

# ‘User pays’ and other approaches to the funding of long-term care for older people in Australia

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## **ABSTRACT**

It has been argued that without some system in which future generations of users are able to pay for their care the cost of services for an increasingly large group of older people will be borne by a declining base of economically active younger people. Is the answer a user pays approach to the financing of aged care, as promoted by recent changes to aged care financing? This paper reviews this concept and its recent history in Australia. On the basis of a brief review of alternative funding systems, it also considers the potential of public and private insurance schemes to increase funding by potential service users and underwrite the long-term viability of funding for aged care services.

**KEY WORDS** – aged care, Australia, demographic trends, funding, insurance, long-term care, policy.

## **Introduction**

Surveying the rise of social provisions for older people over the 20th century, Guillemard (1983: 3) pointed out that the ‘so-called welfare state is first of all a welfare state for the elderly’. Now, less than 20 years on, the optimism that once surrounded the welfare state has receded and support for older people can no longer be taken for granted as fears of the economic consequences of the growth of the aged population have been used to justify a range of policy decisions. The costs of health and long-term care provided for older people has been one area that has been a focus of particular attention in a number of countries. As well as looking to innovative and more efficient ways of delivering services, new approaches to financing have been introduced or proposed in a range of countries, as governments have been seeking to find ways of reducing expenditure whilst maintaining the political support of increasingly large numbers of older voters.

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While demography is often cited as the stimulus for change, it has not been the main determinant of existing policies. Neither is the cost or financing of care for older people a key determinant of population ageing or of wellbeing amongst them, as is readily apparent from a comparison of the aged population and the levels of health and aged care expenditure (public and private) in OECD countries. Comparing Australia, the United States and the UK shows that while the UK population is much the oldest, it has a much lower expenditure on health and aged care than the United States. Australia's population is just slightly older than that of the United States, but its health care expenditure, expressed as a proportion of GDP, is in the middle range. More than this, variations on health expenditure are not matched by similar variations in health outcomes or longevity. Life expectancy is higher in Australia than in Britain, and is lowest in the United States. International evidence, therefore suggests that higher levels of expenditure do not necessarily achieve better population health, nor is high expenditure a necessary result of an older population profile (Howe 1997).

In Australia in 1996, fears of the consequences of an ageing population were used by the newly elected conservative national government to justify significant cuts in general expenditure. Particular attention was given to the reversal of existing public funding mechanisms for aged care by requiring those admitted to nursing homes to pay more for the care they received. This approach, which saw increased payments by users as part of a move to a market-based approach to service provision, was widely referred to by politicians and others as the introduction of a 'user pays' system of financing.

This article provides an overview of the context within which the movement towards the introduction of user pays in government programmes has emerged, and examines the theoretical rationale for the approach. It focuses on a review of the principles of payment by consumers for aged care services and canvasses a range of different approaches to the application of user pays principles. Following a brief introduction to the concepts of 'aged care' and 'user pays' in the next section, the main terms of the debate, the characteristics of an ideal market are considered and their application to the field of care for older people discussed. Like health care, care of older people is shown to lack key characteristics of commodities that can be suitably traded on the market. Following this, the article examines international experience with both private and public insurance based alternatives to market funding of care provisions. To provide a secure system of ongoing care to future populations of older people, it is important to ensure that

funding is adequate and viable over the longer term. It is argued that without some system in which future generations of users are able to equitably share the risks of paying for their own care, it is likely that a declining proportion of younger people will be required to fund services for an increasingly large group of older people. While user pays approaches are both inequitable and, by and large, difficult to reconcile with constraints on spending, social long-term care insurance can, under certain conditions, be reconciled with fiscal responsibility and equity.

### **‘Aged care’ and ‘user pays’: linking the key terms in the debate**

Aged care, in the Australian context, is generally understood to refer to specialised services for older people in need of ongoing care. In addition to nursing home and hostel facilities supplied by residential care providers, it includes extended personal support provided at home and in the community. Whilst, in some respects, there is an overlap between specialised aged care and health care services, the two sets of services have evolved separately and their funding and administration is distinct (Fine and Stevens 1998). Residential care services are funded largely by the Commonwealth (*i.e.* national) government with a user co-payment, and community-based services are funded on a shared basis by the Commonwealth and State governments (AIHW 1996; AIHW 1997). Health services, in contrast, are administered largely by State governments, and are funded either through direct payments by the State governments through Medicare (the national public medical insurance scheme) or through private payments, including private health insurance (AIHW 1998). Neither public nor private health insurance covers assistance provided by aged care services.

The concept of user pays, widely applied in financial circles is, at first sight, an unlikely term to be linked with aged care. The Martin Committee, in its 1991 report on banking and deregulation, explained that:

The term ‘user pays’ refers to the general practice of charging customers in such a way that the prices they face reflect the costs of providing the goods or services. The philosophy of user pays is not an end in itself but is held to lead to desirable consequences. It avoids (often arbitrary) cross subsidies. It also increases economic efficiency as clients face appropriate price signals rather than being encouraged to over consume some apparently ‘free’ services and under consume others. (Martin 1991: paragraph 7.1)

TABLE 1. *Commonwealth expenditure on age pension and age care*

Item	1995-96 (actual)		1998-99 (Budget)		1999-00 (est)	
	\$m	%	\$m	%	\$m	%
Age pensions and allowances and partner allowance	12 441	80	14 413	78	14 993	78
Residential care subsidies: low care needs (previously hostels)	528	3	723	4	758	4
Residential care subsidies: high care needs (previously nursing homes)	2 064	13	2 262	12	2 310	12
Home and community based provisions <sup>1</sup>	564	4	1 018	6	1 086	6
Total (A)	15 597	100	18 416	100	19 147	100
Total Commonwealth outlays (B)	126 705	12 <sup>2</sup>	141 570	13 <sup>2</sup>	146 566	13 <sup>2</sup>

Source: Commonwealth Budget Statements 1996-97 and 1998-99, Budget Paper No. 1.

