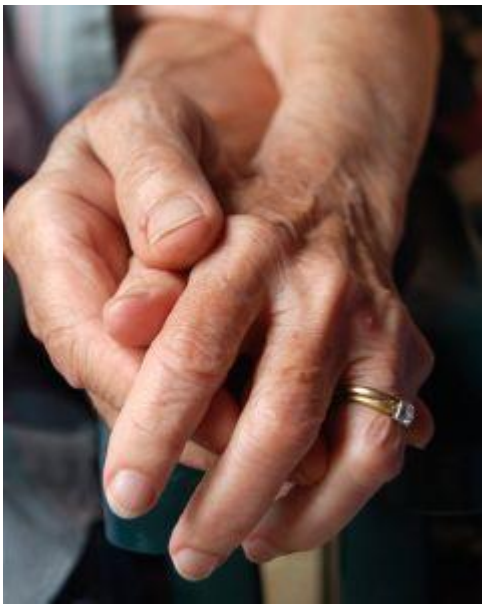
States of Jersey
States Assembly

États de Jersey
Assemblée des États

Health, Social Security and Housing Scrutiny Panel

Long-Term Care Scheme



Presented to the States on 6th November 2013

S.R.11/2013

CONTENTS

CHAIRMAN'S FOREWORD

As they prepare for the potential implications of the demographic time bomb, most western nations are trying to ensure that those who need long-term care can access it without facing an open-ended financial burden.

Jersey entered into this discussion five years ago, when the previous Health, Social Security and Housing Scrutiny Panel published its report on the subject in December 2008 and since then, considerable progress has been made. Most notably, the States agreed unanimously to the concept of collecting money through the Social Security system to assist in providing long-term care (P108/2011) in July 2011. Then Health and Social Services received approval of their White Paper and "A New Way Forward for Health and Social Services" (P82/2012) in October 2012. The current Minister for Social Security has added his own thinking and brought forward this version of a long-term care system for Jersey in publishing P.99/2013.

The combination of the health reforms alongside the long-term care proposals provide a much needed structure to make community based care available, together they will help to reduce the high rate of institutionalised care we see in Jersey, in effect bringing down some of the cost and also improving the quality of life of those who wish to remain in their own homes whilst receiving care.

Many of the nations who are looking at this issue have not yet been able to reach a conclusion, particularly when the question of funding arises. Those who have brought the debate to this point should be applauded for their foresight and perseverance.

I would also like to extent my thanks to my Panel colleagues, Deputy Jackie Hilton and Deputy James Reed. They have both contributed to our review with their habitual diligent and careful work and also our Scrutiny Officers who always respond to our demanding schedule with a calm smile and positive attitude.

Deputy Kristina Moore
Chairman, Health, Social Security and Housing Scrutiny Panel

Terms of Reference

The Panel will examine the proposition proposing a new charge for long-term care. In particular:

1. A comparison of what is being proposed in P.99/2013 “Long-Term Care Scheme” compared to what was approved in P.108/2011 “Draft Long-Term Care (Jersey) Law”;

2. To determine how the figures within the proposals have been justified;

3. To consider the financial implications as a result of the proposed changes;

4. To assess the social and economic outcomes of the proposals.

Panel Membership

The Health, Social Security and Housing Panel comprised the following Members:

- Deputy Kristina Moore, Chairman
- Deputy Jacqueline Hilton, Vice-Chairman
- Deputy James Reed

Expert Advice

The Panel appointed the following expert advisor:

- **Dr Susan Harkness**

Dr Susan Harkness is a senior academic in social policy at the University of Bath. Her qualifications include a PhD in Economics, University College London, MA in Development Economics, University of Sussex and BA in Economics, Queen’s College, Cambridge. Dr Harkness produced a report for the Panel to consider which can be found in appendix one.

