 90% of a population totaling over 82 million. Germany's statutory health insurance automatically insures employees with income below a specified annual level,[1] and its coverage extends to the dependents of the insured at no extra cost. Additionally, health coverage is extended to the unemployed. Self-employed persons and state employees with an income above the specified annual level are not automatically insured by the social insurance program. They are required to join a state health insurance system or purchase private health insurance.

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[1] The 1999 income limit was DM 76,500 a year in western Germany (US $41,500), and DM 64,500 a year in eastern Germany (US $35,000).

Over 1,200 individual sickness funds (health insurance plans) provide health insurance coverage in the form of both cash and in-kind benefits at a high level of service for those insured.[2] The sickness funds are financed through pay-as-you-go contributions, ranging from 12% to 15% of employment income.[3] Typically, half of the contribution to the sickness fund is paid by the employer while the other half is paid by the employee. Though regulated by federal legislation, the health care system is administered by the states. Persons with statutory health insurance may choose their sickness fund.

Demographic Trends. Changing demographics were an influential factor in establishing a long-term care insurance system for Germany's aging population. In 1980, 9.4 million people in the Federal Republic of Germany were 65 years of age or older.[4] In 1997, the number of 65+ in Germany grew by 38% to almost 13 million. This growth is partially attributed to the reunification of the German Democratic Republic (East Germany) and the Federal Republic of Germany (West Germany).

The younger generation in Germany is decreasing both in absolute terms and as a proportion of the total population. In 1997, the number of people under 15 years of age totaled 13.1 million (16% of the total population), a slight decrease compared to prior years.[5] The Federal Statistical Office of Germany calculates that in a few years there will be more people aged 65 years and over than those 15 years and under. The United States Bureau of the Census population projections for Germany confirms this estimate.

The total German population is projected to fall to 57 million people in the year 2050, a 30% decrease from the 1997 total population. It is estimated that 5.3 million people, or 9.2% of the population, will be 14 years of age or younger while 20.7 million people, or 36% of the population, will be 65 years of age or older. This represents a 59% increase over the number of people 65 years of age or older in 1997.[6] With life expectancies at birth estimated at 74 years for men and 80 years for women, and a total fertility rate of 1.25 children born per woman, these projections are likely to significantly affect the demand for long term care services in the future.[7]

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[2] Sickness funds are quasi-public, not-for-profit insurance organizations that operate under statutory requirements but vary in the extent to which they provide services, pay health care providers, and how much they charge in contributions. In January 1996, employees in a local, company, guild, or other statutory health insurance fund were given the freedom to choose the fund that would cover their needs.

[3] The average health insurance contribution rate in May 1998 was about 13.6% of the non-exempt employee income in western Germany and about 13.9% in eastern Germany. (Federal Ministry of Labour and Social Affairs.)

[4] Schwab, Teresa. *Caring for an Aging World*. New York, 1989.

[5] Federal Statistical Office Germany. *Population*. June 24, 1999.

[6] Ibid.

[7] CIA, The World Factbook 1998.

Table 2. Population Projections for Germany, 2010-2050

Year	Total population (in thousands)	Percentage by age group		
		0-14	15-64	65 and over
2010	81,012	12.4%	67.0%	20.5%
2020	77,848	11.3%	65.5%	23.3%
2030	72,375	10.7%	59.8%	29.6%
2040	65,402	9.5%	55.9%	34.6%
2050	57,429	9.2%	54.7%	36.0%

Source: Table prepared by the Congressional Research Service (CRS) based on data from the U.S. Bureau of the Census, International Data Base.

Long-Term Care

Projections about the growing older population and a desire to expand home and community-based care led to a major redesign of the German long-term care system. The redesign was enacted into law in 1994. The law established a mandatory universal social insurance program for long-term care (*Pflegeversicherung*) financed through equal employer and employee contributions.[8] The program is separate from the general health insurance program.

Before the enactment of a social insurance approach, long-term care services for the chronically ill were covered under the federal welfare law, and financed at the local level. Under the welfare program, eligibility for services was means-tested and determined by assessing a person's income and assets. Services received included cash support and/or in-kind benefits.

The long-term care social insurance program is considered a capped entitlement program with maximum per-person benefits. It provides nearly universal coverage and, unlike the prior welfare program, eligibility is not related to a person's income and assets.[9] For persons covered by the statutory health insurance program administered through the sickness funds, long-term care insurance is compulsory and is also administered by the sickness funds. Privately insured persons, i.e., self-employed persons, are required under the new legislation to purchase private long-term care insurance. While the long-term care insurance program covers institutional care, the new insurance system favors home care over institutional care. Non-

[8] The German Bundestag (Lower House) approved a draft bill addressing social provisions for long term care on April 22, 1994. One week later, the Bundesrat (Upper House) consented to the bill. On January 1, 1995, long term care insurance was established as an independent branch of the social insurance system and gradually phased in. The long-term care insurance program has provided benefits for home care since April 1, 1995, and for long-term institutional care since July 1, 1996.

[9] Cuellar, Alison Evans and Joshua M. Weiner. Structuring a Universal Long-Term Care Program: The Experience in Germany. *Generations*, v. XXIII, no. 2, summer 1999. p. 45ff. (Hereafter cited as Cuellar and Wiener, *Structuring a Universal Long-Term Care Program*.)

professional caregivers receive training and compensation for their caregiving efforts under the new law, and providers of institutional care are compensated on a per resident, per month basis.

In January 1997, the number of persons with long-term care insurance totaled 71.7 million or 87% of the total population. Of that number, 51.1 million were contributing members while 20.6 million were insured non-contributing family members. At the end of 1997, 1.7 million, or 2.3% of the total insured population, had been beneficiaries of the insurance with 72% requiring out-patient care and 28% requiring in-patient care.[10]

Eligibility. The long term care insurance program provides benefits and services to anyone requiring assistance with the "regular tasks" of daily life on a long term basis (estimated at 6 months or longer).[11] Under the public long-term care insurance program, the medical service department of each health insurance fund is responsible for assessment of individuals in their own homes to determine eligibility and the extent of need for long-term care services.[12] Each person in need of assistance is assigned to one of three levels of care, ranging from a need for 90 minutes of care per day for Level I to at least 5 hours of care per day for Level III. Each level of care is associated with a maximum insurance allowance, i.e., level of cash and services a person may receive. The entitlements provide for both home care services and nursing home costs. National guidelines and pre-determined benefits ensure uniformity of assessment and equality of treatment.

While the long-term care insurance program is focused on the elderly, it also provides for the younger disabled population in need of nursing care. These persons receive a flat rate allowance to help cover treatment costs. The goal is to help disabled people live in the community rather than residing in nursing homes. German law emphasizes integration of persons with disabilities into the community and the workplace by promoting employment of such persons. The law requires that at least 6% of the workforce of government and private employers (with more than 16 employees) be persons with disabilities. If the employment quota for the disabled is not met, the employers must pay a fee which ultimately subsidizes costs for those who do employ disabled persons.

