Viewpoint

Decentralisation and privatisation of long-term care in UK and USA

Charlene Harrington, Allyson M Pollock

In the USA and UK, decentralisation of long-term care programmes have shifted management responsibilities to state and local government. These two countries have also moved towards privatisation of the provision of long-term care.

The final goal of these policy changes is to transfer responsibility for funding from society to the individual. In the UK, this move is a radical departure from society covering the costs of all its members, irrespective of the ability of some to pay. Access to care has become increasingly based on ability to pay and large variations and inequalities in access to care have arisen. 20–30% of some of the costs go to shareholders of the health-care industry. Privatisation and decentralisation of funding have been introduced without public debate or democratic decision making, and affect the most vulnerable groups in society. The Blair government in the UK and Clinton administration in the USA are committed to restraining public-sector expenditure, and with so many competing public-sector priorities, long-term care is low on the agenda.

Care in the USA

Long-term care includes formal services such as nursing-home and residential-care services, and home and community-based health and social services. In the USA, long-term care is a personal responsibility, but more commonly is paid for from two public-funding streams—the Medicaid and Medicare programmes.[1] The Medicaid programme is administered by each state and funded by federal and state governments. Eligibility is based on financial need. Medicare is the federally funded health-care programme for the elderly and disabled, which funds short-term nursing-home care and home health-care services.

Most older people pay for their own long-term care until they become eligible for Medicaid coverage. To prove financial eligibility for Medicaid-funded nursing-home care is inordinately complex. States vary in how they set financial entitlement and the benefits available under Medicaid and other programmes for the medically needy.[2,3] Many states have linked eligibility for Medicaid to federal criteria for supplemental security income and assets, so that an individual's assets cannot exceed $2000. However, only slightly more than half of elderly people eligible for supplemental security income actually receive benefits, which makes the proving of eligibility for Medicaid difficult. Some states place long-term nursing-home benefits under a different programme and link financial eligibility to an income limit. The income limit allows states greater discretion in testing income and assets and individuals may be required to spend income and assets until they are within the criteria for supplemental security income, which can happen very rapidly since the average annual nursing-home-care costs are between $35 000 and $50 000. Each year a third of nursing-home residents "spend-down" to become eligible for Medicaid.[4] The income limit can be up to 300% of supplemental security income. However, people may then have too much money to qualify for Medicaid-funded nursing-home care and too little to qualify for private-paid nursing-home care.

The federal Medicare Catastrophic Coverage Act of 1988 prevents the impoverishment of the at-home spouse when the other enters a nursing home. However, the amount the spouse is allowed to retain varies across states. In some states the home is included in asset calculations even if it is owned in joint names or has been transferred to the spouse or family.[5] Some states make a claim against the estate of the resident at death.[3] Congress is, however, considering a repeal of this basic protection.

States were given responsibility for administration and part funding of the total expenditures at Medicaid's inception in 1965. Federal controls over the state-run programmes were loosened in the early 1980s after the first of many cuts to the federal portion of the Medicaid budget. The Reagan administration tightened financial eligibility for the programme in terms of assets and income limitations.[6] Greater regulation of the entry of new providers into the market and screening programmes before administration were used by states to decrease access to nursing-home care for individuals eligible for Medicaid.[7,8] In the 1980s, state Medicaid programmes were encouraged to implement stringent prospective payments for long-term-care providers, and many states cut their payment rates to nursing homes.[9] In response, many providers began to screen applicants and select those with less need of care.[7]

Devolution of funding responsibilities for long-term care has not controlled costs. In the USA, nursing-home and home-health care accounted for 12% of the total personal health-care expenditure bill in 1995, and cost $78 billion and $29 billion, respectively.[1] Federal and state government paid for 58% of nursing-home care and 56% of home care in 1995. The cost has increased substantially since 1970, when the government was paying 40% of nursing-home care. Whether new federal cuts in the Medicaid programme proposed by Clinton in 1997 will achieve the reduction of long-term care expenditures remains to be seen.[10]

Lancet 1998; **351:** 1805–08

Department of Social and Behavioural Sciences, University of California, San Francisco, California, USA (Prof C Harrington PhD) **and Department of Public Health Sciences, St George's Hospital Medical School, London SW17 0RE** (A M Pollock FFPHM)