1. Introduction

The Panel agreed to undertake a review of the long-term care scheme, and appointed Dr Susan Harkness from the University of Bath as its expert advisor. As the work surrounding the development of the long-term care scheme was of a highly technical nature, the Panel requested its advisor to undertake a desktop study to cover its Terms of Reference. The advisor's study includes: a comparison of the 2011 and 2013 proposals; how the figures within the proposals have been justified; the financial implications of the scheme and the scheme's social and economic outcomes. The full report can be found in appendix one.

The Panel's preliminary background research has included consideration of the Dilnot report "Fairer Care Funding" published in 2011 and the King's Fund study into integrated health and social care in Canterbury, New Zealand. The Panel also considered the King's Fund report "Paying for Social Care: Beyond Dilnot" and in addition, the previous Scrutiny Panel's report "Long-Term Care of the Elderly" (S.R.12/2008) and various media articles on the subject.

Although the long-term care scheme falls under the remit of Social Security, it interrelates with the work currently being undertaken by the Health Department. In that regard, the Panel's work has also included reviewing its past research into the Health White Paper: "Caring for each other, Caring for ourselves" and the redesign of health and social services.

The Panel has held meetings with the Minister for Social Security, Minister for Treasury and Resources and the Jersey Finance Fiscal Strategy Group to discuss the scheme in detail. In addition, the Panel received written submissions from the Institute of Directors, Jersey Citizen's Advice Bureau and some members of the public.

Long-Term Care (Jersey) Law (P.108/2011)

In July 2011 a new long-term care law (P.108/2011) was debated by the States Assembly. The majority of Members were in support of the proposition, and this was reflected in the result of the vote, which was approved unanimously by all 48 Members who were present at the time.

The law was a culmination of a consultation programme which included the publication of Green and White Papers and a report from the Health, Social Security, and Housing Scrutiny Panel of the day (S.R.12/2008). The Green Paper explained long-term care funding in other countries including Guernsey's "Long-Term Care Insurance Scheme". The Guernsey scheme is explained further on in the report.

The principles of the law were to collect money from social security contributors to be paid into a new ring-fenced fund and to use that money to help adults aged 18 and over to pay for long-term care. To encourage the growth of care services in the community, it was proposed that the new benefit would be available to people receiving care in their own homes, as well as those living in a care home.

In his opening speech during the debate, the then Minister for Social Security stressed that the proposition was an enabling legislation which required further work but would be the first step to a new scheme.

He explained what consultation had been carried out, and briefly outlined the main messages from the Green and White Papers. There had been a clear desire for change and a clear consensus on the preferred future direction, namely that of creating a long-term care benefit funded by dedicated Social Security contributions into a ring-fenced fund.

The Minister concluded his opening speech by highlighting the fact that he was proposing the changes at a time of economic challenge, which he said showed how important an overhaul of long-term care was.

Long-Term Care Scheme (P.99/2013)

In May 2012, the current Social Security Minister issued a statement to advise that the Department had undertaken a review on all aspects of the law. He explained that the impact of the new law, once implemented, must be fair both across generations, and between richer and poorer Islanders. Therefore he advised that the scheme would be implemented during 2014, rather than 2013, as originally anticipated.

One year later, in May 2013, the Social Security Minister issued a second statement announcing that he would soon be lodging a proposition which would set out the full details of the scheme. It was confirmed that the income tax department would act as the agent for Social Security and use existing methods to collect the contributions. Therefore, anyone who pays income tax would also make a contribution to the ring-fenced long-term care fund.

Accordingly, the proposition detailing the proposals for the long-term care scheme was lodged on the 22nd August 2013 (P.99/2013).

The Guernsey Long-Term Care Insurance Scheme

Following the publication of a policy report in 1999 recommending the introduction of an insurance scheme for long-term care, Guernsey introduced its “Long-term Care Insurance Scheme” in January 2003[1]. The Panel has considered the key principles of the Guernsey scheme and makes the following comparison with Jersey’s proposals.