Services Provided. Germany began phasing in its long-term care insurance program in 1995. Home care benefits were provided beginning April 1, 1995. In July

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[10] "In-patient" care refers to care requiring hospitalization "for the purpose of observation, care diagnosis, or treatment." "Out-patient" care is same-day services in which the person is not hospitalized. (On health Medical Dictionary, [http://onhealth.com])

[11] Section 14(4) of Volume 11 of the Code of Social Law defines regular tasks as *personal hygiene* – washing, bathing, cleaning teeth, combing hair, shaving, emptying bowels and bladder; *food* – preparing or administering food; *mobility* – getting in and our of bed, dressing and undressing, walking, standing, climbing stairs, leaving and returning to one's home; and *household tasks* – shopping, cooking, cleaning the home or apartment, washing-up, changing and washing bed linen and clothing or heating of the home.

[12] Section 18 of the Code of Social Law XI.

1996, the second phase began, providing for institutional care. Anyone paying into the long-term care insurance fund can immediately receive full benefits.

The insurance plan in Germany provides both cash and services so that beneficiaries may receive a nursing allowance, a home care allowance, and/or payment of full institutional care. There are no restrictions as to the combination of cash and services received so that anyone may benefit from comprehensive services and minimal amounts of cash, or may choose to receive all benefits in the form of cash and buy privately delivered services. Although cash has been a major choice of long-term care clients, recent trends show the number of people choosing only cash is declining. One reason may be because the majority of people in need of long-term care desire to live at home or in familiar surroundings for as long as possible. More people seem to prefer tailored individual home care services or combination packages that provide both in kind and cash benefits.

Long-term care cash allowances determined by a person's care requirement level are paid as flat-rate reimbursements for costs assumed to have been incurred. No proof of costs is required from individuals providing home care. However, monitoring by a professional caregiver (similar to a case manager) takes place every 3 to 6 months. The professional caregiver must assess the quality of the home care situation and suggest possible improvements.

Care in residential homes is generally restricted to cases in which proper care cannot be provided in the home. If the individual requires institutional care, long-term care insurance will pay expenses for basic care, social services, and treatment according to the level of care required. However, the insured person is responsible for paying the costs for room and board and must pay at least 25% of the nursing home charges if the home is relatively low in cost. A person's benefit rate may not be granted in full if it is more than 75% of the nursing home charges.[13]

Home care services may be provided by friends or family members. This policy was designed to provide financial security for the caregivers of recipients residing at home, and to assist spouses of persons with disabilities who had no pension income. Additionally, the policy reinforced support for home care rather than institutional care. Although the policy has shifted towards providing increased home care, there are still approximately 490,000 people in nursing homes. This represents 28% of the 1.75 million people requiring long-term care in Germany[14]

Long-term care insurance also provides respite care for caregivers so that persons providing home care for at least 12 months may take up to 4 weeks of holiday leave per year. Similarly, a caregiver providing at least 14 hours of unpaid care per week, and is unemployed or works no more than 30 hours, is covered by statutory pension insurance and accident insurance. Contributions for pension coverage for caregivers is paid by the long-term care insurance program.

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[13] "For example, the DM 2,000 monthly rate cannot be granted in full if a nursing home charges less than DM 2,660 a month." (Federal Ministry of Labour and Social Affairs, p.60)

[14] Federal Ministry of Labour and Social Affairs, *Social Security at a Glance*. p. 56.

Financing. The public long-term care insurance plan is financed entirely through equal employer and employee contributions. Assistance received, however, is not related to amount paid in to the insurance fund or to a person's financial situation. What began as a 1% contribution rate in 1995 rose to a rate of 1.7% of wages income with the enactment of the second phase of the program. Contributions are split evenly between the employer and employee.[15] Contributions are subject to a ceiling of DM 6,375 (US $3450) a month in western Germany and DM 5,400 (US $2920) a month in eastern Germany in 1999.[16] They are directly deducted from wages and transferred to the health insurance fund. When costs of care exceed benefit levels, the difference must be paid by the person requiring care.

Because long-term care insurance is mandatory under law, those self-employed in Germany have an obligation to pay for their own private long-term care insurance. Those privately insured typically have higher incomes than federal insurance contributors. Premiums (private contributions) for compulsory private long-term care insurance are determined by the individual's age, with premiums not to exceed the maximum contribution of DM 108.38 (US $59) a month as of January 1, 1999.[17] Only cash benefits and reimbursements of covered long-term care expenses are offered by compulsory private long-term care insurance.

In 1997, benefit expenditures totaled DM 27.9 billion (US $15.6 billion). Since the inception of the long-term care insurance program, mandatory contributions and premiums have accumulated reserves amounting to DM 5.5 billion (US $3 billion) at the end of 1997. It is anticipated that these funds will help stabilize the contribution rate in the future.[18]

Administration. Cost containment played an important role in the development and introduction of long-term care insurance. The legislative objective was to significantly reduce the number of people dependent on social assistance (welfare) and increase the relative share of home care.[19] Prior to implementation of the long-term care insurance program, responsibility fell on each Länder (state) to provide efficient administration and services to persons in need of long-term care.

Under the long-term care insurance program, the health insurance plans have an important role. The medical service department of each health insurance fund is

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[15] To compensate one day of employers for bearing half the contributions to long-term care insurance, one day of holiday pay was eliminated and became an extra working day except in the state of Saxony. In Saxony employees contribute 1.35% of their income and employers contribute 0.35% of wage towards the insurance fund. This contribution is assumed to be in addition to the 12-15% contribution made to state health insurance funds.

[16] Federal Ministry of Labor and Social Affairs, Social Security at a Glance. p. 60.

[17] Ibid., p. 61.

[18] Answers from the Federal Ministry for Labor and Social Affairs to Questions submitted by the Royal Commission on Long Term Care for the Elderly during its visit to Germany on June 17-18, 1998.

[19] Ibid.

responsible for determination of eligibility and need for care.[20] Similarly, personnel of the medical section of the health insurance plan must determine if adequate rehabilitation measures are available for the insured individual. Some observers have pointed out, however, little formal case management takes place and individuals are not assessed on a regular basis.[21]

Japan

Summary

- In 1998, about 20.5 million people, 15.7% of the population, was 65 years of age or older. By the year 2050, the elderly are expected to represent one-third of the total population.
- Family care has historically characterized care for the elderly in Japanese society. Lower fertility rates, decreasing youth population, high life expectancy, and the fading tradition of family care have altered the system of elder care. Women, the primary caregivers, are entering the labor force at a greater pace than in previous years.
- In April 2000, a new public long term care insurance system was implemented. Public subsidies will pay one half of the total benefit expenditures. Elderly beneficiaries pay insurance premiums based on their income, as well as a coinsurance amount on the services they receive.
- Eligibility for the new long-term care insurance system is determined by assessment of an individual's cognitive and functional condition. Individual service plans are developed and consumers will select services from 12 types of home care and three institutional care levels, based on need. Municipalities are responsible for assessment and administration of services.