Correspondence to: Dr Allyson M Pollock

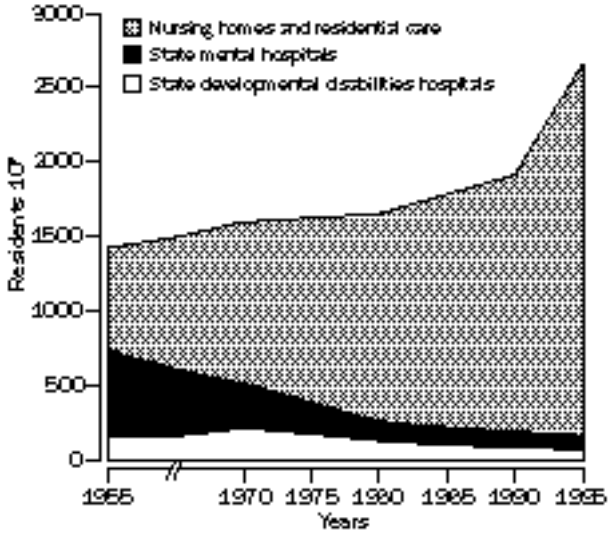

Figure 1: **Residents in long-term-care facilities in USA**

Since the 1950s, long-term care for mentally ill and residents with learning difficulties has been more widely privatised. The number of places for residents in government-operated mental institutions has decreased substantially.[11] The number of places for people with learning difficulties in large state facilities has also decreased from 559 000 in 1955 to 90 000 in 1995 (figure 1).[12] Mentally ill patients moved to smaller private proprietary nursing homes and into the community. The number of residents in nursing homes and residential care increased from 698 000 in 1955 to 2·5 million in 1995.[13,14] However, the number of places available have not kept pace with the ageing of the population: nursing-home beds declined from 610 per 1000 population aged 85 years or more in 1978, to 491 per 1000 in 1995.[15] The total number of hospital beds, including acute-care beds, available also decreased (figure 2).[16] Many patients who were deinstitutionalised became homeless without public or private housing or residential-care options.[10]

Since the early 1980s, home health-care services have been increasingly delivered by profit-making organisations.[17] Nursing facilities and home-health agencies, like other segments of the health industry, have consolidated into large health-care organisations.[13,18] The growth in the private sector is spurred by large profits[15,18,19] and has been concomitant with the escalating costs of long-term care in the USA.

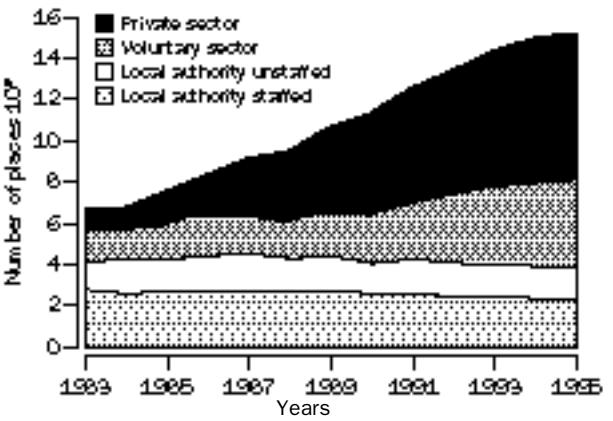

Figure 2: **Places in residential accommodation for people with mental illness, England, 1983–95**

Care in the UK

Total residential-care expenditure for the elderly, chronically ill, and physically disabled was just over £8 billion in 1995, and another £3·7 billion was spent on non-residential care, including the National Health Service (NHS), social services, and domiciliary care.[20] Until the 1980s, funding and delivery of care were primarily shared by two public sectors. The NHS funded and provided care of long-stay hospitals, day hospitals, and community-health services; local authorities funded and their social services provided residential care and community-based home-care services, such as meals delivered to homes and home helps. All services provided by the NHS were free, whereas local authorities had discretionary powers to raise charges and test means of recipients, although before the 1980s few authorities chose to do so.

Policies of community care and deinstitutionalisation in the 1960s and 1970s resulted in the closure of NHS and local-authority institutions and the transfer of people with learning difficulties and mental illness into the community (figures 2 and 3). In the 1980s, the trend extended to include geriatric and psychogeriatric patients, but led to reinstitutionalisation in the private sector.

Private-sector provision for long-term care increased when the conservative government used an amendment of the Social Security Act to encourage the rapid growth and expansion of the private sector. This amendment allowed residents entering private-sector homes to claim board and lodging allowance to pay homes for their care. Residents under the direct care of the local authority or the NHS could not claim this allowance to reimburse their own provision in the public sector. As a result, local authorities encouraged residents to opt for the private sector, which allowed the release of income through the closure and sale of public provision. Responsibility for funding was, therefore, transferred, to the central social-security budget. The amount of NHS and local authority provision fell substantially throughout the 1980s, whereas private-sector provision rose (figure 3). As the social security budget spiralled, fuelled in part by the long-term-care bill, concerns were expressed that the effect of this amendment had been to skew public expenditure toward nursing-home and residential care and away from community-based services.[21–23] However, policy did not change until the NHS and Community Care Act of 1990, was finally implemented in 1993.[24]

The Act devolved responsibility for the funding of long-term care to local authorities and "turned off" the social security funding stream. Furthermore the Act gave the NHS only a residual role in long-term care. Health authorities were required to draw up very strict eligibility criteria known as continuing care criteria. Thus, the NHS now provides only for the most sick and health-care-dependent patients.