Anyone who has been resident in Jersey continuously for 10 years with 1 year immediately prior to the year of claiming is eligible for the long term care benefit. In Guernsey, the recipient must have been resident in Guernsey or Alderney for a period of 5 years with 1 year immediately prior to the year of claiming. The proposed contribution costs for the Jersey scheme are 0.5% in 2015 with a proposed rise to 1% in 2016. This contribution will be paid by all tax payers, will have an upper earning limit of approximately £152,000 and be collected by the tax department. The Guernsey contribution rate is 1.4% as a social security contribution and is payable by everyone over 18 - whether employed or not.

[1] International Social Security Association

The Jersey scheme requires individuals to make a **minimum** co-payment of £300 per week towards the cost of care in a care home. This could rise depending on the choice of home and any extra services or facilities received. Individuals who opt for care in their own home will continue to meet their own living costs and will not need to make this co-payment.

The Guernsey scheme does not cover care in the home and requires individuals to make a co-payment of £182.98 per week towards the cost of care which is currently at £405.44 per week residential care and £756.98 per week nursing care[2].

A total asset disregard of £419,000 will be applied to household assets as part of the Jersey scheme. This value is based on the average value of a 2 bedroom house over the last 3 year period at £394,000 and an additional lump sum of £25,000. Claimants in Jersey who have total household assets of less than £419,000 will be able to request help with their care costs through means tested support and in Guernsey, individuals who cannot afford the co-payment of £182.98 per week will receive help through means tested supplementary benefit.

[2] Leaflet 50 – Long Term Care – Social Security Department, Guernsey

2. Key Findings and Recommendations

Key Findings

Based on its advisor's report and discussions with various stakeholders, the Panel make the following key findings:

1. The demand for long-term care, and the cost of its provision, is expected to rise substantially in coming decades. There are compelling reasons for additional State intervention in the market for long-term care, and as the demand rises, the need to address this issue is becoming increasingly pressing.

2. Reforms to the provision of long-term care must be seen in the wider context of competing demands for government spending. The ageing population is predicted to lead to increased pressure on healthcare services and spending on pensions. The Health Insurance Fund is similarly facing pressures from an ageing population. These predictions suggest that tax payer contributions will rise significantly to fund these areas in the future.

3. Funding of long-term care by compulsory contributions is supported by 70% of the population. However, opinions on taxation are at odds with this support as there is little support for increased levels of taxation.

4. The OXERA report notes that there is evidence that the average length of stay in care, in Jersey, is greater than in the UK. However, Jersey plans to invest in a range of community based services in order to reduce demand and enable people to remain in their own homes.

5. Estimates in the 2011 proposal showed that if the government were to do nothing to reform long-term care provision, the cost of long-term care to the States would double reaching £60 million in real terms by 2026. Individual contribution would similarly double over the period.

6. The 2013 proposals will lead to a rise in the cost of care compared to the current provision, first because the new capped cost offer provides an immediate subsidy to those not eligible for means tested support with the highest long-term care costs, and second because the asset disregard for means tested support will rise substantially.

7. The key differences between the 2011 and 2013 proposals relate to how costs are shared between government and individuals, and the mechanism by which individuals' assets are protected against very high costs of care.

8. The 2011 proposals suggested that homes worth up to £750,000 together with assets to £25,000 would be disregarded from means testing. For non home-owners a much lower disregard of £100,000 was proposed. The new scheme proposes a much lower asset disregard value of £419,000 (which has been based on the value of a two bed property (£394,000) plus £25,000) and is not limited to homeowners.

9. Both homeowners and non-homeowners are on the same level of asset disregard. The introduction of property bonds in 2009 has already meant that the elderly no longer need to sell their homes in order to pay for long-term care. Currently no interest is charged by Social Security, but under the 2013 proposals interest will be charged at the Bank of England base rate plus 0.5%.

10. All individuals in receipt of residential long-term care will pay accommodation costs in the form of a "co-payment". The proposed value of the co-payment is currently £300. This value is just under the median income of a single pensioner after housing costs, but is significantly higher than the current States pension for a single pensioner of £193.48 (based on 2009/2010 figures).