Background

Health insurance coverage has been available in Japan since enactment of the Health Insurance Law of 1922. In 1947, the Japanese constitution established the goal of holding the government responsible for providing health care to its citizens, but universal health coverage was actually achieved 14 years later in 1961. There are several insurance systems in Japan. A government-managed health insurance plan covers employees of small businesses; mutual aid associations insure public employees and teachers and agricultural workers; the self-employed are insured under another system.[22] Japan's current health program for the elderly is part of this multi-part national health insurance system.

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[20] Section 18 of the Code of Social Law XI

[21] Cuellar and Wiener, *Structuring a Universal Long-Term Care Program*, p. 48.

[22] Japan Pharmaceutical Manufacturers Association, *National Health Insurance Systems*, July 15, 1999.

In 1963, the *Welfare Law for the Elderly* provided coverage for all elderly in need of services and financial support, regardless of income. An amendment to this law in 1973 established free medical care services for those 70 years of age or older who met certain income tests. Subsequent high medical costs for this population led to the enactment of the *Health and Medical Service Law for the Elderly* in 1982 which required the elderly to make co-payments. This law also provided for more comprehensive services, including rehabilitation and prevention services. Amendments to the law established health care facilities for the bedridden and senile elderly in 1986 and a home-visit nursing care system in 1991.

Overlapping goals of health care and welfare services led to their unification in 1989. A 10-year *Gold Plan* was established by the Ministry of Health and Welfare as a strategy to promote health care and welfare for the elderly including the enhancement of in-home and institutional services. In 1994, higher goals were set to build the foundation for elderly long-term care services with more rapid implementation, called the *New Gold Plan*.

In 1996, the Japanese government reevaluated its programs and began structural reform of its social security system. The primary objective of the reform was to improve overall efficiency. The second objective was to promote self- sufficiency to enable individuals to live in their homes as long as possible. As part of this reform, a public long-term care insurance system was enacted in April 1997 and was implemented in April 2000. The system is designed to provide comprehensive and high quality long-term care services, including home care and institutional services. It builds upon the existing health care program.

Demographic Trends. The Japanese tradition that stresses filial duty has characterized the country's system of care for many years. While most elderly remain in their own homes, many reside with their eldest son. In 1998, approximately half of elderly persons lived with their children. Once a Japanese older person begins to live with his/her child, the daughter-in-law becomes the main provider of care, often spending years tending to the nursing and daily needs of her "patient."

While children of aging parents carry the responsibility of providing care for the senior population, this Japanese tradition is being affected by a number of social and demographic factors. These include: a rapidly growing elderly population, lower fertility rates, decreasing youth population, and high life expectancy. In addition, modern Japanese women are entering the labor force in larger numbers and are increasingly leaving behind the role of housewife and caregiver.

In 1980, 10.6 million people were 65 years of age or older, representing 9.1% of the total population. By 1998, this number had increased dramatically – by 93% to 20.5 million people, or 16.2% of the total population. The large growth has been partially due to a baby boom that occurred in Japan around 1930. The large expansion in the older population, coupled with high life expectancy rates (averaging

77.2 years for men and 84 years for women in 1998) have heightened concern about the need for long-term care.[23]

The total population of Japan is expected to peak in 2007 with 127.8 million people, and then begin to decline in absolute numbers falling to 100.5 million by the year 2050. Population projections indicate continued growth of the older population coupled with a decline in the number and proportion of younger persons. Persons aged 65 years of age or older are expected to increase from 17.2% of the total population in 2000 to 32.3% by the year 2050, as shown in **Table 3**. The working age population (age 15-64) is expected to decline from 68% of the total population in 2000, to 54.6% in 2050.

Table 3. Population Projections for Japan, and Percentage by Age Group, 2000-2050

Year	Total population (in thousands)	Percentage by age group		
		Under 15 years	15 to 64	65 and over
2000	126,892	14.7%	68.1%	17.2%
2010	127,623	14.3%	63.6%	22.0%
2020	124,133	13.7%	59.5%	26.9%
2030	117,149	12.7%	59.3%	28.0%
2040	108,964	12.9%	56.1%	31.0%
2050	100,496	13.1%	54.6%	32.3%

Source: Table prepared by the Congressional Research Service (CRS) based on data from Ministry of Health and Welfare, 1998. Medium-variant projections as of January 1997.

The population under age 65 has been decreasing in number and as a share of the total population since 1985. This means that potential caregivers have not grown as rapidly as the elderly population. The decreasing number of potential caregivers is expected to affect the dynamics of family care that has historically characterized Japanese society.

In 1980, there were 78.8 million people (67.4% of the total population) between the ages of 15-64. By 1998, this number grew only 10% to 87 million (69% of the total population) while the share of future caregivers under 15 years of age decreased by 31% to 19.1 million (15.1% of the total population). Caregivers, however, are typically older persons themselves. Almost half of Japan's caregivers were 60 years of age or older in 1998.[24]

In addition, it is not clear that the future working generation will be able to support the elderly to the same extent it has in past generations. The labor force is

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[23] CIA, The World Factbook 1998.

[24] Ministry of Health and Welfare of Japan, *Outline of Long-Term Care Insurance in Japan*, Chapter 3.

expected to decrease as indicated by Japan's low fertility rate of 1.38 children born per women (1988).[25]

Table 4. Japanese Population by Age Group, 1980-1997 (in thousands)

Year	Total	Under 15 years		15-64		65 and over	
1980	116,989	27,507 (23.5%)	—	78,835 (67.4%)	—	10,647 (9.1%)	—
1990	123,267	22,468 (18.2%)	18% decline 1980-1990	85,904 (69.7%)	9% growth 1980-1990	14,895 (12.1%)	40% growth 1980-1990
1995	125,440	20,014 (16%)	27% decline 1980-1995	87,165 (69.5%)	11% growth 1980-1995	18,261 (14.6%)	72% growth 1980-1995
1997	126,166	19,366 (15.3%)	30% decline 1980-1997	87,042 (69%)	10% growth 1980-1997	19,758 (15.7%)	86% growth 1980-1997

Source: Table prepared by the Congressional Research Service (CRS) based on data from the Statistics Bureau, Management and Coordination Agency, [www.stats.go.jp].

Long-Term Care

Japan's public long-term care insurance system was implemented beginning in April 2000. It will provide comprehensive in-home and institutional benefits for persons aged 40 and over who need long-term care services. Its purpose is to provide comprehensive and high-quality long-term care services, including in-home care and institutional services. The goals of this new system are to:

- allow users to choose freely from diversified services;
- offer integrated welfare and medical services; and
- provide more efficient medical services for long-term care.