<sup>1</sup> Calculated by summing amounts for Home and Community Care and Community Aged Care Packages; Nursing Care for Veterans and Dependents; and Home Nursing Service.

<sup>2</sup> Aged pension and aged care (row A) as a percentage of total Commonwealth outlays (row B).

In other words, user pays pricing was regarded by the Martin Committee, as by many economists, as a general means of ensuring economic efficiency through the operation of markets linking producers and consumers. While the phrase user pays may give the impression that the onus of responsibility for achieving that goal is on the user or consumer, the above description makes it clear that there is a dual responsibility. Producers must also be able and motivated to charge prices which reflect the true costs of producing goods and services. Competition between producers and other suppliers is said to provide such market discipline, as competition for a limited market can drive down excessive prices which might be charged by a small number of non-competing suppliers able to extract a sellers' premium for their scarce product.

Fairness, too, is one of the key principles of user pays, as it quite explicitly minimises what might, in many contexts, be seen as unjustified cross-subsidisation of consumers by others who do not use the service or purchase the commodity in question. This is an important issue in the case of ageing, where the risks of ill-health and infirmity are widespread and, for individuals, largely unpredictable and arbitrary. In these circumstances, it could be argued that the cross-subsidisation of those who are ill and in need of care by those who are healthy and not in need of care, is desirable.

How, it might be asked, did the concept of user pays come to be

central to debates about care for older people? Although the field of aged care accounts for a much smaller proportion of government expenditure than does income support for older people (see Table 1), it is nonetheless a significant item in the budgets of both Commonwealth and State governments in Australia. Significant reforms to the Australian aged care system, intended to optimise the cost-effectiveness of public expenditures and ensure the longer term viability of provisions, were undertaken as part of the Aged Care Reform Strategy (1983–1996) (DHHCS 1991). Further initiatives currently under way, such as the Coordinated Care Trials and the NSW Healthy Ageing Framework, are being undertaken in the hope of further developing a more cost-effective and integrated approach to care (DHAC 1999; Fine 1997; NSW Government 1998). These, and most other planning and efficiency measures adopted by the Commonwealth in the field of aged care during the period of the Labour government (1983–96), focused largely on supply-side interventions intended to redirect service utilisation from relatively expensive, institutional care facilities (nursing homes) towards less expensive forms of home and community-based care. A number of parallel service fee and subsidy measures introduced during this time were also intended to ensure equitable access amongst older people to the available services.

In contrast, the *National Commission of Audit* (NCA), established by the coalition government shortly after its election in March 1996, recommended the introduction of demand side measures in the field of aged care which would effectively introduce a form of user pays funding for most nursing home care. This was aimed not so much at reducing the utilisation of nursing home services (although it may well have had this effect) as increasing the funding by users, developing a more market-based approach to their utilisation, and shifting responsibility for funding away from government.

As part of a wide-ranging but brief review of the management and financial activities of the Commonwealth government, the NCA considered the costs associated with providing health care for an ageing population well into the next century. Setting out its ‘working hypotheses’ as a series of dot points, the NCA argued that:

- demographic change will increase pressure, overall, on Commonwealth finances;
- pressure will come mainly through health and social security (mainly retirement income) programs and policies;
- attention therefore needs to be directed to what improvements can be made to such programs and policies. (NCA 1996: 136–137)

Estimates presented by the NCA were that health care costs for older

people would be under four per cent of GDP in 2001. The NCA then argued that if health care costs for older people continued to rise at an average of two per cent per annum, while GDP per capita growth averaged 1.25 per cent, then:

health expenditure on the aged ... would account for 9.6 per cent of GDP a year by the year 2041, or over double the cost of pensions. (NCA 1996: 138)

In a footnote to the figure of 9.6 per cent the NCA observed that 'if growth in per capita health costs can be contained to one per cent in real terms', health expenditure on the aged in 2041 would account for just 5.7 per cent of GDP (NCA 1996: 138). This figure is much closer to the result of projections and analysis undertaken in a report on the future costs of Australia's ageing population published by the Economic Planning Advisory Council only two years earlier (EPAC 1994).

The Commission went on to make two recommendations regarding the financing of aged care:

*Better targeting of nursing home benefits*

While maintaining universal access to nursing homes for those in need, the government should change funding arrangements so that those able to contribute more towards their own care do so. This could be achieved by introducing means testing for nursing home benefits and, for income poor but asset rich clients, providing scope for the government to recover the cost of nursing home benefits from their estates. (NCA 1996: 140)

*Aged care insurance*

To encourage those able to contribute towards their aged care needs, the Government should explore the potential for private insurers to develop long term care insurance products along the lines of a life policy. (NCA 1996: 140, recommendations 6.2 and 6.3)

Both these proposals suggest the adoption of different forms of user pays strategies for aged care although, interestingly, not for the broader health care system<sup>1</sup>.

User charges, of course, were not new in Australia and already formed a key component of the funding system for aged care. Payments amounting to approximately 25 per cent of the cost of services have been a long-standing feature of the residential care system in Australia. Although poorly documented and less standardised, a comparable proportion of the costs of home and community care services are also paid directly by users. In nursing homes, what was called the Standard Resident Contribution was set at 87.5 per cent of the Age Pension. This contributed around 25 per cent of the total funding (DHHLGCS 1993). For most residents this was met from the Age Pension, but an

equivalent amount was required to be met from their own resources by those who were not full pensioners.

