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Abstracts

Medicine in Society — J. Grimley Evans

S. R. Nuttall, R. J. L. Blackwood, B. M. H. Bussell, J. P. Cliff, M. J. Cornall, A. Cowley, P. L. Gatenby and J. M. Webber. 1994. Financing long-term care in Great Britain. *Journal of the Institute of Actuaries*, **121**, 1–53.

Medical Research Council. 1994. *Topic Review: The Health of the UK's Elderly People*. Medical Research Council, London.

These two publications set out a problem and outline the components of a coherent response. The actuarial study by Nuttall and colleagues essays the prediction of the changing costs of long-term care as the British population ages into the twenty-first century. There are two main determinants of population ageing, the first being the number of babies born and surviving into adult life in successive generations. As populations undergo economic development there comes a point when, for reasons that are not always clear, child mortality rates fall. There is usually a gap, typically of twenty years or more, before fertility rates also fall. There is therefore a 'bolus' of unprecedented survivors of childhood released into the population and decades later these swell the ranks of the old. This 'demographic transition' took place in Britain in the early years of this century. Child mortality rates turned downwards around 1900 and fertility fell steeply into the interwar years. It is the products of this sequence of events who will dominate the demography of later life into the early years of the next century. The population will show another burst of ageing however around 2030 when the cohort of post-war 'baby boomers' reach old age. All this is predictable.

Less predictable are the effects of the second process contributing to the growth of the elderly population, a fall in mortality rates in middle age and beyond. For middle aged women mortality rates have been falling for more than 70 years but for men, rates have turned downwards much more recently, as the epidemic of coronary heart disease deaths has begun to wane, and fewer men are killing themselves with cigarettes. Apart from the question of how far and how fast mortality rates will continue to fall, there is uncertainty over the extent

to which rates are falling because middle aged people are becoming fitter as distinct from chronically ill, and disabled people living longer as a result of modern medicine and social support. Clearly the implications of these two processes for the health and social services for older people are very different and, astonishingly, we have no data to tell us which is happening. The MRC review urges research into measurements of outcomes of health and social services that could be used in continuous national surveys of older people. One such measure is Healthy Active Life Expectancy (HALE), the average years-of-life remaining before the onset of dependency at specified ages in the later years. This actuarial measure would be analogous to the expectation of life which estimates the average number of years remaining at specified ages before death.

Nuttall *et al.* take a range of estimates about the numbers of older people we can expect up to 2030 and apply different assumptions about the costs and the needs for long-term care. They use the broader American definition of long-term care to include domiciliary as well as institutional. They conclude that on moderate assumptions, 8.5 per cent of the GNP will be required to pay for long-term care by the year 2011. This will be equivalent in today's money to £1,485 per annum for each adult of working age. For the year 2031 the figures will be 10.8 per cent of the GNP and £2,014 per adult of working age. If the needs of older people increase or costs rise in real terms the picture could be even more daunting. To put these figures into context, we may recall that only 6.5 per cent of the GNP currently pays for the whole of the National Health Service. This could be claimed as the most serious predictable challenge facing our society; what can we do about it? There is certainly no point in joining in the current fashion for half-witted chatter about euthanasia as if mass extermination were an option.

There are three things that need to be done. The first, as the MRC review implies, is to ensure that the actual services we deploy in long-term care are actually effective and the most efficient that we can provide. Very little research has been done in these areas. We have no idea if home helps are actually cost-effective; there has never been an adequate controlled trial of day centres or day hospitals. We do know how to specify the optimal balance between therapeutic and prosthetic interventions for many common health problems in old age. Prosthetic interventions (home help for example) enable a person to live with their disability; therapeutic interventions (such as a hip replacement operation) aim to cure the disability. We do know that as levels of disability increase the costs of domiciliary care increase steeply and

there comes a point where they are higher than institutional care. One Social Services director has quoted people being kept at home at a cost of £700 per week in an area where residential care can be provided at £120 per week. We have not addressed the ethical question of whether people have a right to consume the extra resources necessary to keep them at home if this means that others can have no care at all. This is one context where the issue of efficiency in the deployment of long-term care needs to be examined.

The second thing we must do is to reduce the need for long-term care. This calls for research and practice in preventive and interventive health care to delay the onset of disabling illnesses in middle age and beyond. What data there are suggest that, the older one is when disability strikes, the shorter the period one survives. There is increasing evidence that older people can benefit as much as younger from preventive and interventive care: the medical profession has been guilty in the past of inappropriately excluding older people from research into treatments from which they could benefit. The Medical Research Council has declared that this is no longer acceptable.

Neither of these approaches will do more than mitigate to some extent the coming crisis. The third thing to be done, therefore, is to identify the sources of funding for the increasing need for long-term care. Nuttall and colleagues provide a critical review of the options. Three emerge as the most plausible. One is some kind of insurance model. This would be an option for the rich, and the poor would presumably be insured by the State. The burden on the intermediate income groups in an age of intermittent employment might well be fiscally and politically insupportable. Insurance models must also seem a socially inadequate response; whether premiums are paid by older people or their children, those families most in need of preserving their little wealth will be those least able to pay.

The second approach would be through increased taxation. Germany has recently introduced a tax on workers and employers specifically to pay for long-term care and this seems to have been generally acceptable to employers and unions. Germany however was moving from a system in which families were liable for the costs of care of their older members. The British might be less willing to move from a system where much of the care has been provided 'free' by the NHS. Moreover, there may well be ideological objections from lower-paid workers paying taxes so that the rich can protect their inheritances.

The third possibility would be to make long-term care a charge on old people's own assets. Although the British government has not come clean on the subject, it seems that this is its present strategy. Recently-

issued guidance on the funding of long-term care emphasises the obligation of the NHS to provide free long-term care for some older people but implies criteria for eligibility which, if rigorously applied, might well produce an empty set. The aim clearly is to transfer as much long-term care as possible to the means-tested social services budget. Thus funding will be by what is in effect a discriminatory inheritance tax; those old people unfortunate enough to become disabled will suffer the added grief of seeing the resources they had hoped to be their final gift to their children melt into the pockets of nursing home proprietors and shareholders. In the longer term, no doubt the rich at least would find ways of avoiding payment, and the problem will reappear.

COMMENT

In the immediate future the principal issue is the funding of long-term institutional care, although Nuttall *et al* imply that at some stage payment for long-term domiciliary health care might also be put into question. Although at any one time only around five per cent of our elderly population are in institutions, this gives a misleading picture. American data show that for people aged 65 years, one man in seven and one woman in three will spend a year or more in institutional care before they die. Whatever the decision about the future, the present generation of older people may feel that society is reneging on a contract; if they had known that their life savings would be consumed in nursing-home fees they might have been less prudent. The technical problems in this area are complex indeed; the ethical issues probe the very roots of British society.

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Social Policy — Lorna Warren

The following article takes a comparative stance in two major respects: firstly, the papers chosen for discussion are linked by the common goal to analyse welfare provision in Sweden, and secondly, their approach explicitly or implicitly invites comparison with provision in other countries.