

Department of Social & Family Affairs



# **Study to Examine the Future Financing of Long-Term Care in Ireland**

undertaken by Mercer Ltd. on behalf of the  
Department of Social & Family Affairs

# Study to Examine the Future Financing of Long-Term Care in Ireland



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# Contents

Minister's Foreword	2
Executive summary	3
Glossary of terms	28
1. Introduction	30
2. Context	32
3. Review of international approaches	50
4. Estimating long-term care needs	63
5. Needs assessment and benefit design	78
6. Financing options	102
7. Partnership options	136
8. Costings	141
9. Implementation issues	151
10. Pre-funding	154
<i>Bibliography</i>	159
<i>Appendices</i>	
<i>I. Assumptions underlying the population projections</i>	162
<i>II. Long-term care in other countries</i>	163

The Government is committed to ensuring that older people and people with disabilities can fulfil their potential and make their full contribution to the economic and social life of our country. In particular, we will build service provision and the legislative frameworks which enable this to happen.

We have already provided significant improvements in supports for carers which have resulted in more than doubling the number of people in receipt of Carer's Allowance. We intend to continue in this vein by further developing and co-ordinating our policies for carers and the people for whom they care.

Both the Government's Agreed Programme and the Health Strategy put emphasis on maximising support for community care. Fundamentally, this means achieving a more even balance between institutional care and home care and targeting resources in a way that provides the most appropriate care to those most in need.

This study examines the future financing of long-term care in Ireland including the best way to structure such support and the most effective and equitable methods of funding. I hope that this comprehensive report will facilitate discussion and debate on the many strategic issues relating to the further development of policy in this area.

These issues are of relevance to a broad range of interested parties including older people, people with disabilities, carers, the social partners and the relevant public and private service providers and organisations. All these stakeholders have a significant part to play in the development of an adequate and sustainable long-term care system.

The issues involved are complex and will take time to address fully, bearing in mind the competing demands for resources in our society. Progress must, however, be made and must be co-ordinated across a broad range of Government departments and agencies. I look forward to working closely with my colleague, Micheál Martin, T.D., the Minister for Health and Children to advance proposals in this area.

Mary Coughlan, T.D.

Minister for Social and Family Affairs

November 2002



Tá an Rialtas tiomanta do chinntiú gur féidir le daoine aosta agus le daoine atá faoi mhíchumas a bpoitéinseal féin a bhaint amach agus a gcion a dhéanamh do chúrsaí eacnamaíochta agus sóisialta na tíre seo. Tógaimid soláthar seirbhíse agus creata reachtaíochta, go háirithe, a éascaíonn é sin.

Tá feabhsúcháin shuntasacha déanta againn, cheana féin, ar thacaíocht do ghairmeacha beatha, rud a d'fhág dhá oireadh daoine ag fáil liúntais do

chúramóirí. Tá sé i gceist againn leanúint ar aghaidh ar an gcaoi chéanna trínár gcuid beartas do chúramóirí, agus do na daoine sin a ndéanann siad cúram dóibh, a fhorbairt tuilleadh agus a chomhordú.

Leagann Clár Comhaontaithe an Rialtais agus an Straitéis Sláinte araon béim ar uasmhéid tacaíochta a chur ar fáil do chúram pobail. Go bunúsach, is éard a chiallaíonn sé sin ná cóimheá níos cothroime a bhaint amach idir cúram institiúideach agus cúram baile agus spriocdhírú ar acmhainní ar bhealach a sholáthraíonn an cúram is oiriúnaí dóibh siúd is mó a bhfuil gá acu leis.

Déanann an staidéar seo scrúdú ar mhaoiniú amach anseo don chúram fadtréimhseach in Éirinn lena n-áirítear an bealach is fearr leis an tacaíocht sin a struchtúir agus na modhanna maoiniúcháin is éifeachtaí agus is féarálte. Tá súil agam go n-éascóidh an tuarascáil chuimsitheach seo díospóireacht agus plé faoi go leor de na saincheisteanna straitéiseacha a bhaineann le forbairt bhreise an bheartais sa réimse seo.

Baineann na saincheisteanna sin le raon leathan páirtithe leasmhara lena n-áirítear daoine aosta, daoine atá faoi mhíchumas, chúramóirí, na comhpháirtithe sóisialta agus na heagraíochtaí agus soláthraithe seirbhíse ábharthacha poiblí agus príobháideacha. Tá ról nach beag le himirt ag na páirtithe leasmhara sin maidir le córas inmharthana agus leordhóthanach cúraim fhadtréimhsigh a fhorbairt.

Tá sa saincheisteanna atá i gceist casta agus glacfaidh sé tamall aghaidh a thabhairt orthu ina n-iomláine, go háirithe i bhfianaise éilimh iomaíochas ar acmhainní sa tsochaí. Caithfear dul chun cinn a dhéanamh, áfach, agus ní mór an dul chun cinn sin a chomhordú i raon leathan gníomhaireachtaí agus ranna Rialtais. Táim ag súil le hoibriú go dlúth le mo chomhghleacaí, Micheál Ó Máirtín, T.D., an tAire Sláinte agus Leanaí, chun moltaí sa réimse seo a chur chun cinn.

Máire Ní Chochláin, T.D.

An tAire Gnóthaí Sóisialacha agus Teaghlaigh

Samhain 2002

# Executive summary

## Introduction (Section 1)

This is a review of long-term care financing commissioned by the Department of Social and Family Affairs. It considers possible financing options, including:

1. Private sector or combined public/private sector approaches.
2. Use of the PRSI system to finance/fund long-term care.
3. Whether the current system of long-term care financing (through taxation) should remain the status quo.

It includes consideration of:

- Future demands for long-term care.
- International experience and financing models in other countries.
- The framework in which different financing options might operate.
- Whether benefits should be provided in kind or in cash form.
- Support for family care.
- Issues relating to pre-funding of long-term care.


## Context (Section 2)

Long-term care may include both personal care and medical care. The primary focus of this study is the need for personal care, whether on a residential basis or in the community. The broader needs of people with disabilities, including, for example education or transport, are beyond the scope of this report.

Long-term care is needed by those with functional or cognitive disability. Whilst such disability is more prevalent amongst older people, there is also a substantial number of younger people with disabilities. There are distinctly different issues to be addressed for the two groups. Our consideration of potential financing mechanisms is intended to address the needs of all age groups. Attention is drawn, where appropriate, to differences in the potential of the various mechanisms to address the needs of the different groups.

The ageing of the population means that the demand for long-term care is growing. Also, the availability of informal care may reduce in future as a result of falling birth rates and greater participation by women in the labour force. Social and technological change will also impact on future needs and preferences in relation to long-term care in ways that are difficult to predict.

Currently, long-term care in Ireland is financed principally from general taxation and private out-of-pocket expenditure. The public health system provides both residential and community services, but current funding arrangements favour residential care.



Health Boards provide residential care in public extended care beds and through beds contracted in private nursing homes. In addition, a subvention is available for care in a private nursing home if the recipient satisfies dependency criteria and a means-test. The level of subvention currently payable (maximum €190.50 per week) is generally insufficient to bridge the gap between income and the cost of care. There are approximately 22,000 public and private extended care beds, with a high level of occupancy. The level of dependency of those in extended care beds is quite varied.

Residential care is also provided, generally in separate facilities, for younger people with disabilities.

Community care services include community nursing (by public health nurses), home helps, respite services, day care centres and meals services together with paramedical services such as physiotherapy, occupational therapy, chiropody and speech therapy. Health Boards are empowered but not obliged to provide such services and access to such services has been limited and variable within and among health board areas. In recent years, significant additional funding has been made available for community services.

Sheltered housing – or “assisted living facilities” – has the potential to bridge the gap between living independently at home and residential care. This is an area that requires further development in Ireland, as does community care.

Most long-term care is informal care provided by family members and friends, with most of the burden usually falling on one principal carer. Data from the Census pilot in 2001 suggests that 52,000 people provide 20 or more hours unpaid personal care per week and a further 79,000 people provide 1–19 hours care. The principal financial support for carers is the Carer’s Allowance. This is a means-tested benefit (€122.60 per week from April 2002), with supplementary amounts available in certain circumstances.

There are also various tax allowances available, for example, in respect of the cost of private residential care or the cost of employing a carer. In the 2001 Budget, standard rate relief was introduced for qualifying long-term care insurance policies. To date, however, no such insurance policies have become available.

A Eurobarometer survey has found that the Irish public is strongly in favour of public coverage for long-term care. On the other hand, research carried out by Swiss Re found that most people expected to provide care or to help finance private nursing care for their parents. This indicates that whilst there is a strong desire for State financing of long-term care, there is little expectation that this will be available and/or a continuing preference to provide care within families.

### Review of international approaches (Section 3)

Appendix II provides a synopsis of the system of long-term care financing and provision, along with details of current reforms, for each of 13 countries.

Relevant factors are as follows:

- Most countries have an ageing population. This has moved the issue of long-term care into the front line of policy debate.
- In most countries, the majority of long-term care is provided informally. As in Ireland, there are concerns that informal provision will reduce.
- Until recently, residential care has dominated provision, with, perhaps, the exception of the Scandinavian countries. Most countries are attempting to shift the focus to home care (although this is not necessarily a cheaper option for those with high dependency levels). This is not an easy task where budgets and programmes are fragmented.
- Countries seeking to sustain informal care have generally adopted two approaches: provision of cash benefits to support informal carers and/or provision of services that support carers, such as day care, respite care and information services.
- Most countries that have reformed long-term care financing have adopted a model similar to that which is used for financing general health care.
- Generally, long-term care financing schemes aim to cover the cost of care but not the living and accommodation costs associated with care in a residential setting.
- In some countries, benefits are available in cash or voucher form in order to facilitate consumer choice and allow flexibility in the services that can be provided. There may be a mix of public and private sector provision both in residential and home care.
- In most countries, a pay-as-you-go approach has been adopted.

A recent study (OECD, 1998) found that the costs of long-term care are currently of manageable proportions: less than 2% of GDP in most countries. Cost increases due to population ageing are similarly expected to be at a sustainable level.

Lessons for Ireland include the following:

- Firstly, there is no blueprint solution to financing long-term care.
- The case for the State to take the lead in financing care seems compelling, having regard to the uncertainty and to the distribution of the risk of needing long-term care.
- However, it would be prudent to require individuals to make some provision for themselves.
- It seems unlikely that private insurance can be harnessed to provide a substantive proportion of long-term care financing.

- In general, countries have tended to choose solutions that fitted with their existing method of financing health services. However, Ireland's health care financing system is virtually unique: combining a "national health service" with voluntary private insurance covering almost 50% of the population. Consequently, there is no long-term care financing solution that is an obvious "fit" with the system of financing health care in Ireland.
- For the future, the provision of informal care by family members can no longer be presumed upon. For informal care to continue to be the bedrock of home care provision, more extensive support for family carers will be needed.
- A significant shift in financing towards home care services is needed, in line with customer preference and Government policy.
- Greater consumer choice, including choice of provider, would be desirable.

#### Estimating the future need for long-term care (Section 4)

In order to estimate the number of people needing long-term care, we have applied estimated disability prevalence rates to the projected number in each age group within the older population. We have made allowance for possible future trends in prevalence rates. Whilst we have carried out projections for the next fifty years, the degree of uncertainty as to future trends in the prevalence of disability are such that even short and medium term projections must be regarded as tentative.

There is limited data available as to the current prevalence of disability in Ireland. We estimate that, in total, 23%-25% of the over-65s receive at least some long-term care either in the community or in residential care. We estimate that 18%-19% receive "more than occasional" care. 4.6% of people over age 65 occupy extended care beds.

Given the limitations of the data available for Ireland, we have used a major study of disability prevalence carried out in the UK in the mid-1980s by the OPCS. We have used disability levels 5-10 from the OPCS data and have categorised these levels of disability as follows:

OPCS Category	Estimated requirement for personal care	
5-6	Moderate:	Less than daily (estimated at 10.5 hours per week)
7	High:	Significant daily care (estimated at 21 hours per week)
8-10	Continuous:	Continuous care (estimated at 42 hours per week)



We have adjusted the OPCS UK data, for the purpose of estimating disability prevalence in Ireland in 2001, on the basis of life expectancy and healthy life expectancy trends in the two countries.

Following a review of international research into trends in healthy life expectancy and disability prevalence, we have assumed, for our central projection, that healthy life expectancy will increase in line with total life expectancy and have estimated future reductions in disability prevalence rates accordingly.

### Central projection – Numbers needing long-term care

#### All ages

	Moderate	High	Continuous	Total	High/ Continuous
<b>2001</b>	75,400	25,900	51,600	152,900	77,500
<b>2011</b>	84,100	28,900	58,100	171,100	87,000
<b>2021</b>	94,100	32,700	66,400	193,200	99,100
<b>2031</b>	105,800	38,200	79,500	223,500	117,700
<b>2041</b>	117,300	44,400	95,200	256,900	139,600
<b>2051</b>	120,800	47,200	103,200	271,200	150,400

#### Older People (65+)

	Moderate	High	Continuous	Total	High/ Continuous
<b>2001</b>	35,700	15,200	33,100	84,000	48,300
<b>2011</b>	39,100	16,900	37,500	93,500	54,400
<b>2021</b>	47,600	20,300	45,000	112,900	65,300
<b>2031</b>	59,600	26,100	58,700	144,400	84,800
<b>2041</b>	73,100	32,700	75,200	181,000	107,900
<b>2051</b>	81,400	36,700	85,200	203,300	121,900

The total number of older people in need of moderate or higher levels of care (84,000) represents 19.5% of the population. This figure is inclusive of those in residential care (an estimated 19,650 people).

The estimated number of older people needing high or continuous care is 48,300 of whom approximately 17,000 are in residential care, with the remainder receiving care at home. The model suggests that there are a further 29,000 children and adults aged under 65 who need high or continuous care either in residential care or in the community<sup>1</sup>.

Projections were also carried out on a number of alternative bases:

- Projection 2: Based on **static disability prevalence rates** (no change from the OPCS base rates)
- Projection 3: An **optimistic** projection that assumes that the reduction in disability rates will be greater than has been assumed in our base projection
- Projection 4: A **pessimistic** projection that assumes disability rates will increase in future years by 0.25% per annum.

In considering the various policy options, it is important to be cognisant of the wide “funnel of doubt” as to future needs and costs.

## Needs assessment and benefit design (Section 5)

### Needs assessment

We consider that the introduction of an objective, independent, comprehensive and nationally consistent basis for assessing an individual’s entitlement is crucial, whatever financing option is adopted.

The purpose of the needs assessment process should be to help determine an individual’s eligibility for or entitlement to specified benefits or services on a basis that is objective and consistent with regard to agreed and transparent criteria.

At present, the level of dependency and/or needs of frail older people and of younger people with disabilities are assessed by a number of different State organisations for various different purposes. We understand that there is much variation as to the assessment procedures used.

We recommend that national guidelines for measuring dependency and entitlement to benefits and services should be developed by a national Expert Committee, whose task it would be:

- to develop appropriate standardised assessment tools,

- to provide a comprehensive and quantified scale of assessment for disability as well as housing and social circumstances,
- to relate that scale to eligibility for or entitlement to available long-term care benefits or services, and
- to designate the appropriate care setting for the various categories of assessed need.

The method of assessing dependency could be based on an individual's ability to perform specified activities of daily living together with a measure of cognitive impairment. The assessment process could and, indeed, should encompass an assessment of the carer's abilities and needs as well as the needs of the care recipient.

The needs assessment process would need to be implemented by Health Board teams. For those with complex needs, the assessment should be multi-disciplinary.

### Benefit design

The public financing of residential care should not occur at the expense of resources for the alternative of home care. In our view, therefore, a subvention should be available for home care, as an alternative to the subvention for residential care. We envisage that the amount of the community-based subvention would be scaled on the basis of the assessed level of dependency. A subvention should also be payable to individuals who are resident in assisted living facilities.


The form of the subvention could consist of services, vouchers to enable the recipient to purchase services, or cash (which would give the recipient complete flexibility, either to purchase care or to use the benefit for some other purpose). A further option would be to provide the recipient with a choice of services or cash. Different models have been adopted in different parts of the world.

#### Spectrum of delivery mechanisms



A choice of provider, whether arranged directly with the funding body, or facilitated by the use of vouchers, direct payment mechanisms or cash benefits, would increase consumer choice. Consumers would be able to select the mix of services that best suit their preferences.

<sup>2</sup> As in the UK model, described in detail in section 5.



The use of independent providers may have benefits in terms of enhancing the overall cost-effectiveness of services, but would require monitoring in relation to the quality of services.

It may be appropriate to pilot some of the alternative forms of service delivery along the spectrum shown above with a view to determining the most appropriate benefit design for a new financing scheme. There is, however, a strong case to be made in favour of a more consumer-oriented approach. We suggest, therefore, that, initially, benefits for home care services would be offered in the form of a choice of in-kind services and a cash alternative.

In-kind services could be provided either by the Health Board or by an independent provider or providers. Where in-kind services are required, we suggest that:

- a value be placed on the services to which the individual is entitled from the Health Board
- a care manager – provided by the Health Board - would be available to help the recipient to select a package of care within that budget and negotiate its implementation with Health Board and/or independent service providers.

Whilst there is little independent home care provision at present, we would suggest that supply is likely to emerge as significant additional funding becomes available and as individual beneficiaries begin to exercise choice in the allocation of that funding. There is scope to stimulate this effect by encouraging, or even requiring, the health boards to use independent providers to deliver a proportion of their own service obligations (this was done in the UK in the early 1990s in the context of the reforms designed to shift the focus of care to the community).

Labour shortages have been cited as a potential barrier to expanding the supply of home care services. However, labour market pressures are likely to have eased as a result of the recent economic slowdown. Potentially, recruitment efforts could focus on older people who may want to continue working, perhaps on a part-time basis, following formal retirement. The future availability of care workers may also be partially dependent on future immigration policy.

The role of the family in providing long-term care is critical in Ireland as in most other countries. To date, there is no evidence of a reduced commitment to family caring. The availability of informal carers (relative to the number of people in need of care) is, however, likely to reduce, due both to demographic change and increasing female labour participation rate. The demographic effect will be relatively slight over the next 25 years but very significant in the subsequent 25 years. The impact of increased labour force participation could reduce the availability of informal care by around 15% over the next 10 years.

The purpose of the cash benefit alternative proposed above would be to provide support for informal care. We therefore suggest that the cash benefit would not reflect the full cost of formal care services but would rather be set at a level consistent with the policy of supporting rather than substituting for informal care.

The question arises as to whether the cash benefit should be paid to the care recipient or the carer. We suggest that consideration be given to a flexible system whereby, following needs assessment, the person in need of care and their principal caregiver (if they have one) would select in-kind services or a cash payment or a mix and it would be determined whether the cash payments should be made to the care recipient or the carer.


### A template benefit design

For the purposes of discussion, we have set out one possible benefit structure. It is important to note that the suggested benefits outlined below would apply in respect of personal care needs arising from a significant level of dependency. Eligibility for benefits would be determined on the basis of an objective quantified needs assessment as outlined previously. Benefits would not therefore be payable to people with disabilities generally.

- Benefits for residential care for older people on the following basis:
  - Where the individual occupies a public bed, the full cost would be covered subject to a retention equal to 90% of the Non-Contributory Old Age Pension (NCOAP)
  - Where the individual occupies a private bed:
    - ▶ If the assessed level of need is for “continuous” care, a benefit equal to 90% of the nursing home charge less 90% of NCOAP, up to a maximum benefit of €375 per week
    - ▶ If the assessed level of need is “high”, a benefit of 90% of the nursing home charge less 90% of NCOAP, up to a maximum benefit of €225 per week.

- Benefits for home care:

Assessed level of need	Formal services to the value of:	Cash benefit alternative
Moderate	€113 per week	€68 per week
High	€225 per week	€135 per week
Continuous	€375 per week	€225 per week



The suggested benefits for residential care reflect current nursing home charges and take into account the principle that people should contribute towards accommodation and daily living costs just as they would if they were living in the community.

The benefits for home care services for moderate and high levels translate into an hourly rate of just under €11<sup>3</sup> based on the assumed number of hours of personal care required as set out in section 3. The benefit of home care services for people in need of continuous care has been linked to the benefit for private residential care. Similarly, the proposed benefit for private residential care for those with a high level of need has been linked to the corresponding home care benefit. This is intended to eliminate the bias towards residential care.

The cash benefit alternative, where formal services are not required, is set at 60% of the cost of formal services. This alternative is not intended as a payment for family care, but rather as a measure to support family carers. We would suggest that, in most cases, the long-term care benefit would replace the payment of Carer's Allowance or Carer's Benefit.

### **Linking housing needs to care provision**

There is scope for much more development of assisted living facilities. A public initiative could potentially be undertaken to increase this type of provision, having regard to the need to find an intermediate form of care – between home care and full residential care – in particular for older people living alone. A public/private partnership approach could involve:

- The Department of the Environment and Local Government legislating for appropriate planning regulations (e.g. that all developments above a prescribed size must involve a specified proportion of assisted-living accommodation).
- The Department of Finance perhaps providing a system of tax credits to building developers who meet specified criteria in relation to assisted-living accommodation.
- The Departments of Health and Children and Social and Family Affairs financing and/or providing the required health care and social services needed to enable the assisted-living programme to operate.

<sup>3</sup> O'Shea (2000) estimated the hourly cost of a home care attendant at £6.30 (€8) and of private personal assistance at £4.83 (€6.13). However, we understand that rates of pay have increased significantly.

## Financing options (Section 6)

### Pattern of care need

As a preamble to the consideration of financing options, we consider the pattern of care need in terms both of incidence and duration.

In the UK, it is estimated that the lifetime risk of needing residential care is 20% for a man aged 65 and 36% for a woman aged 65. We estimate that the overall probability that someone aged 65 will become so severely disabled as to require continuous care is 23% for a man and 44% for a woman. These probabilities may reduce in the future, if the incidence of disability reduces alongside improvements in life expectancy.

We estimate that the average duration of severe disability, where the age of onset of that level of disability is 75, is 3 years for a man and 5 years for a woman (note, however, that the stay in an extended care facility is significantly shorter than this, perhaps 2 years for a man and 3 years for a woman).

The degree of uncertainty in relation to the need for long-term care and, in particular, the duration of that need, is such that some form of risk pooling is the most efficient means of paying for long-term care.

### Financing options

We considered the following financing options:

■ Private savings, including residential property	■ Equity release – private ■ Equity release – public sector involvement ■ Estate tax
■ Private insurance	■ Premium/tax subsidies ■ Compulsory private insurance ■ Long-term care insurance as an employee benefit ■ Pension-linked financing
■ Public tax-based finance ■ Social insurance ■ Earmarked long-term care tax	

We describe and analyse each type of financing and draw the following conclusions:

### Private financing options

- |   |   |
|---|---|
| <b>Private savings</b>                                    | It is not practicable to expect people to provide for long-term care costs by means of savings or the accumulation of assets.   |
| <b>Equity release</b>                                     | Equity release products fulfil a valuable role in allowing people to use the value of their housing equity to fund care whilst remaining in their home. The State should seek to encourage further development of the equity release market, including pension fund investment.   |
| <b>Tax relief/premium subsidies for private insurance</b> | <ul style="list-style-type: none"><li>■ Private insurance can only address the long-term care needs of older people. Moreover, private insurance will not be available to everyone and will not be affordable for many.</li><li>■ Tax reliefs or premium subsidies are unlikely to stimulate the long-term care insurance market to the extent of catering for the long-term care needs of more than a relatively small proportion of the population.</li></ul>   |
| <b>Compulsory private insurance</b>                       | A system of compulsory private insurance has some similarities to a social insurance system. However, it would be more complex to implement and it is unlikely that the insurance industry would be keen to become involved with such a scheme. We conclude that it would not be an appropriate solution to financing long-term care in Ireland.  |
| <b>Long-term care insurance as an employee benefit</b>    | <ul style="list-style-type: none"><li>■ Long-term care insurance could become available to a wider section of the population if it were offered as an employee benefit.</li><li>■ It could be made mandatory for employers to provide access to long-term care insurance (similar to the proposed framework for PRSAs).</li><li>■ It is suggested that consideration should be given to the State providing an example to private sector employers by establishing a group long-term care insurance scheme for public sector employees. This would be particularly appropriate if a “partnership” financing model is adopted.</li></ul> |
| <b>Pension-linked financing</b>                           | <ul style="list-style-type: none"><li>■ Long-term care has a natural link with pensions.</li><li>■ Those who can afford to do so should be strongly encouraged to effect long-term care insurance when they retire. This could include allowing an additional tax-free lump sum to be taken to fund a single premium long-term care insurance policy.</li></ul>   |



## Public financing options

Two key issues arise in relation to benefits or services funded through general taxation: whether such benefits or services should be means-tested or universally available and whether eligibility for, or entitlement to, the benefits or services will be provided.

Means-tested public provision has the advantage of targeting public resources to those with the greatest need (both those on low incomes and those on higher incomes whose care needs are so extensive that their own resources become insufficient to meet the continuing costs of care). However, a means-tested system tends to work best where income is more unevenly distributed i.e. where services can be targeted on a small number of poor people. The incomes of the majority of older people fall within a relatively narrow range and it is likely that the distribution of incomes for younger adults with significant long-term care needs is not dissimilar. Hence, a universal approach to financing long-term care would arguably be more appropriate.

The argument for not means-testing benefits is stronger for home care than for residential care, since it may be difficult – if not impossible – to tap into housing assets to help pay for home care.

If an individual has a statutory entitlement to a benefit based on specified criteria, then that benefit must be provided, notwithstanding any budgetary constraints to which the public body charged with providing the benefit may be subject. If, however, an individual is eligible for a service or benefit, then it is possible that that service or benefit may only be provided if resources permit.

We conclude that:

- there are arguments in favour of providing long-term care benefits without means-testing or on a universal basis
- statutory entitlement to home care benefits must be introduced if the policy of maintaining people in the community insofar as is possible is to be achieved
- there is scope for demand and consequently costs to escalate if universal entitlement to benefits is provided; this highlights the vital importance of an objective and explicit needs assessment process.

### **Estate tax**

We believe that the option of an estate tax to fund long-term care benefits would not garner sufficient public or political acceptance to be a viable policy option.

### **Financing from general taxation: the status quo**

- General taxation accesses the broadest tax base, including total income, spending and capital taxation.
- However, it is likely to be difficult to raise additional taxes in order to enhance current long-term care provision.
- Benefits financed through general taxation are subject to budgetary constraints. Provision could be cut back if the economic climate were unfavourable.
- It would be difficult to provide universal benefits from general taxation due to budgetary constraints.
- Tax-based financing would not facilitate a partnership scheme.

### **Social insurance**

- Social insurance would provide a stable and lasting framework for long-term care provision. It would also raise public awareness of long-term care issues. This could help to encourage further private provision to supplement the basic social insurance benefits. In particular, it would facilitate a partnership scheme.
- Social insurance would eliminate means-testing for those whose contributions qualify them for benefits, but social assistance benefits would still be required for those who do not make contributions.
- The public may be more willing to pay additional social insurance contributions than higher taxes to fund long-term care.
- Social insurance contribution income is affected by the economic cycle. Hence, it may be necessary to supplement the social insurance fund from general tax revenues or borrowing during an economic downturn.
- We conclude that social insurance financing for long-term care would provide a reasonable “fit” in the Irish context. Moreover, the strong entitlement to benefit that social insurance financing would confer, along with earmarking of the contributions made to pay for the benefit, would, we believe, engender good public support.
- However, we would not consider it appropriate that the level of long-term care benefits provided should vary as between social insurance and social assistance beneficiaries, as this could imply the provision of different standards of care as between the two groups.

### **Universal benefits/ earmarked tax**

- Under such a scheme, the entitlement to benefits would have statutory backing and, while the entitlement would not be contingent on payment of the earmarked tax, there would be a perceived link.
- As with the social insurance option, the health levy could be used as the basis for developing this option. It is already earmarked for health care and could, in future, be earmarked more specifically for long-term care. Alternatively, or in addition, other forms of taxation could be earmarked for this scheme, for example tobacco or alcohol taxes.
- The advantages and disadvantages are largely the same as for the social insurance option, with the further advantage of eliminating the need for social assistance benefits.

### **Comparative analysis**

#### **■ Meeting long-term care needs in the medium and long term**

All of the public financing options are capable of meeting long-term care needs in the medium and long term, if taxation/PRSI rates are increased accordingly. However, funding through general taxation would be more vulnerable to periods of budgetary constraint. Also, there is likely to be a greater acceptance of additional social insurance contributions or an earmarked tax rather than an increase in general taxation.

Social insurance or an earmarked tax could eliminate most means-testing. This would do much to help address unmet need for long-term care benefits and services. Whilst the earmarked tax option is theoretically attractive, in that it could provide universal benefits without contribution criteria, it does not sit easily with current financing structures in Ireland. We therefore consider that social insurance would be a more robust option.

Finally, we consider that social insurance is the only viable platform from which to build a partnership scheme for long-term care financing.

#### **■ Reducing unnecessary recourse to institutional care**

Reducing unnecessary recourse to institutional care is more a question of the benefit design than the financing mechanism that is used to generate the funds to pay for benefits.

However, with a view to reducing unnecessary recourse to residential care, we consider that a statutory entitlement to home care benefits should be provided. Whilst this can be done regardless of the financing mechanism, the social insurance system would provide the strongest entitlement.

## ■ **Widening consumer choice**

Widening consumer choice is principally to be achieved by making the services and benefits that are available more flexible and more responsive to recipients' needs and preferences. However, we consider that social insurance financing would do most to widen consumer choice.

## ■ **Operational issues**

The operational issues are broadly similar across all of the potential financing options. In particular, the introduction of a national needs assessment process is a critical feature regardless of the financing mechanism. Also, the proposed provision of choice of provider and a cash benefit will give rise to significant operational issues, particularly for Health Boards. Additional resources may be required to administer these options.

Financing through social insurance would require an increase to current contribution rates. In addition, we would consider it appropriate that social insurance contributions should be paid by pensioners, since the need for long-term care typically does not arise for a number of years after retirement and there is a need to spread the cost as equitably as possible across generations. This would have operational implications, as, at present, pensioners do not pay contributions, except for the health levy.

Financing through a new earmarked tax would likely give rise to the most significant operational issues, as this is, effectively, a new concept that does not fit in with any current method of financing public services.

From an operational perspective, a financing method that did away with the need for means-testing would have a positive impact.

With regard to the transition to a new financing system, social insurance would most easily facilitate the phased introduction of benefit entitlement, should this be considered desirable.

Primary legislation is likely to be required for any of the financing options.

## ■ **Consumer preferences**

In the Eurobarometer survey around two thirds of Irish people who expressed a preference for public financing of long-term care selected tax-based financing whilst the remainder opted for "public insurance" (compulsory or voluntary). This probably reflects an expectation that any public financing of long-term care would be on a similar basis to health care financing. We consider that a public debate on the issues relating to the financing of long-term care would likely result in good public support for a social insurance approach, because of the strong entitlement to benefit that social insurance financing would confer.

We note also that the National Council on Ageing and Older People has recommended that "*social insurance be actively considered as the principal means of financing long-term care*".

In conclusion, we consider that social insurance financing offers most advantages.

Alternative benefits would be required for those who did not have a sufficient contribution history. Rather than means-testing such benefits independently, we suggest that they could be provided automatically to anyone in receipt of a non-contributory Old Age Pension (or an associated dependant's allowance) or a Disability Allowance. It is likely that this would cater for a very significant proportion of those who did not meet the contribution criteria for the social insurance benefit.

We suggest that contribution criteria similar to those that apply to Invalidity Pension would be appropriate as the need for benefit will arise as a result of a contingency rather than as a planned event, as in the case of retirement benefits. We would also suggest that consideration be given to making benefits available to children on the basis of a parent's contribution record. Such benefits could then continue into adulthood.

**Partnership  
options  
(Section 7)**

The cost of providing comprehensive long-term care benefits to everyone would be very significant and would likely not be affordable. It is therefore important to consider options whereby the costs of long-term care are shared between State and private financing. Most partnership options are more suited to the financing of long-term care for older people, so that the financing of care needs for younger people with disabilities might need to be catered for separately.

### **Voluntary social insurance**

Social insurance caters more readily for compulsory than voluntary participation and the administration of a voluntary scheme would clearly be very difficult. Moreover, it may not be feasible to provide only means-tested benefits for non-participants in a voluntary scheme. Consequently, we do not think a voluntary social insurance scheme would be a viable approach. However, it could be possible to start in this way with a view to extending the social insurance system to everyone in the longer term.

### **Mix of voluntary private insurance and taxation**

An alternative approach, operating from a somewhat different perspective, would be for the State to provide universal benefits from general taxation, but to strongly encourage those who could afford to do so, and who can obtain cover, to purchase private long-term care insurance, as an alternative to availing of State benefits. Those who chose not to effect private insurance would be liable for an additional long-term care tax, which would contribute to the cost of providing the State long-term care benefits.

**However, it is unlikely that this form of approach to financing long-term care would garner public acceptance in Ireland.**

### **Social insurance or universal benefits for home care only**

Another option would be to make public funding available for home care without a means-test and for residential care for older people with a means-test. This would reflect the fact that most older people have little spare income or capital when living at home, but capital from the home can be released when they move to residential care<sup>4</sup>.

**However, given the substantial costs associated with residential care, we consider that social insurance should include at least some cover for such care.**

### **Short-term social insurance benefits (“front-end cover”)**

“Front-end cover” would consist of social insurance benefits for a specified period of, say, one year. Financing for longer term needs for older people would only be made available on a means-tested basis. This would significantly alleviate the cost to individuals (and, indeed, would cover the full cost for many). Individuals with means in excess of the means-test threshold would need to make their own provision for care needs of more than a year’s duration.

A refinement of this approach, which we would favour, would be to provide home care without a means-test for an indefinite period, with residential care for older people being provided without a means-test only for the first year. This bias in favour of home care would be in keeping with the policy of favouring care in the community where possible. It would also reflect the fact that many older people have housing assets that may disqualify them from means-tested benefits but that cannot readily be used to pay for home care.

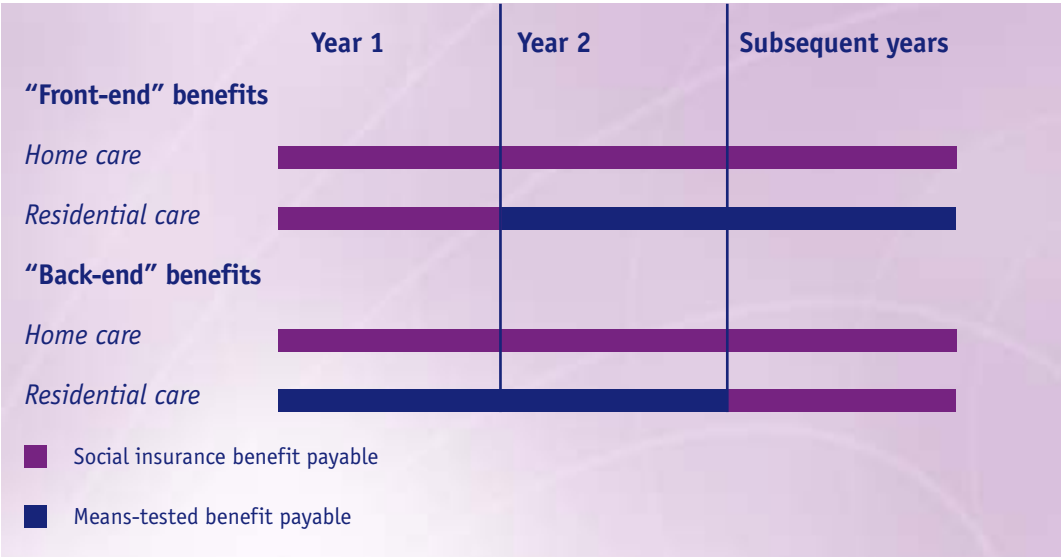
### **Catastrophic cover (“back-end cover”)**

This would involve the provision of benefits on a means-tested basis for an initial period, say two years. Social insurance benefits would be provided for care needed beyond the two year cut-off point. This would mean that those who would not satisfy a means-test would need to make their own provision for up to two years’ care. This should be manageable in most cases, through private long-term care insurance, equity release or savings.

As is the case with the “front-end cover” option, we believe that it would be desirable to provide social insurance benefits for home care throughout the duration of need, in order to make it as feasible as possible for the person to remain in the community.

<sup>4</sup> Wittenberg et al (2000). Note that, as at present, the means-test for residential care should not take into account housing assets if a spouse or other dependent is living in the home.

Comparison of “front-end” and “back-end” schemes



We consider that there is substantial merit in both the “front-end” and “back-end” options for social insurance benefits for residential care (we suggest that home care benefits should be provided for an unlimited duration). From the State’s perspective, either option would be significantly less expensive than providing social insurance benefits for residential care throughout the duration of need. Individuals should be able to make their own provision, in the case of the “front-end” scheme, through private insurance or sale of assets or, in the case of the “back-end” scheme, through savings or private insurance.

The “back-end” scheme provides a greater degree of risk pooling than the “front-end” scheme and would, undoubtedly, help to provide “peace of mind” to very many older people. On the other hand, it would likely be more difficult to administer than a “front-end” scheme. It also shelters the assets of the better off.

The “front-end” scheme is the more practical from an operational perspective and would support rehabilitation. It is also not unreasonable for a person, after a period of a year in residential care, to begin to spend down their assets<sup>5</sup>. If they do not wish to do so, they may effect private long-term care insurance to protect themselves against this eventuality. We therefore recommend that consideration be given to introducing “front-end” cover for residential care within a social insurance scheme for long-term care.

5      If their spouse were still living in their house, they would not be required to spend down housing assets, as these would be excluded from the means-test.

## Costings (Section 8)

We have estimated the cost of:

- current State provision for residential and home care, and
- providing the “template” benefits outlined in section 5, either:
  - without limit as to the duration of benefit
  - with benefits for residential care payable for a period of up to one year only (“front-end cover” as outlined in section 7)
  - with benefits for residential care payable only after an individual has been in residential care for two years (“back-end cover” as outlined in section 7).

### Estimated future cost of current State provision

€million – constant price terms

	Residential care	Home care			Overall	
		Home Help service	Carer's Allowance	Domiciliary Care Allowance	Total home care	
<b>2001</b>	277	86	129	21	235	513
<b>2011</b>	421	131	198	29	358	779
<b>2021</b>	663	193	291	37	521	1,184
<b>2031</b>	1,148	278	417	47	742	1,889
<b>2041</b>	1,926	395	593	58	1,046	2,971
<b>2051</b>	2,832	508	763	71	1,341	4,173



## Estimated future cost of template benefits – no limit on duration of benefit

€million – constant price terms

### Residential care

Dependency:	Moderate	High	Continuous	Total
2001	28	76	285	388
2011	42	115	432	589
2021	67	181	679	927
2031	117	316	1,170	1,604
2041	199	534	1,959	2,692
2051	295	789	2,882	3,966

### Residential and home care

Dependency:	Moderate	High	Continuous	Total
2001	324	261	890	1,475
2011	495	397	1,364	2,256
2021	727	595	2,053	3,375
2031	1,041	904	3,156	5,101
2041	1,457	1,353	4,813	7,623
2051	1,865	1,828	6,579	10,272

We then calculated the **additional** cost of the social insurance benefits over and above the cost of current benefit programmes as a percentage PRSI contribution as follows:

**Additional costs expressed as a percentage PRSI contribution (that contribution to be payable by employees, employers and the self-employed)**

	Central projection %	Static projection %	Optimistic projection %	Pessimistic projection %
2001	1.5	1.5	1.5	1.5
2011	1.5	1.6	1.4	1.6
2021	1.7	1.9	1.5	2.0
2031	2.1	2.5	1.8	2.7
2041	2.7	3.1	2.2	3.4
2051	3.1	3.7	2.6	4.1
<b>Equalised rate<sup>6</sup></b>	<b>2.1</b>	<b>2.3</b>	<b>1.8</b>	<b>2.5</b>

*Note that, in respect of employees, the total contribution rate, for example, in the period 2001-2011 would be 3.0% (1.5% payable by the employee and 1.5% payable by the employer).*

**“Front-end  
cover”**

**Cost of residential care benefits for a maximum of one year**

€million – constant price terms

	Central projection	Static projection	Optimistic projection	Pessimistic projection
2001	167	167	167	167
2011	259	268	243	275
2021	408	437	359	459
2031	732	810	603	873
2041	1,275	1,396	1,043	1,542
2051	1,908	2,080	1,556	2,356

These estimates suggest that the cost of providing residential care for up to one year only is in the range 43% - 48% of the cost of providing such care without limit as to the duration of care. In practice, however, it would be necessary to provide a means-tested benefit for those who require residential care for more than a year but do not have the resources to pay for it.