Building on the recommendations of the Gregory Reports (Gregory 1993*a*, 1993*b*) into nursing home funding undertaken under the previous government, the first of the NCA's proposals provided an important stimulus for the development by the Coalition Government of a funding regime for nursing home care which reflected the principles of user pays. The measures initially introduced included new income testing arrangements, lifting fees from around \$21 a day for all residents, to up to \$63.30 a day for non-pensioners, and accommodation bonds in nursing homes which effectively required an American style asset run-down by older residents forced to realise the value of their assets by selling or mortgaging their homes to meet the charges incurred<sup>2</sup>. It appears that the new fees, together with entry contributions, would have provided around 50 per cent of the cost of nursing home funding for residents receiving lower levels of care. However the overwhelmingly unfavourable reaction of the older people, their families, and service provider organisations to the schemes when they were introduced in October 1997, led to a delay in their full implementation as they were made the subject of a Ministerial Review to be undertaken by the Funding and Other Implementation Issues Working Group (FUNIWG). As an interim measure, accommodation payments of up to \$12.00 a day, a maximum of \$4,380 a year per nursing home resident, were introduced (DHAC 1998).

Surprisingly, little was heard of the second proposal concerning long-term care insurance products until April 1998, when the Commonwealth government initiated a feasibility study to review the option of private insurance for long-term care. According to one media report, the move was part of a consideration of what was termed 'Aged Care Insurance for Rich Baby Boomers'. The report went on:

The Howard government is considering a shift to privatised aged care funding, developing a two-tier system in which wealthier Australians could insure against nursing home charges, home care costs and 'five star' facilities. The Department of Health has commissioned a feasibility study of the proposal, arguing that baby boomers will not only be wealthier users of aged care, but fussier about service standards and prepared to pay for choice. (Tingle 1998)

### **Economics and the theory of user pays**

Broadly speaking, two main arguments are commonly advanced for the introduction of user pays principles and practices in areas such as health and aged care. The first concerns the general advantages and

benefits said to be entailed in the operation of market mechanisms. The second arises from the need to raise revenue, either to pay for provisions directly, or to raise revenue for other purposes. This may stem from political pressures to reduce government outlays, or from economic and financial pressures placed on the state to limit expenditure. The levying of user payments at the point of consumption, it should be noted, is but one of a number of options for raising revenue to ensure the viability of financing for aged care. Other options which would need to be considered in a comprehensive review of the means for generating revenue from other sources, include a range of what might be termed the imposition of indirect user funding through social or private insurance funds, and increased taxation, levied to either increase general revenue or with the specific purpose of funding aged care provisions. A number of these options are discussed later in the paper.

The attempted introduction of user pays principles for aged care can be seen as broadly in line with the increasing reliance in many English speaking democracies in what Self (1993) has termed ‘government by the market’. The first objective of this has been to slim the state and to introduce market forces in a variety of ways, such as deregulation and through monetary and fiscal policy. The second objective has been to introduce market concepts and incentives into the operations of government itself (Self 1993: 59). As Self explains, some economists have adopted the neoclassical view that markets ‘respond spontaneously to consumer demands, thereby achieving “allocative efficiency”’.

In an abstract theoretical sense, a market can be thought of as perfectly efficient if one person purchases everything that is for sale. The fact that most people cannot afford to buy diamonds, for example, does not affect the theoretical efficiency of the market for diamonds. In other words, an efficient market outcome, in economic terms, may be unfair. But, for a market to work efficiently in practice, distributing necessary goods to those who need them, at a price which will ensure that supply will be continuous, more is required than simply that all things that are produced are consumed. Economists argue that the market will operate efficiently if the following conditions hold:

- *Perfect information* – both sellers and consumers understand the product completely, and are able to make sound judgements about the value of what is for sale. In many spheres of human services, such as health care, it is apparent that consumers lack such information and must rely on the advice and judgements of others, such as medical practitioners. Because medical practitioners are themselves generally the providers of services and could



often be said to have an interest as a seller that may conflict with the interests of the consumer, alternative arrangements such as case managers or service brokers have sometimes been developed to attempt to make informed choices on behalf of consumers;

- *Freedom to choose* – consumers must be able to choose whether or not to purchase the particular goods or services, just as they must also be able to cease to use them after a time by, for example, reselling the goods or by terminating an agreement or contract for a particular service;
- *Freedom of entry and exit* – producers and sellers of goods and services must be free to enter the market and to leave it (for example, by ceasing operations). For example, it is difficult, if not impossible, under current Australian legislation, for new nursing homes to open in competition with existing ones. Whilst it is also almost unimaginable that an existing facility should close while still operational and filled with residents, they can change hands as there is a ready market for profitable facilities;
- *Perfect competition* – this requires that there be a sufficiently large number of sellers who compete with each other for the market, thereby driving the price of goods and services down to the lowest level at which it is still financially worthwhile for them to continue. Similarly, there must be a sufficient number of consumers competing to buy the goods or services produced;
- *The absence of market failures* – market failures occur when all the costs and benefits of producing and purchasing are not accounted for in the market price. This may happen when ‘external effects’ of the operation of a market are not borne by the sellers or buyers who enact the transaction. The failure of markets to ensure the production, distribution and use appropriate to aged care services and treatments poses both direct and indirect threats to the general population. Direct threats could emerge from the build up of infectious conditions amongst untreated patients and through potentially dangerous acts undertaken by those incapable of rational action (for example people with advanced dementia living alone). Indirect effects could arise through demands on family to provide support beyond the level which could threaten employment and savings.

Many of these conditions do not apply to the field of aged care. For markets to operate efficiently, consumers need to be well informed about the choices they make. Because the consumer of health care does not have the same level of knowledge as the seller, for example, the ‘market for health services’ is quite different from that for most

common goods or services. In many day-to-day economic activities, such as shopping, the consumer makes a conscious decision, a choice, to make a purchase. In health care it is typically a service provider (the doctor or therapist) who decides the level of services the consumer is to use. In both public and private sectors it is usually a third party who pays the bills. Prices for medical care are not set by the market, but by a complex set of agreements between providers (such as the Australian Medical Association's schedule of recommended fees) and through government regulations and payments.