It is anticipated that services offered through the insurance system will rectify the over use of expensive long-term stays in hospitals, or the practice referred to as "social hospitalization." "Social hospitalization" (or "social admissions") refers to hospitalizing those in need of long-term care due to the shortage of community care and nursing homes. In Japan, almost 6% of the elderly population are institutionalized (compared to about 5% in the United States). However, some analysts still point to an insufficient number of nursing homes (as well as home care providers) for the tens of thousands in need of care. Some Japanese reports find 47,000 people are currently

[25] CIA, The World Factbook 1998.

on waiting lists for the 3,942 nursing homes in existence.[26] Only those who are bedridden or have senile dementia are accommodated because of the high demand. One half of all bedridden persons are bedridden for 3 years or more. Two-thirds of Japan's institutionalized elderly are cared for in private hospitals, mostly owned by doctors. Of the elderly in hospitals, one-third remain there for more than a year.

Eligibility. A "certification"or assessment process administered by the Long-Term Care Certification Committee in each municipality will assess a person's eligibility based on his/her mental and physical condition. Standards for certification will be objectively determined nationwide. Each municipal committee will determine whether long-term care or support is required and certify a need for care based upon a doctor's opinions.[27]

Under this system, people age 65 and older will be the "primary insured." This group is expected to total 22 million in FY2000. The "secondary insured" will be those between the ages of 40 and 64, expected to be almost twice the size of the 65+ group with 43 million people in FY2000. These two age groups are categorized as "primary" and "secondary" because of differences in the method of assessment and collection of premiums for each.

People between the ages of 40 and 64 may receive in-home and institutional care based on age-related factors leading to early onset of senility, cerebrovascular disorders, and other illnesses associated with aging. Those 65 and over who require long-term care or support because they are bedridden, physically weak, or have dementia may receive care under this system. Those who require support because of physical weakness will be provided with in-home services to prevent the necessity of institutional care.[28] The degree of family support available will not be a factor in eligibility determinations. Those disabled under age 40 will be cared for under the existing welfare system.

Services Provided. After determination of an individual's needs, a care planning organization will then allow the insured to select his/her preferred services from 12 types of at-home care programs, creating a service plan. The goal is to allow users to choose the services they want.

With the new insurance system, frail persons in need of physical support may receive approximately ¥60,000 (US $520) per month in home benefits while those

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[26] Personal communication from the Ministry of Health and Welfare, Bureau of Social Welfare and Labor Division.

[27] There is no indication that Japan uses the equivalent of limitations in activities of daily living (ADLs) or instrumental activities of daily living (IADLs) in determining need for care. ADLs refer to basic human functions, including bathing, eating, dressing, getting around inside, toileting, and transferring from a bed to a chair. IADLs are tasks necessary for independent community living including shopping, light housework, telephoning, money management, and meal preparation. Those who are bedridden, with dementia, feeble, or suffering from age-induced illnesses are eligible for care under the plan.

[28] Ministry of Health and Welfare. *Annual Report on Health and Welfare 1996-1997*. p. 179-180.

requiring more intensive care (for example, those who are bedridden or have dementia) may receive an amount between two and a half to about six times that amount per month depending on the level of care needed.[29] Benefits for institutional care will be fixed for each type of institution. The amount of financial support for institutional benefits will be fixed depending on the level of care required.

In-home services include:

- Home-visit care (home help),
- Home-visit bathing services,
- Home-visit nurse,
- Home-visit rehabilitation,
- Commuting assistance for rehabilitation,
- In-home medical care management guidance,
- Commuting assistance for care (day service),
- Short stays in facilities,
- Communal living facilities with care-takers (group homes),
- Long-term care at fee-charging homes for the elderly,
- Rental service for welfare equipment, and
- Funds for home improvement.[30]

Institutional care services include:

- Special nursing homes for the elderly,
- Health services facilities for the elderly, and
- Sanatorium-type wards, etc.

– Sanatorium-type wards,
– Medical care wards for dementia, and
– Medical care wards with enhanced nursing staff[31]

Financing. The current health program for the elderly, under the 1982 law, is financed through an insurance pool in which health plans, EHI and *Kokuho*, originally contributed 70%, and national government and local governments contributed 30%. In 1991, a reform raised, in part, the share of combined contributions made by the national and local governments from 30% to 50% keeping a 70%/30% share in principle. Although insurance premiums vary, generally employers and employees contribute equal shares of 8.5% of the employee's salary for health insurance.[32] In FY1996, medical expenditures for the elderly totaled 34% of the total national medical expenditures.

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[29] Ministry of Health and Welfare of Japan. *Outline of Long-term Care Insurance in Japan*. Chapter 3 and personal communication from the Social Welfare and Labor Division of the Ministry.

[30] Ministry of Health and Welfare. *Annual Report on Health and Welfare 1996-1997*. p. 179.

[31] Ibid., p. 179.

[32] Japan Pharmaceutical Manufacturers Association, *National Health Insurance Systems*.

Financial support for the long-term care insurance program will come from the national government, prefectures,[33] medical care insurers, and pension insurers. Public subsidies will pay one half of the total benefit expenditures, with the national, prefectural and municipal governments contributing 25%, 12.5%, and 12.5%, respectively. To keep a balance between service users and non-users, and to raise awareness of service costs, beneficiaries will pay a 10% coinsurance amount for long term care services. Moreover, recipients will be responsible for their own meal costs at long-term care facilities.

"Primary" insured users (age 65 and older) will pay fixed insurance premiums based on income, as determined by each municipality. Premiums will be deducted from pensions. The medical insurance systems of the "secondary" insured users (aged 40 to 64) will determine premiums for long-term care, based on a national standard. A portion of these premiums for this group will be paid by employers. These premiums will be collected together with the medical insurance premium by the medical insurer.[34]

In FY1995, total expenses for long-term care amounted to ¥2.2 trillion (US $21.3 billion[35]). Most of these funds were spent on the elderly, while a small amount (an estimated ¥0.1 trillion (US $968 million, or about 4.5%) was spent on long-term care for people 40 to 64 years old. Projected FY2000 expenditures for long-term care under the new insurance program for the elderly alone are expected to reach ¥4.3 trillion (US $41 billion), with an approximate monthly insurance premium of ¥2630 to 2910 (US $25-$28).[36] One source projected expenses for 2010 at approximately $53 billion. It is anticipated that premium amounts will increase in succeeding years as total expenses increase.

Administration. Since 1990, municipalities have been responsible for the administration and provision of the long-term care insurance system. Under the new public long-term care system, they will continue to be involved. They will be responsible for "certification" and assessment of individuals in need of long-term care, collection of long-term care insurance premiums from the primary insured group, and administration of benefits and services. The national government will be responsible for provision of public subsidies and establishment of assessment standards.