11. Regulations will prevent individuals from divesting their assets to avoid long-term care costs by including any assets divested in the previous 10 years in the assessment.

12. A cap of £50k provides protection for individuals against the very high levels of costs that affect 1 in 10 over 65s. However, the scheme does not just benefit those incurring these costs, but rather acts as insurance against such costs for the wider community, removing financial uncertainty as individuals move into care.

13. The estimated growth in the cost of long-term provision is based on the tripling of the elderly population over the next 30 years.

14. The level of migration plays an important role in determining population trends in Jersey, and estimated population numbers are highly dependent on assumptions about migration patterns. This has potentially important implications for both the demand for long-term care and for its finance.

15. Investment in cost saving measures such as more suitable housing and technologies to enable people to stay at home for longer, may reduce costs of long-term care provision. This was recognised in P.82/2013 "A New Way Forward for Health and Social Services" and is currently being implemented by the Health and Social Services Department.

16. There is no co-payment payable by those receiving care in their own home which results in a saving of £300 per week, although these savings are arguably not real because costs of living still have to be paid.

17. One omission from the OXERA report is discussion of pensioners' income, the median value of which was £326 per week in the 2009/10 Jersey Income Distribution Survey, and how assumptions about variations in pensioners' income may impact on the value of state spending on means tested support.

18. The proposed long-term care rate of 1% will be in addition to taxes levied on the individual. The long-term care liability for all taxpayers (marginal and full-rate) will rise to 1/20 of their income tax liability in 2016 or £5 for every £100 of tax paid. An Upper Earnings Limit (UEL) is to be applied with contributions due only on income up to UEL £152,232.

19. The fund is to be financed from a combination of funding from central government and new funding to be raised from contributions paid through the income tax system. It is proposed that the States will transfer current annual spending on long-term care into the fund, which at present stands at £31 million a year. Although this amount is going to be increased by RPI on an annual basis, there will be no growth in the real value of this contribution over time.

20. It was recognised during the development of the long-term care scheme that the benefit it would provide for older people needed to be balanced against the costs it would impose on younger people. Therefore, pensioners will also be liable for the long-term care contribution, with payments liable on all earnings and other income. Between one-third and a half of all pensioners are expected to be liable for the contribution.

21. The average duration of long-term stay data has been taken from UK evidence. Improved data that is specific to Jersey would enable better assessment of the cost implication of setting a cap on the cost of care.

22. Couples who both require long-term care will have a care cost cap set at £75,000. The 2013 proposals assume that income will be assessed on the basis of an individual and their partner's incomes. How much income a partner will be allowed to retain when their partner enters long-term care is unclear.

23. The long-term care scheme covers everyone over the age of 18. Younger people (those under 65) in receipt of long-term care are treated in the same way as pensioners in the proposals.

24. Discussions between Social Security, Treasury and Resources and Health and Social Services are taking place to determine what services currently provided by the Health Department will be passed onto the long-term care fund. The Panel is concerned that this work has not yet been completed.

25. Although the Minister is determined the long-term care fund will be ring-fenced, the Panel is concerned that the criteria for care could be expanded to include other healthcare services, broadening the original intention and cost of the fund.

Recommendations

1. Improved data on the average duration of long-term stay specific to Jersey should be gathered and maintained.

2. Regular analysis of Jersey-specific data relating to the duration of long-term stay should be carried out in order to monitor and assess the cost implications of the long-term care fund and its financial condition. This should not only be included in the Department's actuarial review but also reported to the States on an annual basis.

3. Further work should be undertaken by Social Security in order to understand the potential variations to pensioners' income caused by economic changes and the likely impact on the long-term care fund.

4. The publicity campaign carried out by the Social Security Department should not only include an explanation to the public of how the scheme works but also impress on them the need to save for their future, particularly in order to cover the £300 per week accommodation costs.