Because the price charged by individual health care providers in a market context serves as neither a signal of their relative quality nor as a mechanism for rationing consumer pressures, it cannot produce the same pressures for cost minimisation as in normal commodity markets. This is because consumers are not able to assess issues such as adequacy, quality and effectiveness of medical care themselves, but are dependent on the advice of medical practitioners who are themselves suppliers of medical services. In the case of private practices and some private nursing homes, doctors are also owners of the service. That is why health economists such as Fuchs (1978) term much of the demand for health care 'supply induced demand'. Prior to the introduction in Australia of Aged Care Assessment Teams (ACATs) in the 1980s, for example, criticism was made of the fact that some doctors recommended that substantial numbers of older people be admitted to nursing homes which they, as medical practitioners, either owned outright or in which they had major financial interests (Senate Select Committee 1985).

As the citation from the Martin Committee (above) makes clear, one of the virtues often seen in user pays approaches is the issue of fairness involved in having consumers pay for what they use themselves. Approaches based on user pays deliberately minimise cross-subsidisation by those who do not personally use the services or commodities involved. However where consumption is not discretionary but imposed by accident or misfortune, as is the case with the need for support in old age or with the need for access to health care, strong arguments can be made for risk sharing between a larger group of those potentially affected. The elements of risk sharing are crucial in schemes for long-term care insurance, an issue discussed later in the paper.

### **The market for aged care**

To understand the interplay between economic theory and the idea of user pays, it is useful in the depiction of the aged care market, to classify

services and goods by their process of provision and the nature of the benefit provided. First, it is helpful to differentiate between the care and the accommodation and domestic support parts of aged care, as set out in Table 2. In nursing homes, as the name itself suggests, these two components are combined in a single care package which provides both nursing care and a home. At home, accommodation and domestic support is provided by residents themselves, while all or part of the care component often comes from outside, brought in by community services, general practitioners or non-resident family members.

Many of the arguments used to support the public provision of health care apply also to the public provision of this aspect of aged care. Whilst there are important differences between hospitals and nursing homes, for example in the significance and amount of specialist medical care provided, for the service users it is not always possible to distinguish between the assistance provided by nurses in the hospital and the nursing home. It could, indeed, be argued that it is both inefficient, in economic terms, and inequitable that an 80-year-old person might receive a free heart bypass operation worth many tens of thousands of dollars, whilst a nursing home resident of the same age receiving ongoing nursing care is required to pay significant user charges.

One of the striking features of the data on the use of residential care facilities is the substantial proportion of nursing home residents with quite short lengths of stay. As might be expected, those admitted for respite care tended to stay for no more than three months. But even amongst those in permanent care, nearly 40 per cent of those in nursing homes were there for less than six months. The reason for this is that many are admitted only in the last months of life. As Table 3 shows, there is a very different pattern of service utilisation between nursing homes and hostels. Requiring residents of hostels to pay for a place to live for two to four years is clearly quite different from requiring those admitted to nursing homes to pay for a bed in a facility in which they receive health care for an unpredictable but generally relatively short time.

Reviewing this brief account of some of the key characteristics of aged care, it is clear that the system bears a number of characteristics which make it difficult to regard it as a free market. Aged care does not represent the type of market in which the introduction of user pays principles would enhance efficiency. There is little evidence in Australia of competition between providers of different nursing home services. Even where a degree of rivalry exists, currently this does not translate into competition based on price, as the price of services is usually

TABLE 2. *The two arms of 'aged care'*

Care	Accommodation and domestic support
<ul style="list-style-type: none"> <li>● medical care</li> <li>● nursing and paramedical care</li> <li>● personal care</li> </ul>	<ul style="list-style-type: none"> <li>● housing (the person's home or place of residence)</li> <li>● food</li> <li>● heating</li> <li>● cleaning</li> <li>● laundry</li> </ul>

TABLE 3. *Cumulative expected length of stay of permanent hostel and nursing home residents, 1995–96*

Length of stay	Hostels	Nursing Homes
	%	%
1 month	3.4	17.0
2 months	7.4	25.2
3 months	11.0	30.3
4 months	13.7	34.3
6 months	18.4	40.0
1 year	30.2	50.2
2 years	48.9	64.4
3 years	62.4	74.4
5 years	78.6	87.0

AIHW (1997: Table 8.19).

determined elsewhere than in the market place. Aged care (as compared with aged accommodation) is not a commodity which users (or potential users) choose to use. Admission to a nursing home, for example, is determined through a system of referrals and assessments in which eligibility for admission lies for a large part in the hands of ACAT team members, general practitioners and the staff of the aged care service.

Perhaps most importantly, there is evidence of market failure which has required the development of a system of public provision to ensure equitable access to support. The removal of this support would lead to the withdrawal of vital services for an important, but unknown, proportion of older people: those unable to afford them. This risk is especially serious if it is nursing home care which they need.

Whilst there may be strong revenue arguments for increasing user charges, attempts to (re)introduce a user pays system of funding in these circumstances would not necessarily foster an efficient market for

care. Indeed it has been argued that user pays could, as in Australia's recent past, lead to gaps in provision in remote or disadvantaged areas, and to over-provision in others. Given the conditions required for commercial markets to expand, it is also possible that with a user pays system, growth pressures would emerge which would distort provision, leading to an expansion of more profitable services (such as nursing homes) and a possible reduction in less profitable services (such as community aged care services). To provide services for people with low incomes, a lowering of service standards would be required to match assistance to the price they could pay. Conversely, at the middle and upper ends of the market, problems of 'supplier induced demand' would not be unexpected.

### **Other ways of financing aged care**

Difficulties with the application of user pays principles to the field of aged care are not simply theoretical. Consistent evidence about the failure of user payment systems emerges from the history of residential aged care which, in Australia as overseas, has been one of the most enduring activities of organised charity and government.