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[33] Japan is divided into 47 prefectures, which are administered by governors and assemblies. A prefecture is further subdivided into minor civil divisions, including the city, town, and village, which have their own mayors, or chiefs, and assemblies. [www.eb.com]

[34] Ministry of Health and Welfare. *Annual Report on Health and Welfare 1996-1997*. p. 177, 180.

[35] FY1995 currency values are converted with December 31, 1995 rates.

[36] Ihara, Kazuhito. *Japan's Policies on Long-Term Care for the Aged: The Gold Plan and the Long-Term Care Insurance Program*. International Longevity Center. New York, 2000. p. 18.

Canada

Summary

- In 1998, 3.7 million people, 12.3% of the Canadian population, was 65 years of age or older. By the year 2041, the elderly will represent 22.6% of the total population.
- Canada provides universal, publically-financed health care insurance coverage for all its citizens. The program, Medicare, enforced by the Canada Health Act (CHA), is described as an interlocking set of 10 provincial and three territorial health insurance plans which provide hospital, in-patient, and out-patient services, physician services, and dental surgical services performed in a hospital.
- The Canada Health Act is focused on hospital and physician services and as such, does not encourage the development of extended care services in the provinces or territories. As part of the annual reporting conditions under the Canada Health Act, provinces and territories are only required to provide information on extended health care services. They do report a range of institutional, home and community-based options. The types and levels of services, as well as access, vary widely. In addition to provincial funds, these services may be financed by client fees and portions of a federal block transfer.
- Generally, provision of long-term care in provinces relies on a case management system where case managers assess an individual's functional disability and need for long-term care services, develop a plan of care, monitor and review client needs, and adjust plans accordingly. While physicians control access to hospital-based rehabilitations or chronic care beds, they may not authorize eligibility for long-term care benefits in nursing homes or for at-home care.

Background

Health care in Canada was a private service until 1947 when a public insurance plan for hospital services was introduced by the province of Saskatchewan. Nine years later, the federal government offered to pay for roughly half of hospital and diagnostic services in *all* provinces if acceptable hospital insurance programs were developed in each. Public insurance plans were established by 1961 with all ten provinces and the two territories providing universal coverage for at least in-patient hospital care that qualified for federal cost-sharing. Comprehensive medical care legislation with cost-sharing provisions was enacted by the federal government in 1968. By 1972, all provincial and territorial health insurance plans included physicians' services, establishing a more comprehensive health care insurance system. The government's vision was to provide health insurance for everyone regardless of income, age, or residency.

Today, Canada provides universal, publically-financed health insurance coverage for all its citizens. The program, Medicare, is described as an interlocking set of ten provincial and territorial health insurance plans which provide hospital, in-patient, and

out-patient physician services. The Canada Health Act (CHA) of 1984 stipulates five criteria that provincial health plans must meet in order to receive federal funds. These are:

- *Public Administration*: each health insurance plan must be administered and operated on a non-profit basis by a public authority responsible to the provincial government.
- *Comprehensiveness*: each health insurance plan must insure all medically necessary services provided by hospitals and physicians, and where permitted, by other health care practitioners.
- *Universality*: all insured persons (that is, eligible residents) are entitled to insured health services on uniform terms and conditions;
- *Portability*: residents are entitled to coverage when they move to another province or abroad.
- *Accessibility*: each health insurance plan must provide reasonable access to insured hospital and physician services without barriers. Charges, such as extra billing by physicians and user fees by hospitals, to insured persons for health care services are not generally allowed.[37]

These five criteria do not however apply to long-term care services in home and community-based settings.

In accordance with these criteria, each province and territory administers its own health care plan. Although the federal government contributes to health care costs, each province has primary funding responsibility. Under provisions of the Canada Health and Social Transfer (CHST), implemented in 1996-97, the federal contribution for health care services was wrapped into a block grant program with other social program funds. The formula for distribution of funds to provinces varies according to regional differences. Each province receives a per capita amount for health care services based on the formula.

Demographic Trends. The elderly population of Canada has been growing rapidly in number and percentage, with a current life expectancy at birth of 76 years for men and 83 years for women. In 1971, 1.8 million people or 8% of the Canadian population was 65 years of age or older. By 1998, the number of people aged 65 more than doubled to 3.7 million, or 12.3% of the total population. This is an increase of almost 2 million people aged 65 and over from the 1971 total. This represents a 112% growth over a span of 27 years. **Table 5** below presents the rate of growth from 1971 to 1998.

[37] If it is determined that either "extra-billing" or user charges are being used by a province, then the federal government makes a mandatory dollar-for-dollar deduction from the federal cash contribution. A few provinces have charged minimal amounts in the past.

Table 5. Canadian Population aged 65 and over, 1971-1998

Year	Total (in thousands)	As % of Canadian population	
1971	1,762	8.0%	—
1981	2,377	9.6%	35% growth 1971-81
1991	3,217	11.4%	83% growth 1971-91
1998	3,736	12.3%	112% growth 1971-98

Source: Table prepared by the Congressional Research Service (CRS) based on data from Statistics Canada.

Current projections for the year 2011 estimate that Canada will have close to 5 million people aged 65 and over, representing 14.1% of the Canadian population. The number of people 65 years of age or older is expected to total almost 10 million by the year 2041. Many Canadian policymakers point to the growing elderly population to highlight the importance of and need for comprehensive long-term care services. They emphasize the need to change the way that health and social services for the elderly are organized and delivered.

Table 6. Population Projections for Canada, aged 65 and over, 2001-2041

Year	Total (in thousands)	As % of Canadian population
2001	4,031	12.6%
2011	4,981	14.1%
2021	6,891	17.8%
2031	8,937	21.7%
2041	9,670	22.6%

Source: Table prepared by the Congressional Research Service (CRS) based on data from Statistics Canada.

Long-Term Care

Each province has an extended health care services (EHCS) benefit program,[38] sometimes referred to as "continuing care." Benefits provided include a range of institutional and home and community-based services programs. The types and amount of services and eligibility criteria for long-term care services vary widely by province. Provinces receive federal funds for EHCS as part of the per capita amount they receive for their health services plans. However, because the full range of long-term care services are not insured services under the CHA, provinces are responsible for financing some part of the long-term care services they provide.

To understand long-term care in Canada, it is necessary to look at the activities of individual provinces. The provinces, not the federal government, are responsible for the organization of long-term care services. Currently the provinces receive block grant funding for health, social and post-secondary education programs under the CHST and can use any portion of this block fund for long-term care. Up to 1996 when the CHST replaced the Established Programs Financing (EPF) and the Canada Assistance Plan (CAP), the provinces received a separate small per capita amount for extended health care services. Because many of the services offered as continuing or long-term care are not insured services under the Canada Health Act (CHA), the five criteria and other conditions such as user fee prohibitions do not apply. Thus individuals who receive care outside of a hospital in their communities or homes may be required to pay the full or partial cost of certain services.

