The Finance and Provision of Long Term Care for Elderly People in the UK: Recent Trends, Current Policy and Future Prospects

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1. Introduction

There have been a number of major policy initiatives concerning long term care for elderly people in the UK in recent years. In common with a number of other countries, these have been prompted by a rate of growth in the numbers of elderly people that has placed pressure on traditional methods of financing and provision (Wittenburg, Sandhu and Knapp, 2002). In addition, in the UK, the often unclear distinction between health and social care - which are subject to different charging arrangements - has posed a perennial problem for policy-makers and has led to a complex and often haphazard system. This paper reviews this system and current reforms.

The paper is divided into four main sections. First, there is a review of recent trends in the long term care of elderly people in the UK. Second, there is a discussion of the major policy changes that have taken place over the last two to three years. Third, the paper sets out briefly some projections for future spending to 2051. Finally, the paper concludes with a discussion of the implications of UK experience for Japan. By way of introduction, however, there is a discussion of UK definitions of long term care.

2. Definitions of long-term care

Long-term care has been defined as:

> *...all forms of continuing personal or nursing care and associated domestic services*
> *for people who are unable to look after themselves without some degree of support,*
> *whether provided in their own homes, at a day centre, or in an NHS or care home setting.*

Joseph Rowntree Foundation (1996), p.1.

Such care involves a continuing commitment over a period of time and is typically necessary in the case of long-term chronic illness and/or disability. It covers nursing services, together with personal assistance and domestic help. Apart from elderly people, this sector caters for the needs of people with physical disabilities, mental illness and learning difficulties. This paper concentrates on long-term care for elderly people, although sometimes data sources do not distinguish between these different client groups. Care provided for elderly people falls into three main categories; namely, domiciliary care, residential home care and nursing home care.

Domiciliary care is provided in a person's own home. It may take the form of formal or informal care. Most formal domiciliary care is provided by trained care workers employed by local authorities, although some is provided by NHS community health service staff. Spending on domiciliary care amounted to an estimated £4.9 billion in the UK in 2001/02, of which about £4.1 billion was spent in England. Of the English total, the NHS spent £1.7 billion (40.2%), local authorities spent £2.1 billion (49.9%) - gross of charges - and personal expenditure accounted for £0.4 billion (9.8%) (Laing and Buisson, 2002). In addition to the formal domiciliary care sector, there is a vast amount of informal care provided on an unpaid basis by relatives and friends of elderly people. It is difficult to obtain accurate figures for this expenditure. However, it was estimated that the market value of this care in 1992 was £39.1 billion (Laing, 1993).

Residential and nursing home care are provided in institutional settings. The distinction between the two forms of care relates to the level of dependency of the residents. Residential home care caters for less dependent residents and offers accommodation and assistance with everyday living. Nursing home care - as the term implies - involves a nursing component and takes place in NHS long-stay geriatric units or registered nursing homes where qualified nursing staff are required to be on duty. Residential care is provided by both the public sector (NHS hospitals and local authority homes) and the independent sector (private and voluntary homes). Funding comes from both the public and private sectors. In April 2002, there were an estimated 511,300 nursing and residential care places for the elderly, chronically ill and physically disabled people in the UK. The private sector accounted for about 83% of these places. Total expenditure amounted to approximately £9.4 billion, with £6.3

billion (66.9%) spent in the private for-profit sector, £1.3 billion (13.8%) spent in the private not-for-profit sector and £1.8 billion (19.3%) in the public sector (Laing and Buisson, 2002).

3. Recent trends in long term care

When the UK welfare state was set up after the Second World War, social care arrangements for elderly people were treated as a residual category. They were not included in the mainstream social insurance arrangements. While the health care needs of the sick were met by the NHS and provided free of charge, responsibility for providing social care for elderly people rested with the local government and was subject to means testing (Richards, 1996).