Although the proposals for reform of nursing home funding in Australia, outlined earlier in the paper (NCA 1996), have been justified in terms of the supposed advantages of user pays, it is difficult to envisage how the introduction of a system of user pays financing alone would ensure efficiency or enhance the general accessibility of services to those people most likely to need ongoing care. It would also have significant equity effects, with the financially disadvantaged or those living in areas that are less profitable, losing out. Indeed, a careful reading of the recommendations suggests that the main motivation for changing the system of payments for aged care is to 'enable those able to contribute more towards their own care to do so' (NCA 1996: 140). Accepting for the moment the argument that revenue raising and the security offered by a dedicated funding stream for aged care is a valid motive for financing reforms in the field, it is useful to consider the various options that might encourage potential users to contribute more to the costs of their own care. A short synopsis of the most widely encountered options is presented in Table 4.

For governments, as for individuals, insurance represents perhaps the most attractive and viable way in which potential service users can be enabled to pay for their care. Over time, insurance contributions have the virtue that they also provide a simple savings mechanism, with

TABLE 4. *Funding options for aged care*

Payment	Coverage	Example
<i>User pays</i>		
Payment by user at point of consumption, possibly requiring use of savings and assets	Selective, requiring back up means-tested public assistance for those unable to pay	USA (backed up by Medicare and Medicaid provisions for those unable to pay)
<i>User fees or co-payment</i>		
Payment of fixed fees which cover all or part of cost of provision	Usually means tested	Most Western European countries; Canada; Australia
<i>Private LTC Insurance</i>		
Voluntary individual contributions over many years	Selective	USA; proposed in UK 1996; under review in Australia 1998
<i>Social LTC Insurance</i>		
Compulsory contributions over working life, or from set age ( <i>e.g.</i> 45 years)	Universal	Netherlands; Germany; Israel; Japan
<i>General Revenue</i>		
All taxpayers	Universal or selective (which can be used with means tested co-payments by users)	Most Western European countries; Canada; Australia

individuals making contributions in measured amounts at a time in their lives when earnings enable them to do so. Insurance also has the advantage that it spreads risk amongst a larger pool of potential beneficiaries, reducing the amount that each individual may be required to put aside.

In practice there are two forms of insurance which can be identified: private insurance, which has been promoted in both the UK and the USA; and social insurance, as used in the Netherlands, Germany, Israel and, most recently, Japan. International experience with each of these forms is discussed briefly below.

### **Private long-term care insurance**

Private long-term care (LTC) insurance is an option for financing aged care which is much discussed, although in practice it has proved neither popular nor successful. As discussed earlier in this paper, private LTC insurance was recommended by the NCA for Australia in 1996, a suggestion taken forward by the Australian Government in

April 1998. The most extensive experience with this form of payment is in the United States where it has been marketed by insurance companies for a number of years and deliberately encouraged in a number of States through the provision of incentives of various kinds. Despite this, the take-up rate for such insurance has been low.

In the early 1990s, for example, four American states – Connecticut, New York, California and Indiana – implemented a demonstration programme involving private long-term care insurance as a supplement to public entitlements based on a model developed by the Robert Wood Foundation. The programme in New York was intended to protect all assets from recovery by the Medicaid administration. The other states introduced a modified scheme. The programme of experimentation is not complete but, according to published reports, the take-up rate has not been high. By March 1995, only 9,000 policies had been taken out (Weiner 1996, cited in Glennerster 1996). This poor result is all the more remarkable when it is considered that market conditions have long dominated the American health system and that the requirements for obtaining public assistance for aged care, as for acute health care, through Medicaid are very severe, requiring a run down of all personal and most family assets (including the family home) before eligibility can be established.

This mirrors the experience of the USA with private long-term care insurance since the 1930s (Schulz 1992; OECD 1996: 210). Friedland (1997: 140) suggests that while the market for private LTC insurance in the USA has expanded markedly in recent years, 'it has not yet become a significant form of financing long-term care'. He estimates that in 1993, up to 300,000 elderly persons in Continuing Care Retirement Communities and as many as 2.4 million people of all ages would have had some form of private LTC insurance. These figures are based in part on insurance cover for 'home health care' which forms part of the extended private health insurance held by many Americans (see also Weiner and Illston 1996). With regard to the extensive type of insurance product more commonly understood as LTC insurance, he observes,

Altogether it would be too generous to say that more than one per cent of the elderly had any form of long-term care insurance, the proportion of the non-elderly population with such protection is virtually nonexistent. (Friedland 1997: 140)

A report by the OECD is somewhat more optimistic (OECD 1996). Citing slightly different figures, it suggests that in the United States, growth in the private LTC insurance market has been considerable in

recent years. Part of this growth comes from the addition of care options to existing life insurance policies, but much comes from the increase in the number of companies marketing various LTC products. At the end of 1992, it is claimed, a total of 2.93 million policies were sold by 135 insurers. This represented 'an average annual increase in policies sold of 29.4 per cent for the years 1987–92' (OECD 1996: 210, citing figures from Coronel 1994). Most of this growth in policy holdings represents purchases by consumers of policies well in advance of expected use. However, the OECD notes that despite this growth:

Less than 1 per cent of current nursing home expenditures are being financed by private long-term care insurance. Even in the longer term, the global effects on payment for care will probably be fairly modest. Projection of current trends suggests that between 10 and 30 per cent of the elderly could have private long-term care insurance by the year 2020. If, at the top of the range of estimation, 30 per cent of the elderly have private long-term care insurance in 2020, then aggregate out-of-pocket expenditures for long-term care would be reduced by 6 per cent and Medicaid costs reduced by 3 per cent in comparison with likely funding patterns if no elderly people had purchased their own insurance. Those holding private insurance, however ... would be likely to reduce their anticipated out-of-pocket costs for nursing home care by about half. (OECD 1996: 210)

The reason private LTC insurance has such a small impact on public expenditures in the USA is that the policy holders are individuals who would not in any case have qualified for public assistance. By paying an insurance premium over a long period of time, policy holders are effectively using private insurance as a savings scheme to cover some of their out of pocket expenses for which they would have been liable when they needed care.

