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

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Abstract

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

Introduction

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

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

> We should emphasize that this analysis rests primarily on the experience of industrialized countries. The conditions in the developing world and their initial experience in developing long-term care systems are quite different. Thus, not only the resolution of the basic long-term care design issues, but even the strategy for defining and analysing those strategies must be different.
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> Brodsky e*t al.,* 2003, p.269

A very similar line is being drawn by the authors of a discussion of key issues in the design of long-term care systems when they argue that 'for reasons both of principle and practicality, a public, comprehensive, independent system of long-term care is appropriate *in advanced countries*' (Ikegami and Campbell, 2002, p.22; my italics). It is not just that different social and economic conditions might call for different policies, but rather that social and economic conditions are *so* different in the developed and developing world that policies have to be selected from a quite different set of options with different criteria guiding the choice between them. Even if we insist on the essentially global nature of the demographic and socio-cultural trends that are exerting so much of the pressure for change in existing provisions for the care of the frail elderly both inside and outside the OECD, there is really little point in trying to generalise across countries that are as different as, say, Sri Lanka and Germany. Were we to try to characterise the policy challenge that these pressures create in such a way that both governments can be seen to confront the *same* policy challenge, we would almost certainly come up with something rather bland and uninteresting – such as 'how to increase both the quantity and quality of formal long-term care provision for elderly people'. It is not easy, in other words, to say anything that would be of much interest to policy-makers without incorporating some assessment of the magnitude or urgency of this challenge, and of the way in which it is shaped and framed by an institutional context. How can we even begin to debate appropriate policy responses without taking account of the existing state of formal provision – the service infrastructure – as well as competing social priorities and the level of resources available to meet them?

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

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

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

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

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

USA

For several US commentators (Kaplan, 2005; Johnson, 2005; Moses, 2005; Mulvey, 2005) who have written recently on the theme of long-term care policy the central problem is a financial one: *who* is to pay for the additional formal long-term care (LTC) services that are going to be required as a result of population ageing? There may indeed be a problem, in the USA as elsewhere, with both the quality and appropriateness of care services that are provided for the most part by the private sector (Eaton, 2005), but for these particular commentators it is the increasing reliance of middle-income Americans on *Medicaid* that underpins the case for reforming existing arrangements for the provision of formal LTC services in the USA. Most Americans cannot readily pay 'out-of-pocket' for LTC services, especially when these services involve placement in a nursing home[1]; and only a small minority of Americans take out private LTC insurance (less than 10 per cent of people aged 55+ in 2002). Medicare, which pays for the medical care of almost all Americans aged over 65, does not as a general rule cover the long-term needs for non-medical care that often arise as a result of chronic disabling illness; and Medicaid, the health component in the USA's means-tested public assistance programmes, pays for the long-term care only of those people who are judged to be sufficiently poor to require welfare support.[2]

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

Germany

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

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

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

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

United Kingdom

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

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

> The underlying problem for the UK is that we have not fully made up our mind to what extent long-term care, like health treatment, should be part of 'universal' public provision or, like housing, be paid for by private individuals except for those who cannot afford to do so.
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> Hirsch, 2005, p.11

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

Sweden

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

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

And for the future? There is, according to Mats Thorslund (2004), considerable public consensus in Sweden about the importance of the core values and principles which have characterised the country's welfare arrangements since the 1950s, and it is this which sets the terms of the policy challenge for the country's system of providing formal LTC services to the frail elderly. Although it seems likely that the pressures for change will be much less severe in Sweden than in other parts of Europe – Germany say – they are nonetheless real enough. The challenge, therefore, is to adapt arrangements for the provision of formal LTC services to changing socio-demographic conditions without sacrificing values and principles that have been given definite form by popular institutions. The need for adaptation only arises of course if we suppose that the volume of provision cannot be allowed to expand in line with increasing demand – on the grounds that this would place too great a strain on the already highly-taxed Swedish economy. If, on the other hand, we quarrel with this supposition, there is no need to accept the socio-demographic case for cost-containment, and the 'adaptations' it implies. The challenge, on this view, is not how to adapt formal LTC services to changing socio-demographic conditions but how to obviate the need for adaptation – how to ensure that the economy continues to generate the resources that are required to pay for the welfare services that the public wants. The country stands, therefore, at a kind of crossroads: it can choose either to try and resist the pressures for adaptation or it can go along with them by providing a service with reduced ambitions. Thorslund's view is that the country will choose the second route – and furthermore that it will do so not simply in response to economic constraints but also because of 'new ideas about the appropriate way forward' (p.126).