During the 30 year period following the end of the war there was a broad expansion of publicly funded, long-term care services for elderly people, provided by NHS long-stay geriatric hospitals and wards, local authority residential homes and private and voluntary sector homes. Places were provided free of charge in NHS hospitals and, despite the existence of means testing, the majority of people qualified for free care in local authority homes. Local authorities met the costs of about 60 per cent of private and voluntary sector residents. Public funds were, however, subject to cash limits and so there was considerable unmet need. In addition, as had always been the case, the bulk of care was provided on an informal, unpaid basis.

From the mid 1970s, tight controls over public expenditure generally meant that local authorities found it increasingly difficult to meet the spending requirements of the growing demand for long-term care. Pressure built up for the central government to meet the costs of residential care for those people who could not afford fees and for whom local authorities were unable to pay. As a result payments under the national, cash-based, social security system became widespread. In 1983, it became part of national policy for anyone with less than £3,000 in capital to be eligible to apply for supplementary benefit as a right in order to meet the costs of residential or nursing home care. No assessment of need was required in order to qualify for benefits. This system remained in place until 1993, although the capital limit was increased from £3,000 to £8,000.

Because the supplementary benefit system was part of the non-cash limited social security system, these payments fuelled a major expansion of the residential and nursing home care sector. The total number of long-term care places for elderly people grew from just under 300 thousand beds in 1983 to nearly 535 thousand beds in 1993 (see table 1). Moreover, these payments were made during a period when the Conservative government - under Prime Minister, Margaret Thatcher - was keen to expand the private sector. In keeping with this objective,

Table 1. Provision of long-term care places for elderly, chronically ill and physically disabled people, UK, 1983-2001*.

Year	NHS long stay geriatric	Local Authority Residential Homes	Private / Voluntary Residential Homes	Private / Voluntary Nursing Homes	TOTAL**
1983	46,900	136,500	100,000	29,000	312,400
1985	46,300	137,100	130,400	38,000	351,800
1993	37,800	94,600	218,200	187,900	562,900
1994	34,500	85,900	224,100	201,500	568,100
1995	33,000	80,100	226,000	211,300	570,500
1996	29,800	77,300	230,200	220,200	575,600
1997	27,300	71,000	233,200	224,400	572,600
1998	24,500	68,600	234,200	221,400	564,100
1999	22,100	64,200	237,100	213,200	551,100
2000	21,000	59,900	239,500	204,800	538,400
2001	20,300	55,900	240,200	196,800	525,600

* Official figures do not disaggregate between beds for elderly people and those for younger groups with chronic sicknesses and physical disabilities. However, estimates suggest that elderly people account for approximately 95% of the total.

** Totals include long stay psycho geriatric and long stay young disabled not shown separately.

Source: Laing and Buisson, 2002.

supplementary benefit payments were payable to residents of private and voluntary homes but not to residents of local authority homes. As a result, the numbers of private residential homes grew rapidly from the mid 1980s while the local authority sector at first remained static and then fell in size. As table1 shows, the number of long-term care places in the private and voluntary sectors increased by more than threefold between 1983 and 1993, whereas the number of places in the local authority sector declined by nearly a third over the same period.

This dramatic increase in social security spending on long-term care attracted a number of criticisms. It was claimed that the system provided a perverse incentive for people to enter residential care rather than receive domiciliary care in their own homes. An Audit Commission report, *Making a Reality of Community Care*, published in 1986 pointed to £500 million spent on residential care from the social security budget and argued that many people could have been cared for quite adequately in their own homes at a lower cost (HMSO, 1986). The House of Commons, Public Accounts Committee claimed that 77 per cent of those elderly people in institutions could be cared for in the community if appropriate domiciliary services were made available (Baggot, 1998).

Reacting to these criticisms, the prime minister's policy adviser, Sir Roy Griffiths, was asked to examine the situation and to make recommendations. The subsequent Griffiths Report (DHSS, 1988) was based upon three main objectives. First, to ensure that public resources were targeted on those people who needed them most. Second, that recipients of long-term care should have more choice about the services that were offered to them. Third, that wherever possible, people should be given assistance to enable them to remain in their own homes (Hunter and Judge, 1988).