5. Prior to the implementation of the scheme, it should be made clear how much income an individual will be allowed to retain when their partner enters long-term care.

6. In order for the Council of Ministers to fulfil what was approved by the States in P.82/2012 "A New Way Forward for Health and Social Services", the long-term care charge should not be increased above 1% until further consideration is given to the sustainable funding mechanism for health and social care. The outcomes of the discussions should be reported back to the States before the end of September 2014.

3. Assessment of social and economic outcomes

To assess the social and economic outcomes of the proposal, the Panel undertook a consultation process with key stakeholders.

This involved writing to various nursing and residential care homes on the island (25 in total). The Panel was disappointed with the amount of responses, however, this may have been due to the fact that the Social Security Department ran its own consultation process consisting of an online portal where concerns could be submitted directly to the Department.

Although the Panel did not hold any public hearings specifically aimed at long-term care, it questioned both the Minister for Social Security and the Minister for Health and Social Services at recent quarterly hearings. The Panel also held meetings with the Minister for Social Security and the Minister for Treasury and Resources and the Treasurer of the States to discuss the financial impact of the scheme.

The Panel undertook research into the area of long-term care as it was keen to see how other jurisdictions with long-term care schemes in place were administered. In particular, the King's Fund report about the integrated system in Canterbury, New Zealand, provided some useful background as to how long-term care schemes could work in practice.

The Panel met with the Jersey Finance Fiscal Strategy Group (JFFSG) and received written submissions from representatives of the Institute of Directors (IoD), Jersey Citizen's Advice Bureau (JCAB) and members of the public. These are detailed below.

Meeting with Jersey Finance Fiscal Strategy Group

The JFFSG's main concern was that the new charge for long-term care would be perceived as a tax increase. It explained that the current 20% tax rate was Jersey's ultimate selling point and even though contributions were to be collected by the tax department, any perception of an increase may detract investors and skilled professionals considering relocating to Jersey.

Concern was also expressed that any rises in contributions to the scheme would not require new legislation, and that it would be easy for the 1% initial contribution rates outlined (starting at 0.5%, rising to 1% and potentially rising to 3%) to be increased. It suggested that an overall cap on the 1% contribution rate would be reasonable, and that if more money was required, it could be raised from other sources. The Panel subsequently discussed this concern with the Minister for Social Security who advised that any rises in contributions would be brought back to the States for approval. It is noted that the Draft Social Security (Amendment of Law No.6) (Jersey) Regulations 201 – which were recently lodged by the Minister, provide regulations to control the long-term care contribution rate.

The JFFSG considered that the principles of long-term care were well founded but questioned whether it would be affordable in the future, and whether it was right to make provision for those that could afford their long-term care. The JFFSG was also unclear on how the scheme had been modelled and what alternatives had been considered.

Institute of Directors

Similarly to the JFFSG's concern, the IoD consider that the proposed charge for long-term care will be perceived as a tax. The IoD believe that the introduction of the charge at a time when many individuals and businesses are feeling the effects of an economic decline does not send a positive message. Although it had serious concerns about the short-term economic impact in the original proposals of a 1% contribution rate in 2014, the IoD welcomed the proposals to delay contributions until 2015 starting at 0.5%. The IoD does suggest however, that the rate should be kept at 0.5% until GVA (Gross Value Added) grows.

Concern was also expressed that the Fiscal Policy Panel (FPP), given their mandate, had not had input into the development of the proposals, which the Minister confirmed during a quarterly hearing with the Panel at the beginning of October. The Minister advised the Panel that an economic impact assessment had been carried out by the Economic Adviser, and that the FPP had not been involved because it worked with Treasury and Resources rather than Social Security[3]. The Minister also advised that since the contributions would be built into a ring-fenced fund held by Social Security, this will be subject to the same process of audit as other funds through actuarial review. The IoD had suggested that the FPP's comments were sought before the matter was progressed.