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

And from outside the OECD

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

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

givers will usually be the main source of both *daily life care* and *illness care*.[10] This is partly because of the sectoral and/or geographical concentration of health care resources: and partly because of the high costs that individuals frequently have to bear in order to purchase the health care they need. Health care resources are as a rule *much* more thinly spread in rural areas than in urban areas, and they are often very much concentrated on the acute care sector. In Mexico, for example, about 10% of the population lack regular access to basic health care facilities; and the publicly subsidised health care that is received by about 40% of the population[11] is firmly based in the hospital sector. Although the country *is* developing home-based or community-based alternatives to hospital care, it is still very much at the beginning of this process (Knaul *et al.,* 2003).

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

Contrast this with the situation in China, which is marked, firstly, by enormous disparities in both pension and health coverage between urban and rural areas, and secondly, by extraordinarily high levels of internal migration from rural areas to cities (with most migrants having no pension and health coverage[12]). Some cities in China, such as Shanghai, offer a home-bed medical service for people who are permanently housebound *and* include financial support for this service in their medical insurance scheme. Not all conurbations offer such extensive medical insurance coverage, however – and even where the 'home-bed' service exists and is affordable, there tends to be a lack of public confidence in its quality (Hua, 2003). Outside the conurbations, in rural areas, people are much less likely to have *any* health insurance, and notwithstanding the existence of an extensive network of public hospitals and clinics, out-of-pocket payments make up a much greater proportion of total health care spending in rural than in urban areas. In 2002 Chinese households paid 58% of health care expenses out-of-pocket – and that figure will be much higher in the countryside than in the cities (Howe and Jackson, 2004).

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

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

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

A problem of justice?

> The problem of care is a complicated logistical problem for any society. It is also, most emphatically, an ethical problem, a problem that must be addressed not only with resourceful policy thinking but also with the best normative thinking that we can muster. All too often, economic thought addressing this problem proceeds as if it is only a matter of efficiency, and not as well as matter of justice and equity. The first step in addressing this problem is to recognise that it is an ethical problem, a problem of justice.
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> Nussbaum, 2004, p.34

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

Certainly if we suppose that the basic issue to be settled is the balance of public and private responsibility in the provision of help with daily life care, then we are very likely to agree with Nussbaum on this point. The policy choices we make will reflect our judgements about the extent to which – as well as the way in which – the burden of care *should* be shared through public institutions and collective arrangements. Since, even in OECD countries, the major part of this burden takes the form of unpaid work undertaken by the families of people who need help with daily life care, this decision must incorporate some sort of view about the share of the burden of providing long-term care that families may be fairly expected to shoulder in this form. And since the help with daily life care that is not provided by unpaid labour has to be purchased, it also has to be decided to what extent the financial costs of purchasing long-term care should be born by the individuals who need it. These issues, though evidently connected, are clearly distinct. It could be argued, for example, that the full costs of purchasing care for someone who needs it should be shared amongst people who do not themselves need care (mostly the active working population) – which is quite compatible with the view that the amount or kind of care which is purchased should take some account of the availability of family caregivers to provide unpaid care. And similarly, the view that nothing in the way of unpaid work should be expected of the close family of someone who needs care is compatible with the advocacy of financing arrangements that require most people who need care to bear a considerable portion of the costs of purchasing it.

The role of families in the provision of care

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

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

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

Means-testing and universalism

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

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

Inside and outside the OECD

The balance of public and private responsibility in the matter of long-term care is tipped most heavily towards social solidarity in burden-sharing when it is accepted (i) that nothing in the way of unpaid work should be expected of the close family of someone who needs care and (ii) that the *full* costs of purchasing care for someone who needs it should be shared amongst people who are not themselves currently in need of care (mostly the active working population). It is not easy, however, to find an OECD country where this particular combination of views underlies the arrangements for publicly subsidised long-term care (Denmark perhaps?). There seems rather to be a convergence towards the view that (i) universal programmes can justify some measure of cost-sharing in the form of user charges (OECD, 2005), and (ii) the commitment to voluntarism is hard to sustain.