Canada faces the challenge of providing appropriate and affordable long-term care services for its aging population. In planning for the future, policymakers have favored home and community based services over institutional care. Many programs and agencies, recognizing the need for improvement, have initiated changes in care models and services for seniors, contributing to a widespread move towards better and more integrated methods of service delivery for the elderly requiring a broader range of services. A recent Canadian study[39] has found a number of common goals that have been adopted or are in the process of implementation by agencies and programs to better serve community needs. These goals include improved client choice of and access to services, better coordination of services, and increased education of long-term care services staff.

The same study pointed out that Canada needs to address a number of issues in program development and delivery of long-term care. These include a lack of public understanding of the need for "continuing care" for older persons that addresses both health and social needs over a long period of time. Other challenges include a lack

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[38] Extended health care services are defined in the Canada Health Act as nursing home intermediate care, adult residential care, home care, and ambulatory health care. These services are part of a broader range of health and social services to residents of a province. Canada Health Act Annual Report, 1997-98. See: [http://www.hc-sc.ca/medicare].

[39] Innovations in Best-Practice Models of Continuing Care for Seniors. Report prepared on behalf of the Federal/Provincial/Territorial Committee (Seniors) for the Ministers Responsible for Seniors, March 1999. p. 2.

of resources, high public expectations for quality services, and geographic dispersion of population.[40]

Eligibility. Eligibility for long-term care services varies widely by province. However, eligibility for services is frequently determined through a "single entry system" that is a single central source in local communities for individuals to obtain comprehensive information and access to the "continuing care" system available in the community.[41] Through this system, case mangers screen and assess people in need of long-term care services, determine the level of care that is needed, establish an initial individual care plan with a specified amount and type of services to be delivered, regularly monitor and review client needs, and adjust plans accordingly. Need is determined by an individual's functional disabilities.

Case managers are professional coordinators who determine the need for care and function independently of the delivery of medical care. Most case managers are public employees. Case managers work mainly in community care centers, hospitals, housing units (through community support agencies, insurance companies, and different care programs), and in independent practices, with growing occurrences of the latter sector.[42] Physicians control access to hospital-based rehabilitation or chronic care beds, but cannot authorize eligibility for long-term care benefits in nursing homes or for at-home care.

Services Provided. Long-term care services range from various types of institutional care, including nursing homes, adult care homes, and a range of home and community-based services. Provincial home care programs may include the following services, among others:

- assessment and case management,
- nursing and health care treatment services,
- personal care and homemaker services,
- minor home repair and maintenance,
- social assistance services, social contact, and security services (i.e., friendly visiting and telephone reassurance), and
- drugs and medical supplies.[43]

Though service delivery mechanisms vary among provinces and territories, nursing, personal care, and homemaking services are available in all provinces and territories. In 1997-1998, 3% of the population, or 1 million Canadians received home care services.[44] In addition, many provinces include adult day care as part of their long-term care system.

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[40] Ibid., p. 56.

[41] Hollander, M. J., and E. R. Walker. *Report of Continuing Care Organization and Terminology*, 1990.

[42] As reported by the Ontario Case Managers' Association to Ms. Sonia Ménard, Reference Librarian, Library of Parliament (Canada).

[43] Health Canada, *Home Care: Definition and Methodology*.

[44] *Provincial and Territorial Home Care Programs: A Synthesis for Canada*. p. 33.

Family and friends continue to serve as caregivers though it is becoming increasingly difficult. The most common family provider of care is the woman, either the wife, daughter, or daughter-in-law. Women providing care experience low pay-rates when providing formal, professional service, or compromise their own job promotions or forego earning opportunities when providing informal family service. A few corporations provide leave to care for the elderly, and professional, formal caregivers have begun to unionize to achieve better pay and regular employment.[45] Studies have indicated that the elderly who cannot be maintained safely and economically at home by paid services, and have minimal family caregiving services, generally enter long term care institutional facilities at greater cost than home care.[46]

Financing. Canadian health care expenditures are primarily publicly financed. About 70% of total health expenditures is funded through the public sector, from tax revenues. The remaining 30% is privately financed through supplementary insurance, employer-sponsored benefits or directly out-of-pocket by the consumer.[47]

Under the Canada Assistance Plan (CAP) of 1966, the provinces and the federal government shared much of the cost of long-term care for the chronically ill, disabled, and frail. CAP funding was provided by the federal government in the form of a transfer payment to the provinces, and was conditional on administration of needs tests, absence of residency requirements, and establishment of an appeal system. CAP provided open-ended social assistance and social services to needy Canadians through 50/50 cost-sharing.

In fiscal year 1996-1997, a new single block transfer, the Canada Health and Social Transfer (CHST), was created by the federal government. This consolidated the government's contribution to provincial health and social programs, replacing CAP and EPF with its provisions for extended health care services. Through the CHST system of block funding, the federal government transfers are provided through cash payments and tax points with movement to a per capita amount calculated for each province. However, the federal CHST addresses health, social and post-secondary education and while any portion of the block transfer may be used for long-term care, the provinces are the primary financers of long-term services.

Recently, the federal government has attempted to provide assistance to home care consumers through tax credits and deductions. Some of these tax credits[48] include:

- *Disability Tax Credit* – a federal and provincial income tax reduction of up to $1,020 for taxpayers with a serious physical or mental disability; and

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[45] Shapiro, E. *Community and Long-Term Health Care in Canada*. p. 347. Blomquist, T. and D. M. Brown, eds. *Limits to Care: Reforming Canada's Health System in an Age of Restraint*.

[46] Ibid., p. 355.

[47] Health Canada, *Canada's Health System: Health Spending*.

[48] In Canadian dollars.

- *Caregiver Tax Credit* – a maximum savings of $400 in federal taxes for those providing care at home for an elderly parent or a disabled child over age 18.

Federal government contributions and support for home care services are also provided through direct programs, such as Veterans Affairs Canada and Department of Indian and Northern Affairs Canada, targeting specific clients. Co-payments for services are made by consumers, and vary by province.

Administration. The Canadian constitution grants the provinces jurisdiction over health and social policy. The CHA requires that each province comply with the five fundamental principles and the extra-billing and user fee requirements mentioned above, but does not establish further guidelines. Consequently, each province has the freedom of designing and providing its own system of care, and administering its own plan. As a result, long-term care in Canada has evolved into complex, but not uniform, systems across and within provinces.