According to Weiner (1994, cited in OECD 1996) in the early 1990s, Japan had the fastest expanding market in private long-term care insurance after that of the United States. A problem for policy holders, however, was the shortage of services available to buy with the benefits. Moreover, despite the growth in the market, only a small proportion of older Japanese were actually covered by valid insurance, with many of the 1.5 million policy holders being too young to receive benefits.

Disney (1996) argues that, while the emergence of improved private insurance products linking may improve the take-up rate somewhat (for example, through the linking of LTC insurance to life insurance), it is unlikely to prove viable as a major source of funding for aged care. He suggests, nonetheless, that the sale of LTC insurance in conjunction with private pensions may have greater appeal than attempting to sell it as a stand-alone product.



To maintain the costs of contributions at anything like a reasonable level, it is necessary for insurers to limit the extent of benefits available through private insurance. To guard against the costs of adverse selection, high risk contributors – those most likely to use care – need to be screened, either with a view to excluding them from schemes or to enforce payment of additional premiums. Both approaches appear to discourage policy holding amongst consumers with known or existing high levels of need, mitigating against the effectiveness of private insurance as a real solution to the problems of paying for long-term care. Insurers also need to limit their commitment to entitlements to ensure that the cost of each individual does not exceed the scheme's capacity to pay. This too, can have significant adverse effects on the attractiveness of insurance schemes. Friedland (1997), for example, illustrates this by pointing to an American scheme in which the benefit for nursing home care is limited to \$100 a day, regardless of the actual cost of nursing home stay (which often exceeds \$140 a day in the USA). As a result, where the difference between the actual cost and the amount paid by the policy is out of reach of the policy holder, a situation can emerge where the person cannot qualify for Medicaid, but is still too poor to obtain access to care – despite the fact that they have paid for private insurance cover for many years. This 'payment gap', familiar to many Australians holding private health insurance, also appears to have been a disincentive to recruiting new policy holders.

In Britain, proposals for a 'partnership arrangement' were published by the former Conservative Government in May 1996. These were intended to protect individual assets by alleviating the means test for those who had taken out private long-term care insurance. It was anticipated that the discussion document would be followed by policy proposals and a White Paper. However, the costliness of partnership arrangements, and the doubts over their viability, together with the imminence of the 1997 General Election no doubt encouraged some caution in this highly controversial area, and no such proposals were published. The Labour Party, on the other hand, made an Election Manifesto commitment to establish a Royal Commission on Long Term Care in order that these issues might be properly debated and considered. The Commission was duly established in December 1997, seven months after the New Labour Government took office, and reported in March 1999 (Royal Commission 1999).

The Commission's major conclusion was that there needed to be risk pooling in the area of long-term care. However, unlike the approach favoured in some other countries, the use of either private or social

insurance was rejected as a means of achieving this objective. Private long-term care insurance has a brief and largely unsuccessful history in the UK. Launched in 1991, only 23,000 policies have been sold and the market has been slow to develop. There is believed to be little prospect of this changing. The Commission concluded that policies are unlikely to become universally affordable; people are reluctant to take out private long-term care insurance, and the market does not want to offer policies to all. Parker and Clarke (1997, 1998) surveyed attitudes towards long-term care insurance and found little support for the idea of compulsory private insurance (only 15 per cent of respondents were in favour of such an approach). People are typically risk averse, but are also opposed to paying for something which they believe they have already paid for through tax and national insurance contributions.

The Royal Commission's major recommendation is to separate the personal care component of long-term care from the associated housing and living costs. Individuals, it is argued, should be responsible for paying the latter elements (subject to means testing). Personal care costs, however, should be totally exempt from any means testing or co-payment, in recognition of the catastrophic nature of the risk of needing long-term care and the scale of the costs involved. The Royal Commission advocates that this collective approach is the most efficient way of covering the risks, and that the costs should be met through non-hypothecated general taxation, rather than through a pre-funded insurance system.

### **National long-term care insurance schemes**

One of the attractions of private LTC insurance to governments is that the initiative and costs associated with their establishment are largely outside the sphere of the state. Nonetheless, the problems encountered with their limited coverage mean that there are good reasons for considering an alternative approach to insurance. National LTC Schemes (often termed social insurance) appear to have a number of advantages over private schemes.

First, as such schemes are universal there are no problems of adverse selection. Each citizen is required to contribute, just as each citizen is entitled to benefits if they meet the eligibility criteria (*i.e.* have a need for such care). Second, there is no excluded group (as occurs with non-policy holders for private insurance) because the insurance covers all people. Because contributions are means tested and proportional to income, those with the lowest incomes pay either nothing or a very small amount of their income. Contributions increase with income, so

that the contribution of those on higher incomes effectively helps extend cover to all groups.

Third, because there is a single ‘payer’, there are significant administrative efficiencies which can be achieved. As Osberg (1995) has argued, such a system also makes it possible to help contain final costs of provision, because the costs of administration are lower and because a single payer has greater capacity to restrain service provision costs than multiple, competing purchasers. Fourth, because National LTC insurance schemes are earmarked solely for expenditure on care provisions used by the contributors and their family members, and because the system requires all people to contribute (*i.e.* there are no freeloaders) there appears to be a political legitimacy and acceptance of the schemes in those countries in which they exist, that makes them popular amongst voters – this phenomenon appears to be similar to the effect that Australian politicians of both major parties have discovered with the Medicare scheme. Yet a review of experience with social LTC insurance reveals that, despite these and other advantages, there are a number of difficulties which need to be understood as part and parcel of a dedicated national insurance programme.