The principal financial recommendation of the Griffiths report was that budgetary responsibility for funding long-term care should be transferred from the central government, social security budget to local authorities. Under this system, all elderly people requiring long-term care would be subject to a needs assessment carried out by a case manager from their local authority, social services department. On the basis of this assessment, an appropriate package of care - which could involve domiciliary, residential or nursing home care - would be agreed. In the case of nursing home and residential home care, those individuals qualifying for public funding would have their costs met by the local authority. But there would be an expectation that more cost-effective packages of care would reduce the emphasis on residential care.

In addition, another important feature of the Griffiths proposals was the recommendation that *non-cash-limited*, non-means-tested social security payments should be replaced by with *cash-limited grants* to local authorities and needs-assessed provision of long-term care.

The Griffiths proposals formed the basis of the National Health Service and Community Care Act, 1990 which was implemented in April 1993. While the Griffiths principles were a central feature of the new financing system, the government added some of its own gloss. For example, it made it clear that maximum use should be made of the private and voluntary sectors. Thus local authorities were required to allocate 85 per cent of any new money received from the central government to services provided by the private sector. This continued the earlier emphasis on the expansion of private residential and nursing homes. There was also an expansion of privately provided domiciliary services. In 1992, only 2 per cent of home care contact hours funded by local authorities in England was provided by the independent sector. By 1995, the proportion had risen to 29 per cent (Baggot, 1998).

While the 1990 Act addressed a number of problems in the long term care sector, it also introduced a some of its own. These arose from the persistence of different payments systems and providers. Long-term care services provided by the NHS - whether domiciliary or residential - were provided free of charge. But, over time, the NHS cut back on the provision of long-term care. The number of NHS long-stay geriatric beds fell by about 57 per cent between 1983 and 2001 (26,600 beds). The supply of private nursing home beds increased by over 700 per cent over the period 1983-1994 (195,000 beds), but has since then contracted each year - from a peak of 224,000 beds in 1997 to 196,000 beds in 2001 - as the tighter public funding regime started to bite (Laing and Buisson, 2002).

Long-term domiciliary services provide by local authorities were subject to charges. However, there was a wide variation between different local authorities in the application of these charges. Some of them charged a small flat rate, while others charged full costs. Local authorities also varied in the extent to which means tests were used as a basis for determining payment. Revenue from charges amounted to about £200 million in 1996/

97. But it was in the area of payment for residential or nursing home care that large anomalies had arisen and where most discontent was expressed.

If an individual was assessed by the local authority social services department as being in need of nursing home or residential care, his or her eligibility for financial assistance with the fees depended upon their income and capital assets. If the individual's income was sufficiently high, they were expected to pay the full fees. Moreover, if their capital assets were above £10,000 (including assets held in the form of equity in their homes), they were expected to meet part or all of the fees.

As owner-occupation levels have increased (just under 60 per cent of UK households with a head of household 65 years of age or older is currently an owner occupier), and property values have increased, these requirements meant that a growing number of elderly people were required to draw on their equity holdings in their homes in order to finance long-term care.

This state of affairs led to widespread and vocal discontent. People who had paid taxes all their working lives and expected the welfare state to look after them in their old age found that they were required to use their savings to fund care. There was a general view that the government has reneged on its social contract with elderly people. In fact, as the preceding account has shown, there never really was such a contract. Social care in the UK has always been subject to means-testing. The sense of betrayal felt by many elderly people (and their relatives and heirs) arose because this fact was not apparent as long as the NHS took responsibility for providing social care as well as health care needs, and while the numbers of elderly people meant that local authorities could offer sufficient accommodation to avoid widespread discontent.