<sup>6</sup> *i.e. the level contribution rate which, if paid over the 50 year period, would fund the benefits payable over that period. The equalised rates have been calculated on the assumption that the surpluses which would arise in the earlier years of the period would be invested and would generate a return of 2% in excess of the rate of increase in earnings.*

**“Back-end  
cover”**

**Cost of residential care benefits available after an individual has been in such care for at least two years**

€million – constant price terms

	Central projection	Static projection	Optimistic projection	Pessimistic projection
2001	138	138	138	138
2011	203	215	192	220
2021	319	360	288	378
2031	521	622	444	671
2041	827	980	701	1,083
2051	1,186	1,402	1,003	1,589

These estimates suggest that the cost of providing residential care only beyond a two year duration is in the range 30% - 36% of the cost of providing such care without limit as to the duration of care. Again, it would be necessary to provide a means-tested benefit for those who require residential care for up to two years but do not have the resources to pay for it.

**Implementation  
issues  
(Section 9)**

Implementation issues to be considered include the following:

- For a social insurance approach, we would envisage that the Department of Social and Family Affairs would have responsibility for the financing of the scheme, whilst the Department of Health and Children would manage the delivery of services through the Health Boards.
- Funds could be allocated to Health Boards on a capitation basis, based on the number of beneficiaries of the scheme in each Health Board area, weighted by dependency level, rather than on the basis of a global budget as at present.
- There is a need to plan the overall supply of residential services on a national basis and to provide accordingly for some controls in relation to private sector developments.
- The development of a supply of independent home care provision would be beneficial both in terms of cost-effectiveness and widening consumer choice. Measures may be needed to stimulate the development of a market. For example, Health Boards could be required to outsource a certain proportion of home care service provision.
- We suggest an initiative to increase the supply of assisted living facilities.


- We recommend that a national information campaign be undertaken in relation to long-term care. There may be scope to pool public and private resources with a view to undertaking a joint information campaign.
- Transition issues in relation to entitlement to any new long-term care benefits would need to be considered.
- Options for preventive measures should be given further consideration under the auspices of the Department of Health and Children.
- We suggest that consideration be given to the establishment of a body that would undertake responsibility for:
  - overseeing the needs assessment process at national level
  - advising the Departments with regard to appropriate levels of benefit to be provided in respect of the various levels of dependency set by the needs assessment process
  - advising on the allocation of funds to Health Boards
  - monitoring the supply of independent residential and home care providers, the take-up of such provision by beneficiaries and the use of such provision by Health Boards to meet their own service commitments as well as the quality of provision
  - a National Information Campaign relating to long-term care insurance
  - liaison with insurance companies providing private long-term care insurance.

### Pre-Funding (Section 10)

Until recently, State pensions were provided on a pay-as-you-go basis. In 1999, however, the Government began partial pre-funding of Social Welfare and public service pensions. The public health care system continues to be funded on a pay-as-you-go basis.

The arguments for and against the pre-funding of long-term care are broadly similar to the arguments for and against the pre-funding of the State's pension liabilities. These have been set out in detail elsewhere (for example, in the report of the Commission on Public Service Pensions) and are rehearsed only briefly in section 10.

We consider that some element of pre-funding would be particularly desirable if a partnership financing model is adopted. This would provide assurance of the long-term nature of the Government's commitment to its role in the partnership. This in turn would provide a stable environment to facilitate the emergence of private financing vehicles and encourage private provision.



Whilst the establishment of a separate fund for long-term care could have greater benefits in terms of public perception, particularly vis-à-vis a partnership approach, we do not consider it to be a practical option.

Pre-funding for long-term care should therefore be incorporated into the National Pensions Reserve Fund.

<b>Activities of daily living (ADLs)</b>	personal care tasks, including bathing and washing, dressing, feeding, getting in and out of bed, getting to and from the toilet and continence management. The degree of difficulty people experience in carrying out ADLs (and IADLs, defined below) is a measure of their dependency.
<b>Assisted living facility</b>	a facility for people needing assistance with activities of daily living but wishing to live as independently as possible. Assisted living bridges the gap between living at home and residential care. Assisted living facilities provide residents with independent accommodation but offer help with ADLs such as eating, bathing, dressing, laundry, housekeeping, and assistance with medications.
<b>Community care</b>	care provided by health service professionals, in particular, public health nurses, and by home helps and personal care attendants, to people in their own homes.
<b>Disability prevalence rate</b>	the proportion of a particular population that is disabled. An age-specific disability prevalence rate refers to the proportion of the population in a specified age-group that is disabled.
<b>Disabled life expectancy</b>	the expected number of years of life that will be lived with disability i.e. total life expectancy less healthy life expectancy.
<b>Equity release</b>	a financial scheme to enable a householder to draw down some of the equity in the house. The amount drawn down is usually repaid when the houseowner dies or moves out of the house.
<b>Extended care bed</b>	a bed in an extended care facility.
<b>Extended care facility</b>	a Health Board geriatric, welfare or community hospital or a community nursing unit or a voluntary or private nursing home that is designated for the provision of extended care i.e. long-term care.
<b>Formal care</b>	paid care (which may be provided by public, private or voluntary providers).

## Glossary of terms

<b>Healthy life expectancy</b>	the expected number of years of life that will be lived free of disability i.e. total life expectancy less <b>disabled life expectancy</b> .
<b>Home care</b>	<b>personal care</b> or <b>practical help</b> provided to people in their own homes. This is sometimes referred to as care in the community or community care. However, the term <b>community care</b> has a specific application in the health services, and we therefore avoid its use in any other context.
<b>Instrumental activities of daily living (IADLs)</b>	domestic tasks such as shopping, laundry, housework, meal preparation and handling personal affairs.
<b>Informal care</b>	unpaid personal care and practical help, typically provided by family members and/or friends.
<b>Living costs</b>	the normal expenses of daily life: heat, light, food, laundry, cleaning and other sundry expenses.
<b>Nursing home</b>	an establishment that provides residential and nursing care for sick, disabled or frail older people. It may be run by the private or voluntary sector.
<b>Personal care</b>	assistance with the <b>activities of daily living (ADLs)</b> , including assistance with cognitive functions (e.g. reminding, for those with dementia).
<b>Practical help</b>	assistance with the <b>instrumental activities of daily living (IADLs)</b> such as meal preparation, cleaning and housework, shopping etc.
<b>Respite care</b>	temporary substitute care that provides a period of respite for an informal carer. Respite care may be provided in the form of residential or home care.
<b>Residential care</b>	care in an <b>extended care facility</b> .

# 1. Introduction

## Background

- 1.1 In its Review of the Carer's Allowance (1998), the Department of Social and Family Affairs considered a number of alternatives for the future financing of long-term care, both in the community and in institutions.
- 1.2 In the Review of its "Action Programme for the Millennium" in November 1999, the Government agreed that one of its key priorities would be:
  - To develop a "partnership model" to facilitate the development by the State, in conjunction with the private sector of an improved system for meeting long-term care costs.
- 1.3 Subsequently, Mercer was engaged by the Department of Social and Family Affairs to examine further the strategic issues involved in financing long-term care. Specifically, our brief was to examine three broad areas:
  1. The potential of the private sector or a combined public/private sector approach to assist in financing/funding long-term care.
  2. The potential of the PRSI system to finance/fund long-term care.
  3. Whether the current system of long-term care financing (through taxation) should remain the status quo.
- 1.4 We were asked to assess each approach against the following criteria:
  - Meeting long-term care needs in the medium and long term
  - Reducing unnecessary recourse to institutional care
  - Widening consumer choice
  - The general operational issues involved, including any practical issues arising.
- 1.5 The study was overseen by a Project Steering Group comprising officials of the Department of Social and Family Affairs, the Department of Finance and the Department of Health and Children.
- 1.6 We are pleased to submit our report and hope that it will both stimulate public debate on the issues and provide a useful input to future policy formulation.



## Report structure

- 1.7 **Section 2** provides the context for the study by defining long-term care and looking at who needs long-term care and the impact of demographic change. It also sets out in brief current arrangements for the financing and provision of long-term care in Ireland. **Section 3** reviews long-term care financing and provision in other countries and considers the lessons for Ireland. In **Section 4**, we outline the methodology that we have used to estimate the numbers needing long-term care in Ireland on the basis of population projections over the next 50 years. Projections of long-term care needs are provided on a number of different bases, both for the older population and for the overall population.
- 1.8 **Section 5** considers issues relating to a framework for needs assessment and the design of a long-term care benefit scheme. It includes consideration of whether benefits should be provided in the form of cash or services, issues relating to the support of family care. The link between housing needs and care provision and, in particular, the scope to develop “assisted living” facilities is also considered. **Section 6** sets out and analyses the various options for financing long-term care and **Section 7** considers partnership options.
- 1.9 **Section 8** provides costings and **Section 9** considers implementation issues. In **Section 10**, we assess the merits of some element of pre-funding long-term care costs.

## 2. Context

### What is long-term care?

- 2.1 In this section, we provide the context for our study by considering issues such as what is meant by long-term care, who needs it and the potential impact of demographic and social change. We also set out in brief current arrangements for the financing and provision of long-term care in Ireland.
- 2.2 Long-term care can be defined, very broadly, as care provided to those who are unable to look after themselves without support due to long-term physical disability or cognitive impairment disability. This may include any or all of the following:
1. Assistance with the instrumental activities of daily living i.e. activities such as cooking, cleaning or shopping (practical help).
  2. Assistance with the activities of daily living such as eating, dressing, bathing (personal care).
  3. Paramedical services such as chiropody, physiotherapy, speech therapy and occupational therapy.
  4. Medical services, including skilled nursing care and services provided by general practitioners and consultant geriatricians and encompassing assessment and rehabilitation as well as ongoing medical care.
- 2.3 Whilst the latter two clearly constitute health care services, the first two may be classified as social care. In some countries, for example, the UK and Denmark, personal care and practical help, are financed/provided by local authorities/ municipal government rather than through the health care system.
- 2.4 The primary focus of this study is the financing of social care services. This is because there is no particular reason to differentiate between the financing of medical and paramedical services for those with long-term disability and the financing of such services for those with other chronic conditions (for example, heart disease or cancer), nor would it be feasible to do so in practice. The financing of the medical component of long-term care is therefore outside the scope of this report.
- 2.5 It is important to note also that people with disabilities may have special needs other than the need for health and social care. Such needs could include, for example, special education needs or assistance with transport. These broader needs, beyond the need for personal care, are beyond the scope of this report.
- 2.6 Long-term care can be provided either in the recipient's own home or in an extended care facility. Intermediate options include the provision of care in sheltered housing or other "assisted living" type settings. Care provided at home can be provided either by paid i.e. "formal" service providers (from the public, private or voluntary sectors) or on an unpaid basis i.e. "informally" by family members and friends. In practice, at present, family members provide most long-term care in the recipient's home.

## Demographic change

- 2.7 Long-term care is needed by those with long-term disability. Such disability is more prevalent amongst older people, as health, and consequently, the ability to care for oneself, deteriorates with age. Hence, the long-term care needs of older people dominate total need. However, whilst the prevalence of disability is relatively low at younger ages, the number of those aged under 65 who need long-term care is not insignificant. Overall, around 40% of people with significant long-term care needs are aged under 65.
- 2.8 Whilst there is much common ground in terms of the long-term care needs of frail older people and of younger people with disabilities, there are also distinctly different issues to be addressed for the two groups and the nature of the care that they may require may be very different.
- 2.9 In practice, many countries organise the provision of services and benefits separately for the two categories. This is the case in Ireland, with some exceptions, such as the Carer's Allowance, which provides income support to carers of both older people and younger people with disabilities. There are different types of residential care facility and such care is financed under separate programmes for older people and for younger people with physical and intellectual disabilities respectively. Moreover, there are different divisions within the Department of Health and Children dealing with these different groups.
- 2.10 In this report, we have attempted to address the long-term care needs of both categories as uniformly as possible. All of our projections and costings cover all age groups, although in some instances we have also shown figures for the over 65 age group separately. However, we have excluded from our projections of need the estimated prevalence amongst the under-65s of severe intellectual disability requiring residential care, as it is unlikely that the provision of such facilities would be brought within the scope of a general programme for financing long-term care. It might have been appropriate to similarly exclude the prevalence of severe physical disability requiring residential care, but the necessary data was not available to facilitate this.
- 2.11 Our consideration of potential financing mechanisms is intended to address the needs of all age groups. Attention is drawn, where appropriate, to differences in the potential of the various mechanisms to address the needs of the different groups. For example, both savings and private insurance have at least some potential to meet the cost of care for frail older people but none to meet the cost of care for people who have been disabled from birth or an early age.

## Social change

- 2.12 Social change will also impact on long-term care needs and on how long-term care will be provided for future generations of older people. Smaller families will mean that there will be fewer offspring available to care for frail parents, although this may be offset, in part, by lower rates of emigration and fewer single elderly people (marriage rates for the current generation of older people were low). The significant increase in the proportion of women participating in the labour force will also undoubtedly reduce the availability of family carers.
- 2.13 As in other developed countries, the population of Ireland is getting older, due both to increasing life expectancy and lower birth rates. A growing proportion of the population will be aged over 65. Within this larger older population, a change that is sometimes referred to as the “ageing of the aged” is taking place. That is, an increasing proportion of the older population will be very old. This is expected to have a significant impact on the need for long-term care as well as the provision of health services generally.
- 2.14 However, whilst the overall need for long-term care will undoubtedly increase as the population ages, it is important to note that the health of future generations of older people will be a key determinant of the extent of the increase in long-term care needs.
- 2.15 Healthy life expectancy measures the number of years of life that will be free of chronic illness or disability. If healthy life expectancy increases at the same pace as total life expectancy, then the prevalence of disability amongst older people<sup>7</sup> will reduce and overall need for long-term care will not increase at as great a rate as the increase in the older population might suggest. If improvements in healthy life expectancy do not keep pace with improvements in total life expectancy, then the overall need for long-term care will increase at a greater rate. On the other hand, if increases in healthy life expectancy outstrip increases in total life expectancy i.e. if future generations experience fewer years of ill-health at the end of life, then the overall need for long-term care may not increase very much.
- 2.16 A world-wide debate has been taking place about health expectancy trends. Whilst comparative data is limited and the trends are not entirely clear-cut, on balance, international studies suggest that healthy life expectancy is increasing such that the extra years of total life expectancy are free of severe disability.
- 2.17 For the purpose of this study, we have carried out projections on the basis of a range of assumptions about future trends in healthy life expectancy.

<sup>7</sup> *i.e. the proportion of older people that suffer disability*

2.18 On the other hand, the needs, expectations and preferences of future generations of older people may be very different:

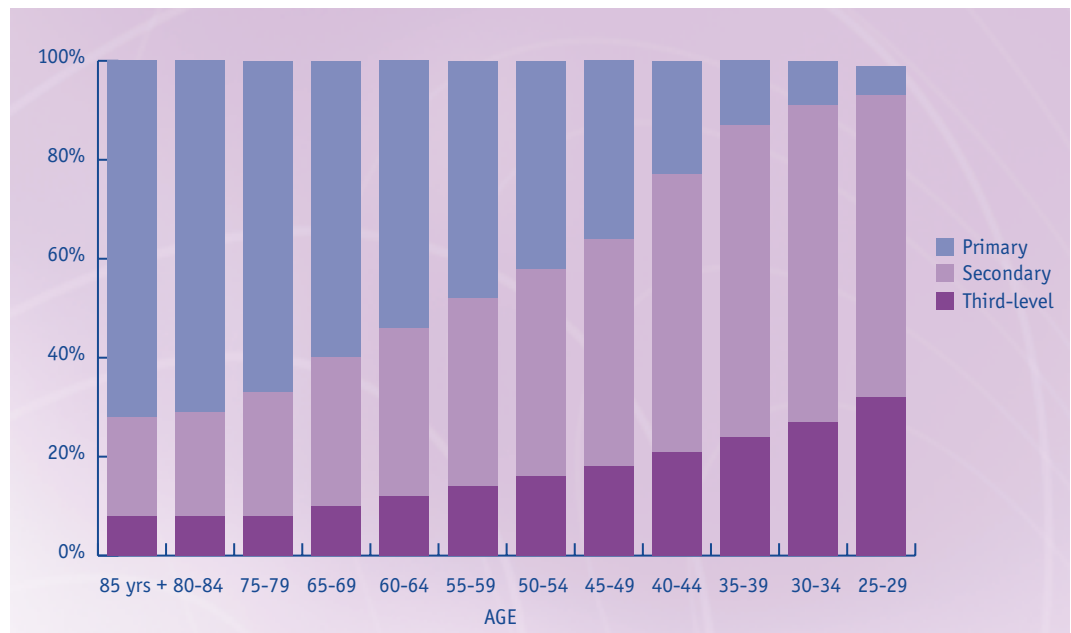
- Future generations with long-term care needs will come from the “consumer society” and may have higher expectations for their care provision as a result. On the other hand, their expectations as to what the State will provide and what provision they will need to have made for themselves will have been shaped by public policy during their working lifetimes and active retirement.
- Future generations will, on average, have a higher level of educational attainment (see the chart below) and have experienced greater economic prosperity. Many will have experienced greater diversity in their careers and have engaged in “lifelong learning” activities. They will have more experience of technology. These factors may impact in a number of ways. For example, the Berlin Ageing Study has found that a higher level of education reduces the likelihood of suffering dementia in later life<sup>8</sup>. They will have a higher level of supplementary provision than the current generation and may therefore have greater resources available to meet long-term care costs.
- On the other hand, increasing social polarisation may mean that a segment of the older population will be particularly disadvantaged, in terms both of significantly higher long-term care needs<sup>9</sup> and poor resources to meet those needs.
- Older people will form a much greater proportion of the population than at present. This, in itself, will give rise to attitudinal changes.

2.19 All of these factors will impact on the kind of long-term care that people will want, and will have available to them, in future in ways that are difficult to predict at this stage.

<sup>8</sup> Baltes & Mayer, 1999, *The Berlin Ageing Study: Ageing from 70 to 100*

<sup>9</sup> *The strong link between socio-economic and health status is well-established.*

**Highest level of education completed, 1996**



Source: Central Statistics Office

2.20 Technological change will also impact on future long-term care needs. New technologies may enable people with disabilities to have more independence and may reduce their need for long-term care. For example, technologies that are already available include devices for opening windows, turning taps on and off, raising and lowering work surfaces, setting alarms, turning off lights and monitoring whether people are moving and may or may not need help.

2.21 Information technology also facilitates the provision of new services, for example, Internet shopping, that may give increased independence to frail older people and people with disabilities.

### Current financing and provision

2.22 Currently, formal long-term care in Ireland is financed publicly from general taxation (as is the public health care system generally) and privately on an out-of-pocket basis. Recently, "equity release" products have become available which enable those who own their own property to release part of its value to pay for care.

2.23 The public health care system provides both residential and community services for those in need of long-term care. However, whilst stated Government policy is to maintain people in the community insofar as it is possible, in practice, funding arrangements still favour residential care.

## Residential care

- 2.24 Under the Health Act 1970 (as amended), the whole population is eligible for “in-patient services”, including extended nursing care. Section 52 of the Act requires Health Boards to “make available” in-patient services to eligible persons. However, the circumstances under which in-patient services are to be made available is not specified. In practice, the availability of such services has been, and continues to be, subject to budgetary constraints.<sup>10</sup>
- 2.25 Health Boards provide such care for older people in a variety of settings including geriatric, welfare and community hospitals and community nursing units. However, there are insufficient public extended care beds to cater for all those requiring residential care.
- 2.26 Under the Health (Nursing Homes) Act, 1990, Health Boards are empowered to make a contribution (“subvention”), on a means-tested basis, towards the cost of private nursing home care for dependent older people. The three levels of assessed dependency that qualify for a subvention are set out in the table below.

Dependency		Weekly subvention (from April 2001)
<b>Medium</b>	A person who requires care because the appropriate support and nursing care required cannot be provided in the community. Their mobility would be impaired to the extent that they would require supervision or a walking aid.	€114.30
<b>High</b>	A person who requires nursing home care but is not bed-bound. The person may have a combination of physical and mental disabilities, may be confused at times and be incontinent. He or she may require a walking aid and physical assistance to walk.	€152.40
<b>Maximum</b>	A person who requires constant nursing care. The person is likely to have very restricted mobility, require assistance with all aspects of physical care or be confused, disturbed or incontinent.	€190.50

- 2.27 To receive the maximum subvention appropriate to their level of dependence a person would need to have income that is less than 120% of the non-contributory Old Age Pension (i.e. €160.80 from April 2002). All income is assessed as means (but an amount equal to 20% of the non-contributory Old Age Pension is disregarded).

<sup>10</sup> Sections of the Health (Amendment) (No. 3) Act 1996 require that Health Boards (their Chief Executive Officers) do not spend in excess of their annual budgets / allocations.

- 2.28 All assets are taken into account, except for the first €7,618. The person's home may be included in the assessment unless it is occupied by a spouse, dependent child or a relative who is in receipt of a social welfare payment. An imputed annual income equivalent to 5% of the estimated market value of the person's home is taken into account. The Health Boards are not required to pay a subvention if the person has assets, excluding their personal residence, of €25,395 or more or if the value of their home is €95,230 or more and their income is greater than €6,349 per annum.
- 2.29 The practice of taking into account the capacity of any of the individual's children to contribute towards the cost of nursing home care has been discontinued.
- 2.30 If the person's means are assessed as less than the weekly rate of non-contributory Old Age Pension<sup>11</sup>, the Health Board may pay an amount additional to the normal subvention not exceeding the rate of non-contributory Old Age Pension<sup>12</sup>. We understand that there is considerable variation between the Health Boards as to the extent to which such enhanced subventions are payable in practice.
- 2.31 Private nursing home charges vary considerably (from around €300 to €900 per week). Data provided by the Department of Health and Children indicates that average charges for the country as a whole were of the order of €400 per week in 2000 (with an average in the Dublin region of around €500 per week).<sup>13</sup> However, charges have apparently increased considerably over the past 18 months. We understand that the average charge in the Dublin region is now around €620 per week, indicating that the average charge for the country as a whole is now around €500 per week. Hence, the level of subvention currently payable is generally insufficient to bridge the gap between income and the actual cost of care.

A person whose only income is the non-contributory Old Age Pension (€134 per week from April 2002) will receive the maximum subvention.

Cost of private nursing home	€500.00
Subvention	€190.50
Income	€134.00
Total	€324.50
Shortfall	€175.50

<sup>11</sup> This may occur because the means of a married person are assessed as half of the joint means of the person and their spouse.

<sup>12</sup> Article 10.6 of the Nursing Home Subvention Regulations (1993), as amended.

<sup>13</sup> Although the rate of subvention varies by level of dependency, we understand that the majority of nursing homes do not vary their charges in this way.



- 2.32 In the Dublin region, the shortfall for those dependent on the non-contributory Old Age Pension and eligible for the maximum subvention is likely to be around €300 per week. This does not take into account the person's need to retain a small amount of money for personal needs (although that need is, on the surface, recognised by the provision for disregarding income equivalent to 20% of the non-contributory Old Age Pension within the means-test for the subvention).
- 2.33 Furthermore, someone with an income of €350 per week or more may not qualify for any subvention, but that income will likely not be sufficient to meet the cost of nursing home care.
- 2.34 In contrast, those who receive care in public extended care facilities are only required to contribute part of their income towards the cost of care<sup>14</sup>, up to a maximum of 80% of the non-contributory Old Age Pension. Also, the value of their housing assets is not taken into account.
- 2.35 This can lead to inequity in the treatment of older people who are placed in public and private extended care beds. As an example, consider an individual who has a house worth €125,000. If he or she is allocated a public extended care bed the maximum that he or she will have to pay is around €5,500 per annum. If, on the other hand, a public extended care bed is not available and the individual is admitted to a private nursing home, he or she may not qualify for any subvention because of the value of the house. Hence, his or her costs may amount to around €26,000 per annum, based on the average cost of a private nursing home.
- 2.36 We understand that public extended care beds tend to be occupied by those with the highest levels of dependency - due to the higher levels of nursing care that are generally available in public extended care facilities - albeit that some such residents could afford to pay for private nursing home care. Moreover, given that there is uncertainty surrounding the eligibility of older people for long-term residential care<sup>15</sup>, it may in practice be difficult to ensure that public extended care beds are occupied by those whose need is greatest, whether in terms of dependency or financially.
- 2.37 We note, however, that the Health Strategy *Quality and Fairness: A Health System for You, 2001* provides for a review of legislation with the objective of providing a clear national framework for entitlement to health and personal social services. It is noted in the Strategy that the Ombudsman has drawn attention to the uncertainty surrounding the eligibility of older people for long-term residential care.

<sup>14</sup> This depends on whether they are deemed to be receiving in-patient services (in which case they are only subject to charges if they do not have a medical card and do not have dependants) or institutional assistance (i.e. "shelter and maintenance in a public institution") in which case they have to contribute to the cost of such assistance in so far as they are able. Although, traditionally beds in welfare hospitals were assistance beds, the distinction has never been very clear.

<sup>15</sup> See, for example, the Ombudsman's report on Nursing Home Subventions (January 2001).

It is stated that “clarification of entitlement in this regard will be given particular attention in the general review of legislation on entitlement.” The Strategy also states that subvention rates payable in private nursing homes will be reviewed.

2.38 Finally, it should be noted that the Health Boards may contract beds from private nursing homes.<sup>16</sup> A private bed may be contracted, for example, in order to provide residential care as close as possible to an individual’s community, or as a practical solution where the person cannot bridge the gap between the nursing home subvention and the cost of private nursing home care. Contracted private beds are categorised separately from both public and private subvented beds. Health Boards negotiate rates of payment for contracted beds with the individual nursing homes concerned; we understand that these rates would generally be somewhat less than the nursing home’s regular charges.

2.39 The Department of Health and Children have provided us with the following information in relation to the number of extended care beds for 2000:

Health Board extended care beds <sup>17</sup>	9,699
Private nursing homes:	
■ Health Board contracted beds	1,281
■ Subvented beds	6,196
■ Other beds	5,160
<b>Total</b>	<b>22,336</b>

2.40 The total number of extended care beds has increased by 20% since 1994, with the bulk of this increase occurring in the private sector.

2.41 The most recent year for which data on occupancy rates are available is 1996, when the national occupancy rate was 93%. This compares reasonably favourably with international occupancy rates for nursing homes. In the US, for example, the average occupancy rate was 87% in 1995.

2.42 In 1996, the percentage of all people in extended care beds who were aged 65 and over was 94.6%.<sup>18</sup> Assuming that this percentage and the occupancy rate have remained stable, there are an estimated 19,650 people aged 65 and over in residential care.

<sup>16</sup> Article 22 of the Nursing Homes (Subvention) Regulations, 1993 as amended

<sup>17</sup> excluding convalescent, respite, assessment and rehabilitation beds

<sup>18</sup> Department of Health, 1996, Long-Stay Activity Statistics

### Level of dependency of those in residential care, 1996<sup>19</sup>

	Low %	Medium %	High %	Maximum %	Total %
Health Board beds	10	21	30	38	100
Voluntary geriatric homes	17	21	28	33	100
Private nursing homes	13	24	30	31	100
Total	13	22	30	35	100

2.43 Whilst the table above indicates that the level of dependency is not that different as between public and private extended care facilities, there is anecdotal evidence to suggest that average dependency levels within the private sector may be lower than is suggested by the table above. Given that the amount of the subvention available to private nursing home residents who satisfy the means-test varies by dependency level, it is suggested that there may be a tendency for people to be placed in the higher dependency categories in order to qualify for higher subvention payments.

2.44 Residential care is also provided, generally in separate facilities, for younger people with physical and intellectual disability. In 1996, approximately 8,000 people with intellectual disabilities were in receipt of care in a residential setting. Information in relation to the number of people with physical disabilities who receive care in a residential setting was not provided to us. The data set out above in relation to extended care beds does not include residential places for people with physical or intellectual disabilities.

### Community and home care services

2.45 Community and home care services include community nursing, home helps, respite services, day care centres and meals services together with paramedical services such as physiotherapy, occupational therapy, chiropody and speech therapy.

2.46 Under the Health Act 1970, Health Boards are empowered but not obliged to provide community care services. Given the discretionary nature of such services, there are, at a national level, no eligibility criteria or rules in relation to charging for services. Currently, access to these services is limited and variable within and among regional Health Board areas.<sup>20</sup>

<sup>19</sup> Department of Health, 1996, *Long-Stay Activity Statistics*.

<sup>20</sup> Ruddle, Donoghue and Mulvihill, 1997, *The Years Ahead Report: A Review of the Implementation of its Recommendations*.

2.47 The Department of Health and Children has provided significant additional resources to the Health Boards in recent years in order to improve the provision of community care services. However, notwithstanding the development and expansion of service provision within the community over the past few years, there is a significant contrast between the nursing home subvention scheme, which provides a statutory entitlement to benefit on the basis of specified criteria, and community and home care services, which remain essentially discretionary.

2.48 As previously noted, the Health Strategy 2001 provides for a review of legislation relating to eligibility/entitlement, which may address this issue. Specifically, the Strategy proposes the introduction of a home subvention scheme for the care of older people at home:

*“The Government intends reforming the operation of existing schemes, including the Carer’s Allowance, in order to introduce an integrated care subvention scheme which maximises support for home care...Having considered these proposals in the context of all of the actions outlined in the Strategy, the Government has committed itself to introducing these changes over a number of years.”<sup>21</sup>*

### Community nursing

2.49 Community nursing is a key service in maintaining older people and other groups in the community rather than in residential care. However, the workload of public health nurses is such that routine visiting of older people and other groups requiring long-term supportive care is necessarily restricted. In 2000, there was a total of 1,422 community nurses. We estimate that this represents a ratio of the order of 1 community nurse to 50 older people with “more than occasional” long-term care needs.

2.50 According to a recent report on Health and Social Services for Older People (HeSSOP)<sup>22</sup>, a survey of older people found that 15% had been visited by a public health nurse in the previous 12 months and the median number of visits per person was three. 27% of those visited had a visit at regular intervals, such as once a month or once a week. However, 48% were visited only once or twice in the previous 12 months.

2.51 Community nursing services are not means-tested and are free of charge.

### Home helps, home care assistants and personal assistants

2.52 Home helps provide help with household tasks, such as cooking and cleaning, and may also provide assistance with personal care such as washing and dressing. Some Health Boards also provide home care assistants whose specific role is to provide assistance with personal care. However, overall provision is low relative to

<sup>21</sup> Department of Health and Children, 2001, *Health Strategy Quality and Fairness: A Health System for You*

<sup>22</sup> Garavan, Winder and McGee, 2001, *Health and Social Services for Older People (HeSSOP)*

the number of dependent people living at home. Around 16,000 older people received a home help service in 2000. Each recipient received, on average, eight hours help per week.

- 2.53 Home helps are provided on the basis of assessed need, taking into account medical and income factors and family circumstances. In practice, it appears that people who are living alone are more likely to receive home help. Recipients may be asked to contribute to the cost of the service if they are deemed to have sufficient means to do so.
- 2.54 Personal assistance services are provided to people with physical disabilities to enable them to live as independent a life as possible. Personal assistants provide assistance at the discretion and direction of the person with the disability both in and outside the home.

#### **Meals-on-wheels**

- 2.55 Meals-on-wheels are provided almost entirely by voluntary groups who are grant-aided by Health Boards. The HeSSOP report found that 1% of those surveyed received a meals-on-wheels service, on average three times per week.

#### **Day services**

- 2.56 Day services for older people may be provided in day hospitals, day care units or day centres or clubs. Typically, day hospitals and day care units provide a more “medical” service, where physiotherapy, chiropody, etc. may be provided. Day centres, on the other hand, have more of a social emphasis. The majority of centres are operated by voluntary bodies with grants from Health Boards. The Health Boards may also fund transport to and from day centres. There are currently approximately 4,700 places available in approximately 200 day centres. Separate day services are provided for younger people with physical and intellectual disabilities.

#### **Paramedical services**

- 2.57 Services such as physiotherapy, chiropody, speech therapy and occupational therapy are also important elements of long-term care. Chiropody is particularly important, given the potential for problems with feet (highly prevalent amongst older people) to impede mobility. In practice, however, these services are provided only to a limited degree outside of the residential and day hospital settings. The HeSSOP report found evidence of significant unmet need for paramedical services:

### Percentage of respondents who reported service needs

	Used service	Used service, but would have liked to receive more <sup>a</sup>	Did not use service, but would have liked to <sup>a</sup>
	%	%	%
Physiotherapy	3	8	5
Occupational therapy	<1	14	1
Chiropody	16	14	12
Speech therapy	<0.5	0	1

<sup>a</sup>percentage calculated from the total number of people who answered these sections.

### Respite care

- 2.58 Respite care provides an informal carer with a “respite” from caring, either for a number of hours at a time (e.g. “night sitting”) or for a number of days (e.g. holiday relief). There is a considerable amount of unmet need for respite care.<sup>23</sup>
- 2.59 Provision of respite care in the care recipient’s home is underdeveloped. There is a relatively small number of respite beds available in Health Board extended care facilities. The Department of Health and Children has provided additional funding in recent years to improve respite provision and all new community nursing units now have a number of beds earmarked exclusively for respite purposes. The Health Strategy 2001 proposes that a grant be introduced to cover two weeks’ respite care per annum for dependent older persons, with the detailed arrangements for the operation of this scheme to be worked out with the Department of Social and Family Affairs.

### Sheltered housing and boarding out

- 2.60 Sheltered housing – or “an assisted living facility” – has the potential to bridge the gap between living independently at home and residential care. Assisted living facilities form an important component of long-term care provision in the Scandinavian countries and are becoming increasingly popular elsewhere, most particularly in the US.
- 2.61 To date, voluntary housing organisations have provided the majority of sheltered housing in Ireland. There is a variety of sheltered housing schemes with considerable differences in size, design, on-site facilities and community care services provided. Ruddle et al (1997) found that: “most of the purpose-built housing for older people does not address special needs or provide supportive communal facilities and services”.

2.62 Capital funding for the development of such facilities falls within the remit of the Department of the Environment and Local Government. However, there is no defined scheme of revenue funding.<sup>24</sup> The nursing home subvention is not available to residents of sheltered housing schemes. The Department of the Environment and Local Government has indicated that the absence of a funding scheme for ongoing care and management costs represents a serious threat to the continued viability of many existing voluntary sector sheltered housing projects as well as being a disincentive to further activity in this area.

2.63 Boarding out is an option that has been tried in some Health Boards and is suited to older people who can no longer live on their own but who do not need personal care. Carers who provide accommodation for an older person receive a weekly payment from the Health Board towards the cost of placement while the older person pays a similar amount from his or her pension.

#### Informal care

2.64 Most long-term care is informal care provided by family members and friends. Usually, the burden of care falls primarily on one principal carer. Typically, that principal carer is a spouse or offspring of the care recipient. Data from the Census pilot in 2001 suggests that 52,000 people provide 20 or more hours unpaid personal care per week and a further 79,000 people provide 1 – 19 hours unpaid personal care per week.

#### Carer's Allowance

2.65 The principal financial support for carers is the Carer's Allowance. This is a means-tested allowance that is provided as income support to carers who look after older or disabled people who need full-time care and attention. The amount of the Carer's Allowance is €122.60 from January 2002 with an additional amount for carers aged over 65 and for each child dependent upon the carer. The allowance is increased by 50% if the carer is looking after more than one person. An annual Respite Care payment (€635 from June 2002) is made to all recipients of Carer's Allowance in June each year. Carers are also entitled to the free schemes (i.e. free travel, free TV licence, telephone and electricity/gas allowances) valued at approximately €725 per year.

2.66 Expenditure on the Carer's Allowance was €130.3 million in 2001, with approximately 19,000 carers receiving the allowance.

<sup>24</sup> Justin O'Brien, 2001, "Linking Housing and Care in the Community", Paper presented to the Irish Council for Social Housing Biennial National Social Housing Conference.

## Carer's Benefit

2.67 An individual who leaves the work force to care for an older or disabled person is now entitled to carer's leave with a social insurance benefit of €132.70 per week (from January 2002) for up to 15 months, which may be taken in separate periods. Employees who exercise their right to carer's leave are entitled to return to their job at the end of the period. The provision of paid leave for the purposes of caring for this duration is, as far as we are aware, unique to Ireland. Sweden has a similar benefit, but it is only available for up to 30 days in the lifetime of the care recipient. Expenditure on the Carer's Benefit was €2.5 million in 2001 with 425 carers receiving the benefit.

## Domiciliary Care Allowance

2.68 Domiciliary Care Allowance is paid to the carer of a child with a severe disability who is living at home. It is payable up to the age of 16 at the rate of €152 per month. Only the child's means, if any, are assessed.

### Cost of current programmes

2.69 The table below sets out estimated expenditure in 2001 for some of the current long-term care benefit programmes.

	Estimated expenditure 2001 €000
Public long-stay residential care	270,552
Contributions to patients in private nursing homes i.e.	93,081
■ Nursing home subvention scheme	
■ Publicly contracted beds in private nursing homes	
Home help service	85,672
Meals-on-wheels services	5,296
Carer's Allowance	130,300
Domiciliary Care Allowance	20,697 <sup>25</sup>

2.70 Other areas of public expenditure in relation to long-term care services include:

- Public health nursing programmes (while public health nurses provide services other than to older and disabled people, the bulk of their time is related to long-term care need).
- Paramedical services such as physiotherapy and chiropody that are provided in the community.

<sup>25</sup> This figure relates to 2000. An estimate for 2001 was not available.



- Residential facilities for younger disabled people.
- The cost of housing adaptations under various programmes.

## Tax Allowances

2.71 There are a number of income tax credits and allowances that are available in relation to long-term care.

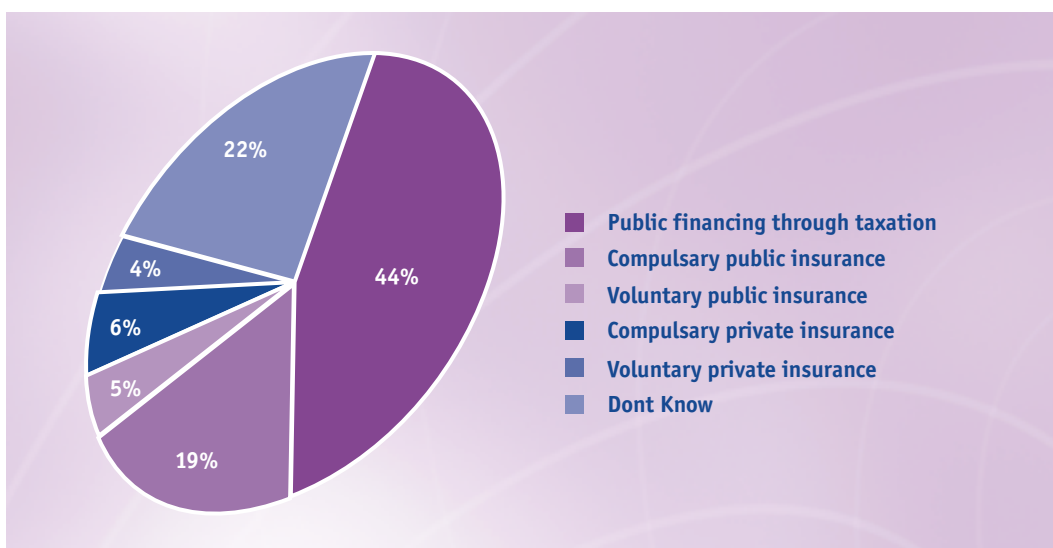
Home Carer's Allowance	Available to those who are at home caring for one or more dependent persons. Tax credit of up to €770 per annum at standard rate
Employing a carer	Allowance of up to €30,000 per annum at marginal rate. May be shared between two or more of the care recipient's family members. The person receiving care must be totally incapacitated throughout the tax year
Medical expenses relief	Relief at marginal rate on medical expenses, including the cost of nursing home care, may be claimed either by the care recipient, or by someone who is paying for care for a dependent relative
Incapacitated Child Allowance	Tax credit in respect of the cost of caring for a permanently incapacitated child up to a maximum of €500 per annum
Dependent Relative Allowance	Tax credit of €60 per annum for those with a dependent relative whose annual income is less than a specified amount
Blind Allowance	Tax credit of €800 per annum plus an additional allowance for a guide dog
Covenant relief	Unrestricted relief available on covenants to permanently incapacitated adults. Relief is also available on covenants to persons aged over 65 subject to a maximum of 5% of the income of the donor
Disabled driver scheme	Tax free cars and petrol for disabled drivers (or passengers, where cars have to be specially adapted)

## Public attitudes to long-term care financing

2.72 In the 2001 Budget, tax relief – at standard rate – was introduced for qualifying long-term care insurance policies. To date, however, no such insurance policies have become available.