Community, home-based, and institutional long-term care programs are administered by the public, private, and voluntary sectors. Home care programs are usually administered by the health and social service departments of each province or territory, or by the community health board. Estimates for 1994 indicated that publicly funded home care programs provided 90% of all home care services. Private services cater to those not eligible under the public system and those wishing to augment the public services they receive.[49]

United Kingdom

Summary

- In 1998, almost 9.3 million people, 15.7% of the population, was 65 years of age or older. By the year 2040, the elderly will represent 26.6% of the total population.
- Prior to 1990, the National Health Service (NHS), the United Kingdom's (U.K.) national health insurance program, financed long-term care services, primarily residential services, without charge to long-term care recipients. Long-term care services were substantially changed in 1990 by the Health Service and Community Care Act, enacted partially in response to growing costs of institutional care services and to create financial incentives for home and community-based services.
- In December of 1997, a Royal Commission on Long-Term Care was appointed by the Secretary of State for Health. The Royal Commission was responsible for examining options for funding long-term care for the elderly and recommended a number of policy changes regarding the financing and delivery of long-term care.

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[49] Canadian Home Care Association. *Portrait of Canada: An Overview of Public Home Care Programs*.

These included recommendations for more public support for home and community-based services and for families and others who provide unpaid, informal care. It also recommended a major restructuring of financial eligibility criteria for personal care services at home and in institutions, and more consistency in service financing and delivery provided by local governmental authorities. Major decisions regarding the Commission's recommendations will take place in summer 2000, but some action by the U.K. government is currently underway.

Background

The expectation of family care in the United Kingdom dates back to the Elizabethan Poor Law of 1601 in which adult children were assumed responsible for the relief of elderly parents. Over three centuries later, in 1946, the National Health Service (NHS) Act established a system of publically financed health care, including hospital and specialist services, general medical and pharmaceutical services, and local health services. From this arose a comprehensive service established in 1948 by the NHS, providing universal coverage and free medical care.[50]

Various changes to the NHS were adopted in the 1970s to respond to increasing public demands and expectations about health service, advances in medical technology, and issues regarding planning and coordination of services. Despite these reforms, by the 1980s, the NHS was being criticized as being inefficient and non-responsive to the needs of patients. As a result, the National Health Service and Community Care Act of 1990 was enacted to increase local authority, decentralize administration over health care, and encourage competition among health care providers.[51] Some provisions of the Act affected long-term care services.

The goals of the Act's long-term care reforms were to: (1) control growth in public spending for residential (institutional) long-term care;[52] (2) consolidate responsibility for providing and funding services at the local level of government; (3) allow older persons with disabilities to remain in their own homes to the maximum extent practicable; and (4) increase consumer choice by creating a market of private providers.[53] Prior to the 1990 law, financial incentives were oriented toward support of residential care which was a means-tested, open-ended entitlement funded through the NHS. In many cases, the costs for residential and nursing homes for individuals

[50] U.S. Library of Congress. Congressional Law Library. *Health Care under International Law and the Laws of Selected Foreign Nations: Great Britain*. p. 85. (Hereafter cited as U.S. Library of Congress, *Health Care under International Law*.)

[51] Ibid., p. 85.

[52] *Residential* care is care in institutions, but excludes nursing care. It is distinguished from nursing home care where nursing and personal care services are provided.

[53] Wiener, Joshua M. and Alison Evans Cuellar. Moving Responsibility for Long-Term Care to Local Governments: the Experience in the U.K. *Generations*, v. XXIII, no. 2, summer 1999. p. 39ff.

were fully covered by the NHS. Home and community-based care was funded at the discretion of local authorities to the extent funds were available.

Under the 1990 law, automatic entitlement to residential long-term care ceased under the NHS, and funds were transferred to local authorities to be used for long-term care services. Payment of costs then changed from a open-ended entitlement system to one where total costs were capped. These funds, similar to a block grant, could be used for home and community-based care *or* residential care.[54] These and other associated changes went into effect in April 1993.

In addition to the aim of changing the bias toward institutional care in favor of more home and community-based care, the 1990 law was designed to consolidate the administration of long-term care services at the local level by making local social service departments responsible for "care management" of persons needing care. Thus, social service departments could tailor long-term care services to meet client needs and preferences, as well as improve coordination of services for clients.[55]

Demographic Trends. The number of people aged 65 years or over increased from 7.3 million people (13.2% of the total UK population) in 1971, to 9.3 million (15.7% of the total) in 1998, a 27% growth. **Table 7** below includes the percentage growth from 1971 to 1998.

Table 7. UK Population aged 65 and over, 1971-1998

Year	Total (in thousands)	As % of United Kingdom population	
1971	7306	13.2%	—
1981	8168	14.8%	12% growth 1971-1981
1991	9084	15.8%	24% growth 1971-1991
1998	9271	15.7%	27% growth 1971-1998

Source: Table prepared by Congressional Research Service (CRS) based on data from the U.S. Bureau of the Census, International Data Base.

It is believed, however, that the UK population will stop growing after the year 2030, with an estimated total population of 59.4 million people, and will actually decline in the future. The projection for 2040 is 57.3 million. However, the

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[54] Ibid., and Barbara Coleman. *European Models of Long-Term Care in the Home and Community*. American Association of Retired Persons. Public Policy Institute. September 1994. p. 30.

[55] Filinson, Rachel. Legislating Community Care: The British Experience, with U.S. Comparisons. *The Gerontologist*, v. 37, no. 3. p. 333.

percentage of people aged 65 years and over is expected to increase from 23.5% in 2030 to 26.6% by 2040. The UK therefore faces a challenge in providing for an aging population with a smaller labor force in the future. This projected population composition will result from low fertility rates, presently at 1.7 children born per woman, coupled with growing rates of life expectancy at birth. In 1998, the life expectancy averaged 75 years for males and 80 years for females. This has been an increase since 1984, when life expectancy at birth was 72 and 74 years, respectively.

Table 8. Population Projections for the United Kingdom, aged 65 and over, 2000-2040

Year	Total (in thousands)	As % of United Kingdom population
2000	9,285	15.7%
2010	9,913	16.5%
2020	11,703	19.4%
2030	13,968	23.5%
2040	15,251	26.6%

Source: Table prepared by the Congressional Research Service (CRS) based on data from the U.S. Bureau of the Census, International Data Base.