Prompted by these criticisms, the incoming Labour government set up a Royal Commission on long term care in 1997. The Commission published their report *With Respect to Old Age* in March 1999. This started from the premise that there is no 'demographic timebomb' and that the future costs of long-term care are affordable. Further they maintained that it is not efficient or fair for people to have to rely on their personal income or savings to cover these costs and argued for a system of risk pooling. They rejected the idea that this should be based on private insurance, arguing that it would not provide cover at an acceptable cost. They also rejected the idea of social insurance either on a pay-as-you-go or funded basis.

Having rejected these options, they argued for services to be funded through general taxation, maintaining that this is the most efficient method of risk pooling and the fairest across all generations. However, recognising that a major increase in general taxation aimed at funding long-term care might not be feasible, they argued for a distinction to be made between *nursing care, personal care* and *living/housing costs*. They proposed that the costs of nursing and personal care should be universally available, non-means tested and paid for through general taxation. Living and housing costs could, however, be subject to user payments according to means. The Commission claimed that, at present, an estimated 2.2 per cent of the revenues collected by the government from tax payments levied on earnings, pensions and investment income is spent on long-term care in residential settings and in people's homes. By improving entitlements so that all nursing and personal care was provided free of charge, they estimated that this bill would rise to 2.5 per cent of total tax revenue by 2051. Put another way: the percentage of GDP devoted to the public funding of long-term care would rise from 1 per cent to 1.3 per cent.

Two members of the Commission, however, did not accept their colleagues views on the future cost of care and their proposals for the way in which it should be funded, and issued a Note of Dissent. They argued that the majority proposals would initially add £1.1 billion to public sector costs rising to £6 billion in 2051. Moreover, they maintained that this would not increase the quantity or quality of long-term care but simple represent a transfer from existing private expenditure to public expenditure. This, they argued, was an inefficient and inequitable use of scarce public funds. They were prepared to see the existing means-test modified so that it did not penalise people with small amounts of wealth or force them to sell their homes. A major thrust of the dissenter's proposal was for a genuine public-private partnership in the funding of care, with private insurance and private savings making some contribution.

4. Current policy on long term care

The government responded to the Commission's recommendations in Summer, 2000. Most of them were accepted. However, on the important issue of the costs of personal care the government chose to accept the Note of Dissent. Under the Health and Social Care Act, 2001 nursing care is now provided free of charge but personal care

is subject to means testing. Moreover, in an interesting constitutional twist, this situation applies in England but not in Scotland where the newly established Scottish Assembly has decided that all nursing and personal care will be free of charge.

The English approach has led to the need for a definition of nursing care and a procedure for assessing the need for it. The government has defined nursing care as: 'registered nurse time spent on providing, delegating or supervising nursing care in any setting'. Three levels of nursing care need have been set, and payments to nursing homes of £35, £70 or £110 per week are made to cover the necessary costs. The average payment is expected to be £85 per week with around 42,000 elderly people benefiting (Brooks, Regan and Robinson, 2002). With regard to means-tested payments by residents, the 2001 Act introduced a three month disregard on the value of an individual's home to avoid the need for a sale in the case of short-term care. The government has also decided to review annually the levels of capital at which individual payments come into force in order to keep them broadly in line with inflation (Laing and Buisson, 2002).

The decision to seek to distinguish between personal care and nursing care has been the subject of substantial criticism on grounds of both principle and practice. Organisations such as Age Concern have pointed to the anomalies that are likely to arise in payments for care of, for example, people with cancer (mainly nursing care) and Alzheimer's disease (mainly personal care). Distinguishing between personal and nursing care is bound to be problematic in these types of situation. The Royal College of Nursing is particularly unhappy with the government's definition of nursing care, arguing that nurses will become gatekeepers to free care and that this could introduce numerous perverse incentives.