2.73 Finally, the attitudes of the Irish public in relation to long-term care financing will be important in considering the various financing options. The pie chart below summarises the findings of a Eurobarometer survey carried out in 1993. The purpose of the survey was to gauge public attitudes within the EU to issues related to ageing.<sup>26</sup> The response of the Irish public was strongly in favour of public coverage. The most favoured option was tax-based financing (44%), followed by compulsory public insurance (19%), compulsory private insurance (6%) and voluntary public insurance (5%). Only 4% thought that long-term care should be financed through private insurance.

### Irish response to Eurobarometer survey - How should long-term care be financed?



2.74 It is important to note that across the range of countries surveyed, whilst public financing was universally preferred, the financing option chosen most often generally coincided with the method of financing health care in that country (see section 3.33). We believe that this reflects an inherent expectation that any public financing of long-term care would be on a similar basis to long-term care financing, rather than there necessarily being a strong preference for one form of public funding over another. With respect to Ireland, we consider that the option of “compulsory public insurance” would probably not have been well understood by many of the survey respondents. It is noteworthy also that a very significant proportion (22%) of Irish respondents didn’t know which option they preferred (compared with an average of 11.6% across the 12 EU countries).

<sup>26</sup> Walker, 1993, *Age and attitudes – main results from a Eurobarometer Survey*, Commission of the European Communities

2.75 Research carried out in Ireland by Swiss Re some years ago asked people whose parents were still alive who they would expect to care for their parents if they ever needed long-term care. 58% expected that they or another member of their family would provide the care; women (63%) were more prepared to undertake such a commitment than men (52%). A further 20% expected to help finance private nursing care for their parents. 10% expected the State to provide care and 6% expected their parents to pay for care themselves. This indicates that whilst there is a strong desire for State financing of long-term care, there is little expectation that this will be available and/or a continuing preference to provide care within families.

### 3. Review of international approaches

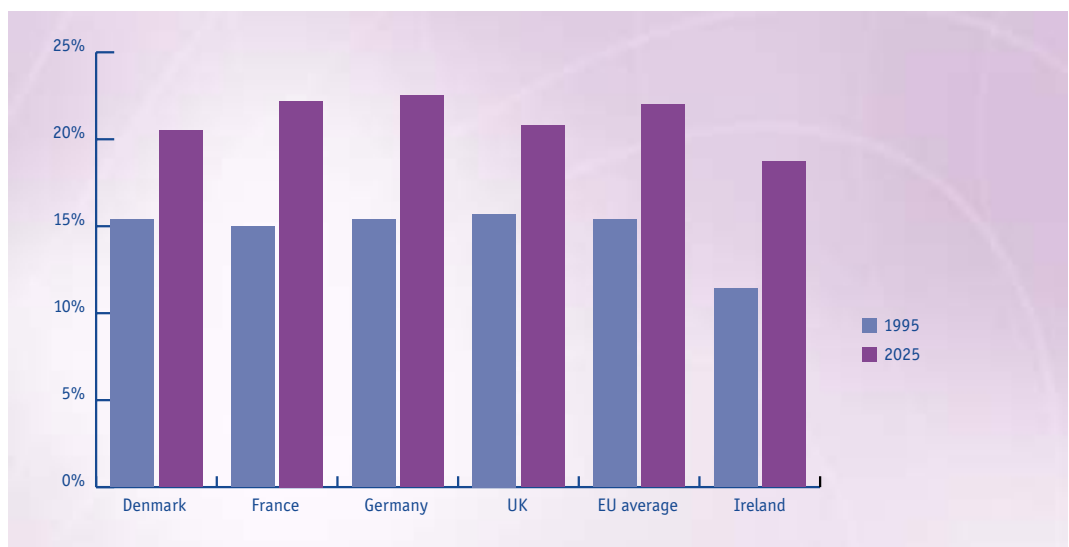
#### Introduction

- 3.1 The challenges that we face in Ireland in relation to the financing and provision of long-term care are by no means unique. Indeed, in most other EU countries, in North America and in Japan the problems are much more pressing as their older populations are already proportionately much larger than ours. It is useful, therefore to review the approaches that other countries have adopted or are considering.
- 3.2 Appendix II provides a synopsis of the system of long-term care financing and provision, along with details of current reforms, for each of 13 countries. These demonstrate the diversity of approaches to the issue of long-term care, depending on a range of factors, including, for example, the nature of social protection in the countries concerned, different cultural expectations and the impact of social and demographic change. In this section, we attempt to draw out the principal themes across the international spectrum. We then go on to consider the lessons to be gleaned for Ireland from international developments.

#### The changing policy context

- 3.3 Most developed countries have an ageing population. This is due to the combined effect of declining overall birth rates (exacerbated by later family formation) and increasing life expectancy for older people (i.e. individuals are living longer than they used to). The increase in the older population means that there are more people in need of long-term care. This, in turn, has moved the issue of long-term care into the front line of policy debate in many countries.
- 3.4 The chart below shows the proportion of the total population that is over age 65 in a number of European countries and the expected growth in the older population from 1995 to 2025. Ireland, in fact, has by far the smallest older population within the EU and this will continue to be the case for a considerable period into the future.

**Population aged 65 and over as a percentage of the total population**



- 3.5 In terms of long-term care, however, it is the very old that have the most need for services. The chart below shows the proportion of the population that is over age 80. Again, Ireland has the smallest proportion in this age category. Moreover, although the number of Irish people over age 80 is projected to grow very significantly over the next 25 years, the projected level of growth will only bring us to broadly the position that many other European countries are already in.

**Population aged 80 and over as a percentage of the total population**



### Social factors

- 3.6 Even today, in most countries, the majority of long-term care is provided informally, by the family (particularly female family members) and friends of those in need of care. There are concerns that the proportion of care provided informally will reduce, due to:
- Fewer offspring being available to care for the future generations of older people, as a result of falling birth rates.
  - Increased participation by women in the labour force resulting in less availability to provide informal care.
  - The trend for more elderly people to be living alone, which increases their need for formal home care and perhaps residential care also.

## Residential care

- 3.7 The table below shows the usage of long-term care services, in institutions within the OECD.

### Proportion of older people receiving long-term care in institutions in OECD Countries, early 1990s

6.5% or above	Canada Finland Luxembourg Netherlands New Zealand Norway
5.5% – 6.4%	Australia Denmark Japan
4.5% – 5.5%	Austria Belgium France Germany Ireland Sweden United Kingdom United States
1.0% – 4.4%	Italy Portugal Spain
Less than 1%	Greece Turkey

Source: OECD, 1996

Note: Unweighted average of 20 Countries (not including Greece and Turkey) = 5.5% of older people.

- 3.8 Ireland's usage of residential care for dependent older people is in the normal range within the OECD (an estimated 4.6% of those over 65 occupy extended care beds compared with an equivalent figure of 5.3% for the UK<sup>27</sup>). As our over 65 population is, on average, younger than in many of the other countries, it can be expected that the proportion of older people in residential care will rise as the proportion that is very old increases. Assuming that the age-related probabilities of entering residential care remain static into the future, we estimate that the rate of 4.6% will increase to 5.4% by 2051.

## Home care

- 3.9 The table below shows that Ireland, in keeping with many other countries has provided relatively little formal home care to date. The provision of home care services is most developed in the Scandinavian countries.

### Proportion of older people receiving home help in selected countries

More than 10%	Denmark <sup>28</sup> Finland Norway Sweden
Between 6% and 10%	Australia Belgium France The Netherlands United Kingdom
Not more than 5%	Austria Canada Germany Ireland Italy Japan Portugal Spain United States

Source: OECD, 1996

- 3.10 In recent years, most countries have been attempting to shift the focus of long-term care provision from residential to home care. This reflects the recognition that care in the home is often better for the recipient than residential care and is usually the preferred option of those who need care.
- 3.11 However, this is not an easy task where budgets and programmes are fragmented (for example, where residential and home care services are financed under separate programmes, as is the case in Ireland). A common theme is the need for better co-ordination between the agencies with responsibility for health and social care<sup>29</sup>, given the desirability of providing integrated or “seamless” services.

<sup>28</sup> Denmark has the highest rate of usage of home help services, with an estimated 20% of elderly people receiving services.

<sup>29</sup> OECD, 2000, *Reforms for an Ageing Society*

3.12 Moreover, hopes that the expansion of home care services could divert a significant proportion of dependent older people from residential care have been scaled down in many countries<sup>30</sup>. While efficiencies have been obtained by improving the allocation of services, especially away from hospitals, straight substitution of home care for residential care has only been possible in a minority of cases. On the other hand, the most recent research from the US indicates that intensive care management may have the potential to reduce the need for prolonged residential care.

3.13 It is also increasingly accepted that home care may not necessarily be a cheaper option for those with high dependency levels.

#### Informal care

3.14 As noted previously, there are widespread concerns as to the sustainability of current levels of informal care. The supposition that informal care will reduce alongside social and demographic change is challenged by evidence that family commitment to caring remains high. Nevertheless, it can no longer be assumed that care will be available from a non-employed female family member.

3.15 Countries seeking to sustain and encourage informal care have generally adopted two approaches (not necessarily mutually exclusive):

- Provision of cash benefits where care is provided informally as an alternative to formal care (e.g. Austria, Denmark, Finland, Germany, Luxembourg).
- Provision of services that support carers, such as day care, respite care and information services (e.g. Australia, Denmark, Germany, Luxembourg, UK).

#### Trends in financing

3.16 In most countries, traditionally, there was only limited public coverage for long-term care services. Demographic change, however, has made this a significant policy issue in many countries and a number have accepted the need for greater State involvement, often through social insurance programmes. Nevertheless, affordability remains a key concern.

#### Alignment with health care financing

3.17 Long-term care has affinities with both acute health services and retirement provision, but the relationship with the health system generally predominates<sup>31</sup>.

3.18 Consequently, most countries that have reformed long-term care financing have adopted a model similar to that which is used for financing general health care. That is, those countries that have introduced social insurance systems to finance long-term care (such as Germany and Luxembourg) also use social insurance to

<sup>30</sup> Royal Commission, 1999, *op. cit.* (Research Volume 1)

<sup>31</sup> An exception to this is Switzerland, where a system of dependency-related pension supplements is used to finance care (the supplementary benefits are means-tested but are pitched at a level above social assistance).



finance health care. On the other hand, countries that fund health care through general taxation (such as Denmark and the UK) have tended to fund Long-Term care in the same way. To quote the UK Royal Commission on Long-Term Care:

*“In general, countries have tended to choose solutions that fitted with their existing method of financing health and social services. None of the “national health service” countries has gone down the social insurance route when financing long-term care, preferring to proceed through setting user charges for service, especially the social care component”.*

- 3.19 This is probably driven more by national preferences for “earmarked” or general financing than the practical difficulties that would arise if a different approach were adopted for long-term care financing.
- 3.20 Notably, countries with tax funded health care systems such as the UK and Canada, seem to be experiencing more difficulty in reaching consensus on how long-term care should be financed and delivered in future. This suggests, perhaps, that it may be more difficult to generate additional revenues to expand long-term care services within a tax-based rather than a social insurance system.
- 3.21 Social insurance financing is more likely to provide non-means-tested benefits and tax-based financing is more likely to provide for means-testing, but this is not always the case. For example, in Austria and Denmark, non-means-tested benefits are financed by general taxation, and in Israel an “affluence test” is a feature of the social insurance for long-term care. Means-testing can extend in some countries to attachment of inheritance and to members of the older person’s family.
- 3.22 A key factor in the debate about financing care through social insurance or through taxation seems to be the fact that “entitlement” to services – both actual and perceived – is generally greater in social insurance than in tax-based systems, which tend to be budget-driven.
- 3.23 Finally, there seems to be a broad consensus internationally that long-term care financing schemes should cover the cost of care but not the living and accommodation costs associated with care in a residential setting.
- 3.24 Separation of the financing and delivery of services may involve the provision of benefits in cash or voucher form and/or may allow the recipient to choose the mix and the providers of services. This facilitates consumer choice and allows flexibility in the services that can be provided.

#### Separation of financing and delivery

- 3.25 The desire for consumer choice is greatest amongst younger people with physical disabilities, whereas the current generation of older people is less likely to seek such choice.<sup>32</sup> There may be concerns as to whether older people want to or are capable of exercising choice. Moreover, there may be concerns relating to the quality of care provided by independent care providers (for example, in Germany and the US).
- 3.26 Countries that have social insurance financing are perhaps more likely to separate the financing and provision of services than those that finance long-term care from general taxation.
- 3.27 Within countries with tax-based financing, public provision of home care services may predominate (as, for example, in Denmark) or there may be a mix of public sector providers and public commissioning of independent providers (as, for example, in the UK).
- 3.28 Moreover, there is a trend towards allowing cash/vouchers as an alternative to direct benefit provision, so that beneficiaries can independently purchase the type of care that they want. This option is available, for example, in both Denmark and the UK, conditional on the person's ability to manage the service himself.
- 3.29 Whilst pre-funding is an option for those countries with social insurance financing, in practice, in most countries, a pay-as-you-go approach has been adopted. According to Pacolet<sup>33</sup>, *"the 'funded' solution is almost absent from the practical European debate on long-term care"*. A notable exception is Singapore, which plans to introduce a funded public insurance scheme.

#### Private insurance

- 3.30 There are private long-term care insurance markets operating in at least 14 countries and these are generally growing. However, in no country with, perhaps, the exception of the United States, is private long-term care insurance expected to provide a significant proportion of the solution.
- 3.31 Even in the US, however, only a small minority of the population has private insurance and the Medicaid Scheme, that provides health care to the poor, bears much of the cost of long-term care services. Some US states seeking to increase private insurance coverage have introduced partnership schemes that relax the means-test for Medicaid benefits for those who have taken out private insurance that provides a certain (limited) amount of cover. However, take up on these schemes has been low.

<sup>32</sup> Tilly et al, 2000, "Consumer-Directed Home and Community Services Programs in Five Countries: Policy Issues for Older People and Government", Urban Institute.

<sup>33</sup> Pacolet J., *Major trends in the organisation and financing of care for the elderly in Europe*.

3.32 In Germany, private insurance provides long-term care cover for approximately seven million people who are not covered by the State scheme and is also used to top up the State scheme if required. There is also a significant market for private insurance in France. French insurers offer policies that interface with those available from the social security system and policies are generally taken out through affinity group schemes rather than on an individual basis.

#### Public attitudes

3.33 The Eurobarometer surveys of public attitudes to ageing and older people were devised to provide baseline information on attitudes towards older people and some of the topical policy issues surrounding them.<sup>34</sup> The answers to a question related to the most appropriate method of financing long-term care are summarised overleaf. According to Walker, the results revealed:

*...“surprisingly widespread opposition to the use of the private sector in this field. More than seven out of ten favoured either a compulsory public insurance scheme or public services financed through taxation and, if the ‘don’t knows’ are excluded this rises to just under eight out of ten. The citizens of Europe have spoken with clear voices on this issue: either the public sector should organise the financing of long-term care or it should both finance and provide it.”*

34 Walker, 1993, *op. cit.*

## Views of the general public on the best way of providing long-term care

	Belgium	Denmark	France	Germany	Greece	Ireland	Italy	Luxembourg	Netherlands	Portugal	Spain	UK	EC12
Compulsory public insurance	45.7	17.9	41.3	48.3	32.2	19.3	34.9	50.1	40.1	31.3	38.2	17.7	36.6
Compulsory private insurance	10.4	6.0	7.9	6.6	4.0	5.7	7.2	7.3	9.9	6.4	2.6	3.8	6.2
Optional public insurance	8.2	4.9	7.1	10.4	8.4	4.9	5.1	8.4	7.9	7.1	5.7	8.0	7.6
Optional private insurance	8.2	5.1	2.6	5.4	3.6	4.0	3.0	3.0	5.2	5.0	2.2	5.0	4.1
Public provision of care finance through taxes	17.7	60.3	32.1	20.6	31.1	44.0	34.7	18.1	27.2	48.0	29.6	56.7	33.9
Don't know	9.9	5.2	9.0	8.7	20.6	22.0	15.2	13.2	9.7	2.0	21.7	9.0	11.6

Source: Eurobarometer survey, 1993

## Cost

3.34 A recent study (OECD, 1998) found that the costs of long-term care are currently of manageable proportions: less than 2% of GDP in most countries. Costs are expected to increase by around 50% over the next 30 years for demographic reasons. Cost projections for some individual countries are set out in the table below.

**Projections of publicly financed long-term care as a share of GDP to the year 2020, selected countries**

	Dynamic projection which assumes that past trends in disability rates and institutionalisation rates continue into the future				Constant trends projection which assumes no change in institutionalisation or disability rates in coming years			
	1996	2000	2010	2020	1996	2000	2010	2020
<b>Australia</b>								
Home Help	0.15	0.15	0.17	0.23	0.15	0.16	0.19	0.26
Institutions	0.66	0.66	0.70	0.76	0.66	0.70	0.88	1.12
Total	0.81	0.82	0.88	0.99	0.81	0.87	1.07	1.38
<b>Canada</b>								
Home Help	0.21	0.23	0.28	0.36	0.21	0.23	0.26	0.33
Institutions	0.50	0.51	0.53	0.57	0.50	0.54	0.66	0.81
Total	0.71	0.74	0.81	0.93	0.71	0.77	0.92	1.14
<b>France</b>								
Home Help	0.23	0.20	0.18	0.19	0.23	0.24	0.27	0.33
Institutions	0.37	0.41	0.54	0.71	0.37	0.41	0.52	0.66
Total	0.60	0.62	0.72	0.90	0.60	0.65	0.79	0.98
<b>Germany</b>								
Home Help	0.32	0.32	0.32	0.35	0.32	0.34	0.39	0.47
Institutions	0.39	0.40	0.45	0.55	0.39	0.40	0.45	0.55
Total	0.71	0.72	0.78	0.90	0.71	0.74	0.85	1.02
<b>Japan</b>								
Home Help	0.08	0.09	0.11	0.12	0.08	0.10	0.14	0.19
Institutions	0.66	0.74	1.00	1.28	0.66	0.76	1.12	1.54
Total	0.75	0.83	1.10	1.40	0.75	0.86	1.26	1.74
<b>Sweden</b>								
Home Help	1.35	1.23	1.05	1.17	1.35	1.31	1.38	1.68
Institutions	1.51	1.48	1.54	1.71	1.51	1.53	1.58	1.93
Total	2.86	2.71	2.59	2.88	2.86	2.84	2.96	3.61
<b>United Kingdom</b>								
Home Help	0.36	0.34	0.33	0.37	0.36	0.36	0.38	0.44
Institutions	0.69	0.72	0.75	0.86	0.69	0.72	0.75	0.86
Total	1.05	1.06	1.08	1.22	1.05	1.08	1.13	1.30
<b>United States</b>								
Home Help	0.24	0.23	0.22	0.25	0.24	0.24	0.25	0.30
Institutions	0.42	0.40	0.37	0.36	0.42	0.44	0.46	0.52
Total	0.66	0.64	0.59	0.61	0.66	0.68	0.70	0.82

Source: Cambois, Jacobzone and Robine, *OECD Economic Studies*, No. 30.

Further data on long-term care costs is set out in the table below.

**Long-term care spending (% GDP 1992 – 1995)**

	<b>Total</b>	<b>Public</b>	<b>Private</b>
Belgium	1.21	0.66	0.55
Denmark	2.24	n/a	n/a
Finland	1.12	0.89	0.23
France	n/a	0.50	n/a
Germany	n/a	0.82	n/a
Netherlands	2.70	1.80	0.90
Sweden	n/a	2.70	n/a
UK	1.30	1.00	0.30
Greece	0.17	n/a	n/a
Ireland	0.86	n/a	n/a
Italy	0.58	n/a	n/a
Luxembourg	0.41	n/a	n/a
Portugal	0.39	n/a	n/a
Spain	0.56	n/a	n/a

*Source: European Commission, "Towards a society for all ages. Employment, Health, Pensions and Intergenerational Solidarity"*

**Lessons for Ireland**

3.35 What, then, are the lessons to be gleaned for Ireland, from the experiences of other countries in seeking to address the issue of long-term care?

- Firstly, there is no blueprint solution to financing long-term care to be gleaned from a consideration of international developments. Each country has developed its own unique approach, reflecting its history, culture and attitudes and the nature of the current policy debate in that country. Ireland must do likewise.
- There is a strong consensus across the European Union in favour of public financing of long-term care, either by means of compulsory public insurance or through taxes. The case for the State to take the lead in financing care seems compelling, having regard to the uncertainty and to the distribution of the risk of needing long-term care.

- However, having regard to the cost increases that will result from demographic and social change, it would be prudent to require individuals to make some provision for themselves.
- It seems unlikely that private insurance can be harnessed to provide a substantive proportion of long-term care financing. Whilst there will be a role for such insurance, it will mainly be of benefit to the better-off, in terms of providing asset protection and/or paying for a more expensive level of care.
- In general, countries have tended to choose solutions that fitted with their existing method of financing health services. None of the countries with a “national health service” has gone down the social insurance route when financing long-term care. Instead, they have tended to means-test or impose user charges for long-term care services. However, the examples of the UK and New Zealand suggest that having most health care covered by one (universal tax-financed) system while long-term residential care is covered by another (means-tested system) creates ongoing tensions both in public opinion and allocation of services. Moreover, Ireland’s health care financing system is virtually unique: whilst we have a “national health service”, almost 50% of the population has opted for voluntary private insurance. Consequently, there is no long-term care financing solution that is an obvious “fit” with the system of financing health care in Ireland.
- For the future, the provision of informal care by family members can no longer be presumed upon. For informal care to continue to be the bedrock of home care provision, more extensive support for family carers will be needed.
- Irish Government policy is strongly in favour of supporting care in the community, in keeping with policy in other countries. If this policy is to be given full effect, a significant shift in financing towards home care services is needed, in line with measures that have been introduced in other countries.
- The separation of financing and delivery of services has been widely embraced. This reflects the desire for increased independence and choice on the part of those with long-term care needs, particularly amongst younger people with disabilities. This is also likely to be of increasing importance to future generations of older people. In Ireland, we already have a mix of public and private residential care providers (although these do not operate on a level playing field). Preferably, the systems should also facilitate a mix of public and private home care providers.



## 4. Estimating long-term care needs

### Introduction

4.1 Estimates of the current and future level of need for long-term care are required in order to inform consideration of the alternative financing and benefit options. The factors influencing future levels of need are:

- The age structure of the population in future years.
- The proportion of the population in each age group with disability (i.e. disability prevalence rates).
- Future trends in disability prevalence rates (these will depend, in turn, on trends in healthy life expectancy).

### Methodology

4.2 In order to project the number needing long-term care, we have applied estimated disability prevalence rates to the projected number in each age group within the older population. However, we have made allowance for possible future trends in prevalence rates on a number of different bases. Each element of this methodology is described in more detail below.

### Population age structure

4.3 For the purpose of estimating future long-term care needs, we have used the population projections contained within the Actuarial Review of Social Welfare Pensions (2000). The assumptions underlying the projections are set out in Appendix I. The projections are summarised in the table below.

### Projection of total population ('000)

Age Group	2001	2011	2021	2031	2041	2051
Children (0-19)	1,138	1,104	1,086	972	899	864
Working Ages (20-64)	2,191	2,416	2,415	2,385	2,256	2,035
Over age 65	430	508	675	852	993	1,077
(over 65s as % of total)	11%	13%	16%	20%	24%	27%
Total	3,759	4,028	4,176	4,208	4,148	3,976
Over age 80	98	117	139	209	273	309
(over 80s as % of total)	3%	3%	3%	5%	7%	8%
Old Age Dependency Ratio <sup>35</sup>	5.1	4.8	3.6	2.8	2.3	1.9
Overall Dependency Ratio <sup>36</sup>	1.4	1.5	1.4	1.3	1.2	1.0

*Source: Actuarial Review of Social Welfare Pensions, undertaken by Irish Pensions Trust Ltd on behalf of the Department of Social and Family Affairs, September 1997 and updated by Mercer for the Department of Finance, October 2000*

- 4.4 The population projections carried out for the Department of Finance cover the period to 2056. We have some concerns as to the validity of attempting to project long-term care needs over a period as long as this. The degree of uncertainty as to future trends in the prevalence of disability is such that even short and medium term projections must be regarded as tentative.
- 4.5 Nevertheless, in Ireland the “ageing of the aged” will occur to a greater extent in the latter part of the next fifty years, as can be seen in the table and chart below. As it is the very old who have the most need of long-term care, it is useful to consider the impact of this trend throughout the fifty year period, albeit on a tentative basis.

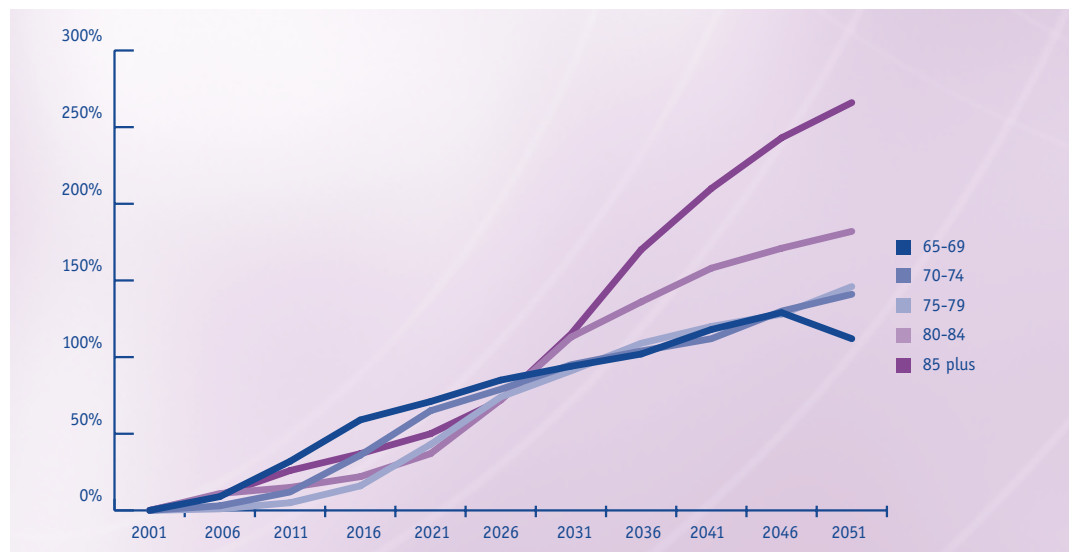
### Projection of the older population ('000)

Age	2001	2011	2021	2031	2041	2051
65+	430	508	675	852	993	1,077
70+	301	338	454	601	711	803
75+	189	212	269	383	473	533
80+	98	117	139	209	273	309

<sup>35</sup> Number at Working Ages per person over age 65

<sup>36</sup> Numbers at Working Ages per person under age 20 and over age 65

### Projected increase in the older population



### Disability prevalence

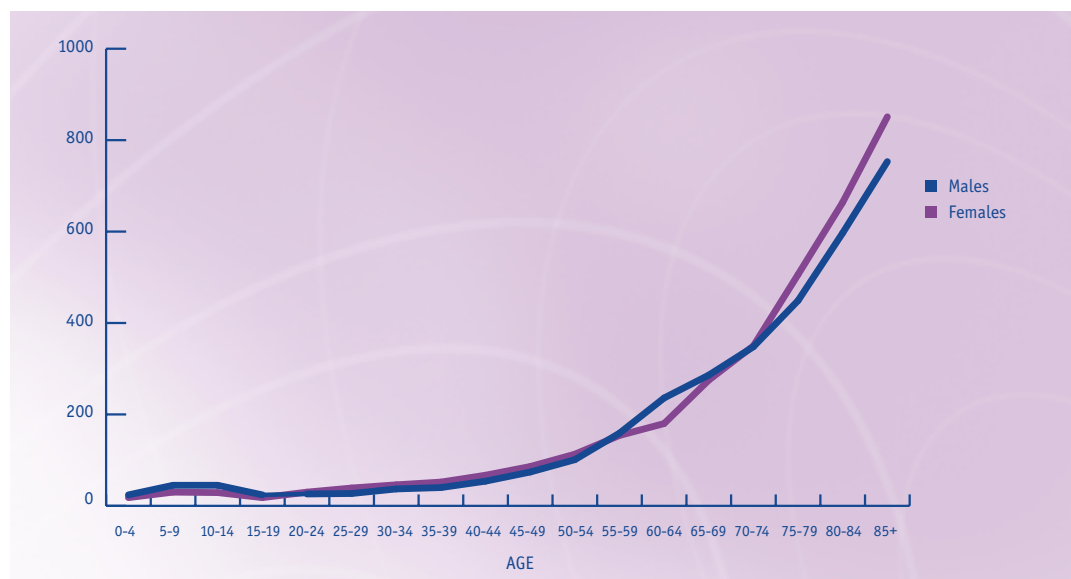
- 4.6 The probability of being disabled or needing long-term care increases significantly with age.<sup>37</sup> Even within the older population, different age groups within the older population have different levels of care need. In order to estimate the impact of the ageing population on future long-term care needs, we need to take into account age-specific disability prevalence rates.
- 4.7 Unfortunately, data in relation to the prevalence of disability or the need for long-term care in this country is sparse. Whilst there is a database on those with intellectual disability, Ireland has not to date collected data on the prevalence of physical and sensory disabilities. The Department of Health and Children is currently in the process of setting up a database on people with physical and sensory disabilities and, when this is available, it will facilitate the assessment of the overall numbers in need of long-term care.
- 4.8 Estimates of the numbers of older people receiving long-term care have been produced by O'Connor, Smyth and Whelan (1988), O'Connor and Ruddle (1988) and Fahey and Murray (1995).
- 4.9 The O'Connor et al study estimated that 19.4% of the over 65 population living in the community had long-term care needs (with 7% needing "a lot of care", 7.3% needing "some care" and 5.1% needing "occasional care"). Fahey and Murray found that 21% of the over-65 population living in the community was dependent on some form of physical care.

37 It is important to note that not everyone with a disability will need long-term care; many disabled people are able to live independently.

4.10 In addition, a proportion of the older population receives residential care in public and private extended care facilities. Based on information provided by the Department of Health and Children, we estimate that 4.6% of the over-65 population is in residential care. In total, therefore, an estimated 23% - 25% of the over-65s receive at least some long-term care either in the community or in an extended care facility. Based on the O'Connor study, it can be estimated that perhaps 18% - 19% receive "more than occasional" care.

4.11 Given the limitations of the data available for Ireland, we have used, for the purposes of our projections, a major study of disability prevalence carried out in the UK in the mid-1980s by the Office of Population Censuses and Surveys (OPCS)<sup>38</sup>. This study provides prevalence rates by age and sex and within 10 categories of disability. The basis on which we have adapted these rates for Ireland is described in more detail below.

#### Estimated number of those with disability per 1,000 population



Source: OPCS, UK, 1988

4.12 The OPCS prevalence rates include every kind and level of disability, from the very minor to the very severe. The prevalence rates for all levels of disability, if applied to the estimated population in Ireland in 2001, would give rise to the following disability rates:

38 OPCS 1988. *Survey of disabilities in Great Britain, Report 1: The Prevalence of Disability among Adults; Report 3: The Prevalence of Disability among Children*

### Estimated prevalence of all levels of disability in Ireland

Age group	% with disabilities	Number with disabilities
0 – 14	3	26,000
15 – 59	6	136,000
60+	38	220,000
<b>All ages</b>	<b>10</b>	<b>382,000</b>

- 4.13 This is broadly consistent with the estimates made in the Report of the Commission on the Status of People with Disabilities. However, the above rates include many people who do not need any or substantial amounts of long-term care.
- 4.14 For the purposes of our projections, we have used disability levels 5-10 from the OPCS data. This follows an extensive review of the available data in relation to levels of care need in Ireland, principally amongst older people, from studies such as O'Connor et al (1988), Blackwell et al (1992) and Fahey and Murray (1994). We consider that these levels should provide a reasonable estimate of those with a need for “more than occasional” care. We have categorised these levels of disability as follows:

OPCS Category	Estimated requirement for personal care <sup>39</sup>	
5-6	Moderate:	Less than daily (estimated at 10.5 hours per week)
7	High:	Significant daily care (estimated at 21 hours per week)
8-10	Continuous:	Continuous care (estimated at 42 hours per week)

- 4.15 The disability prevalence rates, as estimated by the OPCS, include all forms of disability, including intellectual, physical and sensory disabilities as well as disabilities arising from frailty in old age. In practice, different forms of disability require quite different types of service provision and it would probably not be appropriate to bring all of the different types of service within the scope of a single programme for long-term care services. Specifically, in the context of this study, we have assumed that residential services for those with intellectual disability or long-term mental illness would not come within the scope of a general programme for financing long-term care.

<sup>39</sup> It should be noted that the total amount of care provided may be substantially more if practical help with household tasks (e.g. shopping and cleaning) along with general “supervision” is taken into account. In addition, care recipients may need other services such as physiotherapy or chiropody, skilled nursing care or medical services.

4.16 Therefore, for the purpose of estimating the numbers needing services that would be provided within such a general programme, we have adjusted the OPCS prevalence rates to exclude prevalence of intellectual disability (at the moderate, severe or profound level) that requires residential care. We have also adjusted for the proportion of the population in community residences for the mentally ill and those who have been in in-patient psychiatric care for more than a year.

4.17 We therefore estimate the prevalence of long-term care needs as follows:

**Estimated disability prevalence rates (%)**

Age group	Moderate	High	Continuous	Total
0 – 14	0.7	0.4	0.8	1.9
15 – 59	1.2	0.4	0.7	2.3
60+	7.5	3.1	6.7	17.3
<b>All ages</b>	<b>2.1</b>	<b>1.8</b>	<b>1.6</b>	<b>4.5</b>

4.18 Amongst the older population, the pattern of estimated long-term care need is as follows:

**Estimated disability prevalence rates (%)**

	Men				Women			
	Moderate	High	Continuous	Total	Moderate	High	Continuous	Total
65-69	4	2	4	<b>9</b>	6	2	3	<b>11</b>
70-74	5	2	4	<b>11</b>	8	2	4	<b>14</b>
75-79	8	3	8	<b>19</b>	12	4	7	<b>24</b>
80-84	12	6	12	<b>29</b>	15	7	14	<b>36</b>
85+	15	6	18	<b>40</b>	19	12	34	<b>65</b>
<b>65+</b>	<b>7</b>	<b>3</b>	<b>7</b>	<b>16</b>	<b>9</b>	<b>4</b>	<b>8</b>	<b>21</b>

## Disability trends

4.19 The OPCS data relates to the UK in the mid-1980s. We reviewed its suitability for estimating disability prevalence in Ireland in 2001 and for projections over the next 25 years.

4.20 As demonstrated above, there is a clear relationship between age and the prevalence of disability. It is less clear, however, how increases in life expectancy will impact on future age-specific rates of disability prevalence. There has been much debate, worldwide, as to the prognosis for healthy life expectancy

(alternatively known as the expectation of life without disability or disability-free-life-expectancy). This is a difficult subject because the link between morbidity and mortality is so complex.

4.21 The prospects for healthy life expectancy are essentially dependent on expected changes in the incidence of disability and in the rates of mortality experienced by those who are disabled. It can be expected that medical advances will result in a reduction both in the incidence of disability at specific ages and in the rates of mortality experienced by the disabled population. Depending on the relative impact of these two factors, disability prevalence rates at specific ages could reduce or increase.

4.22 There are three main theories as to how disability prevalence rates are likely to change:

■ **Compression of morbidity**

According to this theory, medical advances will result in the postponement of chronic degenerative diseases until the most advanced years of life. The delay of the onset of disease would result in a *compression* of the period of morbidity. This theory suggests that age-specific disability prevalence rates will reduce over time.

■ **Expansion of morbidity**

According to this theory, reductions in mortality rates will not be accompanied by a reduction in morbidity. This would mean that disabled people who would previously have died sooner would live longer. This would give rise to an expansion of the average period of morbidity preceding death. This theory suggests that age-specific disability prevalence rates will increase over time.

■ **The middle ground**

The middle ground is held by those who believe that it will be possible to postpone the onset of chronic degenerative diseases and disabilities such that healthy life expectancy will increase in tandem with total life expectancy. This suggests that age-specific disability prevalence rates will reduce but more gradually than the compression theory might suggest.

4.23 For the purposes of our study, we first examined trends in disability prevalence internationally. Several recent studies provided useful data in this respect, for example:

- Dullaway and Elliott, 1998, Long-term care insurance, A guide to product design and pricing
- Waidmann and Manton, 1998, International evidence on disability trends among the elderly

- Jacobzone et al, 1998, Long-term care services to older people, A perspective on future needs: The impact of an improving health of older persons, OECD Working Paper
- Mathers et al, 2000, “Estimates of Disability-Adjusted Life Expectancy for 191 countries: methods and results”, World Health Organisation.

4.24 The international trends are not definitive. There are data issues and differences in the trends between countries which remain to be explained. However, on the whole, the trends show a decline in the prevalence of significant disability.

*“There has been a significant mortality decline among the old in most developed ‘western’ countries in the last two to three decades, but mixed trends in population health expectancies. Severe disability-free life expectancy is increasing in parallel with total life expectancy, but there has been stagnation in disability-free life expectancy, when all levels of disability are included. During the 1970s and 1980s there was an expansion in the reported prevalence of mild disability and more people reporting poor perceived health. In the last few years, some evidence has started to emerge for improving health in the older populations of developed countries.”<sup>40</sup>*

- 4.25 The WHO study shows that, within the EU, disabled life expectancy (DLE)<sup>41</sup>, weighted by the severity of the disability, lies within a much narrower range than total life expectancy<sup>42</sup>. This indicates some compression of disability, such that disability prevalence rates can be expected to reduce as life expectancy increases.
- 4.26 Moreover, the projections of long-term care costs set out on page 60 show that recent trends are towards lower disability rates as the “dynamic” projections (assuming that past trends in disability rates and institutionalisation rates continue into the future) in general show lower cost increases than the “static” projections (assuming no change in disability prevalence).
- 4.27 Overall, we consider it reasonable to assume that disability prevalence rates amongst older people will reduce in future such that disabled life expectancy stays broadly constant i.e. that healthy life expectancy will increase at the same pace as total life expectancy<sup>43</sup>.

<sup>40</sup> Mathers and Robine, 1997, *International Trends in Health Expectancies: a Review, Presented to the 1997 World Congress of Gerontology*.

<sup>41</sup> i.e. the number of years expected to be lived with disability.

<sup>42</sup> DLE was in the range 5.5 – 6.5 for men and 5.9 – 7.0 for women compared to total life expectancy in the range 73.3 – 77.1 for men and 78.1 – 83.6 for women.

<sup>43</sup> Arguably, it would be appropriate to assume reductions in disability prevalence only for the most severe categories of disability and make a different assumption in relation to moderate disability. However, it is the severe categories that have most implications for long-term care costs. In the interests of simplicity, therefore, we have assumed that trends will apply equally across moderate and severe disability categories.