Long-Term Care

Recognition of the demographic trends and dissatisfaction voiced by many U.K. policymakers with the current long-term care system led to a recent major policy review. In 1997, the Royal Commission on Long-Term Care was appointed by the Secretary of State for Health to analyze the current system and to make recommendations for improvement. The Commission was to examine options "for a sustainable system of funding of Long-Term Care for the elderly, both in their own homes and in other settings." The Royal Commission presented its findings and recommendations in a report to Parliament in March of 1999 (*With Respect to Old Age, A Report by the Royal Commission on Long Term Care).*

While the 1990 Act was designed to improve the system of care, the Royal Commission concluded that the "current system is failing." Reasons for this included insufficient home care and assistance to caregivers, lack of progress in correcting the institutional care bias, poor quality of institutional care, and lack of a client-based focus, among other things. Among the Commission's conclusions were the following:

- "Long-term care is a risk that is best covered by some kind of risk pooling–to rely on income or savings, as most people effectively have to do now, is not efficient or fair due to the nature of the risk and the size of the sums required;
- Private insurance will not deliver what is required at an acceptable cost, nor does the industry want to provide that degree of coverage;

- The most efficient way of pooling risk ... across all generations, is through services underwritten by general taxation, based on need rather than wealth [with some cost sharing];
- ... more care (should be given) to people in their own homes. Therefore the role of housing will be increasingly important in the provision of long-term care.
- More services should be offered to people who have an informal carer [caregiver]."[56]

The following presents information on the current long-term care system in the United Kingdom. It also presents selected findings and/or recommendations made by the Royal Commission to improve or change the current system.

Eligibility. "Local (governmental) authorities" in the United Kingdom, through social service departments, are required to assess an individual's need for long-term care and develop a plan to meet needs. Public services may be received once care managers in local authorities have determined that an individual needs services.

For residential and nursing home care, income and assets, based on a national standard, are assessed to determine the extent of contributions individuals must make toward the cost of care. This contribution schedule is called a "means test." Presently, people with assets above £16,000 (US $25,900)[57] do not receive financial assistance and must pay the full cost of residential or nursing homes. Persons with assets of less than £16,000 must contribute toward the costs of care. For home care services, local authorities have discretion as to the application of financial eligibility standards. Some authorities charge a small flat rate, some charge full costs, and some apply a variety of means tests.[58]

The Royal Commission stated that the present system "leads to the impoverishment of people with moderate assets before they get any help."[59] Its report recommended a radical restructuring of the means testing system, so that personal care services, that is, tasks involved with assistance with daily living, be exempt from means testing. The Commission analysis was based on the following rationale. Persons needing long-term care incur three types of costs: living costs (food, clothing, etc.), housing costs (rent, mortgage), and personal care costs. According to the Commission, personal care costs reflect the true risk, or "catastrophic costs"of long-term care. Therefore, public funding should finance all of these costs, with no charges levied on individuals. Instead, means testing limits and contribution schedules would be applied to the income a person uses to finance living and housing costs. The

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[56] A Report by the Royal Commission on Long Term Care. *With Respect to Old Age: Long Term Care–Rights and Responsibilities*. Presented to Parliament by Command of Her Majesty. March 1999. p. xviii-xix. See also, Roll, Jo. Social Policy Section. House of Commons. *Royal Commission on Long-Term Care*, February 17, 2000.

[57] This includes the value of one's home. In their report, the Royal Commission recommends disregarding the value of the home when determining an individual's contribution.

[58] Royal Commission, p. 34.

[59] Royal Commission on Long-Term Care, p. xviii.

exemption of means testing for personal care services would apply to personal care provided in both residential and nursing homes as well as to care provided at home.

Services Provided. The public, private, and voluntary sectors provide care in a range of settings including care at home, day care, sheltered housing, and residential care. The NHS provides continuing care in nursing homes, hospices and hospitals, and community nurse services. In 1999, there were about 600,000 people aged 65 and older in the UK receiving home care services, and close to 500,000 receiving institutional care.[60]

Unpaid care provided by family and friends provides substantial long-term care support. The Royal Commission estimated that 5.7 million people, about 10% of the total population, provide some form of informal care. Of these, about 800,000 people provide unpaid care for 50 hours a week or more. In 1995, 60% of all caregivers were women and 48% of all caregivers were between 45 and 64 years of age. Twenty percent were over 65 years old and 32% were between the ages of 16 and 24. Forty-three percent of the individuals receiving informal care were the parent or parent-in-law of the caregiver. Unlike the recent trends in Japan, the Royal Commission found no evidence in the UK of women being less willing or available to provide unpaid care.[61]

The Royal Commission found that, despite attempts to lessen the bias toward institutional care in favor of home care envisioned by the 1990 Health and Community Care Act, more effort is needed. The Commission indicated that its proposals to provide personal care services, free of charge, would lead to expansion of home care services. It also recommended that more support be given to families and others who provide unpaid, informal care, and proposed that a national caregiver support program be established.

Financing. The current system of care is financed on a pay-as-you-go basis, with current taxation paying for the benefits delivered at the present time. In addition, persons receiving long-term care contribute toward costs of their care. **Table 10** shows public and private expenditures for long-term care in 1995. Total long-term care expenditures were estimated to be £11.1 billion (US $17.7 billion), with 64% from public sources, and 36% from recipients.

Only about one quarter of total funds was for home and community-based care, with the remainder for care in institutions. Of the amount spent on institutional care, about half was paid by fees from residents, and half from public sources. Expenditures for long-term care are expected to rise to £14.7 billion (US $23.8 billion) in 2010 and £19.9 billion (US $32.2 billion) in 2021.

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[60] Royal Commission on Long Term Care, p. 8.

[61] Ibid., p. 15-16.

Table 10. Expenditures on Long-Term Care Services, 1995

Total: £11.1 billion (US $ 17.7 billion)	
Paid by the state (via NHS and Social services)	£7.1 billion (US $11.3 billion)
Paid by older persons	£4 billion (US $6.4 billion)
Total: £11.1 billion (US $ 17.7 billion)	
Spent on home and community-based care	£2.7 billion (US$ 4.3 billion)
Spent on nursing homes, and residential care, and long-stay hospitals[62]	£8.3 billion (US $ 13.3 billion)

Source: Table prepared by the Congressional Research Service (CRS) based on data from the *Royal Commission on Long-Term Care*, p. 10.

Current expenditures on long-term care in people's homes and in residential settings amount to 2.2% of taxes from pensions, investments, and earnings. However, tax credits have also been introduced for caregivers so that wives providing care may benefit.

The Royal Commission recommended continuation of the current pay-as-you- go model to finance long-term care. While the Commission considered other methods, it recommended no major changes in taxation. As discussed above, the Commission did recommend changes so that individuals would be required to contribute toward the cost of their care.

Administration. Local authorities are responsible for administration and management of funds on behalf of persons in need of long-term care services. This was a result of legislative changes in the 1980s and by the 1990 Act to decentralize administration of health and social services. After consultation with Local Authority Associations, the central government allocates funds to local authorities based on a formula. Local governments are responsible for assessment of individuals and for administration of most institutional and home and community-based care services.

The Royal Commission found that there is inconsistency among local authorities in their application of means testing and determination of an individual's long-term care needs. While it supported local autonomy in administration, it also recommended that the financing and delivery system be revised so that individuals can have clear expectations of what services they may expect from the public sector, and that there be more consistency across jurisdictions regarding services provided and eligibility criteria.

[62] Residential care, as defined by the Royal Commission, does not include nursing care.

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