One of the reasons why the government has opted to means-test personal care is to target extra expenditure on intermediate care. Intermediate care covers a range of services designed to promote independence among patients by: avoiding unnecessary hospital admissions, avoiding unnecessarily long lengths of hospital stay by enabling timely discharge from hospital, promoting effective rehabilitation programmes and planning new services in non- acute hospital environments (e.g. community hospitals, hospital-at-home schemes.) Intermediate care policy is seen as particularly important in the case of increasing numbers of elderly people who are often admitted to acute hospitals, and remain there unnecessarily, because of a lack of suitable facilities. The government has allocated £900 million over the period until 2003/04 for its development (Department of Health, 2001).

There have also been new initiatives relating to quality standards. The Care Standards Act, 2000 set out new arrangements for monitoring and regulating the quality of long term care standards. Following the Royal Commission's recommendations a new body for ensuring high standards, the National Care Standards Commission was established in 2001. However, in the interests of improving co-ordination, this body is shortly to be merged with the Social Services Inspectorate to form a new Commission for Social Care Inspection. This body will have a number of functions, including the responsibility to:

·carry out local inspections of all social care organisations, both public and private, and to ensure that national standards are met.

·register services that meet national standards.

·carry out inspections of local authority social services departments.

·publish star ratings for social service departments, with the power to recommend special measures where there are persistent problems.

·publish an annual report to Parliament on national progress on social care and the use of resources. (Department of Health, 2002).

One final piece of recent policy with clear implications for elderly people is the *National Service Framework for Older People* published by the government in March 2001. This sets out protocols for the treatment of elderly people. Although much of the emphasis is upon NHS services, there is a strong statement of the need for better co-ordination between health and social care. There is an aim of reduced reliance on long term residential care and greater use of proven assessment scales - with a single assessment process - to ensure that individuals have their needs properly assessed.

5. The future demand and cost of long-term care

What are the costs of this system likely to be in the future? Obviously, forecasting the future demand for long-term care involves a number of uncertainties. Nonetheless, some basic predictions can be made on the basis of the future age composition of the population, their ex-

pected levels of dependency and expected increases in unit costs.

Table 2 presents some projections based upon the Government Actuaries figures. These show that the number of people over the age of 65 years of age is expected to increase from 9.1 million in 2000 to 14.7 million in 2040. Thereafter the numbers are expected to fall back to 14.1 million by 2050. Although these projections indicate a substantial rise in the size of the elderly population, it is the increase in the numbers of very elderly people (i.e. 80 years of age and over) that is the more striking. Their numbers are expected to more than double - from 2.4 million to 5.4 million - between 2000 and 2050. It is also relevant to note that the number of people of working age (16-64 years) per person over the age of 65 years will fall from 4.1 to 2.1 over the period 2000 to 2040, thereby reducing the size of the taxpayer base able to fund long term care on a pay-as-you-go basis.

Of course not every elderly person will be in need of long-term care. As table 3 shows, even among those people of 85+ years, severe dependency rates only occur among one in five men and one in three women.

A recent study carried out by researchers at the Personal Social Services Unit, London School of Economics and the Nuffield Community Care Studies Unit at the University of Leicester made projections of long-term care finance for older people to 2051 based on these type of population growth and unit cost projections (Wittenburg et al, 2001). They estimated that long term care expenditure would need to rise by about 260% in real terms between 2000 and 2051 to meet demographic pressures and to allow for annual real increases in care costs of 1% per year for social care and 1.5% for health care. Assuming that GDP increases at 2.25% per year, this rate of expenditure growth would mean that spending on long term care would rise as a share of GDP from about 1.4% in 2000 to 1.6% in 2051. The share of public expenditure would, however, fall from 68% of spending in 2000 to 66 per cent in 2051 as rates of home ownership increased.

These projected expenditure levels are slightly higher than were predicted at the time of the Royal Commission (e.g. 1.6% of GDP in 2051 rather than 1.3%) but they do not appear to represent an unmanageable burden on an economy that will be well over twice its present size in absolute terms by 2051.