- 4.28 Having examined the projected trends in life expectancy for Ireland over the period 2001-2051 that underlie our base population projections, we have translated this into an assumption that disability prevalence rates will reduce as set out in the table below. However, we have assumed that current disability prevalence rates will continue to prevail over age 85.
- 4.29 For the male population aged 40-64, we have translated only a proportion of the expected future improvement in mortality rates into an expected future improvement in disability prevalence rates for our central projection and for women, we have assumed no improvement in disability prevalence in this age group. This takes into account that factors giving rise to improved survival rates in this age group are less likely to give rise to lower disability prevalence rates than is the case at older ages.
- 4.30 For those aged 0-39, the improvement in mortality underlying the population projections is slight and we have assumed that disability prevalence rates will remain constant.

**Base projection – Assumed reduction in disability prevalence rates (% per annum)**

<b>Men 2001 – 2031</b>	
0-39	-
40-64	0.33%
65-84	0.67%
85+	-
<b>Women 2001– 2031</b>	
0-39	-
40-64	-
65-84	0.90%
85+	-
From 2031 (men and women)	-

- 4.31 It was also necessary to adjust the base UK prevalence rates (which were based on 1985 data) into rates applicable to Ireland in 2001. Our basic assumption that disabled life expectancy remains broadly constant suggests that the UK 1985 rates would have been broadly comparable to Irish rates in the early 1990s, having regard to life expectancy trends for the two countries.
- 4.32 We further assumed that the rates of improvements in disability prevalence during the 1990s were the same as those assumed for the future (see the table above). This allowed us to derive a set of assumed disability prevalence rates for Ireland in 2001.

4.33 These form the basis for our estimates of the numbers of people requiring long-term care in the future, as set out in the tables below.

#### Central projection – Numbers needing long-term care

##### All ages

	Moderate	High	Continuous	Total	High/Continuous
<b>2001</b>	75,400	25,900	51,600	152,900	77,500
<b>2011</b>	84,100	28,900	58,100	171,100	87,000
<b>2021</b>	94,100	32,700	66,400	193,200	99,100
<b>2031</b>	105,800	38,200	79,500	223,500	117,700
<b>2041</b>	117,300	44,400	95,200	256,900	139,600
<b>2051</b>	120,800	47,200	103,200	271,200	150,400

4.34 The estimated total number of people in need of moderate or higher levels of care is 152,900, of which 77,500 require high or continuous care.

##### Older people (65+)

	Moderate	High	Continuous	Total	High/Continuous
<b>2001</b>	35,700	15,200	33,100	84,000	48,300
<b>2011</b>	39,100	16,900	37,500	93,500	54,400
<b>2021</b>	47,600	20,300	45,000	112,900	65,300
<b>2031</b>	59,600	26,100	58,700	144,400	84,800
<b>2041</b>	73,100	32,700	75,200	181,000	107,900
<b>2051</b>	81,400	36,700	85,200	203,300	121,900

4.35 The base figures for older people needing long-term care in 2001 are broadly consistent with previous estimates. The total number in need of moderate or higher levels of care (84,000) represents 19.5% of the population. This is consistent with previous studies cited on page 61. This figure is inclusive of those in residential care (estimated in section 2 at 19,650 people).

4.36 The estimated number needing high or continuous care is 48,300. We estimate that this includes approximately 17,000 people in residential care (based on the total number occupying extended care beds who were aged over 65 in 2000

(19,548) and the dependency distribution within residential care). This leaves approximately 31,000 in need of high or continuous care in their homes. This is consistent with an estimate of 29,000 older people in need of full-time care in the Review of the Carer's Allowance.

4.37 The model suggests that there are a further 69,000 children and adults aged under 65 who need moderate or greater amounts of care, of whom 29,000 need high or continuous care. Of these, we estimate that perhaps 1,000 occupy extended care beds. In addition, a further considerable number will be resident in facilities for the physically handicapped, although data in this regard was not available to us.

4.38 As noted there remains significant uncertainty as to future trends in rates of disability. It is therefore appropriate to make projections on a number of alternative bases. We have carried out projections on three further bases:

- Projection 2: Based on **static disability prevalence rates** (no change from the OPCS base rates).
- Projection 3: An **optimistic** projection that assumes that the reduction in disability rates will be greater than has been assumed in our base projection.
- Projection 4: A **pessimistic** projection that assumes disability rates will increase in future years by 0.25% per annum.

4.39 The assumed reductions in disability prevalence rates for the purposes of projection 3 (the optimistic projection) are shown in the table below.

**Optimistic projection – Assumed reduction in disability prevalence rates (% per annum)**

<b>Men 2001 – 2031</b>	
0-39	-
40-64	1.00%
65-84	1.00%
85+	0.67%
<b>Women 2001 – 2031</b>	
0-39	-
40-64	0.67%
65-84	1.35%
85+	0.90%
From 2031 (men and women)	-

4.40 For projection 3, as for our base projection, we have made allowance for a reduction in disability prevalence rates during the 1990s. For projections 2 and 4, we have taken the unadjusted OPCS rates as the base rates in 2001. The results of these additional projections are as follows:

#### Projection 2 – Static disability prevalence rates

##### All ages

	Moderate	High	Continuous	Total	High/ Continuous
<b>2001</b>	78,100	26,900	53,500	158,500	80,400
<b>2011</b>	90,200	31,100	62,300	183,600	93,400
<b>2021</b>	105,700	36,900	74,300	216,900	111,200
<b>2031</b>	124,700	45,300	92,900	262,900	138,200
<b>2041</b>	138,700	52,400	110,600	301,700	163,000
<b>2051</b>	143,600	55,800	119,700	319,100	175,500

##### Older people (65+)

	Moderate	High	Continuous	Total	High/ Continuous
<b>2001</b>	38,200	16,100	34,900	89,200	51,000
<b>2011</b>	44,500	19,000	41,400	104,900	60,400
<b>2021</b>	57,800	24,200	52,500	134,500	76,700
<b>2031</b>	76,700	32,700	71,400	180,800	104,100
<b>2041</b>	92,600	40,400	89,900	222,900	130,300
<b>2051</b>	102,500	45,000	101,100	248,600	146,100

#### Projection 3 – Optimistic

##### All ages

	Moderate	High	Continuous	Total	High/ Continuous
<b>2001</b>	75,400	25,900	51,600	152,900	77,500
<b>2011</b>	80,300	27,600	55,300	163,200	82,900
<b>2021</b>	85,700	29,700	60,100	175,500	89,800
<b>2031</b>	91,400	32,800	67,800	192,000	100,600
<b>2041</b>	100,900	37,800	80,400	219,100	118,200
<b>2051</b>	103,600	40,100	86,800	230,500	126,900

### Older people (65+)

	Moderate	High	Continuous	Total	High/Continuous
<b>2001</b>	35,700	15,200	33,100	84,000	48,300
<b>2011</b>	37,200	16,000	35,400	88,600	51,400
<b>2021</b>	43,000	18,200	40,200	101,400	58,400
<b>2031</b>	51,000	22,100	49,200	122,300	71,300
<b>2041</b>	62,100	27,500	62,500	152,100	90,000
<b>2051</b>	69,000	30,800	70,600	170,400	101,400

### Projection 4 – Pessimistic

#### All ages

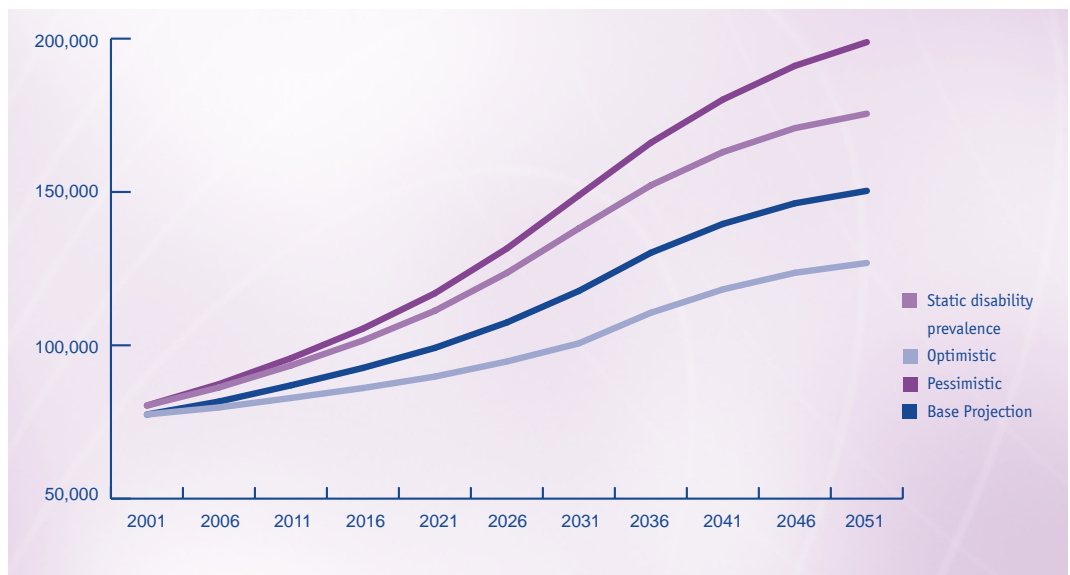
	Moderate	High	Continuous	Total	High/Continuous
<b>2001</b>	78,100	26,900	53,500	158,500	80,400
<b>2011</b>	92,500	31,900	63,900	188,300	95,800
<b>2021</b>	111,100	38,800	78,100	228,000	116,900
<b>2031</b>	134,400	48,800	100,100	283,300	148,900
<b>2041</b>	153,300	58,000	122,200	333,500	180,200
<b>2051</b>	162,600	63,200	135,600	361,400	198,800

### Older people (65+)

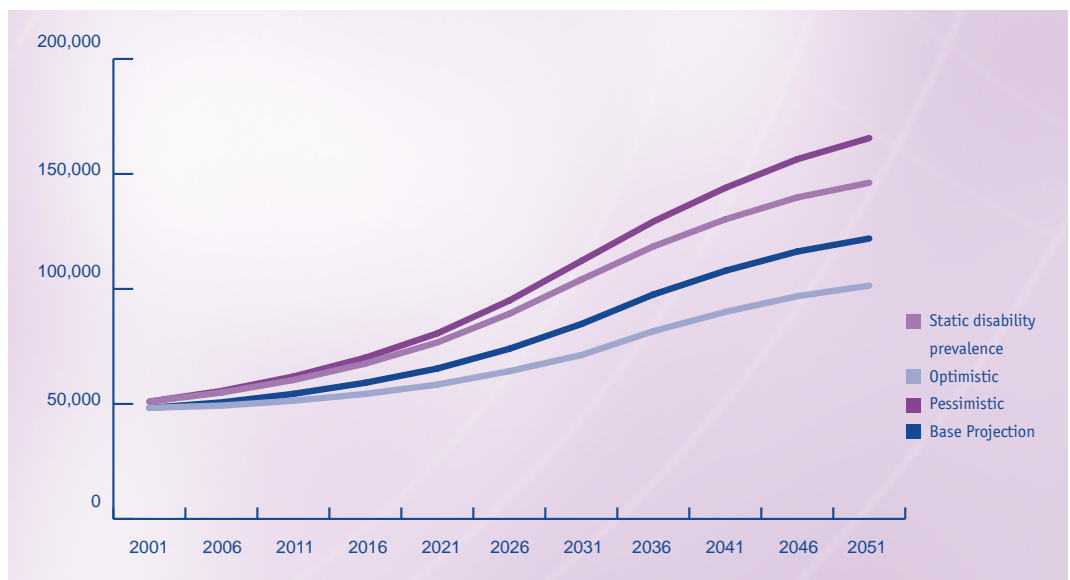
	Moderate	High	Continuous	Total	High/Continuous
<b>2001</b>	38,200	16,100	34,900	89,200	51,000
<b>2011</b>	45,600	19,400	42,500	107,500	61,900
<b>2021</b>	60,800	25,500	55,200	141,500	80,700
<b>2031</b>	82,600	35,200	76,900	194,700	112,100
<b>2041</b>	102,400	44,600	99,300	246,300	143,900
<b>2051</b>	116,200	51,000	114,600	281,800	165,600

4.41 The charts overleaf show the expected growth in the numbers needing high and continuous long-term care on a graphical basis. The rate of increase is much greater amongst the older population, with the projected increase over the 50 year period ranging from 110% on the most optimistic basis to 225% on the most pessimistic basis. The projected increase in the total numbers needing long-term care ranges from 64% to 147%.

#### Growth in numbers needing high and continuous care



#### Growth in numbers aged 65+ needing high and continuous care



- 4.42 In conclusion, the projections demonstrate the possible scale of the increase in long-term care needs over the next 50 years. Our best estimate is that the increase in the number of elderly people needing long-term care will be around 140% (150% for the high and continuous care need categories). This is broadly in line with the expected increase in the numbers of older people over the same period. This means that the assumed reductions in disability prevalence negate the effect of the increase in the numbers that are very old.
- 4.43 We emphasise that this is a difficult area in which to make forecasts and the future is subject to wide margins of uncertainty. Further medical advances could have a major impact and could either reduce or increase the prevalence of disability depending on whether their effect is to cure or alleviate the symptoms of particular conditions (for example, further advances in the treatment of Alzheimer's disease could result in a major reduction in the need for long-term care) or to prolong survival without any curative effect.
- 4.44 In considering the various policy options, it is important, therefore, to be cognisant of the wide "funnel of doubt" as to future needs and costs.

## 5. Needs assessment and benefit design

- 5.1 Before we consider the potential options for financing long-term care, it is helpful to consider what long-term care benefits might be provided, and how the need for such benefits would be assessed, under any such financing scheme.

### Needs assessment

- 5.2 Whatever method is adopted for the financing of long-term care benefits and/or services, we consider that the introduction of an objective, independent, comprehensive and nationally consistent basis for assessing an individual's entitlement is crucial to its implementation.

- 5.3 This needs assessment process is fundamentally important, from the individual's perspective, in order to ensure fairness, equity and transparency in the application process and, from a budgetary perspective, in order to ensure that benefits are provided on an efficient and cost-effective basis.

### What is meant by "needs assessment"?

- 5.4 "Needs assessment" is a relatively broad term, which is open to interpretation in different ways. In its broadest context, it could be interpreted as a process by which an individual's health, housing and social circumstances are assessed with a view to identifying all his or her needs across a broad spectrum.<sup>44</sup>
- 5.5 However, in the context of this study and in emphasising its fundamental importance to any scheme for financing long-term care, what we mean by a needs assessment process is a process by which an individual's eligibility for or entitlement to specified long-term care benefits or services can be determined objectively and consistently with regard to agreed and transparent criteria.

### Current needs assessment procedures

- 5.6 At present, the level of dependency and/or needs of frail older people and of younger people with disabilities are assessed by a number of different State organisations for various different purposes, for example:
- The need for residential care, along with the associated level of dependency, is assessed by the relevant Health Board when an individual applies for a nursing home subvention.
  - Long-term care needs are also assessed by the Health Boards in relation to the provision of community care services such as home helps.
  - For the purposes of the Carer's Allowance, the level of care needed by the care recipient is separately assessed by the Department of Social and Family Affairs on the basis of a certificate provided by the care recipient's GP and, in certain circumstances, medical examination by a Medical Assessor from the Department.

<sup>44</sup> The term "need" in itself is open to different interpretations. For example, need could be defined by an expert or professional working in a particular field ("normative need") or could simply refer to what an individual perceives as his or her needs i.e. "felt need".



- Needs assessments are required by the Revenue Commissioners in respect of various tax reliefs relating to disability.
- Housing repair/adaptation schemes such as the House Improvement Grant for Disabled Persons and Special Housing Aid for the Elderly must also require assessment of need.
- The level of dependency of disabled children is assessed for the purposes of the Domiciliary Care Allowance.

- 5.7 Indeed, according to the report of the Commission on the Status of People with Disabilities, *“there are a bewildering array of schemes, matched by an equally bewildering set of eligibility and assessment procedures”*.
- 5.8 There are also issues as to the consistency of assessment procedures. For example, we understand that, at present, there are a variety of practices across the Health Boards with respect to the assessment of dependency for people applying for a nursing home subvention, both in terms of the criteria and scales used to measure dependency and the professionals who carry out the assessment. Different measures of functional ability are used across the Health Boards and similarly the approach to cognitive assessment varies. Social factors are also taken into account in varying ways.
- 5.9 Similarly, there are issues in relation to the basis of needs assessment for community services such as home helps. The 1998 Review of the Home Help Service recommended that there should be explicit and agreed criteria for assessment of need, standardised criteria for entitlement and national guidelines of service provision based on assessed needs.<sup>45</sup> In this regard, we understand that a Working Group established by the Health Board Chief Executive Officers has recently produced guidelines for the processing of applications and assessment of needs for these services and that these guidelines are to be piloted.

## Development and implementation

- 5.10 We recommend that national guidelines for measuring dependency and entitlement to all long-term care benefits and services should be established for use across the country. These guidelines should be developed by a national Expert Committee, whose task it would be to:
- provide a comprehensive and quantified scale of assessment for functional and cognitive disability as well as housing and social circumstances,
  - relate that scale to eligibility for or entitlement to available long-term care benefits or services,
  - designate the appropriate care setting for the various categories of assessed need, whilst taking into account the preference for care in the community, where possible, and

- develop appropriate standardised assessment tools.

- 5.11 The Expert Committee could also provide advice as to the relative level of services required by those whose needs are at the various points on the quantified scale.
- 5.12 We suggest that the Expert Committee could operate under the auspices of a National Long-Term Care Authority, which would have responsibility for monitoring the implementation of the assessment process across the country (see section 8).
- 5.13 There are many different instruments for assessing dependency or disability, a number of which are currently in use across the Health Boards, including, for example:

- **The Barthel Index**

The Barthel Index contains 10 items that measure daily functioning, specifically the activities of daily living and mobility. These include feeding, moving from wheelchair to bed and return, grooming, transferring to and from a toilet, bathing, walking on level surface, going up and down stairs, dressing, continence of bowels and bladder. The items are weighted according to a scheme developed by the authors. The person receives a score depending on whether they have received help while doing the task. A total score is calculated to assess the person's level of independence.

- **The Clifton Assessment Procedures for the Elderly (CAPE)**

CAPE is used to assess cognitive and behavioural competence in the elderly. The scales relate level of dependency to the likely need for community and hospital care. There are two independent measures that can be used together or separately. The Behavioural Rating Scale has 18 items measuring physical disability, apathy, communication difficulties and social disturbance. The Cognitive Assessment Scale is a short measure of information/orientation, mental ability and psychomotor ability.

- **The Crichton Royal Behaviour Rating Scale**

The Crichton Royal Behaviour Rating Scale has ten dimensions (mobility, orientation, communication, co-operation, restlessness, dressing, feeding, continence, memory and bathing). Points on a scale of 0 to 4 are allocated for each dimension, with the total score indicating the overall level of dependency.

## ■ Independence in Activities of Daily Living (see below)

- 5.14 Whilst the selection of an appropriate instrument for a national assessment process would be a matter for the proposed Expert Committee, we have outlined below for consideration the approach that is widely used by insurance companies internationally and also by the Medicaid system in the US in order to determine entitlement to benefits.
- 5.15 This centres on assessment of the person's ability to perform specified "activities of daily living" (ADLs). This approach was originally developed in Cleveland, Ohio as a clinical tool to assess disability. An individual's need for long-term care is closely related to his inability to perform one or more ADLs. A measure of cognitive impairment is needed to supplement ADLs as a measure of the need for care.
- 5.16 Whilst there are several variations of the ADL approach, there is widespread support for the use of the six ADLs set out in the table below. Generally, insurers provide long-term care benefits if an individual is unable to perform either two or three of the ADLs or is cognitively impaired (in some cases, the maximum benefit is payable if three ADLs are failed and a lower benefit is payable if only two ADLs are failed).

### Activities of Daily Living

<b>Washing</b>	The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.
<b>Dressing</b>	The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
<b>Feeding</b>	The ability to feed one's self once food has been prepared and made available.
<b>Toileting</b>	The ability to use the lavatory or manage bowel and bladder function through the use of protective undergarments or surgical appliances if appropriate.
<b>Mobility</b>	The ability to move indoors from room to room on level surfaces.
<b>Transferring</b>	The ability to move from a bed to an upright chair or wheelchair and vice versa.

- 5.17 An ADL based approach could be appropriate as a basis for assessing need for residential care or personal care in the community. It could be supplemented with an assessment of housing needs, social factors and the need for other services such as physiotherapy, chiropody etc. To the extent that benefits are available in respect of the need for practical help, rather than personal care, a measure based on IADLs could be developed.

- 5.18 The assessment process could and, indeed, should encompass an assessment of the carer's abilities and needs as well as the needs of the care recipient. The carer's needs could, for example, include the need for information, for training, assistive devices, respite services etc.
- 5.19 Once national guidelines are in place, these could be implemented at Health Board level on the ground by Health Board teams, in place of existing processes. If long-term care benefits are to be more widely available than under current programmes, there may be resource issues relating to the assessment process. These would need to be addressed in the implementation plan.
- 5.20 In the UK, the Royal Commission recommended that, in time, the new Primary Care Groups should manage the needs assessment process for long-term care. It recommended that, for those with complex needs, the assessment should be multi-disciplinary. The multi-disciplinary team might include a geriatrician, general practitioner, nurse, social worker, housing manager and occupational therapist (and might additionally include a physiotherapist, speech therapist, chiropodist and others as appropriate). Here, in Ireland, a new system of inter-disciplinary primary care teams has been proposed under the auspices of the Health Strategy. In the future, these teams could manage the Irish needs assessment process.
- 5.21 A further option that could possibly be considered is that of outsourcing needs assessment to suitably qualified independent providers.
- 5.22 Regardless of who carries out individual needs assessments, the system should provide for ongoing monitoring and review and for an appeals procedure. Specific funding may be required to meet the costs of needs assessment.
- 5.23 In conclusion, a nationally consistent and objective needs assessment process must form the cornerstone of any new system of financing long-term care. This uniform needs assessment process should feed into all of the programmes that relate to long-term care needs of disabled and dependent older people, including related accommodation needs.
- 5.24 We move on to consider the benefits that could be provided under a long-term care financing scheme.

## Home care

- 5.25 There is a clear stated policy objective to support care in the community and to reduce unnecessary recourse to residential care. However, at present, the provision of personal care and/or financial support for the costs of personal care is largely limited to a residential setting.
- 5.26 In particular, for older people, the nursing home subvention scheme provides entitlement to a financial subsidy of care costs based on the assessed level of dependency and a means-test. This acts as a bias in favour of residential care.
- 5.27 Moreover, if a family carer is not available, an individual with a high level of dependency and limited means will have no option but to go into residential care, given the lack of provision for personal care costs at home. More and more people are likely to fall into this category in future years, as demographic change and increased female labour force participation lead to a reduction in the availability of family carers. This could substantially increase the cost of residential care provision.
- 5.28 The public financing of residential care should not occur at the expense of resources for the alternative of home care, if this is a viable option for the individual concerned. In our view, therefore, a subvention should be available for home care, as an alternative to the subvention for residential care, based on the individual's assessed level of dependency and social circumstances. This subvention could be used to provide home and community care services that would enable the individual to remain in the community.
- 5.29 The amount of services that are required to support a disabled person in the community will obviously vary, depending on each individual's level of dependency. We envisage, therefore, that the amount of the community-based subvention would be scaled on the basis of the assessed level of dependency. An appropriate dependency threshold to qualify for the subvention would need to be determined. Having regard to resource constraints, the primary focus should be those with the highest levels of dependency. However, it is also important to recognise the potential for preventing increasing dependency by providing services to those with moderate levels of need.
- 5.30 For people in need of continuous care, the community-based subvention should arguably be equal to the subvention for residential care<sup>46</sup>, albeit that community-based care may not always be feasible or appropriate for those with the highest levels of care need. On the other hand, for those in need of moderate care, a subvention should only be available for care in the community and not for residential care. We would envisage, therefore, that the "medium dependency" category for the purposes of the nursing home subvention would no longer be required.

<sup>46</sup> This assumes that the primary purpose of the nursing home subvention is to meet the costs of nursing home care to the extent that these exceed living and accommodation costs i.e. to meet care costs. For those in need of continuous care, the cost of such care will not be any lower if it is provided in the community rather than on a residential basis; rather, the cost of care in the community may be higher.

**Care provision:  
cash, vouchers  
or services**

- 5.31 A subvention should also be payable to individuals who are resident in assisted living facilities.
- 5.32 The form of the subvention could consist of services, vouchers to enable the recipient to purchase services or cash (which would give the recipient complete flexibility, either to purchase care or to use the benefit for some other purpose). A further option would be to provide the recipient with a choice of services or cash. The recipient could also be allowed to choose a mix of services and cash.
- 5.33 A cash-based system – or at least the option of cash – may be preferred by disabled people – in particular, younger disabled people – as it would give them choice and control over who cares for them and how. Service-based systems of support may be insufficiently flexible and may not suit the requirements of the care recipient and/or carer. However, some sources suggest that a service-based system has greater potential to acknowledge the needs of the carer as well as the care recipient and balance the needs of the two parties.<sup>47</sup> Moreover, concerns in relation to the quality of care can arise where cash is provided as an alternative to services.
- 5.34 Cash benefits or vouchers (or the option of cash or vouchers), are more compatible with social insurance-type financing where there is a firm entitlement to a certain level of benefit based on objective criteria, whereas the provision of services has more affinity with a tax-based financing approach (where actual provision may vary depending on the resources available).
- 5.35 Different models have been adopted in different parts of the world. In Austria, for example, only cash benefits are provided.
- 5.36 In Germany, on the other hand, those in need of care can choose between regular cash payments, a set number of service “assignments” in kind or any combination of the two. Where services are selected, the individual can also choose the residential or home care provider from an approved list. The value of cash payments is only about half the value of services in kind. The cash payment is intended more to encourage the recipient to choose informal instead of formal care (and can be used to recompense family caregivers) than to enable him or her to purchase equivalent formal services independently. The cash option has been the preferred one, although the numbers opting for services have increased more recently. In Luxembourg a similar choice of services or cash payments is available.

<sup>47</sup> Ungerson (1997) referenced in the Royal Commission on Long-Term Care, 1999, *op. cit.* (Research Volume 2)

- 5.37 On the other hand, the Scandinavian countries and the UK have principally provided services. Notably, in the UK, there is a mix of public sector and independent sector provision (services are commissioned from independent providers by local authorities, as needed). Also in the UK, under the Community Care (Direct Payments) Act 1996, local authorities may offer people in receipt of services the option of taking cash as an alternative and using it to purchase care independently. Whilst initially the Act did not apply to people over the age of 65, direct payments are now available to anyone over the age of 18 who is deemed capable of managing their own care. Direct payments may also be made to someone with power of attorney for the care recipient, in the case of someone with a cognitive impairment.
- 5.38 Under the direct payments system, the local authority decides the amount of the payments and what they are intended to cover. The recipient must provide information for the local authority, indicating how the money has been spent, for audit purposes. The local authority must also put monitoring arrangements in place to ensure that the assessed needs of the care recipient are being met.
- 5.39 Under the UK system, direct payments cannot be used to reimburse family carers or to purchase services from the local authority. However, under the Carers and Disabled Children Act 2000, local authorities are required to assess the needs of carers and may offer services to support carers. As an alternative to services, they may offer carers direct payments or vouchers for services.
- 5.40 Similarly, the Netherlands has a system of “personal care budgets”, under which a minority of older service recipients are given cash benefits within which to purchase services.

#### **Spectrum of delivery mechanisms**



- 5.41 A fully service-based system is at one end of the spectrum of delivery mechanisms whereas pure cash benefits are at the other.
- 5.42 It is important to note that a service-based system does not preclude a mixed economy of care. Rather, it could provide for the delivery of services by a variety of providers, encompassing both the public and independent sectors. Services commissioned by the public sector from independent providers could be used to augment the resources available for public sector provision. To some extent, such a mixed economy is already in place in the residential care sector. It would also be possible in the home care sector.

- 5.43 A mixed economy of care may have benefits in terms of enhancing the overall cost-effectiveness of services. However, it may not go far enough in widening consumer choice. It is likely to reflect existing models of care provision. Also, it does not necessarily provide care recipients with a choice of provider, although it can do so (as is the case in the nursing home subvention scheme).
- 5.44 A community-based subvention could similarly allow recipients a choice of provider from an approved list. The recipient would need to specify their chosen provider (or, potentially, providers) and the financing body would then make the designated payment to the provider.
- 5.45 Alternatively, consideration could be given to providing vouchers that would enable the care recipient to obtain their desired mix of services from any approved care provider. Vouchers could be issued with a face value expressed either in terms of cash or services, although a cash value would provide the care recipient with greater flexibility and would do more to stimulate price competition. The use of vouchers would make it more practicable for an individual to use more than one provider and to obtain a mix of services, for example, short-term residential care, home care, physiotherapy etc.
- 5.46 Clearly, there is an administrative overhead attached to the use of vouchers. Procedures would need to be put in place for their issue and redemption as well as for the registration of approved providers. However, the administrative burden could prove to be less than for a system that allowed recipients a choice of home care provider with direct payment to the providers concerned or, indeed, a system of direct payments to the care recipients where the use of those direct payments is monitored as in the UK.
- 5.47 In addition, an option that could be considered is outsourcing the management of the voucher system to a specialist voucher provider. Independent voucher providers operate in other countries in areas such as childcare, preventive health care and optical and dental care. It may be feasible to commission such a provider to manage a voucher system for long-term care services.
- 5.48 Arguably, vouchers would be the most effective method of allowing recipients a choice as to the mix of services and service providers whilst ensuring that the funds provided are used to meet the recipient's care needs. However, to maximise consumer choice, the alternative of cash benefits may be considered appropriate. With cash benefits, recipients would be free to use the money to purchase formal care services but would also be able to use the money to pay family carers.
- 5.49 It may be considered appropriate to pilot some or all of these alternative forms of service delivery with a view to determining the most appropriate benefit design for a new financing scheme. The results of such pilot studies should be assessed in terms of the impact on the expansion of consumer choice, the extent to which assessed needs have been met and cost-effectiveness.



5.50 There is, however, a strong case to be made in favour of a more consumer-oriented approach, whereby people with care needs could choose among providers in accordance with their own unique preferences and circumstances. This should enable new, more flexible, models of service delivery to emerge. We suggest, therefore, that, initially, benefits for home care services would be offered in the form of a choice of in-kind services and a cash alternative.

5.51 In-kind services need not necessarily be provided solely by the Health Boards. Indeed, having regard to likely supply constraints, we consider it desirable to make provision for independent providers within the system. Where in-kind services are required, we suggest that:

- a value be placed on the services to which the individual is entitled from the Health Boards
- a care manager – provided by the Health Board - would be available to help the recipient to select a package of care within that budget and negotiate its implementation with Health Board and/or independent service providers.

5.52 The recipient should have a choice of provider where possible. Both Health Board and independent providers would be paid by the funding body for the services provided.

#### Cash benefit alternative

5.53 We suggest that the alternative cash benefit would not reflect the full cost of formal care services but would rather be set at a level consistent with the policy of supporting rather than substituting for informal care.

5.54 Recipients should be allowed to select a mix of services and cash. Indeed, it is possible that many of those who are receiving informal care will not want to avail of much formal personal care – but will want to access respite care and other services such as physiotherapy or chiropody or to be provided with assistive devices such as mobility aids.

5.55 An approach would need to be developed to cater for circumstances in which the recipient is not in a position to decide on his or her own care provision i.e. where he or she has a cognitive impairment.

#### Supply of providers

5.56 There may be concerns as to whether there will be a sufficient supply of home care provision to cater for the increased demand that may emerge as a result of increased funding for such services. There is little independent home care provision at present, although some people do purchase personal home care assistance privately.<sup>48</sup>

<sup>48</sup> For example, O'Shea, 2000, found that approximately 5% of people with dementia had private personal assistance at home, for an average of 23 hours per week.

- 5.57 We would suggest that supply is likely to emerge as significant additional funding becomes available and as individual beneficiaries begin to exercise choice in the allocation of that funding. New providers will begin to be attracted into the market. There is scope to stimulate this effect by encouraging, or even requiring, the Health Boards to use independent providers to deliver a proportion of their own service obligations.
- 5.58 The example of the UK market is instructive in this regard. Prior to the 1993 community care reforms, there was little independent home care provision in the UK, much as is the case at present in Ireland. Under the 1993 community care reforms, local authorities were required to shift the balance of care provision towards the community and away from residential care. In addition, they were specifically required, for a number of years thereafter, to spend a minimum proportion of their budgets on independent, rather than in-house, provision. Whilst this is no longer required, as of 1997, over 40% of home care services funded by local authorities were delivered by independent providers. The market for such independent providers is considered to be sound, albeit that it operates on slim margins. In general, independent providers have been able to provide services at lower cost than local authority in-house services, whilst such in-house services have provided the benchmark for quality of provision.
- 5.59 Labour shortages have been cited as a potential barrier to expanding the supply of home care services, whether through the public or independent sectors. Certainly, this has been a significant issue in other countries. However, shortages are perhaps more likely to occur as a result of economic conditions than demographic trends. In the US, during the economic boom of the late 1990s, with very low unemployment rates, long-term care providers experienced great difficulty in hiring and retaining staff, particularly in the home care industry, due to the sensitivity within this sector to the availability of competing low-wage jobs. Labour market pressures are likely to have eased in Ireland, as in the US, as a result of the recent economic slowdown.
- 5.60 Studies in the US have found that the initiatives most likely to have a positive effect on recruitment and retention of care workers include those that provide competitive salaries, create opportunities for career advancement, explicitly recognise the contribution made by care workers, involve staff in care planning and foster a good working relationship with other health care personnel.<sup>49</sup> Training and education programmes for care workers are considered important along with initiatives that bring professional status to care workers e.g. opportunities to earn credentials.

- 5.61 Potentially, recruitment efforts could focus on older people who may want to continue working, perhaps on a part-time basis, following formal retirement. The future availability of care workers may also be partially dependent on future immigration policy.
- 5.62 The question has also arisen as to whether encouraging an independent home care market could exacerbate recruitment and retention difficulties within the public sector. This should not occur unless the employment terms and conditions offered by public sector employers are less attractive than those offered by their counterparts in the independent sector. Potentially, the independent sector may be able to offer greater flexibility and adaptability to current labour market conditions over the short term. However, this may operate to the benefit of the overall supply of care workers at a given time.

#### Role of the family

- 5.63 The role of the family in providing long-term care is critical in Ireland as in most other countries. There has been some considerable debate as to the likely future availability of family carers, given changing social and demographic patterns, in particular smaller family sizes and increased female labour force participation.
- 5.64 However, most analysts, both here and abroad, have found no evidence to date of a reduced commitment to family caring. Analysis from the UK suggests that increased participation by women in the workforce has not led to any reduction in the supply of informal care thus far. A significant proportion of carers combine caring and employment. Although employment is lower amongst those providing full time care, half the male, and just over one third of the female carers providing over 50 hours of caring in the UK also had paid work in 1985.<sup>50</sup>
- 5.65 The UK Royal Commission found that in no country are formal care providers the primary carer for the majority of frail older people living in their own homes, although in Denmark, which has the most extensive network of formal care services, this proportion reaches 44%.<sup>51</sup>
- 5.66 Future demographic patterns will, however, impact. Smaller families will reduce the pool of potential family carers and those who do not have children may not have any family member to care for them.

<sup>50</sup> Allen and Perkins, 1995, *The Future of Family Care for Older People*, HMSO

<sup>51</sup> *The Royal Commission on Long-Term Care, 1999, op. cit. (Research Volume 1)*

5.67 O'Connor et al (1988) provided data on the age and sex of co-resident carers of dependent older people as follows:

**Profile of co-resident carers of older people**

Age	Male %	Female %
<29	0.0	2.4
30-39	19.4	14.0
40-49	25.0	28.0
50-59	27.8	20.7
60-69	16.7	23.2
70-79	8.3	10.4
80 and over	2.8	1.2
Total	100.0	100.0
	<b>16% of all carers</b>	<b>84% of all carers</b>

5.68 We have used this profile to create an index of potential carers based on the population projections that underlie our estimates of future care needs. The results are set out in the table below. They show that, whilst estimated “carer potential” will actually increase until 2011, thereafter it will fall significantly in line with demographic change.

**Carer potential 2001 – 2051**

	Index of carer availability (1)	Index of long- term care needs (2)	Ratio of carer availability to care needs (1)/(2)
2001	100	100	100
2006	109	106	103
2011	117	112	105
2016	124	119	105
2021	129	126	102
2026	131	136	96
2031	130	146	89
2036	128	159	81
2041	127	168	75
2046	124	174	71
2051	120	177	68

- 5.69 Two points are, however, worth making. Firstly, this analysis focuses on carers of older people. Whilst older people form the majority of those needing care, a substantial proportion of care needs – around 40% of the total – arise in the younger population for whom the carer profile will be quite different. Secondly, it is to be expected that the profile of carers will itself alter with demographic change. If the onset of disability occurs in future at older ages than at present, then carers will likely also be older than at present. Moreover, it is likely that more spouses will be available to care in future, reflecting both increased life expectancies and the relatively low rates of marriage by the population cohorts that were aged over 65 in the 1980s and 1990s.
- 5.70 On the other hand, carer potential is likely to fall further due to increasing participation by women in the labour force, as shown in the table below.

**Labour force participation rate (%)**

Age	Married women				Other women	
	1998 actual	2001 assumed	2006 assumed	2011 assumed	1998 actual	2001-2011 assumed
25-29	67.2	70.0	75.0	78.0	86.6	87.0
30-34	62.6	65.0	70.0	75.0	81.5	82.0
35-39	58.2	63.0	67.0	72.0	82.7	81.0
40-44	54.4	60.0	65.0	70.0	77.2	77.0
45-49	47.9	53.0	60.0	65.0	73.3	73.0
50-54	40.2	45.0	53.0	57.0	67.9	68.0
55-59	29.5	35.0	40.0	45.0	45.8	46.0
60-64	16.4	20.0	20.0	20.0	29.6	30.0
65+	2.6	2.0	2.0	2.0	5.6	5.0

Source: CSO, 2001, *Population and Labour Force Projections, 2001-2031*.

## Responsibility of the family to provide care

5.71 We estimate, broadly, that the impact of increased labour force participation as assumed above could further reduce carer potential by around 15% over the next 10 years. If these trends continue into the future, the availability of family carers is likely to reduce even further.

5.72 The responsibility of the family to provide care requires separate consideration. This is an issue on which there are substantially divergent views. At one extreme is the view that families do not have any responsibility to provide long-term care and that comprehensive services should be provided by the State. At the other is the perspective that the family has the primary responsibility for care and that the State should only provide care for those without family.

5.73 The problem with the former perspective is that it disregards the significant advantages of informal care:

*"Informal care is more flexible, usually more caring, and more reciprocal. The 'intangible' benefits of informal care-giving within families are self-evident, but difficult to measure...Long-term care is, for the most part, not professional care; it is simply helping disabled elders with their everyday lives"*<sup>52</sup>

5.74 On the other hand, the view that formal services should only be made available in the absence of family carers, places a heavy, and arguably unfair, burden on carers. Moreover, it may be inefficient to the extent that the stresses of providing care without support may lead to a breakdown in the provision of informal care, at which stage formal services may have to be provided on a residential basis.