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

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

Concluding remarks: resource constraints and development paths

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

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

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

References

Arntz, M. *et al*. (2007) *The German social long-term care insurance: structure and reform options*. ZEW discussion paper 06–074. Centre for European Economic Research.

Baldock, J. (1997) Social care in old age: more than just a funding problem. *Social Policy and Administration,* 31, pp.73–89.

Brodsky, J. e*t al*. (2003a) *Key policy issues in long-term care*. Geneva: World Health Organisation.

Brodsky, J. e*t al*. (eds.) (2003b) *Long-term care in developing countries: ten case studies*. Geneva: World Health Organisation.

CBO (2004) *Financing long-term care for the elderly*. Washington, DC: US Congressional Budget Office.

Chunsharas, S. and Boomthamcharoen, K. (2003) Thailand. In: Brodsky, J. e*t al*. (eds.) *Long-term care in developing countries: ten case studies*. Geneva: World Health Organisation.

Eaton, S. (2005) Eldercare in the United States: inadequate, inequitable, but not a lost cause. *Feminist Economics,* 11 (2), pp.37–51.

GAO (2005) *Long-term care financing: growing demand and cost of services are straining federal and state budgets*. Statement of the US General Accountability Office before House of Representatives.

Harrington, C.A. (2002) Germany's long term care insurance model: lessons for the United States. *Journal of Public Health Policy,* 23, pp.44–65.

Heller, P. (2006) *Is Asia prepared for an ageing population?* IMF Working Paper 06–272. Washington, DC: International Monetary Fund.

Hirsch, D. (2005) *Facing the costs of long-term care: towards a sustainable funding system*. York: Joseph Rowntree Trust.

Howe, N. and Jackson, R. (2004) *The graying of the Middle Kingdom*. Washington: Center for Strategic and International Studies.

Hua, F., Xue, D. (2003) China. In: Brodsky, J. e*t al*. (eds.) *Long-term care in developing countries: ten case studies*. Geneva: WHO.

Ikegami, N. and Campbell, J.C. (2002) Choices, policy logics and problem in the design of long-term care systems. *Social Policy and Administration,* 36, pp.719–734.

Johnson, R.W. and Uccello, C.E. (2005) *Is private long-term care insurance the answer?* Washington: Urban Institute.

Joseph Rowntree Foundation (1996) *Meeting the costs of continuing care*. York: Joseph Rowntree Foundation.

Kaplan , R.L. (2004) Cracking the Conundrum: Toward a Rational Financing of Long-Term Care. *Illinois Law Review*, pp.47–89

Karlsson, M. *et al*. (2007) Long-term care burden in four OECD countries: fiscal burden and distributive effects. *Health Policy*, 80, pp.7–134.

Kemper, P. *et al*. (2005) Long-term care over an uncertain future: what can current retirees expect? *Inquiry,* 42(4), pp.335–50.

Knaul, F. *et al*. (2003) Mexico. In: Brodsky, J. e*t al*. (eds.) *Long-term care in developing countries: ten case studies*. Geneva: WHO.

Moses, S. (2005) *Aging America's achilles' heel: Medicaid long-term care*. Policy Analysis, no 549. Washington: Cato Institute.

Mulvey, J. (2005) The importance of LTC insurance for the retirement security of the baby boomers. *Benefits Quarterly*, 24, pp.48–55.

Nussbaum, M. (2004) Long-Term Care and Social Justice: A Challenge to Conventional Ideas of the Social Contract. In: LaGioia, O.A. (ed.) *Ethical Choices in Long-Term Care: What Does Justice Require?* Geneva: World Health Organization. Available online at: http://www.who.int/mediacentre/news/notes/ethical_choices.pdf.

OECD (2005) *Long-term care for older people*. Paris: Organisation for Economic Cooperation and Development.

Pearson, M. and Martin, J. (2005) *Should we extend the role of private social expenditure?* IZA Discussion Paper 1544.

Peng, D. and Phillips, D.R. (2004) Potential consequences of population ageing for social development in China. In: Lloyd-Sherlock, P. (ed.) *Living longer: ageing, development and social protection*. London: ZED Books.

Pickard, L. (2001) Carer break or carer-blind? Policies for informal carers in the UK. *Social Policy and Administration,* 35, pp.441–458.