6. Some implications of UK experience for Japan

What relevance does recent UK experience have for Japan? A starting point in seeking to answer this question

Table 2. Demographic projections for Great Britain, 2000 - 2050 (Millions)

Age	2000	2010	2020	2030	2040	2050
0-14	11.3	10.7	10.3	10.3	9.8	9.5
15-64	37.6	38.9	38.4	36.4	35	34.3
65-79	6.7	7	8.5	9.7	10.2	8.7
80+	2.4	2.8	3.1	4	4.5	5.4
Total	58	59.4	60.3	60.4	59.5	57.9

Table 3. Prevalence rates of disability in Great Britain (% of age group)

Age Group	Moderate		Severe	
	Male	Female	Male	Female
65-69	7.2	7	3.8	3
70-74	8	10.4	4	4.1
75-79	14.6	17.9	8.1	7.6
80-84	22.5	28.3	12	14.2
85+	31.3	55.2	18.6	33.9

Source: OPCS Disability study of Great Britain

must be a recognition of the dramatic changes in the demographic pattern taking place in Japan. These mean that Japan has moved from a country having one of the lowest proportions of elderly people in the 1980s to one with among the largest proportion of elderly people in the OECD area by the year 2000. Moreover, the numbers in Japan are forecast to grow more rapidly than elsewhere. To illustrate, in 2000 there were 9.3 million people over the age of 65 years in the UK (15.5% of the population) compared with 22 million people in this age group in Japan (17.4% of the population). By 2051 it is expected that the numbers in this group will rise to 15.9 million in the UK and will account for 24.4% of the total population. In Japan, however, the numbers are expected to rise to 35.9 million by 2050 and account for 35.7% of the population. Put another way: one in every 2.8 people in Japan will be in the elderly age group (Laing and Buisson, 2002; Wittenburg et al, 2001; Takahashi et al, 2002). This rate of growth in the numbers of elderly people is approximately three times as fast as in countries such as Germany, that will also experience substantial population ageing (Ogawa, 1996).

As in the UK, changes will also take place in the proportion of those over 65 years of age who fall into the 75+ years category. Numbers in this age group are projected to rise from 39.9 per cent in 2000 to 56.5 per cent in 2025. This can be expected to add considerably to the demand for long-term care. For example, the number of bed-ridden patients - either at home or in institutions - is expected to rise from 1.0 million in 1995 to 2.29 million in 2025, while the number of cases of senile dementia is expected to rise from 1.25 to 3.22 million over the same period (Ogawa, 1996).

These demographic changes also, of course, have implications for Japan's capacity to fund rising demands on the part of the elderly population. According to projections made by the National Institute of Population and Social Security Research, the working age: elderly population ratio is expected to fall from its present level of 3.9 working age people for each elderly person to 2 working age people per elderly person in 2030 and to only 1.5 workers per elderly person in 2050.

These demographic changes pose a considerable challenge for Japan. In view of this, what implications does UK experience hold for Japanese policy makers? The review presented in this paper suggests that there are at least four areas where UK experiences may hold some interest for a Japanese audience. These cover:

- long term care finance.
- plurality of provision
- quality standards and regulation.
- integration and co-ordination.

Long term care finance

The UK and Japan have decided to go down different routes as far as the funding of long term care is concerned. Following the Royal Commission report, the UK government has decided to retain a tax-funded system, albeit with large elements of user charges. Japan, on the other hand, has launched the most radical programme of mandatory social insurance for long term care in the world (Campbell and Ikegami, 2000).

The Japanese reform process dates from the first "Ten-year Gold Plan for the Development of Health and Welfare Services for the Elderly" published in 1990. The plan was based upon the recognition that a gap had emerged between the pace of ageing of Japanese society and the various policies in place to deal with it. In order to address the predicted gap between demand and supply the National Government announced its intention to introduce a new consumption tax to fund the extra services set out in its long-term plan (Maeda, 1996). This was a form of earmarked tax for age-related expenditures. However, such age-related expenditures have always exceeded the revenue from the consumption tax.