5.75 A balance between these two extremes can be found in the policy articulated in the Review of the Carer's Allowance (1998) as follows:

*"The...view of the State's role as one of support and encouragement, reflects the public policy of community care in Ireland as first set out in 1968 by the publication of the report of the Inter-Departmental Committee on the Care of the Elderly, (Care of the Aged). The formal objective set out in this report of keeping older people in their own homes, or in home-like settings, with adequate support for people requiring institutional care, has been reiterated by successive Governments. This policy of community care recognises the wishes of people to remain in their communities, and aims to support families in their caring responsibilities. The State should support carers to ease their burden of emotional and physical stress caused by caring."*

52 Burwell et al, 1993, "An analysis of long-term care reform proposals", DALTCP, US

- 5.76 This view does not see family care as a substitute for care that should be provided by the State and for which financial remuneration should be provided to family carers. It does, suggest, however, that formal services and/or benefits should be available to support the role of the informal carer, which for the most part has not been the case heretofore.
- 5.77 The concern is sometimes expressed that the availability of formal services will lead to an erosion of informal care. However, international evidence strongly suggests that this is not the case. Studies in the US, for example, have shown that those who receive formal home care services receive no less informal care than do those without formal support. In Denmark, evidence suggests that public services augment rather than substitute for family care.<sup>53</sup>
- 5.78 Heretofore, in Ireland, formal community care services appear to have been directed primarily at unsupported elderly people living alone, reflecting the targeting of scarce resources to the area of perceived greatest need. Respite and day care services have also been limited. Moreover, the respite services that are available are not always structured to meet people's needs. The majority of respite care is provided in residential homes whereas flexible community-based models of respite care may be more appropriate. For example, a study carried out for the Carers National Association in the UK recommended that a minimum guarantee of respite care would be a 4 hour break each week in the carer/care recipient's home.
- 5.79 More support for family care is needed and, with a view to this, we have already proposed that cash benefits should be available as an alternative to the provision of home care services. The question arises, however, as to whether such cash benefits should be paid to the care recipient or the carer.
- 5.80 In their submissions to the Review of the Carer's Allowance, this was an area where the various interest groups had diverging views. According to the Review, in the main, the groups representing people with disabilities favoured the payment of the Carer's Allowance to the care recipient, to allow them to purchase their own care. This is the argument for empowerment, which supports care recipients in allowing them to choose the way in which they want their own care needs addressed. The opposing view, held by the groups representing carers and older people, was in support of the payment of Carer's Allowance to the carer.

53 *Department of Social and Family Affairs, 1998, Review of the Carer's Allowance*



5.81 It is also worth considering international approaches.

- In Germany and Luxembourg, where care recipients can elect to take a cash benefit in lieu of care services, there is evidence to suggest that the recipient does not always pass on this benefit to the caregiver.
- In the Scandinavian countries, on the other hand, care allowances are provided directly to carers. In Finland, for example, Home Care Allowances are awarded on the basis of the care need by the older person but, with the agreement of the older person, are paid by the local municipality directly to the informal caregiver. The allowance is largely intended to substitute for formal service provision. Similarly, payments for family care-giving in Sweden were initiated when services were in short supply. Such payments are also available in Denmark.

5.82 This latter type of approach is broadly similar to the Continual Care Payment that was proposed as an option in the Review of the Carer's Allowance. There may, however, be an argument for providing this type of allowance in situations where care needs are less intensive than was envisaged in the Review. For example, a care allowance that was available in respect of moderate levels of care needs could provide encouragement to potential carers to combine caring and part-time employment. This, in turn, could reduce the need for formal service provision.

5.83 We suggest that consideration be given to a flexible system whereby, following needs assessment, the person in need of care and their principal caregiver (if they have one) would select in-kind services or a cash payment or a mix and it would be determined whether the cash payments should be made to the care recipient or the carer.

5.84 If a substantial amount of care were being provided by the caregiver, it would be most appropriate that the cash payments would be made to him or her. Hence, these payments could replace the need for a Carer's Allowance/Carer's Benefit. In the case of children with significant care needs, this approach could also subsume the current Domiciliary Care Allowance.

**A template  
benefit  
structure**

5.85 For the purposes of discussion, we set out below one possible benefit structure, which reflects the proposals in the preceding paragraphs. We use the term "benefit" to encompass both service provision and cash subventions, as appropriate. It is important to note that the suggested benefits outlined below would apply in respect of personal care needs arising from a significant level of dependency. Eligibility for benefits would be determined on the basis of an objective quantified needs assessment as outlined previously. Benefits would not therefore be payable to people with disabilities generally.



- Benefits for residential care for older people on the following basis:
  - Where the individual occupies a public bed, the full cost would be covered subject to a co-payment equal to 90% of the non-contributory Old Age Pension (NCOAP). This co-payment is intended to cover or contribute to general living and accommodation costs. It is assumed that public beds will be occupied primarily by those with the highest level of dependency. A higher co-payment may be appropriate in respect of any residents with lower levels of dependency.
  - Where the individual occupies a private bed, a cash subvention would be payable, based on the assessed level of need:
    - ▶ If the assessed level of need is for “continuous” care, a benefit equal to 90% of the nursing home charge less 90% of NCOAP, up to a maximum benefit of €375 per week.
    - ▶ If the assessed level of need is “high”, a benefit of 90% of the nursing home charge less 90% of NCOAP, up to a maximum benefit of €225 per week.

- Benefits for home care in accordance with the following table:

Assessed level of need	Formal services to the value of:	Cash benefit alternative
Moderate	€113 per week	€68 per week
High	€225 per week	€135 per week
Continuous	€375 per week	€225 per week

- 5.86 The suggested benefits for residential care reflect current nursing home charges and take into account the principle that people should contribute towards accommodation and daily living costs just as they would if they were living in the community.<sup>54</sup>
- 5.87 The benefits for home care services for moderate and high levels translate into an hourly rate of just under €11<sup>55</sup> based on the assumed number of hours of personal care required as set out in section 3. The benefit of home care services for people in need of continuous care has been linked to the benefit for private residential care. Similarly, the proposed benefit for private residential care for those with a high level of need has been linked to the corresponding home care benefit. This is intended to eliminate the bias towards residential care.

<sup>54</sup> Department of Health and Children, 2001, *op. cit.*

<sup>55</sup> O'Shea, 2000, estimated the hourly cost of a home care attendant at £6.30 (€8) and of private personal assistance at £4.83 (€6.13). However, we understand that rates of pay have increased significantly.

- 5.88 The cash benefit alternative, where formal services are not required, is set at 60% of the cost of formal services. This alternative is not intended as a payment for family care, but rather as a measure to support family carers. It can potentially be viewed as a mechanism to create a partnership between the State and families in the provision of long-term care.
- 5.89 Where the majority of care is provided by a family carer, it would be appropriate that the cash benefit would be payable to that carer, as noted in paragraph 5.84. In most such cases, we would suggest that the long-term care benefit would replace the payment of Carer's Allowance or Carer's Benefit. The amount of the template long-term care benefit is greater than either the Carer's Allowance or Carer's Benefit where the need is for high or continuous care, while we would not envisage that someone caring for a person with moderate care needs would qualify for the Carer's Allowance/Benefit. It may, however, be necessary to continue to pay, under the Carer's Allowance scheme, dependent child allowances to carers who have dependent children.
- 5.90 The Carer's Allowance is an income support payment rather than a payment for caring. The extent to which such income support would continue to be required following the introduction of a long-term care benefit would depend on the criteria for payment of such a benefit. If, for example, the long-term care benefit were to be a universal benefit, payable in respect of every care recipient with the specified level of care needs, then the Carer's Allowance should no longer be required, except perhaps in exceptional cases. If, on the other hand, the long-term care benefit was subject to a means-test<sup>56</sup> or other eligibility criteria (e.g. social insurance contribution criteria), there would be cases in which a long-term care benefit would not be payable but the primary caregiver would need income support. An alternative approach could be to provide a long-term care benefit only where the carer is not receiving the Carer's Allowance.
- 5.91 Similar considerations apply in respect of the Carer's Benefit. We would not envisage that a dual payment of long-term care benefit and Carer's Benefit would be made. If, however, the long-term care benefit was not to be a universal one, then we suggest that Carer's Benefit would continue to be payable if a long-term care benefit was not.
- 5.92 We would also envisage that a long-term care benefit, if universally available, would subsume the Domiciliary Care Allowance. If the long-term care benefit was to be means-tested, then the Domiciliary Care Allowance would presumably continue to be payable to those who did not qualify for a long-term care benefit (for children with care needs, we assume that means-testing for the long-term care benefit would be based on the parents' means).

<sup>56</sup> which would presumably be based on the means of the care recipient

5.93 As is evident from the preceding paragraphs, the interaction between the proposed benefit in respect of long-term care needs and existing income support and social insurance measures may not be entirely straightforward. An appropriate approach could only be fully worked out when eligibility criteria for the long-term care benefit have been determined.

**Linking housing  
needs to care  
provision**

5.94 A number of schemes are available to provide repairs or adaptations to the homes of people with disabilities: the Essential Repairs Grant Scheme, the House Improvement Grant for Disabled Persons and Special Housing Aid for the Elderly.

5.95 A review of Special Housing Aid for the Elderly was completed by the Comptroller and Auditor General in 2000. It concluded that the scheme represents value for money in contributing to the ability of older people to remain at home and avoid moving into more expensive residential care. However, it stated that there is an urgent need to introduce a system of formal needs analysis in relation to the scheme.

5.96 Moreover, the review found that the implementation of the scheme varied between Health Boards and between community care areas within Health Boards.

*“The effect of the diversity of approach is that the ability of elderly people to avail of the scheme and the manner in which they benefit from it depends on where they happen to live.”* Comptroller and Auditor General, 2000, Report on Value for Money Examination: Special Housing Aid for the Elderly

5.97 With a view to optimising the provision of long-term care in the most appropriate setting, it would seem that there is scope to co-ordinate the organisation of this and the other schemes that cater to the housing needs of older and disabled people with the financing and provision of long-term care services. We have previously highlighted the crucial role for a nationally consistent and comprehensive basis for assessing long-term care needs. Ideally, this should extend to assessing the scope for adapting and improving housing with a view to maintaining the elderly person in the community.

5.98 To date in Ireland there is only a limited supply of sheltered housing suitable for older people with significant long-term care needs. The National Council on Ageing and Older People has recently, in its comments and recommendations on the HeSSOP report, recommended that there should be increased provision of sheltered housing. In particular, it recommends:

*“the implementation of a properly defined funding scheme for on-site support in voluntary sheltered housing schemes incorporating care costs and management costs. This scheme should cover the provision of services distinct from health board provided community care services.”* National Council on Ageing and Older People, 2001

- 5.99 We recommend that long-term care benefits should be available to people in sheltered housing or assisted living facilities, based on the residential care scale outlined above. The providers of such facilities should become approved providers for the purpose of allocating care subventions as outlined above. This would help fund personal care provision within sheltered housing and assisted living facilities; separately, Health Boards would continue to provide community care services to residents within such facilities.

### Continuing care retirement communities

- 5.100 Continuing care retirement communities (CCRCs) are common in the USA and in some countries in continental Europe. One such community (Hartrigg Oaks) has recently been established in the UK by the Joseph Rowntree Foundation and is described below in order to illustrate how CCRCs operate.

#### Hartrigg Oaks CCRC

Incoming residents purchase a bungalow in the Hartrigg village when they are in good health. If care support is needed it is normally provided for residents in their own bungalow, which is linked through an alarm system to the Oaks Centre. When care needs reach a high level (i.e. more than 21 hours support per week), the individual moves to a room in the Oaks Centre that is equivalent to a nursing home. The Centre also provides respite and rehabilitation care.

Residents pay both a residence fee and a community fee (the community fee covers the cost of running the Hartrigg Oaks complex and care costs). There are three methods of payment for each fee.

#### Residence fee options

- A refundable one-off payment – the purchase price for the occupation of a bungalow and the use of a room in the Oaks Centre if required (repayable on the death of a resident or earlier withdrawal).
- A non-refundable one-off payment (equivalent to a reversionary cost of the refundable fee, based on the individual's age at entry).
- Monthly payments equivalent to rent.

#### Community fee options

- A standard annual fee which is calculated on a pooled basis (i.e. independent of the actual care support the individual receives) based on the individual's age at entry.
- A reduced annual fee combined with a non-refundable capital sum on entry.
- The cost of actual care services plus a fixed sum for the Community running costs.

The most popular combination of payment is the Refundable Residence Fee together with the Standard Community Fee. Many of the incoming residents already own property and are, in effect, “trading down”. They sell their existing house and buy the right to occupancy of the bungalow and either retain the cash balance or use it to secure care services for life.

The financial viability of the CCRC is dependent on whether the community fees plus the capital appreciation on the Refundable Fee basis and the full value of the properties on the non-refundable Residence Fee basis are sufficient over the long-term to cover all the running and care costs and give them an interest return on the capital cost of establishing the village.

- 5.101 The level of uncertainty is such that commercial providers may be reluctant to become involved in the financing of such ventures. In addition, there was negative comment / publicity in recent times about a particular retirement village which was not dissimilar in concept to a CCRC. This is likely to impact negatively on public opinion with regard to any future private developments in this direction.
- 5.102 There may, however, be scope within the voluntary sector for this type of provision. One example of a voluntary sector development is a project that includes a day centre, a “village” of independent housing units supported by an on-site caretaker and a high support unit which provides “in-house” sheltered accommodation for 30 people.
- 5.103 Residents in the independent housing units wear electronic alarms that are monitored by the caretaker and, as backup, by an off-site monitoring station. A community bus, meals-on-wheels or meals at the day centre and laundry facilities are available to residents. The average age of the residents is eighty.
- 5.104 The high support unit consists of a number of double rooms with communal facilities including a day room, dining area, kitchen, and consulting room for visiting paramedics. Some of the initial residents in the independent units have subsequently moved into the high support unit. The unit is staffed with registered nurses, care and support staff, as well as volunteers and FÁS workers. In addition to the provision of continuing care to long-stay residents, the unit provides respite care, convalescent care following early discharge from acute facilities and terminal care.
- 5.105 We envisage that the availability of a care subvention for residents of this type of facility would contribute towards the running costs.
- 5.106 There is also scope for a public initiative to increase this type of provision, having regard to the need to find an intermediate form of care – between home care and full residential care – in particular for older people living alone.

## Integrated systems of care

- 5.107 An example of how such an initiative might operate is a programme called *“Coming Home: Integrated Systems of Care for the Rural Elderly”* initiated by the Robert Wood Johnson Foundation in the US in 1992, in recognition of the need for assisted-living facilities that people with limited means living in rural areas could afford.
- 5.108 The Orchard House Personalised Living Centre for low income older people at Mt. Angel, Oregon was the Foundation’s first venture and has since been replicated at many low density rural areas throughout the US.
- 5.109 In concept, the “Coming Home” programme requires a partnership approach involving appropriate State agencies not only in providing care services but also in organising suitable sites for assisted-living developments. This initiative in the US involves the concept of tax credits for real-estate developers that apparently have proved suitably attractive to entice resources into the provision of suitable accommodation.
- 5.110 In an Irish context a similar community based system could be put in place through a public/private partnership involving:
- The Department of the Environment and Local Government which would legislate for appropriate planning regulations (e.g. that all developments above a prescribed size must involve a specified proportion of assisted-living accommodation).
  - The Department of Finance – by, for example, providing a system of tax credits to building developers who meet specified criteria in relation to assisted-living accommodation. This could build upon existing relief for conventional nursing home accommodation.
  - The Departments of Health and Children and Social and Family Affairs in the financing and/or the provision of the required health care and social services needed to enable the community based assisted-living programme to operate.
- 5.111 In an Irish context the Robert Wood Johnson Foundation’s *“Coming Home”* programme demands closer study – particularly the manner in which it operates in conjunction with such legal instruments as the National Affordable Housing Act of 1990. It appears to have the ingredients to work equally well in Irish rural and urban environments. In the words of David Nolan, vice president of the NCB Development Corporation (US):

*“...if an affordable Assisted-Living facility can be built and operated successfully in Ullin (a village of 500 residents in Southern Illinois) it can be done anywhere”.*

5.112 Finally, we note that the Department of the Environment and Local Government has announced in Action on Housing (2000) that:

*“The National Building Agency will pilot a home ownership sheltered housing development for elderly private homeowners wishing to purchase housing more suitable to their needs within their community and locale. The pilot will serve as a demonstration model that can be taken up by the private house building sector and local communities throughout the country”.* Department of the Environment and Local Government, 2000, Action on Housing.

5.113 Perhaps this initiative could provide a starting point from which to explore the potential for a partnership approach to developing integrated assisted-living housing schemes on the “Coming Home” model.



## 6. Financing options

### Pattern or care need

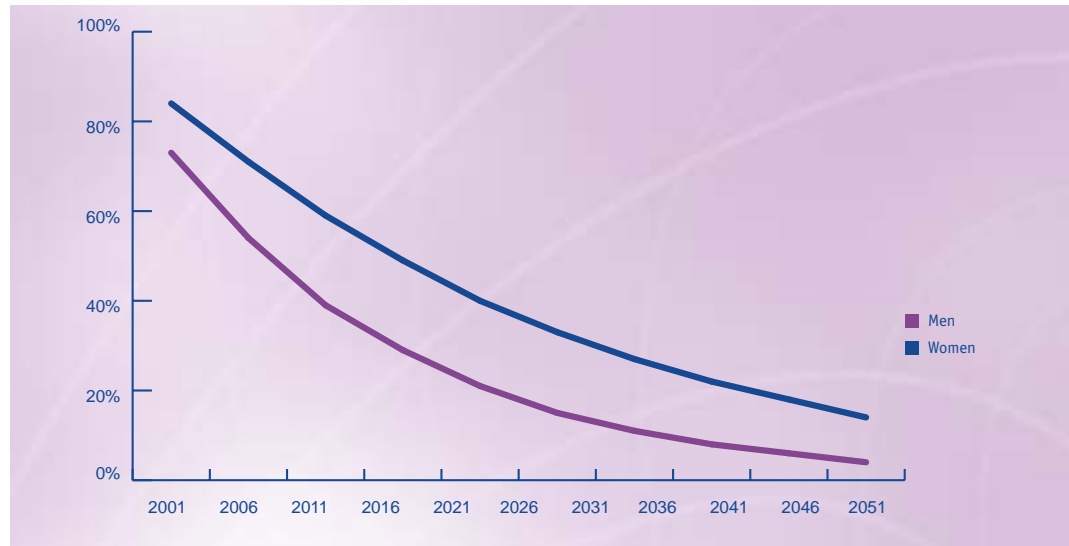
- 6.1 Before examining the various financing options, it is important to consider the pattern of care need in terms both of incidence and duration. This will be important in terms of considering the duration over which long-term care benefits should be provided and the scope for developing a partnership approach.
- 6.2 The need for long-term care is a risk not a certainty for most people (the exception being those who have had a disability since birth or from an early age). In terms of long-term care for older people, estimates from Sweden and the US suggest that the probability of someone who is aged 65 being admitted to an extended care facility home during the remainder of their lifetime is around 40%.<sup>57</sup> However, this figure may include relatively short-term “convalescent” type hospital stays.
- 6.3 In the UK, it is estimated that the lifetime risk of long-stay entry into a nursing home, based on 1995/96 admission rates, is 20% for a man aged 65 and 36% for a woman aged 65.<sup>58</sup> Similarly, incidence rates for severe disability derived by Dullaway and Elliott (1998) on the basis of the UK OPCS data, suggest that the probability that someone aged 65 will become so severely disabled as to require continuous care is 23% for a man and 44% for a woman. These probabilities may reduce in the future, if the incidence of disability reduces alongside improvements in life expectancy.
- 6.4 In terms of financial risk, moreover, it is the duration, rather than the incidence, of long-term care need that is critical. In many cases, long-term care will be needed for a relatively short period. However, for a relatively small proportion of people, care will be needed for a number of years and, for these people, the financial impact is enormous.
- 6.5 Based on work by Dullaway and Elliott, we estimate that the average duration of severe disability where the age of onset of that level of disability is 75 is 3 years for a man and 5 years for a woman (note, however, that the average nursing home stay is significantly shorter than this). The chart below illustrates the variability of the duration of disability around that average.

<sup>57</sup> OECD, 1996, *Ageing in OECD Countries, A Critical Policy Challenge*, Social Policy Studies No. 20

<sup>58</sup> “long-stay entry” is defined as an admission where a date of discharge has not been set prior to admission.



### Proportion of people surviving by duration since inception of severe disability (age at inception: 75)



6.6 The degree of uncertainty in relation to the need for long-term care and, in particular, the duration of that need, is such that some form of risk pooling is the most efficient means of paying for long-term care. In this respect, long-term care is broadly similar to other morbidity risks, such as the need for acute health care or for income protection in the event of inability to work due to illness.

### Financing options

6.7 This leads us to consideration of the various alternative financing mechanisms. There are broadly four possible approaches to funding long-term care:

- Private savings, including residential property
- Private insurance
- Public tax-based finance
- Social insurance.

6.8 Within these broad options, there are many possible variations and combinations, amongst which we consider the following:

■ Private savings, including residential property	<ul style="list-style-type: none"> <li>■ Equity release – private</li> <li>■ Equity release – public sector involvement</li> <li>■ Estate tax</li> </ul>
■ Private insurance	<ul style="list-style-type: none"> <li>■ Premium/tax subsidies</li> <li>■ Compulsory private insurance</li> <li>■ Long-term care insurance as an employee benefit</li> <li>■ Pension-linked financing</li> </ul>
■ Public tax-based finance	<ul style="list-style-type: none"> <li>■ Earmarked long-term care tax</li> </ul>
■ Social insurance	<ul style="list-style-type: none"> <li>■ Voluntary social insurance</li> </ul>

6.9 In looking at each option, and assessing its effectiveness in meeting long-term care needs in the medium and long-term, we will have regard to the following issues:

- The need for risk pooling.
- Income redistribution.
- Smoothing of financial impact over the life cycle.

### Private savings

6.10 There are many ways in which individuals could save towards the cost of long-term care. One particular route that has been advocated is for people to augment their retirement savings such that a proportion of such savings can be used to finance long-term care. However, it is important to bear in mind that many people may not be making adequate retirement provision at present. Moreover, many people on lower incomes may not be in a position to save enough to finance the expected cost of long-term care.

6.11 Most importantly, though, saving is not an efficient basis on which to finance long-term care, given the uncertainty as to whether any particular individual will need long-term care and as to how long care will be needed for. Those who do not need long-term care will have tied up a substantial proportion of their resources unnecessarily, whereas those who need prolonged long-term care are unlikely to have made sufficient provision. Moreover, long-term care for people who have been disabled from birth or an early age cannot be financed from private savings.

6.12 As of today, however, many older Irish people, whose incomes are such as to preclude them from eligibility for a nursing home subvention but insufficient to meet the cost of full-time care, are reliant on their savings to finance their long-term care needs. This must cause significant concern and worry to those people, particularly since, as noted by the HeSSOP report<sup>59</sup>, over 75% of older people have never discussed with their family members what would happen if they needed long-term care.

**6.13 We conclude that it is not reasonable to expect people to provide for long-term care costs by means of savings or the accumulation of assets, with the exception of housing assets, which are considered further below.**

6.14 Levels of home ownership are particularly high in Ireland, especially so amongst older people. In 1997, just over 80% of those over 65 owned their own homes. Moreover, in 92% of owner-occupied households where the head of household is aged over 65, the property is owned outright. In 1997, self-estimates from survey respondents put the average market value of homes headed by an older person at £58,557 (€74,352), a figure that rose to £74,177 (€94,185) for homes in urban areas.<sup>60</sup>

<sup>59</sup> Garavan, Winder and McGee, 2001, *op. cit.*

<sup>60</sup> Layte et al, 1999, "Income, Deprivation and Well-Being Among Older Irish People, National Council on Ageing and Older People

- 6.15 The sale of the family home is therefore a possible method of financing residential long-term care for older people. However, it does not facilitate care at home and does not address the long-term care needs of younger people. Moreover, it may not be a viable option if the spouse of the person in need of care, or other dependent relatives, are resident in the home. Even if the person has moved into residential care and there are no other family members living in the house, it may be undesirable for the house to be sold, if there is a possibility that he or she may recover sufficiently to return to the community or because of the adverse emotional impact at a vulnerable time. In addition, if the individual is suffering from dementia, then it may not be possible to sell the house, unless a family member has power of attorney.
- 6.16 “Equity release” arrangements that have recently become available in the Irish market provide a means of accessing part of the value of the home to pay for care (or indeed for other purposes) without the home having to be sold. The alternative forms of equity release will be described briefly below.
- 6.17 First, however, we must stress again the need for risk pooling, which is not met by a simple equity release mechanism. The average family home is of sufficient value to pay for the average duration of residential care. If, however, care is needed for longer than average, or perhaps if both spouses need care, the value of the home may be insufficient to meet the costs of care.
- 6.18 However, sums raised through equity release could potentially be used to finance a long-term care insurance policy that would provide some element of risk pooling. This option has been promoted by some providers in the UK but has not proved popular with the public – two contracts are involved, an equity release product and an insurance policy. The combination of two profit margins, two margins on interest rates, two sets of expenses and commission and different assumptions on longevity are unlikely to lead to an attractive package for potential customers.<sup>61</sup>

## Equity release

- 6.19 An equity release mechanism is a financial scheme that enables a householder to draw down some of the equity in the house. Such schemes are generally based either on a mortgage or a reversion. The amount drawn down is repaid when the homeowner dies or moves out of the house. Repayment can be deferred until a surviving spouse dies or moves out of the home. Most equity release schemes can be transferred to another house if the owner moves.
- 6.20 Two equity release schemes have recently been launched in the Irish market, one a mortgage type and the other a reversion.

<sup>61</sup> Institute/Faculty of Actuaries, 2001, *Report on Equity Release Mechanisms*.

## Bank of Ireland Life Loan

The Bank of Ireland Life Loan is a mortgage product, which has been available since February 2001. Homeowners with a home worth more than £60,000 (€76,184) can borrow up to 30% of the property value. Interest – at a rate, which is fixed for the first 15 years of the loan – is added to the amount outstanding. The loan is repayable when the homeowner sells the property, vacates it for a period of six months or more, or dies (in the case of a couple, it is the second death that triggers repayment). The borrower is not at any risk of losing his or her home, as there is a “no repossession clause”. Effectively, Bank of Ireland bears the risk that the rolled-up mortgage could eventually exceed the value of the property. It has no recourse to any other assets in the individual’s estate, nor would beneficiaries of that estate be expected to meet the shortfall.

## Residential Reversions

Residential Reversions launched a reversion-based equity release scheme in late 2000. Under this scheme, Residential Reversions purchases a proportion (or all) of the property for either a lump sum or a guaranteed monthly income payable to the homeowner. The income, if chosen, is payable throughout the life of the homeowner or, for a couple, until the death of whichever person lives longer. There is the option of either a fixed income or one, which starts at a lower level and increases annually by 5%. The income may also, optionally, be guaranteed payable for a minimum of five years, even if the individual dies within this period.

The property is leased back rent-free to the existing occupant. If only part of the property is sold in this way, the homeowner continues to benefit proportionately from any future increases in the value of the property. If the individual moves house, the reversion can be transferred to his or her new home.

The minimum property value is £75,000 (€95,230) and a minimum of 25% must be transferred to Residential Reversions. The homeowner(s) must be aged 70 or older. Again, complete security of tenure is guaranteed, regardless of how long the individual lives. When the individual dies or moves into residential care, the property is sold and the proceeds split between Residential Reversions and the homeowner (or his estate) in the appropriate proportions.

## Shared appreciation mortgages

- 6.21 A third type of equity release mechanism, the shared appreciation mortgage, is not currently available in the Irish market but was available for a time in the UK from Bank of Scotland and Barclays Bank. Both schemes have now been withdrawn, as the providers were unable to attract funds from long-term institutional investors, such as pension funds, to finance the scheme. Shared appreciation mortgages were very successful and the quota was quickly sold out. If the funding difficulties could be resolved, then this type of product would likely have appeal in the Irish market also.

- 6.22 Essentially, the shared appreciation mortgage allowed homeowners to release some of the equity in their home at the expense of part of the future appreciation in the value of the property. The original product had two versions. In the first version, the individual paid interest on the loan at a low rate relative to market interest rates and in addition the provider took a proportionate share of the capital appreciation on the house over the period of the mortgage. In the second version, no interest was payable on the loan but the loan repayment was the original loan amount plus three times the capital appreciation in property value on the percentage advanced on the loan. The maximum initial advance for this version was 25% of the value of the house.

**Example**

Value of house

- at outset of mortgage: €200,000
- on death (5 years later): €240,000

Shared appreciation mortgage

- amount advanced: €50,000 i.e. 25% of value of house
- amount repayable: €80,000 i.e. amount advanced plus 3 x 25% of increase in value of house (€40,000)

*No interest payable during 5 years*

- 6.23 In the UK, where equity release products have been available for some years, the majority of older people have been reluctant to use the value of their house to increase income or pay for long term care. Consumer confidence is low and older people are generally suspicious of the products and of the organisations promoting them. This may be partly due to the mis-selling of poorly constructed Home Income Plans in the 1980s.
- 6.24 In addition, there is a strong desire for some people to leave the house as an inheritance for their children or grandchildren. It may be argued that this attitude is changing, but there is little firm evidence for this. Equity release mechanisms that only use part of the value of the house and leave the remainder for an inheritance may help overcome the reluctance to release house equity.
- 6.25 Equity release mechanisms have only been available in the Irish market for a very short period and it is too early at this stage to gauge the level of take-up in the long term. However, the initial experience suggests a reasonable level of interest. More than 500 customers availed of the Bank of Ireland Life Loan in less than four months from the date of its launch, while Residential Reversions aimed to secure deals with 300 clients in its first year and expected that it would comfortably make that target.<sup>62</sup> However, the typical Residential Reversions applicant to date has a property worth €250,000 to €500,000. This suggests that equity release products will be taken up principally by those with more valuable properties.

## Equity release – public sector involvement

- 6.26 There is the potential for public sector involvement to facilitate the release of housing equity. The State could provide long-term care benefits (either in kind or in the form of cash subsidies) on a non-means-tested basis, subject to placing a charge on the recipient's home. After the death of the individual, or a surviving spouse, the house could be sold and the State could recoup its outlays. This approach has been advocated by O'Shea and Hughes, 1994.<sup>63</sup>
- 6.27 The UK Government has gone down this route: it has provided a designated budget to local authorities to promote and encourage the provision of local authority loans to fund long-term care, repayable on death or the eventual sale of the property.
- 6.28 This approach, while it has some theoretical merit, would likely prove unpopular in practice. It is noteworthy, for example, that in the US, the States have generally been very reluctant to seek to recover care costs from the sale of residential property, even after the death of a surviving spouse.
- 6.29 An alternative role for the State would involve the encouragement of pension fund investment to back shared appreciation mortgage vehicles. Elsewhere, pension funds already invest in the securitised interest bearing bonds that back traditional mortgage types. These bonds are attractive to pension funds and life assurance companies since they are long dated and fit in with their asset/liability matching requirements. In theory, pension funds and life assurance companies should find funding of equity release mechanisms that reflect house prices an attractive investment. House prices have moved up steadily in line with average earnings growth over a long period of years. Potentially, the National Pension Reserve Fund could lead the way by making some funds available for residential property investment to back equity release mechanisms.
- 6.30 In conclusion, equity release products fulfil a valuable role in allowing people to use the value of their housing equity to fund care whilst remaining in their home. We recommend that the State should seek to encourage further development of the equity release market, including pension fund investment.**
- 6.31 Long-term care could potentially be financed by the State partly or wholly through a posthumous charge on assets. This approach would have the following advantages:
- It can be perceived as socially just that the present older generation should fund its own care costs from capital that it has accumulated over its own working lifetime. It means that present and future working populations would not have to fund both their own long-term costs as well as the cost of care for the present older population.

- It facilitates risk pooling between those who do not need long-term care or only require care for a relatively short period and those who have high care needs over an extended period and also provides redistribution between those with few and those with significant resources.

The disadvantages are:

- The taxation of inheritances to finance long-term care is a controversial policy option and it would likely be difficult to obtain sufficient political and public acceptance for its implementation. It would, for example, be inconsistent with the recent abolition of probate tax.
- Beneficiaries would be called upon to pay a significant level of tax on an inheritance that may not be represented by liquid assets. Particular problems could arise in relation to inherited businesses or farms (however, as is the case with inheritance tax, costs could be mitigated through life assurance held in trust).

6.32 To discourage people from depriving themselves of assets in order to avoid the duty, a method of levying a notional charge against property gifted to another person would need to be considered.

6.33 In order to derive a broad estimate of the possible base for such a tax, we considered:

- the revenue from probate tax in 2000 plus
- an estimate of the value of housing assets of single and widowed people over age 65.<sup>64</sup>

6.34 Revenue from probate tax in 2000 was £29.5 million (€37.5 million), suggesting an underlying asset base of £1.475 billion (€1.87 billion). In practice, the total value of inherited assets would be greater since the threshold for probate tax was £40,000 (€50,790) in 2000. Also, various other exemptions applied (note that the tax did not apply to property passing to a spouse).

6.35 In addition, we estimate the value of housing assets for single and widowed people over age 65 to have been approximately £1.6 billion (€2 billion) in 2000 (in arriving at this estimate, we used the data on home ownership in section 2, along with data from the Housing Statistics Bulletin as to the average increase in house prices from 1997 – 2000, and the number of deaths by marital status as provided by the Central Statistics Office).

6.36 In total, therefore, there is a very substantial base of inherited assets to which a tax could be applied in order to finance long-term care. Nevertheless, the level of the tax would be not inconsiderable (perhaps of the order of 25%).

<sup>64</sup> Residential property was generally exempt from probate tax; we also considered that any tax should not be applied to the value of housing assets where there is a surviving spouse.



**6.37 In conclusion, we believe that the option of an estate tax to fund long-term care benefits would not garner sufficient political and public acceptance to be a viable policy option.**

#### Private insurance

6.38 At present, long-term care insurance policies are not available in the Irish market. Such products are available, however, in many other countries, including the UK, France and the US. The typical features of this kind of insurance are set out overleaf.

6.39 Private insurance provides a risk pooling mechanism that redistributes from those with less care needs to those with more care needs. However, it is an imperfect pooling mechanism, as private insurers will assess the risks presented by those applying for cover and will decline cover to those who are perceived as most high risk. Hence, for example, a person with a family history of Alzheimer's would not be able to obtain long-term care insurance and could, if they subsequently developed the disease, need long-term care for a prolonged period. Furthermore, private insurance is geared only to the long-term care needs of older people; it does not address the needs of those who have been disabled from birth or an early age.

6.40 Private insurance is not effective in distributing the cost of care amongst those with different income levels. In fact, long-term care insurance is more expensive for those on lower incomes as the benefit that they need to insure - i.e. the expected cost of care less their available income - is higher. Not only are the premiums higher as a consequence, but they have less income from which to finance the premium payments.

6.41 Neither, in practice, is private insurance effective at spreading the financial impact of long-term care throughout an individual's lifetime. In theory, long-term care insurance could be effected at an early age and premiums spread throughout an individual's adult life. In practice, however, experience in other countries suggests that it will generally be purchased by people in their sixties and seventies. At younger ages, there are significant competing demands on people's disposable income.



### Long-term care insurance policies – typical features

Long-term care insurance policies are usually paid for by a single premium or by regular monthly or yearly premiums (payable until time of claim or death) to cover future benefits of a fixed annual value (possibly index-linked). Premiums vary depending on age, sex and health status – rates are higher for women. Applicants are medically underwritten and there are many medical conditions that would preclude an individual from obtaining such insurance.

Long-term care insurance may be provided on a standalone basis or as an extension to other types of life and health insurance, for example, permanent health insurance.

Eligibility for benefits under a long-term care insurance policy typically arises if an insured person is unable to perform two or three activities of daily living (ADLs). For example, a contract may pay up to 50% of the benefit on failure of two out of six ADLs increasing to 100% of the benefit upon failure of three out of six ADLs.

Policies usually have a deferred period, typically three months, after satisfying the conditions for benefit payment, before benefits actually become payable. The longer the deferred period, the lower the premiums will be. Once benefits commence, they are generally payable until death or recovery. Usually, the policyholder can choose to use the benefits either for residential or home care (or to purchase special aids or adapt their home). Benefits are usually paid directly to the care provider.

### Unit-linked long-term care insurance (investment plans)

Unit-linked long-term care insurance is a variation of the typical unit-linked investment plan. These allow individuals to invest regular or single premiums in a number of unit-linked investment funds. The value of these grows with the growth in the underlying investments and charges are deducted to cover the risk of a long-term care claim. Typically, these risk charges are not guaranteed and so policyholders accept the risk that they may be revised, as well as the investment risk inherent in this type of policy.

When care is needed, benefits are payable either by the insurer, or from the accumulated investment value of the plan, or a combination of both. For example, the investment value, or a proportion of it, can be used to meet the initial costs of care, with the insurer subsequently meeting the balance of the cost.

If the policyholder dies without having made a claim for long-term care, the accumulated investment value is payable. In addition, the policy can be surrendered and the accumulated investment value refunded to the policyholder. This type of policy therefore offers more flexibility than the conventional kind.

### Immediate care annuities (“impaired annuities”)

There are a few products in the UK that are aimed at people who are just about to go into care and who need to provide for future costs. These policies provide guaranteed monthly benefit payments in exchange for a single premium. Benefit payments continue for as long as care is needed. The amount of the premium payable for an immediate care policy depends on the insurer’s assessment of the likely duration of care needs.

### Sample premium rates

*Monthly benefit: €1,000, indexed in line with general inflation, payable on failure of X ADLs, after a three month deferred period*

	Single premium (€)		Monthly premiums (€)	
	X = 2	X = 3	X = 2	X = 3
Male, age 65	14,022	9,228	102	66
Female, age 65	24,138	16,408	129	85

*Note: Failure of 3 ADLs is broadly the level of disability that would be likely to warrant admission to residential care.*

Source: Royal Commission on Long-Term Care, Research Volume 1

6.42 A factor that contributes to the cost of the product is the level of uncertainty as to future claim rates. This uncertainty derives from a number of factors:

- The future prevalence of disability is unknown, bearing in mind potential future developments in relation to life expectancies and medical science.
- Insurers may experience adverse selection i.e. those with a higher risk of needing care may be more likely to insure and current underwriting techniques may not be adequate to protect insurers from this increased risk.
- The propensity to use formal care may be affected by the fact that an individual has insurance, leading to higher than expected claims costs (this is referred to as “moral hazard”).
- Care costs may increase at a faster rate than general or wage inflation, due to supply factors.

6.43 Notwithstanding the level of uncertainty that is built into premium rates, insurance is clearly a more effective method of provision than savings. For example, a man aged 65, wishing to secure a monthly income of €1,000 for a period of 3 years would need to invest €24,000 if care were to begin at age 85 and €29,000 if care were to begin at age 75<sup>65</sup>, compared with a single premium of €9,228 for long-term care insurance that would provide the same income.

- 6.44 However, it is not necessarily affordable. A monthly benefit of around €1,350 would bridge the gap between the maximum subvention rate of €190.50 per week and nursing home charges in the region of €500 per week. However, to qualify for the maximum subvention rate, an individual must have income that is less than 120% of the non-contributory Old Age Pension i.e. €160.80 per week and is therefore unlikely to be able to afford the level of premiums illustrated above.
- 6.45 Those with incomes above the level that would qualify them for a subvention may be able to afford long-term care insurance (although they may not perceive that to be the case). However, in 1997 almost 60% of the older population had weekly income (equivalised by household size) of £100 (€127) or less<sup>66</sup>. Less than 10% had weekly equivalised income in excess of £200 (€254).
- 6.46 Also, the higher premiums that apply to women are problematic since women have lower average incomes.
- 6.47 In addition to the question of affordability, take-up of private long-term care insurance, if and when such policies become available in the Irish market, will likely also be affected by:
- The unwillingness of people to focus on the probability that they may need long-term care
  - Perceptions as to the probability of needing care and the likely duration of that need (research carried out in respect of the annuity market in Ireland suggests that most people underestimate their likely life expectancy in retirement; it is not unlikely that they would similarly underestimate their future need for long-term care)
  - The level of understanding of what the State will and will not provide and uncertainty as to the future role of the State.
- 6.48 Experience from other markets suggests that take-up of long-term care insurance could be quite poor. In the UK, for example, it is estimated that only 30,000 – 40,000 policies have been sold over the past 10 years.<sup>67</sup> A leading figure within the industry has estimated that the maximum potential penetration of private long-term care insurance in the UK market is 10% – 15%.<sup>68</sup>
- 6.49 A 1998 US survey by the National Council on the Ageing and John Hancock Mutual Life Insurance Company found that:
- 82% of those surveyed agreed that it would be irresponsible not to plan for their long-term care needs.
  - Only 23% believed that they could fund long-term care without insurance.
  - Only 14% had such insurance.

<sup>66</sup> Layte et al, 1999, *op. cit.*

<sup>67</sup> Swiss Re, *private communication*

<sup>68</sup> Peter Gatenby, then a senior executive in PPP Lifetime, speaking at a Continuing Care Conference debate in 1998.