The Act also required local authorities to set up assessments of need and financial eligibility for all social services including long-stay residential and nursing-home care. Local authorities continued to have discretionary powers to impose charges on community-based services.

National government takes into account charges for residential-home and nursing-home care in its central funding allocation to local authorities. As local authorities tighten eligibility criteria, individuals are

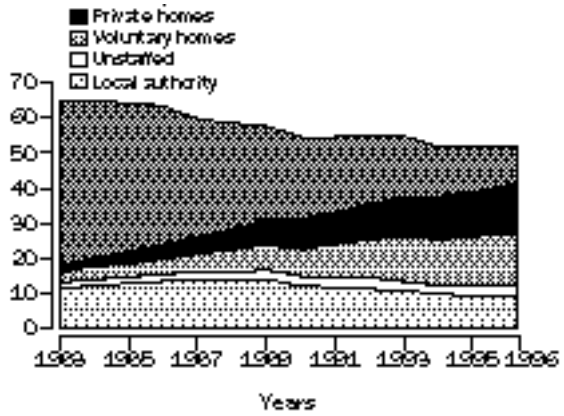

Figure 3: **Places in homes and hospitals for people with learning difficulties, England, 1983–96**

forced to go without or pay for their own care. Increasingly, even those individuals who are eligible for local-authority care find that local authorities have exercised their discretionary powers, and are charging for community-based service provision. Charges now account for 11·2% of social services income. Since April, 1996, means testing for residential and nursing-home care follows national criteria to exclude assets of less than £10 000 or property and assets of £16 000. Because of the expense of nursing-home care, it has been estimated that more than 40 000 individuals sell their homes to pay for care each year and local authorities are expected to provide care for increasingly dependent groups of people with local taxation and charges.

The privatisation of long-term care has had a dramatic effect on the pattern of residential and nursing-home care provision in the UK (figure 3).[25,26] As a condition of central funding, social services are also beginning to shift to the independent and private sector for community-based services.[27,28] In 1996, the private sector provided 32% of the total contract hours of home help and home care in England, compared with just 2% in 1992.

In 1996, local authorities increased the volume of services to individuals but the number of households nationwide receiving home care fell. Although the number of hours increased, the number of households receiving it declined from 528 000 in 1992 to 491 000 in 1996. The total number of residential-care-home places in England declined, despite the growth of the aged population. It is not known how the service needs of

Figure 4: **Places in residential accommodation for elderly and disabled people, England, 1983–95**

these former clients are being met, but an increasing number of individuals probably pay for their own care or are being deprived of care.

These shifts in service delivery and programme adminsitration have to be thoroughly assessed, but the immediate impact of decentralisation has been to introduce wide differences in approaches to needs assessment and financial and service eligibility criteria.[29,30] These differences create inequalities in access to long-term care services across geographic regions.[29] They also increase the problems of working at the health and social-care interface at local level.[30]

In 1995, more than half of the long-term care expenditure was spent in private residential and nursing homes, and 49% of the costs were met from public funding. No financial data are available on spending in community-based private-sector provision.[31] Many large health-care corporations are providing care in the USA and the UK. There is little evidence to show that the shift to private-sector financing and ownership of long-term care by these companies will save money, especially if the corporations in the UK have similar patterns of spending on administration, capital, and profits to those in the USA.

Policy effects

Efforts to contain government funding for long-term care have been the focus of government policies in the USA and the UK. Decentralisation of funding responsibilities and privatisation of long-term care are moving the USA and the UK to converge on financing and delivery systems. Access to care is increasingly based on ability to pay, but fragmentation of services and lack of information makes inequalities difficult to monitor. Sold under the rubric of increasing user choice, these shifts are largely directed at decreasing central government costs and responsibilities. There is no evidence that devolution of funding responsibilty and privatisation of provision have actually lessened the costs to government and taxpayers: they may, in fact, have increased administration costs and inefficiency.

In the short term, decentralisation shifts responsibility for funding care to individuals. In the long term, the combination of decentralisation and privatisation may make the costs of care higher than they need be to government and society. In the USA, the loss of control over the finance and delivery of long-term care seems to have increased the cost to government and decreased quality and access for individuals. The effects of these policies have not been adequately studied and understood in either country.

When President Clinton's proposal for health-care reform was defeated in 1993, so too was the proposal for a modest expansion of public long-term care coverage. Budget deficits in the US have dominated the public-policy agenda and have made public spending for Medicare, Medicaid, and welfare programmes the prime target for budget cuts from 1995 to 1998. The UK public-policy debates are also focused on efforts to contain public spending. In this climate, the focus has shifted away from the revisiting of national priorities, including development of universal funding policies, to policies of cost containment that mitigate against the most vulnerable.[32] The UK Labour government have announced a Royal Commission on the future funding of long-term care; it is to be hoped that the government will

not ignore the future delivery and provision of health and social care. The need for a re-examination of national priorities, including long-term care, is clear but it will take the leadership of Clinton and Blair to refocus the agenda for long term care.