Following developments in the early 1990s, the initial Gold Plan - which covered the 10 year period 1990-1999 - was reviewed and a revised Gold Plan covering the period 1995-1999 was published in 1994. This plan - which was implemented in 1995 - set out a number of detailed plans for the provision of domiciliary and residential long-term care services. It aimed to provide comprehensive public care services for elderly people. (Ministry of Health and Welfare, 1994).

While the Gold Plan initiatives represented important responses to the rapid growth in demand for long-term care in Japan, according to some commentators they were not sufficient (Maeda, 1996). As we have seen, rapidly increasing numbers of elderly people and a rising dependency ratio was expected to make the system very expensive at a time when there was growing resistance to tax increases. For this reason Japan turned away from a tax-based approach and adopted a German style social insurance model (Fukawa, 2002). This programme began in April 2000.

Although, the new long term care insurance sys-

tem will operate mainly on social insurance principles, half of the funding is to come from general revenues - 50 per cent national and 25 per cent each from prefectures and municipalities. This pattern of funding represents an extension of health insurance which is partly subsidised from general revenues. Insurance premiums will be paid by working people between the ages of 40 and 64 years (premiums vary between schemes but on average are 0.9 per cent of monthly income - up to a ceiling - shared with employers) and by people of 65 years and over who will have premiums deducted from their public pensions (Campbell and Ikegami, 2000).

Given that Japan has chosen to adopt a social insurance model whereas the UK has rejected this option, it is worth considering the reasons for the UK decision. In the UK there have been various proposals for moving from a tax-based *health* funding system to a social insurance system. It has been argued that this would increase transparency by providing a clearer link between payments and benefits, and thereby would make people more willing to make payments towards health care. These proposals have usually been rejected on two main grounds. First, the UK does not have an institutional structure capable of managing social insurance in the way that it is managed by, for example, German sickness funds. Second, the tax-base for social insurance is narrower than a general tax-based system and, in particular, that social insurance constitutes a tax on employment and can reduce firms' international competitiveness. Both of these arguments apply to long term care as well as health care. Indeed, the employment cost and international competitiveness case is currently causing a good deal of concern in several European countries, including Germany and France.

It seems that in Japan remarkably little attention was paid to the likely overall costs of the long term care insurance scheme during the run up to implementation. Part of the reason was that take-up of benefits was not expected to be particularly high in the early years as people were unfamiliar with the scheme. But according to some experts this is likely to change as time goes by. They predict that government will change policy so that payments are made by everyone and not just those people over 40 years of age (Campbell and Ikegami, 2000). But the burden on employment costs would still remain and could be a source of concern if the economy remains fragile.

Plurality of provision

Over the last 20 years, there has been a major expansion in the numbers of private and independent providers of nursing and residential care in the UK. In 2002 the private sector accounted for over 80% of beds. The private sector has also been growing in terms of the provision of domiciliary care. The long term care market is now an established mixed economy. What have been the consequences of the growth of this mixed economy in terms of efficiency and quality standards?

The evidence on relative cost-effectiveness of the public and private sectors is mixed and complicated by the fact that the public sector often now caters for residents with higher dependency levels. Notwithstanding this ambiguity, the growing private sector has almost certainly led to more competition and contestability, and this has exerted an influence not only on the new private entrants but also public sector providers faced with competition (e.g. NHS long stay geriatric wards). This has taken place as much in terms of quality as price. On the other hand, the growth of a mixed economy has undoubtedly led to a growth in transactions costs. There are no firm estimates of the size of these costs although more complicated contracting arrangements mean that they have certainly risen (Robinson, 2002). Staff salaries and conditions of service are also usually worse in the private sector.

A system in which private provision has been funded in large part by public payments has also witnessed the closure of many private nursing home places over the last five years as fee levels have not risen sufficiently to cover costs and as resources have been redistributed from care homes to domiciliary care services. Most closures have involved small nursing homes so that the market is becoming more concentrated with large nursing home chains assuming a larger market share.