6.50 In the US, it is estimated that there were in the region of 3.2 to 3.8 million long-term care insurance policies in force in 1997, with private insurance providing coverage to less than 10% of the elderly population. Most US studies estimate that only 10% – 20% of the older population can afford good quality private long-term care insurance policies.<sup>69</sup>

6.51 Nevertheless, in market research carried out by Swiss Re in Ireland some years ago, 33% of those surveyed expressed an interest in an insurance policy designed to meet the expenses of private care. Interest was strongest amongst 25-34 year olds and the ABC1 socio-economic group (47%). However, it is likely that the proportion of people who would actually purchase insurance if it were available would only be a fraction of those who would express a general interest in a survey of this nature.

6.52 The Royal Commission in the UK took the view that private insurance could make only a limited contribution to overall long-term care financing, a view that is widely echoed in the literature. The following are among the reasons cited by the Commission for its view:

- *“There seems little reason to think that private insurance will become more important in the UK than it has become over a 14-year period of development in America”.... According to expert witnesses...private insurance is not now, and is unlikely to become, the major way of funding long-term care in America.*
- *Policies are unlikely to become universally affordable. Long-term care is too remote a risk for many people to think of taking out insurance when they are younger – and 10% of applicants will be refused cover anyway on health grounds”.*

**6.53 We conclude that there will be a role for long-term care insurance but that it will be a limited one. Such insurance will likely be effected primarily by those who wish to protect their assets from being diminished by long-term care costs and/or to provide for the cost of more expensive care.**

**Public sector support for private insurance**

6.54 The public sector could provide support for private insurance in a number of ways in order to increase take-up. For example, premium or tax subsidies could be used to reduce costs to purchasers. It is sometimes argued that such subsidies, in addition to reducing the cost of private cover, have a “sentinel effect”, signalling potential purchasers that the government believes private long-term care insurance is a worthwhile product.

6.55 Standard rate tax relief has recently been introduced for long-term care insurance in Ireland. However, this relief is unlikely to stimulate demand for long-term care insurance to any significant extent, as at present it would be more tax advantageous to make private provision for long-term care by way of additional

pension contributions. These would be relieved at the person's marginal tax rate and would provide an additional income that would be taxed at marginal rate but if it were then used to pay directly for nursing home care would be eligible for medical expenses relief at the marginal rate<sup>70</sup>. So retirement income can be used to fund long-term care on a fully gross basis. Whilst this approach is less efficient in the sense that it does not involve risk pooling, it is likely that many people would significantly underestimate the importance of such risk pooling.

- 6.56 It is perhaps anomalous that medical expenses relief is at marginal rate when health insurance premium relief and most other reliefs are provided at standard rate. Nevertheless, while this remains the case, standard rate relief is unlikely to stimulate significant interest in long-term care insurance in the absence of other policy initiatives.
- 6.57 It should also be noted that tax reliefs benefit the better-off disproportionately. If tax relief on long-term care insurance were harmonised with relief for medical expenses (or employing a carer) at marginal rate, this effect would be exacerbated.
- 6.58 An alternative approach would be for the State to provide a direct subsidy towards the cost of long-term care insurance. However, the value of the subsidy, as a percentage of premiums, would need to be considerable in order to have any significant impact on demand. Even then, the subsidy would be of most value to those on higher incomes who would be better able to afford the net premiums. It would be of no value to those who are unable to obtain insurance due to their own or their family's medical history.
- 6.59 In conclusion, our view is that tax reliefs or premium subsidies are unlikely to stimulate the long-term care insurance market to the extent of catering for the long-term care needs of more than a relatively small proportion of the population.**
- 6.60 The State could possibly stimulate the demand for long-term care insurance through some form of partnership arrangement and this will be discussed in more detail later in this section.
- 6.61 At the extreme, the State could provide support for private insurance by making it compulsory. If insurance were compulsory, insurers could be required to offer it on a community-rated basis<sup>71</sup> and to operate "open enrolment" i.e. dispense with medical underwriting and age restrictions, in line with the basis on which private health insurance operates in Ireland. As is the case with private health insurance, a high degree of regulation would be required.

### Compulsory private insurance

<sup>70</sup> similarly the tax allowance for employing a carer is at marginal rate

<sup>71</sup> Alternatively, premiums for compulsory long-term care insurance could be made more progressive if they were calculated as a percentage of income.

6.62 In the UK, some element of compulsory private insurance – or compulsory contribution to a pension that also includes provision for long-term care – has been advocated by the Continuing Care Conference (CCC)<sup>72</sup>. The CCC estimated that the cost of compulsory provision for long-term care would be relatively low, at around 10-15% of the costs of a reasonable second-tier pension. It advocates that the framework for a compulsory scheme should be set by government and should operate nationally but that the fund should be administered within the private sector, at arms-length from government.

6.63 The following arguments in favour of compulsory private insurance were put forward in a recent public debate organised by the Continuing Care Conference in the UK:

- As is the case with pensions, younger people often do not consider their future needs and are therefore unlikely to insure voluntarily. Then, when they are older, they may be “prisoners of their decisions when young”.
- Compulsion achieves the largest possible risk pool. The larger the pool, the greater the spread of risks and the lower the costs for all.
- Voluntary insurance is more likely to be effected by those who consider themselves to be at risk – “adverse selection” – which increases the cost in comparison with a universal scheme.
- Compulsory insurance means that insurers cannot “cherry pick” the lowest risk applicants.
- Compulsory insurance ensures that those who can do pay. Some people will have sufficient resources during their lifetime to put aside money for their old age but will prefer to spend their resources on other things. Yet society will still feel obliged to ensure that, when they do need care in old age, they are not left on the street.
- It is impossible for insurers to accurately predict the cost of care in twenty – or fifty – years from now. Premium rates will therefore be set on a conservative basis. But care costs may come down if the prevalence of disability amongst older people reduces over time. A national compulsory insurance scheme could include provision for independent arbitration in order to raise or lower contributions as appropriate.
- A compulsory scheme would allow substantial administrative savings from economies of scale.

<sup>72</sup> The Continuing Care Conference is a coalition of commercial, charitable and public service organisations with a mutual interest in providing better care for current and future generations of older people.



6.64 However, it must be noted that many of these advantages would equally follow from a social insurance scheme, of which more later. In addition, the following features of compulsory private insurance may be seen as disadvantages:

- While it provides risk pooling, unlike public financing, it does not provide income redistribution.
- It gives rise to over-provision in that the ability of housing assets - and other assets - to contribute to the cost of care is not taken into account.
- Moreover, it may not be rational to insure the risk of needing long-term care - which is most likely to arise at the end of life - whilst people are at a young age and are likely to have enormous liabilities in the form of a mortgage.
- Financing through private insurance could give rise to a significant increase in overall costs. If insurance policies only provided benefits for formal care, there could be an increased tendency to opt for formal care on the basis that it had been paid for within the premium rate structure. If benefits were also provided for informal care, this would *de facto* give rise to an increase in costs.
- Compulsory insurance would effectively amount to a form of tax on incomes and could therefore impact on the economy's competitiveness.
- Private insurance is not structured in such a way as to readily cater for the financing of long-term care needs for those who are disabled from birth or before joining the labour market.

6.65 A compulsory system raises the issue of how premiums are met for those unable to afford them. The State could pay premiums for those on low incomes. Alternatively, it could continue to provide long-term care directly for those who could not afford long-term care (although this could give rise to significant compliance monitoring to ensure that all those deemed able to afford long-term care insurance actually took it up). This raises the question as to whether a compulsory private insurance system with significant input from the public sector has any advantage over a public sector social insurance system.

6.66 It must be noted that it is unlikely that the insurance industry would be keen to become involved with a compulsory insurance scheme, which would inevitably require a significant degree of regulation. It has already shown a marked reluctance to participate in the private health insurance market due in part to the fact that it is regulated in order to provide for community rating and open enrolment. Following the abolition of VHI's monopoly in 1994, only one other insurer has entered the market.

**Long-term care insurance as an employee benefit**

6.67 Compulsory long-term care insurance would also be inconsistent with the approach now being taken in relation to second pillar pension provision i.e. that of encouraging more voluntary private provision.

**6.68 We conclude that compulsory private insurance is not an appropriate solution to financing long-term care in Ireland.**

6.69 One of the problems with long-term care provision is the lack of awareness of the need for such provision. Typically, people will only become aware of this as an issue if and when their parents begin to need long-term care. It has been argued that the insurance option could be made available to a wider section of the population if it were offered as an employee benefit. Long-term care insurance could conceivably become a regular part of a company's benefits package like pensions and medical insurance.

6.70 While employers may not wish to incur additional costs by contributing to the cost of long-term care insurance, they could make it available on an "employee pays all" basis. Many employers already make VHI or BUPA available to their employees on this basis and the insurers provide a group discount on their premium rates in this situation. As the prevalence of "flexible benefits schemes"<sup>73</sup> increases, employees could choose to use part of their benefit allowance to pay for long-term care insurance.

6.71 One possible option would be to make it mandatory for employers to provide access to long-term care insurance, in the same way that employers will be required to provide their employees with access to Personal Retirement Savings Accounts.

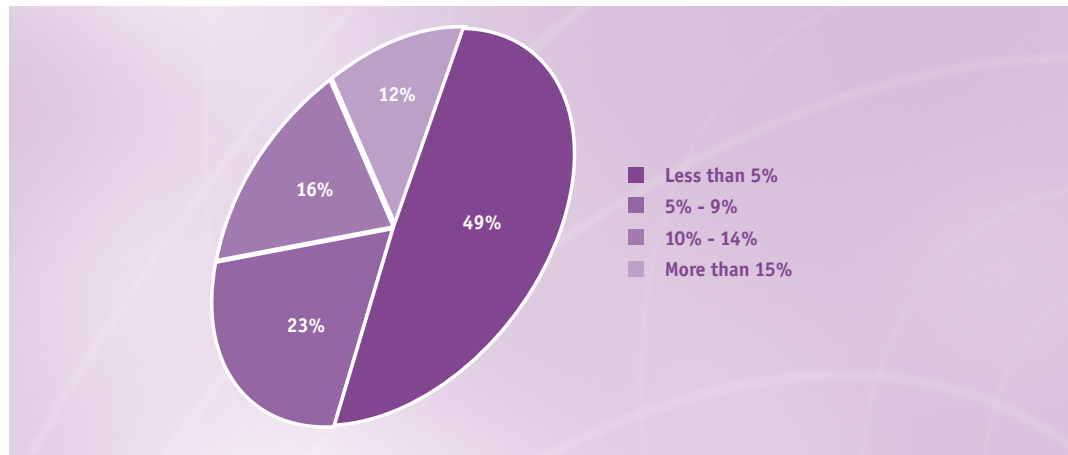
6.72 Again, however, this would need to be considered as only one element in a multi-faceted approach, as while it would likely enhance the take-up of long-term care insurance, it is unlikely that it would result in widespread private provision. Whilst it would enhance awareness, many people would remain unwilling to face up to the likely need for long-term care or underestimate the possible extent of that need or simply not be willing to commit resources to making provision for long-term care needs.

6.73 To illustrate this, we have shown below the results of a 1997 survey by Mercer of 66 US employers that offer long-term care insurance to their employees.

<sup>73</sup> i.e. instead of entitlement to specific fixed benefits (life assurance, medical insurance, pension, etc.) employees receive an allowance which they can allocate to different benefits in whatever proportions they choose.



### Take-up of long-term care insurance offered as an optional employee benefit to US employees



- 6.74 Note that for all except one employer, long-term care insurance was an employee-pay-all benefit (in the one exception, the employer provided a 20% premium subsidy).
- 6.75 An interesting recent development in the US is the Government's decision to offer long-term care insurance to all current and retired federal employees and military personnel and their families. Although those who take up this option will have to pay the full premium themselves, it is expected that the Government's purchasing power will enable them to obtain savings of 15% - 20% on commercial insurance rates. A key component of this initiative will be a prominent public educational and awareness campaign prior to the offering of insurance. The programme is to come into effect no later than October 2002. With this initiative, the federal government intends, as the country's largest employer, to serve as a model to other employers with the aim of accelerating growth in the penetration of private long-term care insurance.
- 6.76 With a view to encouraging private long-term care insurance provision, a similar initiative could be considered in the Irish context. Such an initiative could provide a kick-start to a private insurance market that has, so far, failed to emerge of its own volition. Whether or not such an initiative would be appropriate will depend on the overall policy formulated for the financing of long-term care. In the event of a "partnership" model being implemented - whereby individuals will need to make at least partial provision for their own long-term care costs - it will likely be desirable to encourage the development of a private insurance market as one means to make such provision.
- 6.77 We conclude that consideration should be given to establishing a group long-term care insurance scheme for public sector employees. This could form part of an initiative to develop a partnership approach to financing long-term care.**

- 6.78 In considering private financing options, it is appropriate to give some more detailed consideration to the potential for long-term care financing to be linked to pensions provision. Long-term care has a natural link with pensions, as both are dealing with the needs and funding requirements for those in their retirement years. In practice, State and occupational pensions already constitute a major source of finance for long-term care. It would, however, make sense to develop arrangements that allow a more targeted combined financing approach. In doing so, however, it would be important to ensure that current pension provision is not diverted to the funding of long-term care, given that current pension provision is, in many cases, not yet at an adequate level.
- 6.79 Some of the ways in which current pension arrangements could be modified to address long-term care needs are outlined below.
- At present, pension schemes provide an income for life, either fixed at the outset or increasing over time. The pattern of long-term care needs is such, however, that there is a requirement for a much greater level of benefit at the more advanced ages. Schemes could, therefore, be allowed to provide a “stepped annuity” with a lower starting level and an increased benefit payable once the member has attained a certain age and/or has long-term care needs.
  - Permanent health insurance (PHI) often sits alongside occupational pension schemes. The legislation governing PHI could be adapted to allow combined PHI/long-term care policies to be developed. In practice, however, there could be significant employer resistance to supporting a development of this nature on cost grounds.
  - The point at which an individual is retiring has the potential to be a significant watershed as far as planning for long-term care costs is concerned. There is a heightened awareness of the need to make provision and substantial pension assets and other savings may be available. On retirement, individuals could be allowed to take part of their benefits in the form of a lump sum that they could use to purchase a single premium long-term care insurance policy.
- 6.80 Self-employed individuals and employees with AVCs can do this as matters stand. PRSA holders will also be able to do so. Employees without sufficient AVCs could be allowed to commute a further portion of their pension, over and above the maximum tax-free lump sum amount, in order to purchase long-term care insurance.

6.81 The case has been made for allowing the additional lump sum amount, for the purpose of purchasing long-term care insurance, to be taken on a tax-free basis.<sup>74</sup> It is argued that this should be fiscally neutral. At present, €100 saved for retirement is eligible for tax relief when it is paid into a pension scheme, it then accumulates within the scheme on a tax free basis but the *quid quo pro* is that the resulting pension is taxed as normal PAYE income. If, however, the pension is then used to pay directly for residential care or to employ a home carer, it is eligible for medical expenses relief. So, in effect, retirement income is already used to fund long-term care on a gross basis.

6.82 As already outlined, an increase in the overall level of retirement savings would be required to facilitate pension-linked financing of long-term care.

**6.83 Nevertheless, we conclude that those who can afford to do so should be strongly encouraged to effect long-term care insurance when they retire. This could include allowing an additional tax-free lump sum to be taken to fund a single premium long-term care insurance policy.**

#### Availability of private insurance

6.84 Finally, in relation to long-term care insurance, it must be noted that there are no products currently available in the Irish market, in spite of significant public attention to the issue over the past number of years. Arguably, product development has been impeded heretofore by the lack of clarity in relation to the taxation of long-term care insurance. However, the 2001 Budget has established the position in this regard and as yet, no products have been launched.

6.85 It is likely that long-term care insurance is perceived as a relatively low priority by insurers, given that the market for such insurance would be expected to be small and given that there have been many other pressing issues for insurers (for example, changes in the taxation of life assurance companies, conversion to the Euro and the forthcoming legislation in relation to Personal Retirement Savings Accounts).

6.86 Nevertheless, it is disappointing that to date no insurer has even “tested the water” with a long-term care insurance product. In keeping with the preceding analysis, this does not augur well for the potential of the private long-term care insurance market to make a major contribution to the future financing of care needs.

#### Public financing options

6.87 We turn now to public financing options. Two key issues arise in relation to benefits or services funded through public financing programmes:

- Whether such benefits or services should be means-tested or universally available
- Whether eligibility for, or entitlement to, the benefits or services will be provided.

## Means-testing

- 6.88 Means-tested public provision has the advantage of targeting public resources to those with the greatest need (both those on low incomes and those on higher incomes whose care needs are so extensive that their own resources become insufficient to meet the continuing costs of care). Perversely, though, the current system in operation in Ireland may act as much more than a safety-net in the case of public extended-care beds and an insufficient safety-net for those who can only find accommodation in a private nursing home.<sup>75</sup>
- 6.89 According to Wittenberg et al<sup>76</sup>, a means-tested system tends to work best where income is more unevenly distributed i.e. where services can be targeted on a small number of poor people. Everyone contributes to the cost, but only those on low incomes receive benefits and they contribute less because of their low incomes. A universal system is more appropriate where the distribution of incomes is more equal and most people have similar incomes. The incomes of the majority of older people fall within a relatively narrow range (as noted above, over 90% have weekly equivalised income of £200 (€254) or less), and it is likely that the distribution of incomes for younger adults with significant long-term care needs is not dissimilar. Hence, a universal approach to financing long-term care would arguably be more appropriate.
- 6.90 A system of universal long-term care benefits would also provide consistency with the principle of universal eligibility for public hospital services. The UK Royal Commission argued that people need long-term care not simply because they are old, but because their health has been undermined by a disabling disease such as Alzheimer's disease, other forms of dementia or a stroke. It is inequitable, therefore, that State provision should be less generous in these circumstances than if the individual had a heart attack or cancer (where treatment would be provided free of charge within the health care system). This argument informed the Commission's recommendation that the provision of personal care should not be means-tested.
- 6.91 Several commentators point out the inherent contradiction in a system which seeks to provide benefits for some but to encourage others to make their own provision: in the context of Medicaid in the US this has been likened to encouraging people to buy produce on one side of the street and giving it out free on the other. People who may be in a position to make their own provision may instead "spend down" their assets in order to qualify for State support.<sup>77</sup> This is considered to be a significant issue for long-term care provision in the US (long-term care is not covered by the State insurance scheme for older people - Medicare - but is covered under the means-tested Medicaid system).
- 6.92 Older people tend to be "asset rich, income poor" and are therefore more likely to fail a means-test on asset than on income grounds. The principal asset is likely to

<sup>75</sup> *Eligibility for a public extended-care bed is not explicitly means-tested and, in some cases, people who could afford to pay for private nursing care occupy such beds. On the other hand, subventions for those in private nursing homes are strictly means-tested.*

<sup>76</sup> *Wittenberg et al, 2000, Funding long-term care: the public and private options*

<sup>77</sup> *Of course, in the particular circumstances that prevail in Ireland, they may simply refuse to vacate a public hospital bed.*

be the family home. The argument for not means-testing benefits is therefore stronger for home care than for residential care, since it may be difficult – if not impossible – to tap into housing assets to help pay for home care. On the other hand, once an older person has moved permanently into residential care, housing assets may be used to help pay for such care.

## Eligibility and entitlement

- 6.93 The distinction between eligibility and entitlement to care or related benefits is also important. If an individual has a statutory entitlement to a benefit based on specified criteria, then that benefit must be provided, notwithstanding any budgetary constraints to which the public body charged with providing the benefit may be subject. If, on the other hand, an individual is eligible for a service or benefit, then it is possible that that service or benefit may only be provided if resources permit. If resources – e.g. beds or staff – are limited, then the individual may not receive the service or, alternatively, may have to wait for it (as may be the case, for example, with elective surgery).
- 6.94 Currently, in Ireland, long-term care services are provided on a rather ambiguous basis. Older people are eligible for a public extended-care bed but – subject to meeting the specified dependency criteria – a subvention for private nursing home care is an entitlement. Moreover, people are eligible rather than entitled to receive services in the community and the provision of services is subject to budgetary constraints. In this respect, long-term care is not unique; the provision of hospital services is similarly constrained and services are not always available to those who need them. However, in relation to long-term care, the statutory entitlement in respect of nursing home subventions has tended to give rise to a bias amongst Health Boards, who are the providers of services, towards residential rather than community-based services, which are in effect more discretionary.
- 6.95 This approach has similarly biased service provision to those who do not have informal care available to them and has tended to leave family carers with minimal support. However, the status quo, reliant as it is on a substantial supply of unpaid family care, is unlikely to be sustainable having regard to the expected impact of demographic and social change on the availability of informal care. We consider that the provision of a statutory entitlement to home care benefits is necessary in order to deliver on the policy of maintaining people in the community insofar as is possible.
- 6.96 Providing entitlement to – rather than eligibility for – benefits without means-testing would undoubtedly be far more expensive than current forms of provision. Moreover, there will be concerns about the potential for “moral hazard”<sup>78</sup>, with people having little incentive to restrict their use of services or benefits. This could potentially increase the levels of demand for both residential and home care benefits. In particular, if benefits are provided for formal care only, it could result in an acceleration of the likely trend away from informal care, leading to an increase in cost. If, on the other hand, benefits are provided for both formal and

informal care, the cost will also be greater. This issue highlights the vital role of an objective and explicit needs assessment process, as set out in section 5, as the essential “gate keeping” mechanism, if services are no longer rationed as at present.

#### 6.97 In conclusion:

- **There are arguments in favour of providing long-term care benefits without means-testing or on a universal basis.**
- **Statutory entitlement to home care benefits must be introduced if the policy of maintaining people in the community insofar as is possible is to be achieved.**
- **There is scope for demand and consequently costs to escalate if universal entitlement to benefits is provided; this highlights the vital importance of an objective and explicit needs assessment process.**

#### Public tax based financing

6.98 Public tax-based financing is the primary method by which formal long-term care is currently paid for in Ireland. Public extended-care beds and the nursing home subvention scheme, together with community care services such as public health nurses and home helps, are financed from the budget of the Department of Health and Children, the majority of which comes from general taxation.<sup>79</sup>

#### Advantages of financing long-term care through general taxation

1. Public financing can provide both risk pooling and income redistribution.
2. It can also provide reasonable redistribution of the costs of care over time for the population as a whole (although population ageing will gradually increase annual costs).
3. The long-term care benefits and services currently provided are financed through general taxation and structures already exist for the administration of the existing service arrangements.
4. General taxation accesses a broader tax base, including total income, spending and capital taxation.
5. Funding through general taxation gives maximum control over costs (although this may, in practice, consist of economising on service provision, rather than maximising cost-effectiveness).
6. Benefits and services can be provided on a universal basis (although in practice, resource constraints are likely to make this difficult to achieve).

<sup>79</sup> There is also an earmarked tax (the health levy) of 2% of salary which is paid by employees who earn more than €356 per week. The levy represents a relatively small proportion of the cost of publicly funded health services including long-term care provision; payment of the levy does not confer any entitlement to benefit.

### Disadvantages of financing long-term care through general taxation

1. Significant additional resources will be required in order to enhance current long-term care provision. It is likely to be difficult – if not impossible – to raise additional taxes (in particular, to increase income tax rates) in order to achieve this.
2. Funds for the provision of long-term care benefits and services would not be earmarked; the funds made available could vary over time depending on the balance of priorities within the health and social welfare portfolios.
3. Benefits and services that are financed through general taxation are necessarily subject to budgetary constraints. Provision could be cut back if the economic climate were unfavourable.
4. Whilst it would theoretically be possible to provide universal benefits, in practice it would likely prove very difficult to do away with means-testing, due to budgetary constraints.
5. It would not be possible to pre-fund any of the expected future increase in long-term care costs due to the ageing of the population.

6.99 In order to develop a public/private partnership for the financing of long-term care, it is essential that the State develops and implements a clearly-defined and lasting policy on the benefits and services that will be publicly-financed and on the criteria for such financing. It will need to instil confidence in the public as to the long-term nature of the State's commitment to a specific level of provision before people will begin to make supplementary private provision. Having regard to the disadvantages outlined above, this would be much more difficult to achieve if financing is through general taxation than on a social insurance basis.

6.100 Moreover, we believe that home care services or benefits must be provided as a statutory entitlement (based on specified dependency criteria) if the policy of maintaining people in the community insofar as is possible is to be achieved. The provision of entitlement to, rather than eligibility for, services sits far more comfortably with social insurance than with financing through general taxation.

#### Social insurance

6.101 Like tax-based financing, social insurance can combine risk pooling with income redistribution – allocating services according to need and distributing the financial burden according to ability to pay. Ireland already has in place a comprehensive system of Social Insurance covering, amongst other benefits, retirement/old age pensions, spouse's pensions and disability benefits. With minor exceptions, these benefits are paid on a flat-rate basis. Its principal distinguishing features are:

- The entitlement to benefits is related to contributions paid. This is known as the contributory principle.



- Social insurance contributions are ring-fenced within the social insurance fund and are dedicated to the provision of social insurance benefits (“earmarking”).
- Benefits are clearly prescribed and no means-test applies. Entitlement to benefit is automatic once the contribution and other conditions are satisfied.

6.102 To quote the Discussion Document on Social Insurance in Ireland<sup>80</sup>:

*“The main merit of Social Insurance...from the point of view of individuals and families is that it gives them a degree of certainty in advance regarding their entitlements in the event of the specified contingencies arising. Insured workers know that they, or where appropriate, their survivors, have an entitlement to benefit and can rely on receiving the prescribed benefits at the prevailing rates when the relevant circumstances arise.”*

#### **Advantages of a social insurance scheme for long-term care**

1. It would provide a stable and lasting framework for long-term care provision. It would also raise public awareness of long-term care issues. This could help to encourage further private provision to supplement the basic social insurance benefits. In particular, it would facilitate a partnership scheme.
2. National criteria for entitlement to services – based on standardised needs assessment - would provide equity and could be structured so as to favour home care rather than residential care (or at least eliminate the bias towards residential care).
3. Social insurance financing is more transparent, with a clear link between contributions and spending on long-term care benefits and services.
4. It would facilitate the separation of the financing and delivery of services, thereby increasing consumer choice.
5. Social insurance removes the welfare stigma associated with means-tested benefits for those whose contributions qualify them for benefits.
6. Social insurance offers the potential for pre-funding. This would facilitate some smoothing of the expected increase in costs due to population ageing. This is discussed further in section 10.
7. The public may be more willing to pay additional social insurance contributions than higher taxes in order to fund long-term care benefits.



*“Social insurance schemes, particularly universal schemes with little or no cost sharing, opt out or top-up provisions, provide a major bulwark against the development of dual systems of care. All members of the schemes have access, on similar conditions, to all available services. There is no danger of two types of care evolving – one for the rich and another for the poor. The political power of the middle and higher income beneficiaries provide the guarantee of high quality care for everyone. In fact, poor people may do relatively better, receiving higher benefits relative to their contributions than people who are richer”. O’Shea and Hughes, 1994*

#### **Disadvantages of a social insurance scheme for long-term care**

1. Social assistance benefits will still be required for those who do not make social insurance contributions.
2. Social insurance would narrow the funding base considerably by confining contributions to direct payroll taxation. In particular, those with substantial assets are not called on to make use of any such assets to finance or part finance the cost of long-term care (although notably, in some countries, social insurance contributions have been levied on investment income as well as earnings).
3. Social insurance could give rise to a higher level of inter-generational transfers than broader tax-based financing, although this could potentially be addressed by requiring that pensioners continue to pay contributions in respect of long-term care benefits.
4. Financing through social insurance may reduce the ability of government to control expenditure.
5. Social insurance contribution income is affected by the economic cycle. Hence, it may be necessary to supplement the social insurance fund from general tax revenues or borrowing during an economic downturn.
6. Higher social insurance costs may impact on the economy’s competitiveness.

6.103 In Ireland, the health care system is not part of the social insurance structure. Health care is financed primarily from general taxation, but also by the health levy and by voluntary health insurance (covering 50% of the people and operating, to some extent, as a quasi-public form of insurance). People are, therefore, used to contributing directly to health care costs, through the health levy and by paying voluntary health insurance premiums.

**6.104 We consider, therefore, that social insurance financing for long-term care would provide a reasonable “fit” in the Irish context.** Whilst the health levy is not a social insurance contribution and does not confer any entitlement to benefit, it is potentially a base from which to migrate the funding of long-term care on to a social insurance basis. The health levy could in future be earmarked for the provision of long-term care benefits and services. The rate (currently 2%) would likely need to be increased if comprehensive benefits were to be provided. The new long-term care levy would also need to be extended to the self-employed and public sector employees. On the other hand, some reduction in tax rates should be possible if the cost of current long-term care benefits and services is transferred to the social insurance fund.

**6.105 Whilst it is unlikely that an increase in social insurance contribution rates would be universally popular, we believe that the strong entitlement to benefit that social insurance financing would confer, along with earmarking of the contributions made to pay for the benefit, could engender good public support for a new social insurance scheme for long-term care.**

**Contributory  
principle**

6.106 A key issue in considering social insurance as a means of financing long-term care is the contributory principle that is central to social insurance in Ireland i.e. entitlement to benefits is dependent on payment of contributions.

6.107 The need for long-term care services will arise for many people who have never paid social insurance contributions, in particular those who are disabled from birth or as a result of illness or injuries sustained before reaching working age. Other groups may have insufficient contributions to qualify for benefits (depending on what the contribution criteria are), for example, married women and men working in the home, the young unemployed or atypical workers.

6.108 A distinction could potentially be drawn between long-term care for older people and for the younger long-term disabled population. Benefits for older people could be provided through the social insurance fund, subject to contribution criteria, while benefits (universal or means-tested) for the younger long-term disabled population could be financed from general taxation. The social insurance benefits for older people would arguably set the standard for benefits to be provided to other disabled groups. However, this approach could be viewed as creating a two-tier system that would discriminate against younger people with disabilities. Moreover, there would still be categories of older people who would not qualify for benefits.

6.109 Another option would be to provide entitlement to social insurance benefits to a contributor's dependants (spouse and children) on the basis of the contributor's contribution record. This is the approach usually adopted in countries where health care is financed through social insurance. Also, a precedent exists for this

approach in the provision of dental and optical treatment benefits to dependent spouses. However, this approach would not be compatible with the trend in Ireland, which is towards individualisation of benefits.

6.110 Even with this approach, however, provision would need to be made for people who did not qualify for social insurance benefits. It is likely that the majority of these people would qualify for benefits provided on a means-tested basis. In this regard, **we would not consider it appropriate that the level of long-term care benefits provided should vary as between social insurance and social assistance beneficiaries** as this could imply the provision of different standards of care as between the two groups. This contrasts with practice in relation to pension benefits where the level of social insurance benefit is generally higher than the equivalent social assistance benefit.

**Universal  
benefit/  
earmarked tax**

6.111 It is therefore appropriate to consider whether, as an alternative to funding through social insurance or general taxation, a universal benefit should be provided and financed through an earmarked tax. The entitlement to benefits would have statutory backing and, whilst such entitlement would not be contingent on payment of the earmarked tax, there would likely be a perceived link. This approach might therefore be more palatable to taxpayers than the provision of universal benefits funded by general taxation. This is essentially a new concept in the Irish context, as the current health levy does not confer any entitlement to benefit.

6.112 A scheme of this nature would do away with the need for means-testing, therefore removing the welfare stigma associated with means-tested benefits. Also, like social insurance, it would offer the potential for pre-funding and for a partnership scheme.

6.113 As with the social insurance option, the health levy could be used as the basis for developing this option. It is already earmarked for health care and could, in future, be earmarked more specifically for long-term care. Alternatively, or in addition, other forms of taxation could be earmarked for this scheme, for example tobacco or alcohol taxes.

6.114 The advantages and disadvantages of a scheme of this nature are largely the same as for the social insurance option, with the further advantage of eliminating the need for social assistance benefits.

### **Advantages of a scheme of universal benefits with earmarked taxes**

1. The earmarking of funds would ensure that a specified level of resources is available for long-term care benefits. Moreover, long-term care services would not have to compete directly with other health care services for funding.
2. It could provide a stable and lasting framework for long-term care provision. It would also raise public awareness of long-term care issues. This could help to encourage supplementary private provision and facilitate a partnership scheme.
3. National criteria for entitlement to services – based on standardised needs assessment – would provide equity and could be structured so as to favour home care rather than residential care.
4. Funding would be transparent, with a clear link between contributions and spending on long-term care benefits and services.
5. It could facilitate the separation of the financing and delivery of services, thereby increasing consumer choice.
6. It would remove the welfare stigma associated with means-tested benefits.
7. It would offer the potential for pre-funding.
8. The public may be more willing to pay an earmarked tax than to have general taxation increased in order to fund long-term care benefits.

### **Disadvantages of a scheme of universal benefits with earmarked taxes**

1. The funding base for such a scheme would be narrower than the general tax base. In particular, those with substantial assets would not be called on to make use of any such assets to finance the cost of long-term care (unless an asset tax, such as the “estate tax” outlined previously, was earmarked for the scheme).
2. Financing through earmarked taxes reduces the ability of government to control expenditure.
3. Contribution income would be affected by the economic cycle. Hence, it could be necessary to supplement the earmarked fund from general tax revenues or borrowing during an economic downturn.
4. Higher taxes could impact on the economy’s competitiveness.
5. The unique earmarking of funds for long-term care services could potentially be perceived as giving rise to inequity for those whose need is for other health services (or, indeed, other services such as education).

6.115 We have considered the various possible mechanisms for long-term care and have concluded that the various private financing methods will necessarily have limited application, albeit that both private insurance and equity release can, and likely will, play a useful role for those who can afford insurance or who have significant housing assets.

6.116 We conclude, therefore, that the State must continue to play a dominant role in the financing of long-term care. We have examined various options for State financing i.e.

- General taxation
- Social insurance (with social assistance for those who have not paid contributions)
- Universal benefit/earmarked tax

and our conclusions are set out below with regard to the criteria set out in our terms of reference and with regard to public preferences

■ **Meeting long-term care needs in the medium and long term**

All of the public financing options are capable of meeting long-term care needs in the medium and long term. However, funding through general taxation would be more vulnerable to periods of budgetary constraint.

Moreover, substantial additional funds will be required in order to meet long-term care needs in the medium and long term (in particular, if meaningful home care benefits and/or greater support for family carers) are to be provided. There is likely to be a greater acceptance of additional social insurance contributions or an earmarked tax for this purpose rather than an increase in general taxation.

Social insurance or earmarked contributions would provide an entitlement to, rather than eligibility for, benefits. We consider it essential that such an entitlement be provided in respect of home care, in particular, in order to allow people to remain in the community, in line with Government policy.

Both social insurance and an earmarked tax facilitate pre-funding, which would facilitate some smoothing of the expected increase in costs due to population ageing.

Also, social insurance or earmarked contributions, could eliminate much, if not all, means-testing of benefits, which would help address unmet need for long-term care benefits and services. Whilst the earmarked tax option is theoretically attractive, in that it could provide universal benefits without contribution criteria, it does not sit easily with current financing structures in Ireland. We therefore consider that social insurance would be a more robust option.

Finally, we consider that social insurance is the only viable platform from which to build a partnership scheme for long-term care financing. Various partnership options are outlined in the next section. These have significant merit in terms of providing a method for sharing long-term care costs between the public sector and private provision. However, a prerequisite for any such scheme is a clearly defined, stable and lasting framework for publicly financed services. Otherwise, it will not be practicable to encourage supplementary private provision. In this context, a social insurance scheme would have much greater credibility than a commitment to a scheme financed from general taxation that would be vulnerable to conflicting priorities within the health care system as well as budgetary constraints.

### ■ Reducing unnecessary recourse to institutional care

Reducing unnecessary recourse to institutional care is more a question of the type and level of services and benefits provided in residential, community and assisted living settings than the financing mechanism that is used to generate the funds for those services.

However, with a view to reducing unnecessary recourse to residential care, we consider it essential that home care should be put on a level footing with subventions for residential care in terms of there being a statutory entitlement to benefit based on the assessed level of dependency and other criteria.

Whilst a statutory entitlement to benefit can be provided regardless of the financing mechanism – and, indeed, the statutory entitlement to a nursing home subvention is financed from general taxation – the social insurance system would provide the strongest entitlement – both in actual and perceived terms.

*“Social Insurance provides certainty based on statutory entitlements built up through contributions made during working life...The Social Insurance contributor knows that the prescribed amounts will be paid when the contingency in question arises, that no means-test or other such factor enters the picture and has a reasonable expectation that rates of payment will be regularly updated into the future. The main merit of Social Insurance from the point of view of individuals and families is that it gives them a degree of certainty in advance regarding their entitlements in the event of the specified contingencies arising.”<sup>81</sup>*

### ■ Widening consumer choice

Widening consumer choice is principally to be achieved by making the services and benefits that are available more flexible and more responsive to the needs and preferences of individuals and their families. This can potentially be achieved whatever financing mechanism is employed. However, it will require some separation of the financing and delivery of services and is also most likely to be achieved where there is a statutory entitlement to benefits.

We therefore conclude that social insurance financing would do most to widen consumer choice.

### ■ **The general operational issues involved, including any practical issues arising**

The operational issues are broadly similar across all of the potential financing options. In particular, the introduction of a national needs assessment process, as set out in section 5, is a critical feature regardless of the financing mechanism. Also, the proposed provision of choice of provider and/or a cash benefit will give rise to significant operational issues, particularly for Health Boards. Additional resources will be required to administer these options.

In terms of generating funds, financing through general taxation would have least implications operationally.

Financing through social insurance would require some increase to current contribution rates and this would presumably have some operational implications. In addition, we would consider it appropriate that social insurance contributions should be paid by pensioners, as well as private and public sector employees and the self-employed, having regard to the fact that the need for long-term care typically does not arise for a number of years after retirement and to the need to spread the cost as equitably as possible across generations.<sup>82</sup> This would also have operational implications as, at present, pensioners do not pay contributions, except for the Health Levy (and, following the provision of medical cards to everyone over age 70, most pensioners will, in future, be exempt from the Health Levy).

Financing through a new earmarked tax would likely give rise to the most significant operational issues, as this is, effectively, a new concept, that does not fit in with any current method of financing public services.

From an operational perspective, a financing method that did away with the need for means-testing would have a positive impact. Significant resources, both in the Health Boards and in the Department of Social and Family Affairs, could presumably be released as a result.

With regard to the transition to a new financing system, social insurance would most easily facilitate the phased introduction of benefit entitlement, should this be considered desirable.

Primary legislation is likely to be required for any of the financing options.

Operational issues will be considered in more detail in section 8.

### ■ **Consumer preferences**

In the Eurobarometer survey cited in sections 2 and 3, around two thirds of Irish people who expressed a preference for public financing of long-term care selected tax-based financing whilst the remainder opted for “public



insurance” (compulsory or voluntary). We believe that this reflects an inherent expectation that any public financing of long-term care would be on a similar basis to health care financing, rather than there necessarily being a strong preference for one form of public funding over another.

We consider that a public debate on the issues relating to the financing of long-term care would likely result in good public support for a social insurance approach, because of the strong entitlement to benefit that social insurance financing would confer.

We note also that the National Council on Ageing and Older People has recommended that *“social insurance be actively considered as the principal means of financing long-term care.”*

## Conclusion

### **6.117 In conclusion, we consider that social insurance financing offers most advantages.**

6.118 A social insurance approach would mean that alternative benefits would be required for those who did not have a sufficient contribution history. However, there is potentially a simplified basis on which such benefits could be provided: rather than means-testing such benefits independently, they could be provided automatically to anyone in receipt of a non-contributory Old Age Pension (or an associated dependant’s allowance) or a Disability Allowance. It is likely that this would cater for a very significant proportion of those who did not meet the contribution criteria for the social insurance benefit.

6.119 In terms of contribution criteria, we would suggest that criteria similar to those that apply to Invalidity Pension would be appropriate having regard to the fact that the need for benefit will arise as a result of a contingency arising rather than as a planned event, as in the case of retirement benefits (albeit that, for the majority of people, the contingency will arise after retirement). We would also suggest that consideration be given to making benefits available to children on the basis of a parent’s contribution record. Such benefits could then continue into adulthood.