The IoD also raised the issue of population within its submission and questioned how the new charge could be introduced without a population policy being in place. The IoD were concerned about the cost of the scheme and whether the calculations had factored in sufficient assumptions regarding future population changes. The IoD feared that the scheme could be extremely costly and unaffordable depending on future demographics. Furthermore, the IoD questioned the merit of asking future generations to pay for and preserve the wealth of those that have failed to adequately provide for their old age.

In conclusion, the IoD believe that alternative options should be considered, for example, an alternative based around taxing an individual's capital assets on death, taking into account the need to protect international business, which could raise funds in a more targeted manner. The IoD also believe that funding the scheme out of general taxes and savings in government spending, and/or modest increases in social security, would be preferable to the proposed long-term care charge.

Jersey Citizen's Advice Bureau

JCAB explained that whilst the economic climate continues to give policy makers cause for concern, JCAB sees firsthand how this impacts individuals and their families.

JCAB's work has included involvement in the Health and Social Services White Paper, and in particular the Carers Support Service to identify "hidden carers" and to make better quality information and access to care services available to all. In that regard, JCAB considers the long-term care scheme pivotal to the overall strategy of allowing individuals to make decisions and choices that are based upon care needs, rather than economic necessity.

[3] Public Hearing with the Minister for Social Security, 4th October 2013 page 26

However, JCAB was concerned about the cost attached to the scheme and the fact that family budgets may be further "pinched" by the contribution. Therefore a balance has to be struck between giving people peace of mind for their care needs and how affordable a rise in Social Security contribution, collected via income tax, will be for families that have finely balanced finances.

In broad terms, JCAB supports the introduction of a forward-thinking scheme that offers some protection for those who have certain income and/or assets from expenses relating to the costs associated with residential care. Although some will see the positive aspects of a long-term care scheme, others will not see the positive aspects either because the current benefit arrangements may already suit their personal circumstances, or because they do not intend to stay in Jersey and realise that the contribution is non-refundable.

Members of the public

The main concerns from members of the public were the differences between the 2011 proposals and 2013 proposals including the asset disregard and £50k cap. Concern was also expressed about the equity of the scheme in relation to those who do not make provision to buy their own homes.

The timing of the scheme was also raised in one submission and the fact that implementation of a new long-term care scheme had taken too long.

4. A new way forward for Health and Social Services

In reviewing the Social Security Minister's proposals for long-term care, the Panel has looked back at its work reviewing the redesign of health and social care as outlined in P.82/2012: A New Way Forward for Health and Social Services approved by the States in October 2012.

Under these proposals, it was agreed to create a community care structure that will allow members of the public to receive healthcare in their own homes. Also, Members agreed to request the Council of Ministers to co-ordinate the necessary steps by all relevant Ministers to bring forward for approval proposals for a sustainable funding mechanism for health and social care, by the end of September 2014[4].

Within the report to the proposition, it was explained that work to review and develop proposals for sustainable funding mechanisms would be led by Treasury and Resources, who would be working closely with Social Security and Health and Social Services during 2013 and 2014[5]. It also states:

> *Work will now continue to develop a long term sustainable funding mechanism for Health and Social Services by 2014, this work will consider all the current funding elements, including contributions made to the Health Insurance Fund, co-payment arrangements and base budget allocations, It will also take account of the proposed Long Term Care Fund and the provision of contracts with General practitioners and other healthcare providers.*
>
> *All these elements will be reviewed in order that proposals can be developed for a comprehensive but simple method of ensuring sustainable funding to the Health and Social Services Department in the coming years*[6].

The Panel's report into P.82/2012 identified that it was unclear how the long-term care benefit would underpin the costs of existing or future health and social services.[7]

In her response to the Panel's report, the Minister advised that the Health Department was working with Social Security on the impact of introducing a long-term care benefit and how it would interface with existing funding mechanisms and service provision. Furthermore, consideration would be given to how the current system operates, which would include the long-term care benefit.