National long-term care insurance was first introduced in the Netherlands in 1968 through the 1967 *Algemene Wet Bijzondere Ziektekosten* (AWBZ, the Exceptional Medical Expenses Act). This Act covers all long stay care in the Netherlands including nursing homes, psychiatric hospitals, home care, uninsurable risks and the PGB (*persoonsgebonden budget* or personal care budget). It is not restricted to aged care. Rightly proud of the development, some Dutch commentators consider the Act to be the most significant development in public finance of the postwar period (Juffermans 1982). Initially it operated with a premium of one per cent of salaries, but this quickly increased to cover rising costs. The increased costs came from expansions in the programme (only partly the result of population ageing), and through cost shifting from the general health funds as creative ways were sought to transfer costs to long-term care facilities, costs that had previously been borne by the acute health system and funded through general medical insurance. By the 1990s, premiums for the AWBZ had reached over four per cent of salaries and at times painful measures were required to limit entitlements by reducing services available. Implementation of the Dekker Plan, developed in the 1980s and intended to introduce far-reaching market-based reforms to the Dutch health care system, was quietly abandoned when it became clear that the market approach had increased, rather than decreased, demand and costs of care. In a major reform aimed at increasing administrative

efficiencies and removing opportunities for cost-shifting, the insurance was combined with the general health insurance (Timmermans 1992). In 1998 premiums for health and LTC cover for each employee were set at 8.85 per cent of gross salary (Second Chamber 1990-91; Tweede Kamer 1997-98: 104). These contributions provide cover for all Dutch citizens.

In more recent years, a number of other countries have also introduced various forms of national LTC Insurance. Israel implemented the Community Long Term Care Insurance law (CLTCI) in 1988, which was intended to finance community care but not care provided in residential institutions. The scheme provides for services or cash payments at a basic and a more intense level of assistance (11 and 17 hours care a week, respectively) for those whose needs for care meet the scheme's eligibility criteria. Premiums for the insurance were set at 0.2 per cent of wages, but it has always been necessary to supplement expenditure on the scheme with funds from general revenue (Morginstin *et al.* 1992; Naon 1996).

Following a long and often complex political debate, Germany also introduced a form of long-term care insurance in 1994. Contributions were set at 1.0 per cent of salary in 1995, rising to 1.7 per cent of salary from 1st July 1996, with employers and employees each paying half. Benefits are paid from long-term care insurance funds held by the health insurance schemes (OECD 1996). To ensure that benefits do not exceed contributions a tight limit has been set on eligibility and total payments. Just three levels of need are recognised:

- Level one Considerable need, requires at least 1.5 hours of help a day, including at least 45 minutes with bodily care, nutrition or mobility.
- Level two Severe need, requires help at least three times a day at different times, with a total of at least three hours a day.
- Level three Extreme need, requires help round the clock, including the night, with a total of at least five hours of help a day.

The German, Israeli and the revised Dutch systems share a number of common features. First is the emphasis on care in the home. Second is the very sharply defined limits to the entitlements. Third, both systems maintain a capacity to pay a cash allowance instead of providing services. In both Germany and Israel, cash allowances, paid out at a lower rate than the equivalent level of services, have proved popular with carers as a form of income and with consumers as a means to purchase services, where they are available (Naon 1996; Alber 1996; Eisen 1997) One reason for accepting cash appears to be that it is difficult in many areas to obtain specialised services. This may also be

a short-term effect as new services are developed to meet the increased demand for support at home.

In Japan, after a period in which reliance was placed on increased user charges for care services, and on the promotion of private sector provisions to reduce the burden on public health and social services, long-term care insurance is currently being introduced (OECD 1996). The main aim of the Long Term Care Insurance Bill, which is to be enforced from 2000, is to finance the expansion of aged care services necessary to support Japan's ageing population. It is also being introduced to relieve current pressures on resources in Japan's hospital system, in which it is common to find up to half the beds occupied by older people who remain in hospital for over a year due to a lack of alternative facilities (Nishimura 1997, 1998; OECD 1996). A particularly interesting feature of the LTC social insurance scheme is that it appears to enjoy considerable public support, both amongst the younger population who do not have to pay contributions, and amongst those over 40 who are required to contribute. Amongst this older age group, it need not be assumed that altruism and community spirit are the only incentives for supporting a compulsory levy on all income. The prospect of receiving either a direct benefit as a consumer, or an indirect benefit as a child or family caregiver to parents or siblings, appears to be a quite powerful incentive.

National long-term care insurance represents an important funding mechanism for long-term care in a number of countries. It represents a form of user payment which spreads the costs of contributions among a large pool of potential beneficiaries over a period of many years. To maintain a direct link between contributions paid and benefits received, it is necessary either to increase premiums as occurred in the Netherlands over a number of years, to restrict the benefits available, the approach followed in Germany, or to supplement premiums with general revenue, as has occurred in Israel. The most viable approach may, indeed, be to use some elements of each of these approaches. Because a discrete programme of LTC insurance also creates incentives to shift costs from the acute health system, it is also necessary for clear programme boundaries to be established. An argument can also be made for the insurance to be provided through the same funding mechanism as the general health care system.

## **Conclusion**

In providing a secure system of ongoing care to future populations of older people, it is important to ensure that funding is adequate and

viable over the longer term. In Australia, a range of different approaches has already been recommended as a result of reports and studies in recent years. These include a social insurance scheme linked to superannuation contributions (DHHCS 1991; DHHLGCS 1993), long-term care insurance intended for people with disabilities of all ages (Walsh and de Ravin 1995), and other proposals for developing a social LTC insurance program (McCallum and Geiselhart 1997; McCallum 1999). Another proposal canvassed at a recent conference organised by the New South Wales Ageing and Disability Department involves the use of housing equity to fund care. This approach was reported to have not worked overseas and to be problematic in the Australian context. There are also some who advocate the direct use of superannuation funds (ADD 1997*b*). Although it is clear that detailed analysis of a range of different funding schemes would be necessary were the Australian people to seek to change the basis of funding for aged care, this is not the place for such a detailed comparative evaluation.