## Comparison of public financing options

	General taxation	Social insurance	Universal benefit/earmarked tax
Universal cover	Universal cover is possible; in practice, however, it would be very difficult to raise additional taxes to fund universal long-term care benefits.	Cover is provided for those with a specified social insurance contribution history. Most others would likely qualify for social assistance benefits, so that near universal cover would be achieved.	Universal cover would apply under a scheme of this nature.
Meeting the needs of both older and younger groups	The needs of both frail older people and younger people with disabilities can be met, possibly through different schemes.	As contribution criteria apply, social insurance is more suited to meeting the needs of frail older people. However, benefits for children could be provided on the basis of a parent's contribution record.	The needs of both frail older people and younger people with disabilities can be met.
Transparency	There is only a weak link between tax payments and spending on long-term care.	Earmarked social insurance contributions provide a strong link between payments and spending on long-term care.	Earmarked contributions provide a link between payments and spending on long-term care.
Cost control	If as is currently the case, services are financed from global cash limited budgets, there is strong cost control, but this may lead to under-provision or economisation rather than cost-effectiveness.	There is less cost control, as qualifying beneficiaries are entitled to receive specified benefits/services even if the total cost exceeds budgets. Nevertheless, cost-efficiency can be achieved if service/benefit provision is well-managed.	There is less cost control, as qualifying beneficiaries are entitled to receive specified benefits/services even if the total cost exceeds budgets. Nevertheless, cost-efficiency can be achieved if service/benefit provision is well-managed.

## 7. Partnership options

### Voluntary social insurance

- 7.1 The cost of providing comprehensive long-term care benefits to everyone would be very significant and would likely not be affordable. It is therefore important to consider partnership options i.e. financing options whereby the costs of long-term care are shared between State and private financing.
- 7.2 Most partnership options are more suited to the financing of long-term care for older people, so that the financing of care needs for younger people with disabilities might need to be catered for separately.
- 7.3 In the UK, one proposal for financing long-term care has been social insurance with a “contracting-out” provision whereby those who effect private insurance are exempted from contributing to the State scheme. This *prima facie* seems an overly complex approach. However, an alternative that could perhaps be considered is a voluntary social insurance system, whereby individuals could choose whether or not to participate in the State scheme for financing long-term care. Those who did not participate would be entitled to means-tested benefits only.
- 7.4 Contributions could potentially be set on an age-related basis and full entitlement could build up over a period of perhaps 30 years. Some form of rebate could possibly be provided in the event of a contributor subsequently qualifying for means-tested benefits. Alternatively, people could be offered the option of paying a single premium from their retirement savings at the point of retirement (another approach could be to allow recipients of an old age pension to surrender a proportion of that pension as a premium for long-term care insurance). Premium subsidies could be provided to those on lower incomes.
- 7.5 One attraction of this approach is that it readily facilitates the transition from the current position. In addition, it is possible that a voluntary social insurance programme would be more attractive to a broader segment of the population than private insurance. It would also make insurance available to those who are uninsurable in the private market.
- 7.6 Social insurance caters more readily for compulsory than voluntary participation and the administration of a voluntary scheme would clearly be very difficult. Moreover, it may not be feasible to provide only means-tested benefits for non-participants in a voluntary scheme. **Consequently, we do not think a voluntary social insurance scheme would be a viable approach. However, it could be possible to start in this way with a view to extending the social insurance system to everyone in the longer term.**

**Mix of voluntary private insurance and taxation**

- 7.7 An alternative approach, operating from a somewhat different perspective, would be for the State to provide universal benefits from general taxation, but to strongly encourage those who could afford to do so, and who can obtain cover, to purchase private long-term care insurance, as an alternative to availing of State benefits. Those who chose not to effect private insurance would be liable for an additional long-term care tax, which would contribute to the cost of providing the State long-term care benefits.
- 7.8 This approach has been adopted in Australia in relation to voluntary private health insurance, which operates as an alternative to the public health care system that all citizens are entitled to use. **However, it is unlikely that this form of approach to financing long-term care would garner public acceptance in Ireland.**

**Social insurance or universal benefits for home care only**

- 7.9 Another option would be to make public funding available for home care without a means-test and for residential care for older people with a means-test. This would reflect the fact that most older people have little spare income or capital when living at home, but capital from the home can be released when they move to residential care.<sup>83</sup>
- 7.10 **However, given the substantial costs associated with residential care, we consider that social insurance or universal financing should include at least some cover for such care.**

**Short-term social insurance benefits ("front-end cover")**

- 7.11 "Front-end cover" would consist of social insurance benefits for a specified period of, say, one year. Financing for longer term needs for older people would only be made available on a means-tested basis. This would significantly alleviate the cost to individuals (and, indeed, would cover the full cost for many). Individuals with means in excess of the means-test threshold would need to make their own provision for care needs of more than a year's duration.
- 7.12 A refinement of this approach, which we would favour, would be to provide home care without a means-test for an indefinite period, with residential care for older people being provided without a means-test only for the first year. This bias in favour of home care would be in keeping with the policy of favouring care in the community where possible. It would also reflect the fact that many older people have housing assets that may disqualify them from means-tested benefits but that cannot readily be used to pay for home care.
- 7.13 An advantage of this approach is that it would eliminate the need to consider sale of the person's home on initial admission to residential care. Hence, it would facilitate returning home after a short residential stay having received

<sup>83</sup> Wittenberg et al, 2000, *op. cit.* Note that, as at present, the means-test for residential care should not take into account housing assets if a spouse or other dependent is living in the home.

rehabilitation services. Once the person requires permanent residential care, sale of their home would release capital to pay for care after the first year (if they did not qualify for means-tested benefits<sup>84</sup>).

- 7.14 The principal disadvantage of this approach is that those who need care for particularly long durations will have to pay most (as is presently the case). The level of risk pooling is, therefore, significantly reduced. However, the availability of universal benefits for the first year would make private insurance to pay for subsequent care needs more affordable. Furthermore, the implementation of a clear long-term policy as to State benefit provision should stimulate the market for private insurance to cover care needs beyond the first year. Hence, people who have significant income and assets to protect from the risk of needing residential care for more than a year should be able to obtain private long-term care insurance for this purpose (although, as outlined in section 6, not everyone will be able to obtain private insurance).

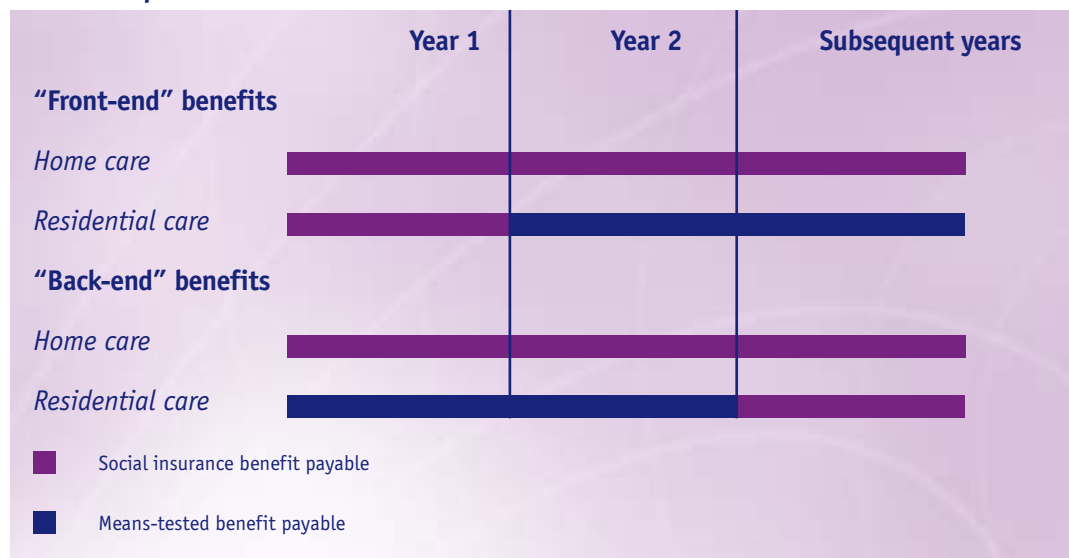
**Catastrophic cover (“back-end cover”)**

- 7.15 It can be argued that public resources would be better used to provide “catastrophic” coverage for those who require care for a very long period.
- 7.16 This would involve the provision of benefits on a means-tested basis for an initial period, say two years. Social insurance benefits would be provided for care needed beyond the two-year cut-off point. This would mean that those who would not satisfy a means-test would need to make their own provision for up to two years’ care. This should be manageable in most cases, through private long-term care insurance, equity release or savings.
- 7.17 This type of approach would likely stimulate product development by life assurers, as it would eliminate one of the most significant uncertainties in pricing long-term care (i.e. the duration of care need). Premium rates provided to us by a UK insurer suggest that the cost of private insurance with a maximum benefit duration of two years would be approximately half the cost of private insurance with an unlimited benefit duration (this ratio would vary depending on the age and sex of the individual applicant).
- 7.18 As is the case with the “front-end cover” option, we believe that it would be desirable to provide social insurance benefits for home care throughout the duration of need, in order to make it as feasible as possible for the person to remain in the community. This would also facilitate the practical implementation of the scheme, since it would give rise to a needs assessment when long-term care is first needed (in order to establish the date from which entitlement to the social insurance benefit for residential care would apply).

We would suggest that the two year “waiting period” would commence at the point at which an individual is assessed as having “high” long-term care needs, as defined in section 4.


- 7.19 From the State’s perspective, it would be significantly less expensive than financing long-term care throughout the duration of need as the average duration for residential care is likely to be in the region of two to three years. It has the merit of simplicity and clarity – every citizen would be clear as to their personal liability.

#### Comparison of “front-end” and “back-end” schemes



- 7.20 We consider that there is substantial merit in both the “front-end” and “back-end” options for social insurance benefits for residential care. We suggest that home care benefits should be provided for an unlimited duration.

- 7.21 The “back-end” scheme provides a greater degree of risk pooling than the “front-end” scheme. It also takes account of the fact that it is the fear of the very considerable expenses arising from a prolonged period of residential care that is the greatest concern to ageing individuals. This type of scheme would, undoubtedly, help to provide “peace of mind” to very many older people. On the other hand, it would likely be more difficult to administer. It also shelters the assets of the better off.



7.22 The “front-end” scheme is the more practical from an operational perspective and would support rehabilitation. It is also not unreasonable for a person, after a period of around a year in residential care, to begin to spend down their assets.<sup>85</sup> If they do not wish to do so, they may effect private long-term care insurance to protect themselves against this eventuality. We therefore recommend that consideration be given to introducing “front-end” cover for residential care within a social insurance scheme for long-term care.

<sup>85</sup> *If their spouse were still living in their house, they would not be required to spend down housing assets as these would be excluded from the means-test.*

## 8. Costings

8.1 In this section, we consider:

- the cost of current State provision for residential and home care, and
- the cost of providing the “template” benefits outlined in section 5, either:
  - without limit as to the duration of benefit
  - with benefits for residential care payable for a period of up to one year only (“front-end cover” as outlined in section 7)
  - with benefits for residential care payable only after an individual has been in residential care for two years (“back-end cover” as outlined in section 7).

### Current provision

8.2 The table below sets out the estimated future cost of current State provision based on our central projection of future care needs. The table overleaf shows estimated costs based on our “static”, “optimistic” and “pessimistic” projections of care needs.

#### Estimated future cost of current State provision

€million – constant price terms

#### Central projection

	Residential care	Home care			Overall	
		Home help service	Carer's Allowance	Domiciliary Care Allowance	Total home care	
<b>2001</b>	277	86	129	21	235	513
<b>2011</b>	421	131	198	29	358	779
<b>2021</b>	663	193	291	37	521	1,184
<b>2031</b>	1,148	278	417	47	742	1,889
<b>2041</b>	1,926	395	593	58	1,046	2,971
<b>2051</b>	2,832	508	763	71	1,341	4,173

### Estimated future cost of current State provision

€million – constant price terms

	Projection 2 Static disability rates	Projection 3 Optimistic	Projection 4 Pessimistic
2001	513	513	513
2011	848	776	868
2021	1,346	1,118	1,413
2031	2,235	1,674	2,405
2041	3,478	2,596	3,837
2051	4,861	3,619	5,497

### Projection basis – current provision

- Expenditure estimates for 2001 have been used as the basis from which to project future costs.
- We have assumed that the relative proportions of extended care beds in the public and private sectors will not alter and that the overall number of extended care beds will increase in line with the numbers needing long-term care and current institutionalisation patterns.
- The estimated cost of residential care in public extended care beds does not include beds designated for convalescence, assessment and rehabilitation.
- Allowance has been made for retentions from pensions for patients in public beds and private nursing home beds contracted by Health Boards, at the rate of 80% of the non-contributory Old Age Pension.
- For the purposes of the projection, we have assumed that residential care benefits will increase in line with increases in nursing home costs. We have indexed nursing home costs – public and private – on the basis of a cost distribution of 50% care costs, 25% other staff costs and 25% non-labour costs. We have assumed that care costs will increase at a rate 1% in excess of the rate of increase in national average earnings; other staff costs are assumed to increase in line with average earnings and non-labour costs at the rate of average price inflation.
- We have assumed that the Carer's Allowance, the Domiciliary Care Allowance and rates of pay in the home help service will increase in line with increases in average earnings.



- In line with the assumptions used for the 2000 update of the Actuarial Review of Social Welfare Pensions, it was assumed that future increases in average earnings relative to price increases would be as follows:

Annual Rate	2001 to 2011	2012 to 2021	2022 to 2036	2037 to 2056
Price/Earnings Differential	3.2%	2.7%	2.3%	2.0%

- Our estimates do not include the cost of residential care in facilities for younger people with physical disabilities.

- 8.3 It is notable that current expenditure is broadly evenly distributed between those in receipt of residential care and home care, although the number in residential care is significantly less than the estimated number receiving care at home. The figures for those aged 65 and over are shown below for illustration purposes<sup>86</sup>:

#### Estimated number needing long-term care, 2001

##### Central projection – older people (65+)

Care needs	Residential care	Home care
Moderate	2,600	33,200
High	4,300	10,900
Continuous	12,800	20,300
<b>Total</b>	<b>19,700</b>	<b>64,400</b>

- 8.4 Moreover, a significant proportion of expenditure for home care relates to the Carer's Allowance. This is an income support benefit and it is likely that a significant proportion of those in receipt of the Allowance would qualify for another social assistance payment. This means that the current balance is in fact weighted even further towards residential care.

#### "Template benefits"

- 8.5 We have also estimated the cost of providing the template benefits outlined in section 5 for illustration purposes. These benefits could be provided on a means-tested or a universal basis, or through a combination of social insurance and social assistance. For the purpose of our estimates, we have assumed that everyone in need of care would qualify for benefits. The cost of means-tested benefits can be derived by multiplying the cost of the universal benefit by the proportion of people who are expected to satisfy the means-test.

86

A comparison across all age groups is not possible, as we do not have data in relation to residential care in facilities for younger people with physical disabilities.

**Estimated future cost of template benefits – no limit on duration of benefit**  
 €million – constant price terms

**Central projection (All ages)**

**Residential care**

Dependency:	Moderate	High	Continuous	Total
2001	28	76	285	388
2011	42	115	432	589
2021	67	181	679	927
2031	117	316	1,170	1,604
2041	199	534	1,959	2,692
2051	295	789	2,882	3,966

**Home care**

Dependency:	Moderate	High	Continuous	Total
2001	296	185	606	1,087
2011	452	283	932	1,667
2021	660	414	1,374	2,448
2031	924	588	1,986	3,498
2041	1,258	819	2,854	4,931
2051	1,570	1,039	3,697	6,306

**Residential and home care**

Dependency:	Moderate	High	Continuous	Total
2001	324	261	890	1,475
2011	495	397	1,364	2,256
2021	727	595	2,053	3,375
2031	1,041	904	3,156	5,101
2041	1,457	1,353	4,813	7,623
2051	1,865	1,828	6,579	10,272

8.6 The estimated costs of providing the benefits to older people only are set out below.

**Central projection (65+)**

€million – constant price terms

**Residential care**

Dependency:	Moderate	High	Continuous	Total
2001	28	76	262	366
2011	42	115	396	553
2021	67	181	628	877
2031	117	316	1,102	1,536
2041	199	534	1,872	2,605
2051	295	789	2,783	3,868

**Home care**

Dependency:	Moderate	High	Continuous	Total
2001	135	93	327	555
2011	202	142	508	852
2021	321	223	800	1,345
2031	502	353	1,286	2,141
2041	758	540	2,023	3,321
2051	1,027	735	2,784	4,545

**Residential and home care**

Dependency:	Moderate	High	Continuous	Total
2001	163	169	589	921
2011	244	256	904	1,405
2021	388	405	1,429	2,222
2031	619	669	2,388	3,677
2041	957	1,075	3,895	5,926
2051	1,322	1,524	5,568	8,413

€million – constant price terms (all ages)

	<b>Projection 2 Static disability rates</b>	<b>Projection 3 Optimistic</b>	<b>Projection 4 Pessimistic</b>
<b>2001</b>	1,526	1,475	1,526
<b>2011</b>	2,418	2,148	2,479
<b>2021</b>	3,777	3,054	3,971
<b>2031</b>	5,968	4,357	6,433
<b>2041</b>	8,872	6,451	9,804
<b>2051</b>	11,940	8,655	13,527

#### Projection basis – template benefit structure

- We assumed that care recipients would be allowed to choose a combination of formal services and cash benefit on a pro-rata basis. We further assumed that a significant proportion of those receiving care informally would opt to continue to do so, but that the proportion opting for formal care would be highest amongst those with the highest level of dependency:

<b>Care need</b>	<b>Formal services</b>	<b>Informal (cash benefit)</b>
Moderate	12.5%	87.5%
High	25.0%	75.0%
Continuous	50.0%	50.0%

- We assumed that current patterns of institutionalisation rates (by age and dependency) would continue. However, it is very possible that a significant change in the benefits available for residential and home care could alter these patterns.
- We assumed that 56% of those in residential care would be in private beds and 44% in public beds i.e. broadly the current mix. We further assumed that benefits for those with moderate care needs would be payable only to those in public beds.
- We assumed that the average weekly cost of care in a private nursing home was €500 and in a public institution was €600 in 2001.
- For the purposes of this projection, we assumed that residential care benefits would be indexed to increases in nursing home costs, which were determined as outlined previously. We assumed that the benefits for home care would be indexed to increases in average earnings.

- As before, it was assumed that future increases in average earnings relative to price increases would be as follows:

Annual Rate	2001 to 2011	2012 to 2021	2022 to 2036	2037 to 2056
Price/Earnings Differential	3.2%	2.7%	2.3%	2.0%

- The cost estimates for residential care do not include the cost of care in residential facilities for younger people with physical disabilities. On the other hand, the cost estimates for home care are based on the total number of younger people with care needs (other than a small proportion who occupy extended care beds).

#### PRSI contribution rate

- 8.7 We considered the PRSI contribution rate that would be required to fund the ***difference between the cost of the template benefits and the cost of current benefit provision.***
- 8.8 Using the model developed for the 1997 Actuarial Review of Social Welfare Pensions, we estimated the value of a contribution of 1% from employees, employers and the self-employed respectively, assuming that allowances and ceilings would apply to these contributions on the same basis as to current PRSI contributions. We used the estimate of total PRSI contribution income for 2001 as a base and projected forward using the model.

#### Value of 1% PRSI contribution (payable by employees, employers and the self-employed) – €million

2001	662
2011	1,002
2021	1,260
2031	1,499
2041	1,739
2051	1,939

- 8.9 We then calculated the **additional** cost of the social insurance benefits over and above the cost of current benefit programmes as a percentage PRSI contribution as follows:

**Additional costs expressed as a percentage PRSI contribution (that contribution to be payable by employees, employers and the self-employed)**

	Central projection %	Static projection %	Optimistic projection %	Pessimistic projection %
2001	1.5	1.5	1.5	1.5
2011	1.5	1.6	1.4	1.6
2021	1.7	1.9	1.5	2.0
2031	2.1	2.5	1.8	2.7
2041	2.7	3.1	2.2	3.4
2051	3.1	3.7	2.6	4.1
<b>Equalised rate<sup>87</sup></b>	<b>2.1</b>	<b>2.3</b>	<b>1.8</b>	<b>2.5</b>

*Note that, in respect of employees, the total contribution rate, for example, in the period 2001-2011 would be 3.0% (1.5% payable by the employee and 1.5% payable by the employer)*

**"Front-end cover"**

- 8.10 We have also estimated the cost of providing the template benefits for residential care only for the first year that an individual requires such care.

**Cost of residential care benefits for a maximum of one year**  
€million – constant price terms

	Central projection	Static projection	Optimistic projection	Pessimistic projection
2001	167	167	167	167
2011	259	268	243	275
2021	408	437	359	459
2031	732	810	603	873
2041	1,275	1,396	1,043	1,542
2051	1,908	2,080	1,556	2,356

<sup>87</sup> i.e. the level contribution rate which, if paid over the 50 year period, would fund the benefits payable over that period. The equalised rates have been calculated on the assumption that the surpluses which would arise in the earlier years of the period would be invested and would generate a return of 2% in excess of the rate of increase in earnings.

- 8.11 Our estimates suggest that the cost of providing residential care for up to one year only is in the range 43% - 48% of the cost of providing such care without limit as to the duration of care. In practice, however, it would be necessary to provide a means-tested benefit for those who require residential care for more than a year but do not have the resources to pay for it.

**“Back-end cover”**

- 8.12 Finally, we have estimated the cost of providing the template benefits for residential care only after an individual has been in residential care for at least two years.

**Cost of residential care benefits available after an individual has been in such care for at least two years**

€million – constant price terms

	Central projection	Static projection	Optimistic projection	Pessimistic projection
2001	138	138	138	138
2011	203	215	192	220
2021	319	360	288	378
2031	521	622	444	671
2041	827	980	701	1,083
2051	1,186	1,402	1,003	1,589

- 8.13 Our estimates suggest that the cost of providing residential care only beyond a two year duration is in the range 30% - 36% of the cost of providing such care without limit as to the duration of care. Again, it would be necessary to provide a means-tested benefit for those who require residential care for up to two years but do not have the resources to pay for it.

**Projection basis – front-end and back-end cover**

- For the purpose of costing the front-end and back-end cover, we have assumed average lengths of stay in accordance with the table below. These have been derived following consideration of international data on lengths of stay.

Age:	65-69	70-74	75-79	80-84	85+
Male	3.33	2.67	2.00	1.33	0.67
Female	5.56	4.45	3.33	2.22	1.11

- We have further assumed one-year “survival rates” (i.e. the proportion of residents at the beginning of a year who are still resident at the end of the year) as follows:

Age:	65-69	70-74	75-79	80-84	85+
Male	74%	69%	61%	57%	22%
Female	84%	80%	74%	64%	41%

## Conclusions

- 8.14 The relative cost of front-end and back-end cover for residential care is primarily dependent on the duration limit or duration threshold selected. We have used a duration limit of one year for front-end cover, and a threshold of two years for back-end cover, simply for illustration purposes. In practice, once a preferred approach is determined, as between the front-end and back-end approach, an appropriate cut-off point could be determined having regard to the available funding and to the preferred mix of State and individual provision.
- 8.15 If extensive cover is provided for home care, as is envisaged in the template benefit structure, the cost of home care benefits will dominate the overall cost. It is clearly preferable to provide, as much as possible, for care at home rather than on a residential basis. However, resource constraints may limit the scope of the benefits that can be provided. Options that could be considered include:
- providing home care benefits only for those with the highest levels of need i.e. those who are on the margin of needing residential care and those who would need residential care were they not receiving substantial informal care
  - scaling back the level of formal services and/or the cash benefit alternative to be made available in respect of home care
  - means-testing of home care benefits.



## 9. Implementation issues

- 9.1 Clearly there are very many practical issues that would need to be considered if any significant changes are made to current arrangements for financing long-term care. Consideration of a comprehensive range of such issues at a detailed level is beyond the scope of this report. This section focuses on the primary issues that would arise.

### Departmental responsibility

- 9.2 If long-term care benefits were to be provided through social insurance, we would envisage that the Department of Social and Family Affairs would have responsibility for raising finance for the scheme, whilst the Department of Health and Children would manage the delivery of services through the Health Boards.

### National Long-Term Care Authority

- 9.3 Having regard to this structure and also the involvement of other departments in relation to various aspects of long-term care provision, we also suggest that consideration be given to the establishment of a National Long-Term Care Authority. The Authority could undertake responsibility for:
- overseeing the needs assessment process at national level
  - advising the Departments with regard to appropriate levels of benefit to be provided in respect of the various levels of dependency set by the needs assessment process
  - advising on the allocation of funds to Health Boards
  - monitoring the supply of independent residential and home care providers, the take-up of such provision by beneficiaries, the use of such provision by Health Boards to meet their own service commitments and the quality of provision
  - a National Information Campaign relating to long-term care insurance
  - liaison with insurance companies providing private long-term care insurance.

- 9.4 The fundamental issue of needs assessment has already been addressed in section 5. Other issues are expanded in the following paragraphs.

### Allocation of funds

- 9.5 Having regard to the suggested benefit design, we believe that consideration should be given to allocating funds to Health Boards on a capitation basis, based on the number of beneficiaries of the scheme in each Health Board area, weighted by dependency level, rather than on the basis of a global budget as at present. Allocations of funds would no longer relate separately to residential, community or home care services. If all services have the backing of statutory entitlement, a structure would need to be established whereby Health Boards could secure additional funds should the initial allocation prove insufficient to meet the statutory commitment. However, this should be accompanied by a cost-effectiveness review. This process could potentially be overseen by the National Long-Term Care Authority.

### Supply of nursing home beds

- 9.6 In recent years, capital allowances have been available for the purpose of developing new nursing homes or developing existing facilities. This has attracted a significant number of new beds into the system. Whilst an under-supply of extended care beds causes obvious difficulties, the over-supply of such beds could equally lead to inefficiencies in the provision of care. There is substantial evidence within the health sector generally to suggest that additional supply (of services or service providers) leads to increased utilisation. In the case of long-term care, this could result in more care being provided on a residential basis than is necessary on the basis of levels of dependency.
- 9.7 In particular, we would be concerned that, if non-means-tested benefits were to be provided in respect of residential care, there could be some increase in the level of utilisation of such care. Over-supply of nursing home beds could exacerbate this.
- 9.8 We believe that there is a need to plan the overall supply of residential services on a national basis and to provide accordingly for some controls in relation to private sector developments. We suggest that this responsibility should fall to the National Long-Term Care Authority.

### Supply of independent home care providers

- 9.9 On the other hand, the Authority could take responsibility for monitoring the development of a market for independent home care provision. We have suggested that the development of such a market would be beneficial both in terms of cost-effectiveness and widening consumer choice. Moreover, if more extensive funding is provided for home care provision, it is unlikely that current Health Board resources would be sufficient to provide all of the additional supply that would be required. The Authority could, if necessary, propose measures designed to stimulate the market. For example, as occurred in the UK as part of the 1993 community care reforms, Health Boards could be required to outsource a certain proportion of home care service provision.
- 9.10 The Authority could also perhaps take the lead on an initiative to increase the supply of assisted living facilities.

### National information campaign

- 9.11 One of the problems in relation to the current system of financing long-term care is the lack of clarity as to the role of the State and the responsibility for individuals to make provision for their own long-term care needs. One of the benefits of restructuring the system would be to make clear where these boundaries lie. Even if no significant restructuring is undertaken, there would be benefits in trying to clarify what will be provided and in what circumstances (even if that merely serves to highlight the extent to which certain services - in particular services in the community - are dependent on the resources that are made available from time to time).

9.12 We would recommend, therefore, that a national information campaign be undertaken in relation to long-term care. We note that in the report by the Irish Association of Pension Funds, the Irish Insurance Federation and the Society of Actuaries in Ireland on Financing Long-Term Care, the insurance industry committed to “*funding, collectively and individually, education and information campaigns*” (presumably tied in to the development of a “partnership” basis of funding that would potentially generate a market for private insurance). There may, therefore, be scope to pool public and private resources with a view to undertaking a joint information campaign.

#### Transition to the new benefits

9.13 A key issue for consideration in introducing any new system is how the transition should be made to the new benefit structure. There would likely be pressure to provide the new benefits with immediate effect but this may not be practicable from a budgetary perspective or having regard to supply-side issues. Having regard to the suggested contribution criterion for social insurance benefits (i.e. five years paid contributions), this could potentially attach to the additional contribution levied to cater for the addition of long-term care benefits. This would defer the implementation of the new benefits for a five year period. There are a number of intermediate options that could be considered. For example, with respect to home care, the cash benefit alternative could be introduced ahead of the formal service entitlement (or, for a period, the formal service entitlement could be set at the same value as the cash benefit alternative).

#### Prevention

9.14 A critical issue that must not be lost sight of is the potential for preventive measures to reduce the need for long-term care in the future. As noted previously, international studies have found that positive trends in healthy life expectancy are already in evidence. Moreover, given the known link between health status and factors such as educational level and income, it is likely that in this country future generations of older people can expect to enjoy good health for longer than the current generation.

9.15 However, there is undoubtedly scope for increasing the implementation of preventive measures. According to the Berlin Ageing Study<sup>88</sup>, “*results of the study show a high degree of morbidity, but also indicate many modifiable risk factors for illness and disability, opening new vistas of prevention and therapy in old and very old age.*”

9.16 We suggest that the options for preventive measures should be given further consideration under the auspices of the Department of Health and Children.

88 Baltes and Mayer, 1999, *op. cit.*

## 10. Pre-funding

### Current approach

- 10.1 Part of our brief was to consider whether the cost of State-provided long-term care should be met on a “pay-as-you-go” basis or should be pre-funded.
- 10.2 Until recently, State pensions were provided on a pay-as-you-go basis. In 1999, however, the Government announced its intention to begin partial pre-funding of Social Welfare and public service pensions. Under this initiative, an annual contribution of 1% of GNP will be made to the National Pensions Reserve Fund. In addition, the net proceeds of the sale of the former Telecom Eireann are to be paid into the Fund.
- 10.3 The decision to begin partial pre-funding reflects the context of present and expected future substantial budget surpluses as well as the impact of the ageing population. Nevertheless, the commitment to pre-funding State and public service pensions is intended to be a non-discretionary one, with a statutory requirement to make the annual contribution regardless of economic, budgetary or other circumstances. The contribution rate, at 1% of GNP, is only a fraction of the rate that would be required in order to pre-fund all pension liabilities, but is regarded by Government as a “prudent and sustainable” commitment.
- 10.4 The public health care system is funded on a pay-as-you-go basis. The Report of the Budgetary Strategy for Ageing Group (1999) considered the impact of ageing on health care costs as well as the cost of pensions. It estimated that the impact of ageing on health care costs will be of a similar magnitude to the impact on social welfare pensions (it estimated that an annual provision of more than 1.4% of GNP would be required to meet extra social welfare pension outlays to 2056 while an annual provision of close to 1.4% of GNP would be required to meet extra health service costs to 2056 because of the increasingly older profile of the population).
- 10.5 However, the Group did not recommend pre-funding of the increased health care costs that will arise as a result of population ageing. Their report indicated that this was because the Group was unable to identify a basis for pre-funding health care costs that would display the characteristics that they required i.e.
- That pre-funding be a non-discretionary commitment, with annual contributions to be made regardless of economic, budgetary or other circumstances.
  - That recourse to the Fund be limited to the specific purposes for which they are established and occur only on the basis of trigger mechanisms to be specified in law.
  - That the actuarial position of the Fund be reviewed periodically with appropriate adjustment of the contribution rate and/or draw-down basis.

10.6 This partly reflects the fact that the provision of health services is currently budget-driven. Hence, in most respects, the scope of the services that will be provided in future years is not explicitly known and the “entitlement” to certain services or benefits may be moot. In addition, it is obviously more difficult to estimate the future cost of health services than pension benefits, having regard to variables such as the development of new medical technologies, trends in health service utilisation, etc.

10.7 We consider it likely, however, that a basis for pre-funding long-term care could be developed that would satisfy the Group’s criteria if, as we have proposed, long-term care is financed in future on a basis which clearly identifies the benefits – in respect of both residential and home care services – that will be provided to those with specified long-term care needs.

#### Funding options

10.8 The options available are as follows:

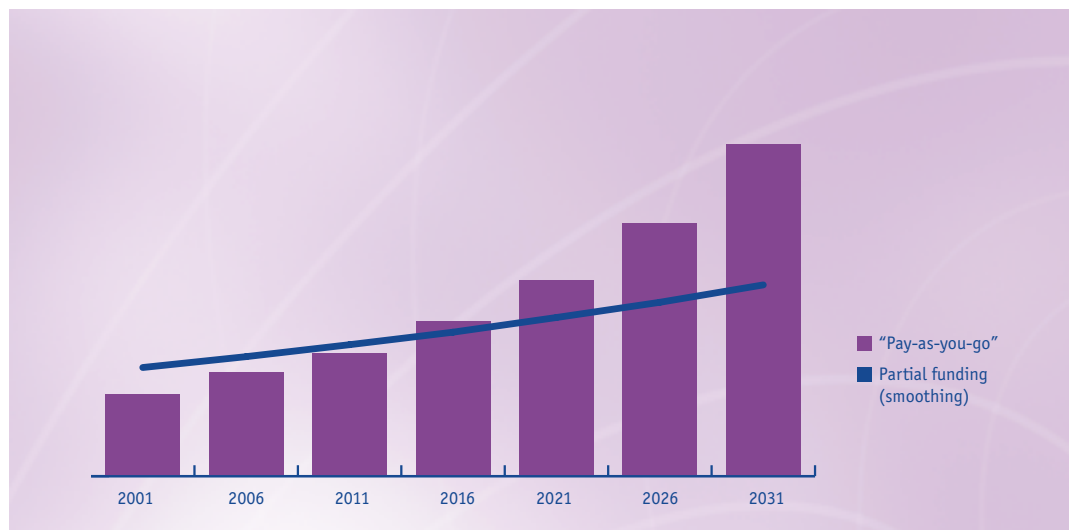
- Pay-as-you-go
- “Full” funding
- Partial funding.

10.9 It is not obvious what would constitute “full” funding in the context of long-term care. The actuarial concept of funding, as applied to private pensions, is not directly applicable, since there will be no distinction, within the entitlement to long-term care benefits, between “past service” accrued liabilities and future service liabilities.

10.10 On the one hand, it could be argued that full funding would require the existence of a fund sufficiently large to meet all of the future costs of long-term care for the current population throughout the remainder of their lifetime. Obviously, this is unattainable. A narrower interpretation could be that full funding would mean a fund sufficient to meet the future costs of long-term care for the current older population, with the ongoing contribution rate set so as to maintain this funding position going forward.

10.11 In practice, whatever the interpretation, full funding is likely to be impracticable. However, partial funding, aimed at smoothing the long-term care bill in the future (on a basis similar to the current initiative in respect of State pensions), may be feasible.

### Illustration of partial funding



#### Pre-funding: the pros and cons

10.12 The arguments for and against the pre-funding of long-term care are broadly similar to the arguments for and against the pre-funding of the State's pension liabilities. These have been set out in detail elsewhere (for example, in the report of the Commission on Public Service Pensions) and will be rehearsed here only briefly in the context of long-term care.

#### Arguments in favour of pay- as-you-go

- Pay-as-you-go is in keeping with the Government's budgetary system generally, albeit that some pre-funding of pensions will occur in future.
- Pay-as-you-go ensures that Government has budgetary flexibility and also the flexibility to allocate the available resources within society as it judges appropriate at a given period in time.
- Pay-as-you-go minimises administration costs, compared with the complex regulatory environment, administrative burden and investment responsibilities associated with the establishment of a fund.
- Future entitlement to benefits can be established under a pay-as-you-go system (as has been the case for social insurance pensions). The existence of a fund would provide no greater level of assurance as to that future entitlement, if, for example, the State were facing a severe financial crisis.
- As yet, no other country, with the exception of Singapore, has undertaken to pre-fund the costs of long-term care.

#### Arguments in favour of partial pre-funding

- Funding would help smooth the expected future increase in long-term care costs. By contributing more than current annual costs in the initial years, the future contribution rate required to fund benefits for an older population can be reduced.
- Whilst State health care and pension benefits are predominantly funded on a pay-as-you-go basis, the principle and benefits of some pre-funding have now been accepted with the establishment of the National Pensions Reserve Fund.

- Pre-funding should enhance public awareness of the implications of ageing, both at the population and the individual level. In relation to long-term care, it is likely to give rise not only to greater awareness of the level of State provision but also a greater degree of certainty as to the future extent of public provision. This should help make it easier to gain public acceptance for the additional contributions that would be required in order to expand current benefit provision and could also help increase private provision.
- Whilst it can be argued that pre-funding, in itself, does not substantially increase the security of the benefit promise, the existence of the fund does provide some degree of assurance that the State will not cut back on benefit entitlements at some future date.
- Many economists believe that funding increases real investment in the economy such that additional resources can be created to ease future costs. However, this is a matter of debate among economists.
- Also, if returns on the fund's investments were greater than the returns that could have been obtained through alternative spending (e.g. repayment of part of the national debt etc.), the overall cost of benefits would be reduced.

10.13 Finally, in weighing up the relative merits of pre-funding and pay-as-you-go, it must be noted that the future growth in long-term care costs, due to the ageing of the population, may be less than the future growth in the cost of social insurance pensions. As outlined in section 3, recent international trends suggest that, as life expectancy continues to increase, the onset of significant disability is occurring later in life (i.e. "healthy life expectancy" may increase in line with overall life expectancy). This means that the prevalence of significant disability amongst the older population may be lower in future than it is currently. Hence, the growth in long-term care costs may be less than that which might be predicted by reference to the rate of increase in the older population. If the projected increase in costs is less significant for long-term care than is the case for pensions, the view could be taken that pre-funding is less necessary.

#### Pre-funding long-term care costs

10.14 Should long-term care costs be pre-funded? Arguably, this depends on the nature of the long-term care benefits that the State wishes to provide in the future and the basis on which these are to be financed. Pre-funding may be considered appropriate if a social insurance model is adopted, but may be less appropriate if the current financing model is maintained. In particular, if the level of benefit provision is budget-driven, as is to some extent the case for benefits currently provided within the structure of the health care system, pre-funding may be neither appropriate nor feasible (this is reflected in the conclusions reached by the Budgetary Strategy for Ageing Group).

**10.15 We consider that some element of pre-funding would be particularly desirable if a partnership financing model is adopted.** This would provide assurance of the long-term nature of the Government's commitment to its role in the partnership. This in turn would provide a stable environment to facilitate the emergence of private financing vehicles and encourage private provision.

10.16 The question as to whether a "long-term care reserve fund" should be established must also be considered in the context of the Government's other long-term commitments, in particular the already established pre-funding initiative for Social Welfare and public service pensions. The view may be taken that the level of contribution earmarked for the National Pensions Reserve Fund is the maximum level of pre-funding to which the Government can prudently and sustainably commit.

10.17 Any greater level of pre-funding for long-term care could simply be directed to the National Pensions Reserve Fund. This could be considered to be as useful in alleviating the future impact of ageing on public expenditure as the establishment of a separate long-term care reserve fund. **Whilst the establishment of a separate fund for long-term care could have greater benefits in terms of public perception, particularly vis-à-vis a partnership approach, we do not consider it to be a practical option.**



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# Appendix I

## Assumptions underlying the population projections

The basis of the population projections are the projections set out in the Report “Population and Labour Force Projections 1996 – 2026” published by the Central Statistics Office, adjusted to take account of the 1996 Census results published by the CSO in July 1997.

Following discussions with the Department of Finance the following rates of migration were assumed. These are broadly the average of the two sets of assumptions – M1 and M2 – in the subsequent CSO Report “Population and Labour Force Projections 2001 – 2031”, published in 1999.

	1999 – 2005	2006 – 2010	2011 – 2015	2016 – 2026
Immigration	40,000	35,000	30,000	25,000
Emigration	25,000	25,000	25,000	25,000
Net Migration	15,000	10,000	5,000	Nil

This compares with an assumption of zero net migration throughout the period to 2026 in the 1997 Actuarial Review of Social Welfare Pensions.