We thank Alison Macfarlane for providing figures 2 and 3.

References

1 Levit KR, Lazenby HC, Bradley RB, et al. National Health Expenditures, 1995. *Health Care Financ Rev* 1996; **18:** 175–214.
2 AARP public policy institute. Access to federal public benefit programs by the elderly. Washington: AARP, 1992.
3 Crown WH, Burwell BO, Alecxih L. An analysis of asset testing for nursing home benefits. Washington DC: American Association of Retired Persons, 1994.
4 Weiner JM, Sullivan CM, Skaggs J. Spending down to Medicaid: new data on the role of Medicaid in paying for nursing home care. Washington DC: American Association of Retired Persons, 1996.
5 If you think you need a nursing home: a consumers guide to financial considerations and medical eligibility, part 2. California: California Advocates for Nursing Home Reform, 1995.
6 Harrington C, Estes CL, Lee PR, Newcomer RJ. State Medicaid policy effects and the aged. *Gerontologist* 1986; **26** (4): 437–43.
7 Harrington C, Curtis M, Carrillo H, et al. State regulation of the supply of long term care services. *J Appl Gerontol* 1997; **16:** 53.
8 Harrington C, Curtis M. State variations and trends in preadmission screening. *J Appl Gerontol* 1996; **15:** 414–32.
9 Holahan J, Cohen J. Nursing home reimbursement: implications for cost containment, access, and quality. *Milbank Q* 1987; **65:** 112–47.
10 US Congress. The balanced budget Act of 1997 (Public Law) 105–33.
11 Mechanic D, Rochefort DA. A policy of inclusion for the mentally ill. *Health Affairs* 1992; **11:** 128–50.
12 Mangan T, Blake EM, Prouty RW, Lakin KC. Residential services for persons with mental retardation and related conditions: status and trends through 1993. Minneapolis: University of Minnesota, 1994.
13 US Department of Commerce. Statistical abstracts of the United States, 1995. Washington DC: 1996.
14 Report to the health care financing administrators. San Francisco, CA: University of California, 1994.
15 Bedney B, Carrillo H, Studer L, Swan JH, Harrington C. 1995 State data book on long term care program and market characteristics. San Francisco, California: University of California, 1996.
16 American Hospital Association. Hospital statistics: annual statistics, 1995. Chicago: 1996.
17 Harrington C, Carrillo H, Thollaug S, Summers P. Nursing facilities, staffing, residents, and facility deficiencies, 1991–95: report prepared for the health care financing administration. San Francisco: University of California, 1996.
18 1995 the guide to the nursing home industry. Baltimore: HCIA and Arthur Andersen & Company, 1995.
19 Walsh M. Annual Report on Health. *Forbes* 1995; **55:** 180–82.
20 Health Committee, House of Commons. Long-term care: future provision and funding, volume 1: third report. London: HM Stationery Office, 1996.
21 Audit Commission. Making a reality of community care. London: HM Stationery Office, 1986.
22 Community care, agenda for action: a report to the secretary of state for social services (Griffiths Report). London: HM Stationery Office, 1988.
23 Caring for People: white paper. London: HM Stationery Office, 1989.
24 NHS and Community Care Act 1990. London: HM Stationery Office, 1990.
25 Department of Health. Residential accommodation statistics 1995: statistical bulletin 1995/21. London: Government statistical service, 1996.
26 Department of Health (DOH) Local Authority Personal Social Services Statistics. Residential accommodation: detailed statistics on residential care homes and local authority supported residents: England 1995. London: Government Statistical Service, Crown Copyright, 1996.
27 Department of Health (DOH) Local Authority Personal Social Services Statistics. Community care: detailed statistics on local authority personal social services for adults: England 1994. London: Government Statistical Service, Crown Copyright, 1995.
28 Department of Health Community Care Statistics 1995. Statistical bulletin 1996/5 April 1996. London: Government Statistical Service, Department of Health, 1996.
29 Henwood M. Fit for change? Snapshots of the community care reforms: one year on. London: King's Fund: Nuffield Institute for Health, University of Leeds, 1994.
30 Leicester MC, Pollock AM. Community care in south Thames (west) region: is needs assessment working? *Public Health* 1996; **110:** 109–13.
31 Laing's Review of Private Healthcare, 1996 and Directory of Independent Hospitals; and Nursing and Residential Homes and related services. London: Ed Laing and Buisson, 1996.
32 Harris J. Qualifying the value of life. *J Med Ethics* 1987; **13:** 117–23.