Sundstrom, G. *et al*. (2006) Balancing family and state care: neither, either or both? The case of Sweden. *Ageing and Society,* 26, pp.767–782.

Thorslund, M. (2004) The Swedish model: current trends and challenges for the future. In: Knapp, M. *et al*. (eds.) *Long-term care: matching resources and needs. A festschrift for Bleddyn Davies*. Aldershot: Ashgate.

Xu, L. *et al*. (2007) Urban health insurance and coverage in China using data from national Health Service surveys from 1998 and 2003. *BMC Health Services Research,* 7(37).

Zhang, Y. and Goza, F. (2006) Who Will Care for the China's Elderly? A Review of the Problems Caused by China's One Child Policy and their Potential Solutions. *Journal of Aging Studies*, 20(2), pp. 151–164.

Notes

[1] According to Johnson and Uccello (2005) about 40% of Americans spend some time in a nursing home before they die.

[2] Though most states allow applicants to subtract medical and LTC expenses from income before determining eligibility.

[3] Since Medicaid rules still make it difficult for frail older people to receive public support for home-based care, the system also seriously distorts the choice between home-based care and institutionally-provided care.

[4] A great deal of American analysis of the challenges for long-term care policy focuses on the 'problem' of the lack of demand for private long-term care insurance. For a useful overview, see Johnson and Uccello (2005).

[5] There is an earnings ceiling above which employees are not enrolled into the scheme, and about 9% of the German population have private LTC insurance cover (Arntz *et al.,* 2007).

[6] Pensioners also pay contributions, and now do so entirely from their own pockets. Prior to 2004 they received a special contribution subsidy from the pension funds.

[7] England and Wales are in a different position in this matter from Scotland, where it was decided that the 'personal care' element in LTC should be free.

[8] This stands in marked contrast to the opening up of debate on the use of capital funding for mandatory LTC insurance in Germany (Arntz *et al.,* 2007*)*.

[9] The assertion is usually intended to reassure us that social change is not undermining the willingness of families in advanced industrial countries to provide care and support for their older members; and also to remind policy-makers of the importance of informal sources of this kind of long-term care – and hence of the importance of helping families to provide this care when their ability to do so is threatened or impaired.

[10] The terminology comes from the WHO report on China, which makes the point that most caregivers are female and usually provide both *daily life care* and *illness care*.

[11] The rest have some form of private health insurance.

[12] See e.g. Xu *et al.,*2007.

[13] In China, for example, about three-quarters of the workforce have no pension coverage at all (Howe and Jackson, 2004). See, also Peng and Phillips (2004) and Heller (2006) for brief summaries of the availability of old-age pensions in China. Older people, and this applies not only to China of course, who have neither pension nor close family are clearly at serious risk of destitution once they lose the ability to support themselves through employment. If they are also in need of help with daily life care, then their position is even worse. All of the countries examined in the WHO report provide some kind of publicly subsidised care for older people who have no family to look after them and insufficient income to support themselves. In other words, they provide a limited amount of institutional care as part of their basic welfare programmes, and this will often include help with daily life care.

[13] As ever, we should be wary of generalisations, but to take China again as an example, according to the 2001 census, 64% of elders aged 65 years or more live with their children (usually a son); and they receive most of their income from the same source (Howe and Jackson, 2004).

[15] Which means not merely that there should be no legal compulsion in the matter, but also that decisions about entitlements to publicly subsidized care should take no account of the availability of unpaid family care, i.e. they should be 'carer-blind' (Pickard, 2001).

[16] For Nussbaum one of the most powerful arguments for the unfairness of requiring anything of families in the way of unpaid care is that familial obligations to provide unpaid care typically bind women to the household.

[17] Consider, for example, the very different views that have been expressed about the role of LTC insurance for middle-income families with assets to bequeath. Whereas Moses (2005) is clearly unhappy with the idea that it is the business of government to provide "inheritance insurance for the baby boomers and their children", the Joseph Rowntree Foundation (1996) appealed to the role of LTC insurance in protecting heritable assets as an argument in favour of their proposal for a social insurance scheme.

[18] Since this line of reasoning explicitly absolves adult children from any responsibility to help their parents with daily life care, it would almost certainly be rejected by many developing countries with rapidly ageing populations.