It was also decided to use the middle of the three fertility assumptions in the CSO 1999 Report. This assumption is that the Total Fertility Rate (TFR) remains constant to 2001, declines to 1.75 by 2011 and remains constant thereafter. This is a slightly different assumption to that used in the 1997 Actuarial Review of Social Welfare Pensions.

### Long-term care in other countries

Australia .....	164
Austria .....	166
Canada .....	168
Denmark .....	171
France .....	173
Germany .....	175
Japan .....	179
Luxembourg .....	180
New Zealand .....	182
Singapore .....	184
Sweden .....	186
United Kingdom .....	187
United States .....	189

## Health care financing

## Retirement income financing

Medicare which is compulsory and financed partly through a tax levy on individual's taxable income, provides a basic level of benefits including shared ward accommodation in a public hospital and a rebate of up to 75% of scheduled doctors' fees and up to 85% for treatment outside hospital.

Medicare does not cover prescription drugs – covered under a separately government funded pharmaceutical benefits scheme (PBS) which provides for approximately 90% of all drugs and medicines. Each patient is required to pay a nominal fee for each prescription – drugs and medicines not on the PBS list are not subsidised. This cost can be offset through membership of a healthcare plan.

Social Security pays a flat rate old age pension financed from general taxation. It is means-tested.

Employer sponsored pension funds generally provide lump sum on normal retirement age at 65.

## Long-term care


### Provision

The Australian system provides a highly centralised system of institutional care and a very decentralised system for home and community care (HACC) services. The former is funded from the Federal Government as an individual entitlement which is assessed by Aged Care Assessment Teams (ACAT) – a service provided on contract through the state health and social service network using a scale of dependency and related bed subsidies laid down by the national government. The number of institutional beds is controlled from central government and negotiations with providers take place directly with the relevant central government department.

### Financing

HACC is partly funded from the government by grants to the states and partly by the states. Distribution of HACC services is not governed by entitlements but by general principles and there are some concerns about consistencies. The states either provide their own home care service and / or contract with suppliers to provide specific services.

Nursing homes provide nursing and personal care free of charge to the individual. Residents pay a nominal contribution (85% of the public pension rate) towards costs. The balance for both care and accommodation are paid directly to the provider by the government. Individuals pay for care (the amount depending on an income and assets test) and the standard fee for accommodation.



Hostels (an alternative form of housing for older people) charge an entry contribution from which the provider can draw down an agreed amount for the services required. Providers are also required to retain a share of places for those who could not afford the charge and for whom costs are met by the social security system.

### **Reform**

The balance of funding between central and regional government for HACC services has now altered – with the states charging more for these services.

Access to institutions is assessed by the Aged Care Assessment Team (ACAT). Candidates are assessed by the team and classified by dependency (on an 8-point scale of dependency). ACAT also assess young adult disabled. ACAT is broadly accepted and permits the government control over admissions and beds.

Nursing homes charge separately for accommodation and care. Carers now have a much wider range and level of available services including respite care. There is a carer's pension to provide income support to those providing care.

Increased charges for HACC services have heightened the conflict between services required by young adult disabled people and older people in particular.

## Health care financing

## Retirement income financing

Universal compulsory cover is provided by a number of Government-approved sickness funds (which operate on a pay-as-you-go basis). These funds cover normal treatment provided by doctors, hospitals and chemists under contract to the funds, subject to certain co-payments.

As the State programme only covers basic hospital accommodation, supplementary health insurance coverage is common, mainly to upgrade hospital accommodation.

Retirement pensions are financed through social insurance contributions (180 months contributions required for full pension). The pension is related to average earnings over the period of contributions.

Second pillar pensions are generally integrated with social insurance pensions and are financed through occupational defined benefit and defined contribution pension schemes.

## Long-term care

### Provision


Since 1994, cash benefits are provided to those with long-term care needs on a universal basis. Care needs must be expected to last for at least six months and must exceed 50 hours per month on average. Need is assessed on the basis of ability to perform activities of daily living as certified by an expert physician. Monthly benefits vary according to the assessed level of care need, as follows:

Category	Care need (hours per month)	Benefit per month (I€)
1	more than 50 hours	114
2	more than 75 hours	211
3	more than 120 hours	326
4	more than 160 hours	489
	more than 180 hours	
5	■ if an exceptional amount of care is necessary	663
6	■ if 24 hour care is required	905
7	■ if the individual is also confined to bed	1,206

The purpose of the benefit is to cover care-related expenditure while enabling the individual to determine how that care is organised and also to support and encourage family care.

The cash benefits are paid by the institutions that pay Social Security pensions.





Additional benefits in cash and in kind are provided under the social assistance scheme to individuals who are unable to pay for care and nursing from income, assets and long-term care benefits. Benefits vary between the states. In most states, individuals are legally entitled to receive such benefits provided that they meet the requisite criteria. Most states provide institutional long-term care as a benefit in kind.

The universal cash benefit is payable regardless of the type of care being provided. However, entitlement to the cash benefit is suspended during in-patient stays in hospital or other institutions if most of the cost of institutional care (in basic accommodation) is covered by a State fund or the Federal Government.

Community care services are provided primarily by independent not-for-profit organisations. Informal care remains prevalent, with an estimated 68% of frail older people receiving care from a family member.

### **Financing**

Unusually, given that both general health care and retirement incomes are financed through social insurance, the universal cash benefit is not specifically funded from social insurance contributions.

### **Reform**

Evaluations of the 1994 reforms have found that people are generally satisfied. In a 1995 research study, more than 82% of the beneficiaries reported that the cash benefit covered “a noticeable part of the cost” arising from care needs. About 57% reported that they were less dependent on unpaid help while 81% felt that the benefit allowed them to compensate family members for care (although only 25% reported regularly compensating caregivers, while 30% saw the cash benefit as part of the common household budget).

Notably, the current system was introduced after some debate as to the relative merits of providing cash allowances or direct provision of services. The dominant voice in influencing the choice of a cash-based system was that of the groups representing younger disabled people who placed a high value on the greater independence that would come from controlling the allocation of these allowances.

## Health care financing

## Retirement income financing

The financing methods for Medicare, the State health care system that provides universal coverage, vary by province. In two provinces, residents are required to pay a premium for Medicare (premiums are not rated by risk and prior payment of a premium is not a pre-condition for treatment). In the other provinces, Medicare is financed through taxation alone. Financial assistance for Medicare is provided by the federal government from federal taxation.

Although the Canadian system is effectively a “national health service”, there is separation of the “purchaser” and “provider” roles and it is often described as a health insurance system.

Waiting times are a significant issue, in spite of the fact that Canada spends much more on health care than is the case for national health systems in the UK or Ireland.

Private health insurance to obtain alternative access to treatment covered under the public system is prohibited. Supplementary private health insurance is, however, common.

There are two State retirement income programs in Canada. The Old Age Security (OAS) scheme provides flat-rate benefits to all over 65s. OAS is financed by general taxation.


The Canadian Pension Plan (CPP) is a social insurance scheme providing earnings-related benefits.

## Long-term care

### Provision

Institutional care is available at a number of different levels: sheltered housing, intermediate level and more intensively supported residential homes. Institutional facilities are independent of the provincial health systems, but are generally subject to a licensing system (except in Ontario).

Similarly, a wide range of formal home care services is available: home nursing, home helps and meal services. In some provinces, settings such as community clinics and day centres are used more intensively than in-home services. Therapy services - physiotherapy, occupational, speech and respiratory therapy - may also be provided. In some provinces, public employees deliver home care services, while others contract out such services to either not-for-profit or commercial agencies. In Ontario, for example, Community Care Access Centres (CCACs) receive funds from the province to pay for home care services.



Since 1996, the CCACs have no longer provided such services themselves; their role now is to assess eligibility for services, determine care needs, select service providers, monitor performance and pay providers. This is intended to foster a competitive market for home care services.

The National Population Health Survey found that the majority of those who report needing help in the home due to age, chronic illness or disability, received no formal, publicly-funded care whatsoever. 80% to 90% of all care for this group is unpaid informal care. Many Canadians do not know what is available to them.

Federal and provincial means-tested programmes provide assistance with the cost of home adaptations.

### **Financing**

Long-term care is financed at a provincial level and there is wide variation between the provinces and indeed within provinces as to what is covered.


Subsidy of institutional care is means-tested in some provinces; in other provinces, care costs are covered by the public system and residents are required to pay accommodation charges depending on the standard of accommodation chosen.

Home care is also financed, again with significant provincial variations in relation to eligibility conditions, covered services and cost-sharing arrangements. A recent study found a three-fold inter-provincial variation in home care expenditures per capita on a risk-adjusted basis. Home care expenditure has grown dramatically in the last twenty-five years (by four-fold in the last ten years). Estimates suggest that public finance accounts for around 80% of all expenditure on home care services, with the balance being out-of-pocket expenditure or financed through private insurance.

There has recently been moderate activity in the private long-term care insurance market: the principal Group insurer for federal employees has introduced a long-term care product, out-sourced to a major US provider. Indications are that others will follow but uncertainty in relation to future public financing has deterred many employers from becoming involved.

### **Reform**

Canadians' confidence in their health care system generally is declining and there is widespread discussion of various possible reforms. This generally centres on the organisation and delivery of care, with a desire for more integrated and efficient forms of delivery.



Home care provision has become a prominent health policy issue and there is a strong public consensus in favour of increased provision, in spite of concern about cost, and a nationally consistent programme. There is considerable concern about the potential burden placed on family members providing informal care.

An experimental model of care which integrates health and social services for frail older people, known as *Système de services intégrés pour personnes âgées en perte d'autonomie (SIPA)* is being tested. A number of projects funded by the Health Transition Fund are focused on funding and delivery models for continuing care and related issues such as informal care giving.

Quebec is currently investigating the possibility of an earmarked tax for long-term care funding.

## Health care financing

Health care is provided through a national health service that is financed from general taxation. Individuals elect from two options annually: Group 1 provides for hospitalisation cover, treatment by approved practitioners and partial reimbursement for dental care and prescriptions; Group 2 allows choice of doctor but costs are reimbursed only to the extent of the Group 1 fee scale.

Individuals may take out private insurance to cover part of the expenses not covered by the national health service and a significant proportion of the population does so.

## Retirement income financing

The basic State retirement pension is financed from general taxation. The pension is flat rate. There is also a supplementary State pension scheme that is financed through flat rate social insurance contributions. State pension supplements are payable on a means-tested basis.

Occupational pension schemes are common and are expected to cover 90% of the working population in future. The majority of occupational pension schemes are defined contribution and a number of industry-wide funds have been set up over the past few years.


## Long-term care

### Provision

Long-term care is provided by the municipalities. Care needs are assessed by the municipality in conjunction with the individual's GP. Benefits are universal – there is no means-testing – and are generally free of charge (although there are co-payments for some services such as meals-on-wheels and day care). Benefits are mainly provided in kind. However, a person under 67 who requires help for more than 20 hours per week can choose to receive cash as an alternative. Cash benefits are also given when disability results in increased living costs e.g. special diet, medication etc.

Help with practical tasks e.g. cleaning, shopping and personal care is provided along with home nursing. Where necessary, sheltered housing is provided, with the individual paying rent for their accommodation (the transition to sheltered housing is made easier by the fact that 47% of Danish housing is in the rented sector). Day care services are also available. All institutional care is provided in nursing homes run by the municipalities. However, no more traditional housing is being built; rather, the trend is towards specially designed and intensively supported independent accommodation for frail older people. Denmark already has the lowest proportion of older people in institutional care in the developed world. Some municipalities are beginning to use private and voluntary sector providers to enable a wider consumer choice.

Family members providing care are paid cash benefits by the municipality.



Community health and social care is of high and dependable quality. The receipt of care when it is needed is regarded as a right and is received by a high proportion (approximately 17%<sup>89</sup>) of older people.

### **Financing**

All long-term care is financed from general taxation. Given the high quality of public provision, there is little incentive for those on higher incomes (and subject to high taxes) to seek alternative private market solutions.

### **Reform**

The current system is very popular and there are no plans for reform. There is no “carers” debate, as families are not expected to shoulder a heavy burden of personal care. There may, however, be some concern about the increasing individualisation of society.

From July 1996, there was a legal requirement on local authorities to offer consultations to everyone aged over 80 in their homes, to provide information about services and identify measures which might prevent sickness or disability; this obligation was extended to those aged over 75 from July 1998.

## Health care financing

Health care is financed through statutory social insurance schemes. Membership is compulsory. Contributions – paid by employees and employers – are earnings-related and the rate is fixed by negotiation between the funds and the social partners.

Under the sickness fund system, patient co-payments for medical treatment are relatively high. Therefore, over 80% of the population purchases supplementary insurance from the mutuelles, co-operative not-for-profit societies, or commercial insurers.

## Retirement income financing

State retirement pensions are financed through social insurance and are calculated on the basis of earnings up to the earnings limit for contribution purposes.

There are a number of supplementary pension plans, mainly for senior employees although some have been extended to all employees. Debate on possible reforms continues.

## Long-term care


### Provision

The French system is noteworthy for its complexity, both in terms of provision and financing.

Institutional care is provided in long-stay wards in general hospitals, in retirement and nursing homes and in intensively supported sections within sheltered housing schemes. Retirement homes are managed by local government, not-for-profit associations or commercial organisations. Bed capacity has remained reasonably static but the trend has been to provide more long-term care in “medical sections” within retirement homes.

Home help services are provided by municipalities under regional social assistance schemes on a means-tested basis. The maximum is 30 hours help per month. Private home help services are also available. Home nursing services are provided by hospitals or local associations, but only to 1% of the older population (or 15% of dependant older people), principally to assist with activities of daily living and mobility. Again, there is some private provision.

Other services which may be provided on an optional basis by local authorities and pension funds include information and referral services, meals-on-wheels, day and night sitting services, home improvement and adaptation schemes including telephone alarm systems. Some social institutions have been experimenting with special winter housing for the rural elderly.



Informal care levels remain high, estimated in the mid-1990s at around three-quarters of all long-term care provision. Respite care, on an institutional basis, is provided and financial measures such as the provision of tax reliefs have been taken to support family care provision.

## **Financing**

The cost of institutional care is met from personal resources, supplemented in certain circumstances by housing allowances and, in particular, by regional social assistance programmes. Where care is provided in the “medical section” of a residential home, a daily flat rate contribution to care costs may be made by the sickness funds (this contribution is paid in about one third of all institutional places, including sheltered accommodation).

Home help services are financed by regional social assistance schemes on a means-tested basis. Private home help services are financed by pension funds. The sickness insurance funds pay for home nursing services, which are prescribed by doctors.

Following a lengthy period of consultation and debate, a new State “autonomy allowance” was introduced in January 1997. This is a social assistance measure that provides financial support for long-term care costs to those with limited means. The entitlement is based on a sliding scale, based on the individual’s income and varies by level of dependency (six specific dependency levels are defined). The maximum and minimum amounts of the allowance may vary on a regional basis.

The allowance may be paid either to a care provider or the individual but it is granted for the payment of pre-defined expenses and the care provision is monitored. The care provider may be a family member or the allowance may be used to pay for the “boarding-out” of the individual.

The cost of the allowance (to the extent that these exceed FFr 5,000) are recovered from the part of any subsequent inheritance by family members that exceeds FFr 300,000.

Those not eligible for the autonomy allowance may benefit from a supplementary allowance awarded to recipients of invalidity or old-age pensions where the individual requires assistance with activities of daily living. In the case of old-age pensions, the need for assistance must be declared before the individual’s 65th birthday. The pension supplement is 40% subject to a minimum of FFr 67,900.

The private long-term care insurance market in France is the largest in Europe. The trend is to affinity group insurance schemes sold to employees.



## Health care financing

Medical insurance through sickness funds is compulsory for all hourly paid employees and for salaried employees earning less than the ceiling amounts. Sickness fund contributions are set as a percentage of salary. Those earning more may choose to join a sickness fund or must otherwise take out private health insurance. Private health insurance is structured on a “whole-of-life” basis with premiums calculated on the basis of age at entry.

The sickness funds cover all hospitalisation and medical expenses subject to some flat rate co-payments e.g. for prescriptions. The German health care system involves a clear separation of the “purchaser” and “provider” roles.

## Retirement income financing

State pensions are financed through social insurance and are calculated on the basis of a complex mixture of career earnings, average pay and insurance periods (full benefits equate to about 40% of final earnings up to the salary ceiling).

Occupational pension schemes provide supplementary cover.

## Long-term care

### Provision

Care needs are assessed by doctors on contract to the sickness funds. There are three categories of benefits and individuals may opt for benefit in kind or cash payments.

### Monthly benefits

Category	Description	Home care service  IR£ equivalent	Home care cash allowance  IR£ equivalent	Institutional care  IR£ equivalent
1	Help required at least once daily for at least two of the specified activities and lasting at least 90 minutes (including 45 minutes of personal care)	301	160	804
2	Help required at least three times daily at different times of the day and lasting at least three hours (including two hours of personal care)	723	321	1,004
3	Help required around the clock, during the night on a regular basis as well and lasting at least five hours per day (including four hours of personal care)	1,125 (up to 1,326 in hardship cases)	522	1,125 (up to 1,326 in hardship cases)

Home care benefits are specifically intended to supplement, rather than replace, informal care. Such benefits may be combined in whatever mix of in kind and cash that is preferred by the recipient. Informal family carers are entitled to four weeks respite care in the home setting. In addition, either part-time care in a day or night centre or short-term institutional care (for up to four weeks per year) may be provided. Technical aids are provided and grants are available for adapting the home to the special needs of care. Courses in care provision are provided for family and other informal carers.

Those assessed as needing institutional care receive a subsidy towards the costs at a higher level. The benefits shown for institutional care are maximum amounts and are intended to cover care costs only (the individual remains responsible for the costs of "bed and board"). Where nursing home fees are low relative to the maximum, the recipient is required to meet 25% of care costs.

The sickness funds contracts with local nursing home and home care providers and provide the applicant with a list of approved providers. They have sought to create an open care market and to foster service, price and quality competition between providers.

Benefits paid out in the second quarter of 1997 were as follows:

- 25% of beneficiaries received a benefit for institutional care

- 56% received a home care allowance
- 7% a home care service and
- 10% a combination of home care cash and service.

There is a noticeable trend, since the scheme began, away from home care cash allowances and towards services.

Prevention and rehabilitation are emphasised and the sickness funds are tasked with increasing their efforts in this regard.

### Financing

A social insurance scheme to finance long-term care was established in 1995. Contributions of 1.7% of salary (expected to increase to 2.4% by 2040) are collected by the sickness funds. Contributions are split 50/50 between employees and employers (one public holiday was eliminated in order to compensate employers for the additional cost). Pensioners also contribute and this is seen as an important feature in order to offset in part the effects of demographic ageing. Participation is compulsory, except for those on high incomes who are allowed to opt out of the sickness funds; however, those opting out (around 7% of the population) are required to effect private long-term care insurance of at least equivalent value. Private health insurance operates under regulatory constraints.

The decision in favour of a social insurance system was influenced by the following factors:

- a universal system was considered desirable as the alternative of means-tested social assistance could be vulnerable to “free riders”
- a new tax financed model would have centralised financing at the Federal level and would have been out of keeping with the principle of subsidiarity
- there would have been resistance to increased taxation whereas sickness fund contributions are seen as separate from taxation
- the principle of paying hypothecated contributions in return for eligibility to specified benefits was seen as an important principle to be upheld.

The existence of a functioning network of health insurance funds to implement the new scheme was also a strong influence.

Social assistance is still required for those with limited means, for example to cover accommodation costs in institutional care. However prior to implementation, 80% of nursing home recipients were receiving social assistance, whereas the equivalent figure now is estimated to be between 30% and 40%.

Finally, it is noteworthy that capital investment for all nursing homes and services – public, not-for-profit and private – is financed by the State from general taxation.

### **Reform**

The new system is regarded as broadly successful and has been relatively simple to implement.

It is designed to favour home care rather than institutional care and there has been significant growth in the number of home care agencies, many of which are new providers entering the market. Waiting lists for nursing home places have more or less disappeared, again partly due to growth in the number of providers.

The system is also designed to incentivise informal care but concerns remain about the likely effect of demographic trends on the future supply of informal carers.

There are some concerns about care quality (although in a 1996 study, 43% of care recipients said that quality of care had improved as a result of receiving benefits whereas only 2% said that it had dis-improved). A Care Quality Bill has recently been published. This imposes obligations on both the sickness funds and nursing home and home care providers in pursuit of improved quality of care. The Bill includes provision for a system of provider accreditation.

## Health care financing

The employees' health insurance provides for various medical and dental care, hospitalisation, medicine etc. Various co-payments apply subject to a ceiling. There are 6 such insurance arrangements catering for different types of worker.

## Retirement income financing

The National Pension is financed through contributions from individuals and government subsidies. To provide a flat rate pension individuals may pay additional contributions to buy additional benefits. In addition the employees' pension insurance provides pensions for which employees and employers share the cost equally – to provide a flat rate and an earnings related pension.

## Long-term care

### Provision

Japan's Gold Plan (revised in 1994) set out specific targets for the numbers of home care aids, day care centres, nursing homes for older people, assisted living facilities etc. These targets were to be achieved by 1999 and progress has been relatively smooth although the supply of home care services has not kept up with demand. The long-term care insurance system has four basic principles:

1. Older people should be entitled to utilise home care services regardless of income level and family situation.
2. Integrate the two existing systems for older people – the welfare system and health service system – removing wasteful overlap of services.
3. Encourage diverse private sector businesses to provide for the increase in demand for long-term care services. Older people and their families may choose freely among service providers.
4. Introduction of the concept of "Care Management" to provide a variety of services to meet the desires of older people.

### Financing

In addition, a new long-term care insurance programme set out in 1997 will take effect in 2000 – to provide institutional care in geriatric hospitals, nursing homes etc. plus home help services. All patients pay 10% co-payment at the time of service. Pensioners' contributions will be deducted from pension payments.

Everyone aged 40 and over is required to contribute. For those under 40 who need long-term care - this will be provided through the existing welfare system. Those over 65 will receive benefits and pay premiums for those benefits. For those aged between 40 and 65 – the new long-term care insurance programme is financed half by premium contributions from individuals and the other half from general tax revenues. The national government will pay 50% and the municipalities will pay 25% each.

## Health care financing

Universal compulsory cover is provided by a number of Government-approved sickness funds. Employees and employers contribute a percentage of earnings and the State also makes a significant contribution from general taxation.

The sickness funds cover most in-patient hospital costs (subject to a small daily co-payment) and a proportion of outpatient treatment costs.

Benefits and the contribution rate are fixed annually on the basis of negotiations between the sickness funds and the social partners, with a view to maintaining a balanced budget.

Supplementary private insurance can be obtained from a small number of insurers.

## Retirement income financing

State retirement pensions are financed through social insurance contributions. The pension is flat rate with an earnings-related supplement.

In the past, occupational pension schemes have not been widespread, partly due to the relatively generous level of State benefits and partly due to the underdevelopment of supportive legislation. New legislation effective from 1 January 2000 aims to encourage wider occupational pension provision.

## Long-term care

### Provision


A new system of social insurance for long-term care ("dependency insurance") came into effect from 1 January 1999. This insurance is managed by the union of sickness insurance funds.

Priority is given to home care rather than institutional care. For home care, benefits consist of the reimbursement of the costs of personal care and practical help, up to a total of 39 hours or 40.5 hours per week, depending on the level of need. Sickness funds negotiate the cost of home care with the various providers.

Benefits in kind may be replaced by a cash benefit provided that the entitlement does not exceed seven hours per week. If the entitlement is between 7 and 14 hours per week, a replacement cash benefit may be provided in respect of 50% of the entitlement between 7 and 14 hours. The amount of the cash benefit is 50% of the value of the in kind benefit.

Reimbursement of the cost of technical aids is provided and home conversions are paid for. To facilitate respite care, cash benefits are doubled for a three week period each year and, in addition, the cost of care during a short-term institutional stay.

Benefits are provided towards institutional care costs on the basis of fixed rates determined in accordance with levels of dependency.



Institutional and home care providers are subject to statutory regulation. A statutory evaluation and guidance unit has been created and has responsibility for:

- Certifying dependency status and determining the level of care needs (including whether home or institutional care is appropriate)
- Proposing measures for physiotherapy and rehabilitation
- Advising the sickness funds and the ministries responsible for financing infrastructure and approving care providers
- Promoting preventive and quality measures.

### **Financing**

Ways of funding the new scheme were debated at length, particularly among the social partners and the solution that was eventually reached is still controversial. 45% of the overall cost will be financed by the State budget. Some of this contribution will come from a form of tax on electricity prices. The remainder of the cost will be met by a “dependency contribution”, fixed at 1% of both earned income and income from property and investments. This contribution is collected through the social insurance system insofar as it relates to earnings and through the direct taxation system insofar as it relates to investment income and income from property.

## Health care financing

Health care is provided on the basis of a national health service model. A Community Services Card – akin to the Irish medical card is provided to those on low incomes. This provides exemption from all charges.

In-patient services are provided free of charge. Out-patient and primary care services are paid for by the user, subject to annual limits on user charges (no family is charged for more than 20 prescription items and five out-patient visits).

Private health insurance is common and there is a general perception that the New Zealand health system is two-tier.

## Retirement income financing

There is no social insurance system but a State retirement pension is financed through general taxation.

Supplementary occupational pension schemes are common. A referendum in 1997 on a plan to introduce a compulsory private savings scheme was heavily defeated.

## Long-term care

### Provision

Services for older and younger disabled people were subject to a review in 1992, following which all of these services were concentrated within the health system (which has been subject to ongoing reforms, many of which have been modified or reversed).

Institutional long-term care for those with high dependency, was traditionally provided in public hospitals but is now mainly provided in private nursing homes, with entry requiring the approval of a geriatrician.

For those with lower dependency, institutional care is provided in “rest homes”.

Home and community care was of very limited scope until recent years. It has grown substantially through the 1990s and is provided by a range of agencies on contract to the central health funding agency. Assessment for all long-term care was previously through a team based around the hospital geriatric department. However, assessment is now being contracted to non-clinical agencies, which may mean that opportunities for preventive or rehabilitative care may not be identified. Institutional care appears to remain the dominant expectation for older New Zealanders.

Services to help carers have been limited and are subject to charges.





## Financing

All public long-term care services are funded by central Government as a safety net and are subject to means-testing. The means-test for institutional care requires a single older person to spend down assets to NZ\$15,000 before receiving public subsidy for nursing home or rest home costs. People may seek to avoid this by setting up family trusts.

A central health funding agency pays for services provided by mainly independent providers.

A report by a National Health Commission on long-term care financing identified that failure to integrate funds from ring-fenced health budgets had led to the fragmentation of service provision and the widespread occurrence of “cost-shunting” between services.

## Reform

Pilot projects are underway to develop an integrated model of long-term care.

There is a “carers” debate similar to that in the UK and Ireland. The charging regime in New Zealand has created a strong financial incentive to care.

The New Zealand Government remains concerned about the sustainability of financing the health and welfare system in the context of demographic ageing. The policy over the last number of years appears to have been to lower the public expectations of state-provided health and welfare.

## Health care financing

Provision for health care costs is made through the Central Provident Fund (CPF). Everyone contributes to a MediSave Account within the CPF (employee and employer contributions are age-related and based on earnings). Funds in this account can be used to pay for medical services from Government-approved providers.

CPF members also join the MediShield insurance plan (provided that they are under 75 when they join). Premiums are payable from the MediSave account and vary by age. Alternatively, premiums to other approved insurance schemes can be paid from MediSave funds.

Medifund is an endowment fund that provides a safety net for the poor.

Services from public hospitals are heavily subsidised by the State. This mitigates the level of charges payable through MediSave and MediShield.

## Retirement income financing

Provision for retirement is also made through the Central Provident Fund (CPF). Everyone contributes to individual accounts within the CPF on a compulsory basis (employee and employer contributions are age-related and based on earnings). On retirement, income can be drawn down from the CPF Retirement Account or the accumulated fund can be used to buy an annuity.

## Long-term care

### Provision

Health care services for older people are primarily run by voluntary welfare organisations (VWOs) which receive financial assistance from the Government. There are 3 geriatric day hospitals, 4 community-based hospitals, 2 chronic care hospitals, 47 nursing homes and hospices, 23 rehabilitation centres and 6 home care organisations providing services for older people in Singapore. About 4% of older people receive some form of home care services.

### Financing

Government provides up to 90% of capital expenditure and cyclical maintenance costs to the VWOs as well as up to 50% for operating expenditure. Manpower assistance is also provided through the secondment of doctors and nurses and the training of nursing aids. Government also pays fees for institutional care on behalf of needy individuals.

## Reform

An Inter-Ministerial Committee (IMC) on Ageing Population was formed in 1998 to identify challenges posed by the rapidly ageing population and develop policy directions.

The IMC's key recommendations in relation to long-term care covered the development of long-term care facilities and services in partnership with VWOs, ensuring the quality of care services and measures to finance long-term care. In relation to financing, the IMC recommended:

- An insurance scheme to help individuals and their families pay for the high costs of long-term care for the small proportion of older people with severe functional disabilities
- A means-test to channel Government subsidies for long-term care to those who need financial help the most
- Government subventions to cover home medical care and home nursing services.

The Government has committed to a number of financing initiatives related to health care and long-term care for older people:

- To address the fact that only 61% of Singaporeans aged over 60 are covered by MediShield or MediSave-approved insurance schemes, the Government will pay MediShield premiums for the over 60s for a period of two years. Those who are not eligible to join MediShield or MediSave-approved insurance schemes will receive a MediSave top-up instead.
- An endowment fund, called the ElderCare Fund, has been established to finance operating subsidies for the entire range of elderly and continuing care services. \$200 million was injected into the fund in 1999 and a further \$300 million in 2000. The goal is for the Fund to reach a capital sum of \$2.5 billion by the year 2010, after which it is expected that interest income on the fund should be sufficient to fully finance the operating subsidies.
- A long-term disability insurance scheme will be introduced in two to three years time to help older Singaporeans pay for their share of nursing home care costs.

## Health care financing

Those resident and registered in Sweden are compulsorily covered by Social Security health insurance providing extensive coverage including hospitalisation, medical care by public or private doctors subject to a low-cost sharing by patients.

Hospital treatment is reimbursed in full, subject to patient fees of SEK 120 per day. This fee is usually deducted at source from sickness benefits.

Maintenance drugs and drugs of a life-saving nature are free of charge. Doctors' fees and prescription charges are limited to an annual maximum. Children and youths do not have to pay the charges.

## Retirement income financing

With effect from 1 January 1999 a new (defined contribution) arrangement targeting 60% income payable from age 61 after payment of forty years contributions was introduced. Currently the contribution rate is 18.5% Earnings (50% Employee/50% Employer) of which 16% is applied to pay current pensions.

The prior arrangement was for a flat-rate basic pension (AFP) scheme & an earnings-related (ATP) scheme. The AFP/ATP scheme is to be gradually replaced by the new arrangements over a period.

## Long-term care

### Provision

Recent developments have focused upon community services and home help. About 20% of the population are Old Age Pensioners and while the majority live either with their spouses or live alone, surveys have shown the occurrence of a high frequency of 'visitation-care' by children.

Municipal nursing homes and (more recently) "special group homes" care for the most dependant elderly. Many nursing auxiliaries are employed part-time and work both in an institutional and a home-setting. A major emphasis has been on the adaptation of homes for special needs and subsidies towards this are available. Travel subsidies are available for those receiving home care.

### Financing

Individual counties fund home nursing and provide for home help services after the requisite needs-assessment. The National health insurance program funds long-term wards. An income-related co-payment is required for home help. Recent cost-containment strategies have focused upon the elderly as the largest consumer group of emergency care. The recipients meet about 10% of the cost of long-term care services. Cash grants are available for the care of the elderly and government funding can be obtained for capital developments.

A popular option is that of custom-built accommodation, which can usually be purchased by the sale of an existing property.

## Health care financing

Health care is provided on a universal basis through a national health system (the NHS) funded from general taxation.

Treatment is generally provided free of charge subject to co-payments for prescriptions. There are significant waiting times for elective treatment.

Around 13% of the population purchase private health insurance, which enables them to use private hospitals and thereby obtain much faster access to elective treatment.

## Retirement income financing

The social insurance system provides for both flat rate & earnings-related pensions.

Employers can establish occupational pension schemes and contract out of the earnings-related component of the social insurance system, such that lower social insurance contribution rates are payable by both employees and employer. 70% of private sector organisations with more than 20 employees and almost all public sector organisations provide occupational pension schemes. Stakeholder pensions, akin to the Personal Retirement Savings Account concept, will become available shortly.

## Long-term care

### Provision

Institutional care is provided in both public and private residential homes (low care intensity) and nursing homes (high care intensity). Sheltered housing provision is currently in decline, although the Joseph Rowntree continuing care retirement community recently established near York is an interesting innovation in this area.

Home care services are provided by the national health system and by local authorities (for example, home nursing is provided by NHS district nurses, home helps are provided through local authorities). The local authorities are responsible for assessing needs and devising a "care package" for each individual. Assessments are based on locally set criteria, so that the type of care an individual receives can depend on where he or she lives. The local authority also assesses the individual's ability to contribute (see financing section).

There is a significant reliance on informal care. Carers have access to respite services.

### Financing

In keeping with the financing of general health care, State contributions to long-term care costs are funded through general taxation.

State financing of institutional care is means-tested based on a standard set of national rules relating to the individual's income and assets. If the individual has assets in excess of £16,000, he or she must meet the cost in full. The value of the individual's home is taken into account in the means-test, unless it is occupied by a spouse or other specified family members.

There is a wide variation between local authorities in the application of charges for care at home: some charge a small flat rate, some charge full costs, some apply a variety of means-tests.

A non means-tested Attendance allowance is paid to disabled people over age 65 who have personal care needs as a result of illness or disability. The principal social assistance scheme - income support – provides flat-rate premiums to groups with special needs. People living in residential care and nursing homes can claim income support, together with most premiums, plus a special residential allowance.

An active private long-term care insurance market exists but has achieved very limited penetration, arguably due to the prolonged public debate about the future role of the State.

### **Reform**

A Royal Commission was established in 1997 to examine the short and long-term options for a sustainable system of funding long-term care for older people both in their own homes and in other settings. The Commission reported in 1999 and recommended that all personal care costs should be met by the State from general taxation (social insurance funding was specifically rejected by the Commission). The UK Government subsequently rejected this central recommendation but has acted or has indicated that it will act on others, for example:

- The value of an individual's home will be disregarded in the means-test for institutional care for a period of up to three months to allow an opportunity for rehabilitation. Capital limits in the means-test will also be increased to restore their 1996 real value.
- Local authorities will be enabled to provide care free of charge subject to the costs subsequently being recouped when the individual's home is sold – effectively a publicly financed equity release mechanism.
- NHS home nursing care will in future be provided free of charge.
- A new form of “intermediate care” will be developed to facilitate the transition between home and institutional care and vice versa.
- A nationally consistent basis for charging for home care services is to be developed.
- More resources will be provided to support family carers.

## Health care financing

Health care is financed through private insurance. However, there are State programmes to finance care for older people (Medicare) and the poor (Medicaid). Medicare is effectively a social insurance system but it is administered by private insurers. Medicaid benefits are means-tested and financed from general taxation.

Health Maintenance Organisations (HMOs) & Preferred Provider Organisations (PPOs), which integrate the financing and provision of health care, are now common. These replace the traditional fee-for-service private practice style of US medicine.

About 15% of the population are covered neither by insurance nor by the State programmes.

## Retirement income financing

State pensions are financed through social insurance contributions. Pensions are calculated on the basis of earnings and contribution history.

Occupational pension schemes cover a large proportion of the working population. These are supplemented by 401(k) plans, which are individual long-term savings plans, not unlike the "Personal Retirement Savings Account" concept.

A significant proportion of the older population in the US remains in the work force.

## Long-term care

### Provision

Long-term care is provided in private institutional facilities and by private home care providers. As in Europe, the trend is for a shift towards non-institutional care. Continuing care retirement communities are popular.

Informal care constitutes a significant proportion of long-term care provision.

### Financing

Most Americans believe that Medicare or their own health insurance plans will cover the costs of long-term care, but this is generally not the case. Medicare cover for long-term care is limited to post-hospital convalescent and rehabilitative care, either in a skilled nursing facility or in a home setting, with the principal objective being to get older people out of hospital sooner.

When Medicare benefits are exhausted, the individual must rely on his or her own resources until these have been depleted to the extent that he or she will qualify for Medicaid benefits. Typically, to qualify for Medicaid, assets must be below \$2,000 excluding the value of the individual's home, car and certain life assurance policies. There are rules, which prohibit the transfer of assets at less than fair market value for

thirty-six months prior to application for Medicaid eligibility. Recipients of Medicaid must also contribute towards costs from their income, excluding a specified amount for personal expenses.

An active market for private long-term care insurance has existed for two decades, but market penetration is still low in spite of an average annual growth rate of around 25%. About 5% of the population over the age of 55 now hold long-term care insurance. Currently, only 1% of expenditure on nursing home care is financed by insurance (due to the fact that insurance is generally purchased well in advance of the expected risk of needing care). Employer sponsored schemes are becoming more common, although typically employers only make a group scheme available to their employees and do not contribute to the cost.

Initially, long-term care insurance products only covered the cost of nursing home care, which made them unattractive to older people who would rather remain in their own homes. By 1994, however, a significant proportion of products also provided cover or home care benefits. Originally, benefit payments were restricted to a maximum duration of 2 or 3 years, whereas more recently, many products provide benefits for an unlimited duration.

Medicaid accounts for around half of overall long-term care spending in the US. The growing pressure on the Medicaid budget led a number of States to introduce so-called Partnership schemes during the 1990s with a view to encouraging more private provision.

Under the Partnership schemes offered by Connecticut, Indiana, California and New York, individuals were encouraged to share the cost of care with the State by purchasing an insurance policy. In general, these insurance policies had to be with participating authorised insurers. Exceptionally, the California Public Employees Retirement System, which also provides partnership policies, self-insured its arrangements.

- Each of the Partnership programmes required that the policies offered by participating insurers include certain features, for example:
  - a minimum daily benefit and benefit duration limit
  - inflation protection, normally at 5% p.a.
  - benefit entitlements based on functional impairment (i.e. assistance needed to complete two or more activities of daily living) or cognitive impairment
  - several features to protect policyholders including provision for a nominee who will be informed if a policy is about to lapse due to non-payment of premium.

Only Medicaid approved services qualified for asset protection although other services could be provided.



Two different types of partnership scheme were offered:

- **Dollar for dollar policy**

Under this system, an individual purchased a policy to cover long-term care expenses incurred. Subject to certain minimum benefit levels, the individual could choose the level of cover required. In particular, the level of cover chosen would depend on the level of assets the policyholder wished to protect. Once cover under the policy is exhausted, the individual may apply for Medicaid benefits. The individual is allowed to retain \$1 of assets for each dollar paid out by the policy and such retained assets do not count towards the Medicaid means-test. The individual is still required to contribute from income towards the cost of care.

- **Time based system**

Under this system, partnership policies provide benefits for a minimum period. For instance, the minimum period for nursing home care is 3 years and for home care is 6 years. Minimum daily benefits are also stipulated (\$110 for nursing home care and \$55 for home care in 1995). Once benefits under the policy have been exhausted, the policyholder is entitled to Medicaid benefits, without regard to the type or amount of his assets. The policyholder is still required to contribute from income to the cost of long-term care.

Uptake on partnership policies has been low. As of September 1999, only 50,000 policies were in force, compared to a population of over seven million older people in the four states. This has been attributed to:

- cost, mainly due to obligatory policy features
- a lack of public awareness of the need for protection
- uncertainty about future healthcare reform
- a reluctance amongst agents to sell long-term care policies generally (largely due to the complexity of the product)
- limited protection (i.e. only within State) and lack of portability.

## **Reform**

In 1993, President Clinton promised a wide-ranging review of health care provision including long-term care. This review produced four options, none of which achieved widespread support. The debate about health care reform has continued unabated since, but there does not appear to be any prospect of achieving a national consensus on the way forward.

Congress is unwilling to allocate large sums of public money to a universal solution so the emphasis remains on potential private solutions. However, many argue that private long-term care insurance will remain a niche product. Affordability is arguably the principal barrier to purchase but lack of knowledge about the risks of needing long-term care, misinformation about Medicare coverage and competing priorities also play a role.