This range of experiences has clear relevance for Japan as, under the reforms of 2000, the traditional, monopoly social service provision of home care services is to be liberalised. For-profit companies and independent providers are both about to enter the market and are seen as posing a competitive threat to traditional providers in what is expected to be a vastly expanded market. Users will be given greater choice between public and for-profit private providers. Competition is, however, expected to be mainly in terms of quality as prices will be subject to a fee scale established by the national government. With the growth of mixed public-private provision in Japan,

some concerns have been expressed about the quality of care provided by the private sector (National Institute of Population and Social Security Research, 2001). Similar concerns have been expressed in the UK and, as a result, a new regulatory structures have been set up.

Quality standards and regulation

As pointed out earlier, there have been a number of initiatives aimed at setting, monitoring and improving standards in the NHS generally over the last five years. These have now started to be applied to social care as well. Prior to the Labour government coming to power in 1997, there had been no national standards governing long term care and no regulation of the domiciliary care sector. National standards have now been set for residential and nursing care and are under consultation in relation to domiciliary care (where, incidentally, specification of standards that can be monitored seems to be more difficult). Through the Care Standards Act, 2000, the newly established Commission for Social Care will be charged registration of providers, inspection and review. It will also publish an annual report for Parliament on national progress in social care. Based upon the National Institute of Clinical Excellence, a Social Care Institute of Excellence was established in April 2001 with the aim of establishing and disseminating information on evidence-based best practice in social care. Finally, a National Service Framework in relation to services for older people has been published setting out national standards designed to drive up quality and tackle variations across the range of older peoples services (Department of Health, 2001).

Integration and Co-ordination.

Long term care policy in UK has been bedevilled by fragmentation and lack of co-ordination. The earlier discussion in this paper explained how this had its origins in the differential treatment of health care, on the one hand, and social care on the other. In recent years, there have been a number of attempts to overcome this problem.

One widely publicised micro-level approach has been based upon budget-holding, care managers. In the experiment that took place in the county of Kent, individual care managers in social service departments were given needs-based budgets with which they could assemble appropriate packages of care for individual clients. This was seen as a means of allocating resources in a consumer-sensitive and cost effective manner. In particular, it was seen as a means of preventing costly care home admissions when clients could be adequately cared for in their own homes, given the right level of domiciliary care support. Despite the publicity that centred on the Kent scheme it was never really applied nationally. Care managers continue to put together packages of care for client but they do not generally hold budgets.

However, in the case of domiciliary care, recent reforms have taken budgetary devolution even further. Elderly people are to be given direct payments (i.e. cash payments) with which they can purchase care or aids, rather than having them provided indirectly through public sector funding.

At the intermediate level, several policy initiatives have aimed at improving co-ordination and integration between the health and social care sectors. The government has placed a statutory duty on health and social services to work in partnership. New flexibilities have offered them the opportunity to pool budgets and to appoint lead commissioners for social care services within a single, unified management structure. Some primary care trusts (i.e. primary care based organisations responsible for providing primary and community health services and commissioning secondary care for their registered patient populations) have had their scope widened so that they can commission the bulk of social services for their registered patients as well as health services. These are known as care trusts. The first four care trusts were established in April 2002. However, the complexities associated with setting up these organisations suggest that most primary care trusts will seek to achieve co-ordination through closer working and joint commissioning with social services departments rather through becoming care trusts.

7. Concluding comment

Both the UK and Japan face demographic changes that can be expected to lead to increases in the demand long-term care for elderly people over the next 50 years. In comparative terms, however, Japan is facing a far larger challenge and, possibly for this reason, the ways in which it is approaching policy in this area displays some marked differences to the UK approach. In particular, it has chosen to launch a major social care insurance scheme.

On the supply side, however, there are a number of common concerns and approaches. Greater use of the private sector and approaches to setting, monitoring and improving quality standards are two of these. At the mo-

ment the UK has rather more experience of these developments. Comparative analysis provides a mechanism for making this experience available to Japanese policy makers.

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