While there is clearly scope for different approaches, the finance of aged care in the future is likely to depend on an adjustment of the balance of funding sources used at present. Currently, in Australia as in most developed western nations, aged care has been financed largely through general taxation revenue. This is supplemented to varying degrees in different countries by revenue from three other streams: co-payments or fees and out of pocket expenses paid by consumers; funding arrangements tied to aged care through long term care insurance, and other funding mechanisms. While the balance of funding from different sources differs between countries at present, general revenue programmes are used to finance a large share of the costs of long-term care in all countries. Payments by or on behalf of individual users form an important part of the funding mix in most countries, but these payments generally take place within a confined and highly regulated system of subsidised funding, and are not true market payments.

Whilst user contributions have been, and are likely to continue to be, one important pillar of funding, user pays has at best only a limited role to play in the funding of aged care. As the long history of intervention in the market by charities and governments has shown, market models of finance have not worked well in the field of aged care. Many of the reasons for the emergence and enduring need for such intervention in the market are relatively simple. By virtue of their age and their health, those in need of care are unable to earn income through work and are unable to pay for their own care through their limited income resources. The large amounts of money that could be involved if

ongoing care is required, as is the case in nursing homes, particularly if the period of care extends over several years, is also likely to exceed the capacity of those with even modest savings to pay. Even if all people were able to save sufficiently over their lives to pay for such care, it is still not possible to predict precisely who is likely to actually require it.

Glennerster (1996: 18–19) argues that it is important to keep in mind four basic objectives in seeking to develop a secure system of financing aged care. These are:

- People reaching retirement should be secure in the knowledge that they do not face catastrophic costs or stressful burdens on their family;
- The care they receive should be an agreed and integrated pattern of services and family support, and not dominated by a set of perverse institutional and financial incentives;
- Claims on public and private budgets should be sustainable; and
- Individual savings should be encouraged, not deterred.

He further proposes that:

The perverse results of trying to provide universal health care alongside selective, public assistance based systems of long term care are becoming unsustainable. There is no clear distinction to be made between the two. Long term care and health care for the aged have to be financed from the same pot and as part of the same system. ... Housing or the costs of residence need to be treated in a comparable way across the board. (Glennerster 1996: 19)

These principles are not compatible with a system based on user charges imposed at the point of consumption. A system based in large part on market principles, as the American evidence has shown, is likely to operate as a segmented system of care. A small proportion of better-off users have access to care by virtue of their continuing high income in old age, or through private insurance cover. Others must sacrifice all their life savings in an asset run-down to gain access to the support they require. In such systems, however, a large public assistance programme is still required, both to pay for those without sufficient resources in any form, and to pay for the costs of those who have used their assets but continue to require care.

The four principles enunciated by Glennerster could be readily adapted to the Australian case, encouraging saving and providing increased security – to those who are now old, as well as to those who are younger and whose need for long-term care may be thought of as remote. Importantly, implementing such an approach would not require the introduction of a new administrative system for LTC funding. Such a programme could be funded through general taxation



revenue collections, as recently recommended in the United Kingdom (Royal Commission, 1999). This will, however, be subject to political pressures on budgets, as recent Australian history so aptly demonstrates. A more financially secure approach would require contributory funding. The social insurance schemes discussed above all provide this.

In Australia, to minimise opportunities for cost-shifting between acute health and long-term care provisions, it would be possible to introduce a similar contributory LTC insurance regime along the lines of, perhaps even as part of, the Medicare levy. A limitation of the approach, however, is that it lacks a savings component by which healthy people of working age could be enabled to pay into a scheme which would provide care for them if they later needed ongoing care. There still remains the question of the timing of contributions to the (insurance) funds and of payments out. Three of the social insurance programmes considered, the Dutch, German and Israeli LTC Insurance schemes, operate as pay-as-you-go schemes. The amount collected each year in contributions equals the amount paid out. In this way such schemes are not unlike an additional taxation levy. As the proportion of the population that is aged increases, the remaining working population will still be required to fund the increased amounts of services required.

To ensure that aged and extended care become clearly user funded, it may be desirable for a savings component to be introduced, making it comparable to the Superannuation Guarantee Levy, as recommended in the Mid-Term Review of Aged Care (DHHCS 1991; DHHLGCS 1993). This approach would, at its most limited, operate like a system of private retirement savings accounts. But it might be possible to combine elements of risk-sharing across a generation. Drawing on the experience in Japan, an option for the funding of such a scheme could be to increase premiums only for those aged 40 or 45 and above and whose incomes, after costs of children, exceed a certain threshold. The aim of such a system of financing would be to enable those who need health care to receive it for the same cost in any setting (home, hospital or residential facility), whilst still being responsible for the payment of their costs of accommodation, food and other aspects of material support.

In the final analysis, households and families fund aged care services, whether this is through direct payments from users, through general taxation revenue, through insurance or other savings and risk spreading mechanisms, or through any combination of these approaches. It could be argued that because of its administrative simplicity and capacity for exerting cost control pressures, the government in Australia should



consider further the implementation of a national LTC insurance scheme. To promote the integration of service delivery and to prevent problems of cost shifting, consideration should be given to tying the administration of such a scheme to the existing system of national health insurance, Medicare. For the same reasons, as well as for reasons of equity, it would also be desirable to consider the extension of the scheme to cover long-term care for all population groups, in particular for people with disabilities who do not currently qualify for aged care services. Contributory funding, however, would need to be along lines that would encourage savings over a person's lifetime. Such an approach offers considerable potential long-term advantages, enabling the development of a more integrated, and therefore potentially efficient system of care to develop.

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### **NOTES**

- <sup>1</sup> This is despite the fact that the NCA's own data show that use of general health resources by older people far exceeds that of the more specialised and confined fields of nursing homes and 'aged care' (NCA 1996: 138–140).
- <sup>2</sup> Details of the Commonwealth government's changes may be found in AIHW (1997: 255–259) and Productivity Commission (1999: 34–37).

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