In order for the Council of Ministers to fulfil what was approved by the States in P.82/2012, the long-term care charge should not be increased above 1% until further consideration is given to the sustainable funding mechanism for health and social care.

During its current review, the Panel heard that discussions are currently taking place between Social Security, Treasury and Resources and Health and Social Services regarding

[4] Proposals were originally due to be brought back to the States by the end of 2014, but the Panel amended the proposition to ensure proposals would be lodged by the end of September 2014
[5] P.82/2012 – A new way forward for Health and Social Services , page 65
[6] P.82/2012 – A new way forward for Health and Social Services, page 68
[7] Key Finding 30 – S.R.7/2012

what services currently provided by the Health Department will be passed onto the long-term care fund. The Treasury Department advised that once this had been established, a clear Memorandum of Understanding would be issued to ensure the types of services and budget for them was made clear. The Panel is concerned that this work has not yet been completed. Although the Minister is determined the long-term care fund will be ring-fenced, the Panel is concerned that the criteria for care could be expanded to include other healthcare services, broadening the original intention and cost of the fund.

Healthcare systems in other jurisdictions

The Panel note that providing integrated care i.e. care that crosses the boundaries between primary, community, hospital and social care is a goal of health systems worldwide[8]. Another goal is to achieve that care within resources that are likely to be heavily constrained as the world recovers from the impact of the global financial crisis[9].

A recent case study into the healthcare system in Canterbury, New Zealand is considered by the Panel to be an important piece of research in relation to healthcare systems in other jurisdictions. It demonstrates that changes made to the system since 2007 mean that Canterbury now has a system in which good quality general practice is increasingly keeping patients who do not need to be in hospital out of it, is treating them swiftly once there, and discharging them safely to good community support[10]. These areas have all been mentioned as key issues to address within the new way forward for Jersey's health and social care.

Canterbury's health system was also under pressure and beginning to look unsustainable when the future pressures of the ageing population was considered. The authorities in that region took the necessary steps to transform its system from one of fragmented care towards integrated care with measurable success[11].

The Canterbury health system can claim it has saved patients more than a million days of waiting for treatment in just four clinical areas in recent years. Fewer patients are entering care homes –'aged residential care' in New Zealand terminology – as more are supported in the community. A rising curve of demand for residential care has been flattened. Better, quicker care, with more of it provided without the need for a hospital visit, is being delivered. A health system that in 2007 was almost NZ$17m in deficit on a turnover of just under $1.2bn was in 2010/11 on track to make an $8m surplus[12].

The Panel also makes reference to the "Boyle Report" which was commissioned as part of its review into P.82/2012 a new way forward for health and social services. Appendix one of the Boyle Report gives details of the charges levied on individuals accessing various types of health and social care in other jurisdictions including Switzerland, Sweden, Norway,

[8] The quest for integrated health and social care. A case study in Canterbury, new Zealand, Timmins, N and Ham, C, 2013, page 4
[9] The quest for integrated health and social care. A case study in Canterbury, new Zealand, Timmins, N and Ham, C, 2013, page 4
[10] The quest for integrated health and social care. A case study in Canterbury, new Zealand, Timmins, N and Ham, C, 2013
[11] The quest for integrated health and social care. A case study in Canterbury, New Zealand – Key Findings
[12] The quest for integrated health and social care. A case study in Canterbury, New Zealand, page 4

Finland, Denmark, United Kingdom, New Zealand, France, Germany, Ireland and Luxembourg.

Within these countries, long-term care is sometimes built into health and social care systems. It also shows that co-payments, where an individual is expected to pay a proportion of the cost of the service, are common (appendix one of the Boyle Report is included in appendix two of this report).

The Panel consider it important that healthcare systems and the way in which long-term care is funded in other jurisdictions are considered when developing new policy.

5. Conclusion

There is no doubt that the Island faces a substantial increase in both the number and proportion of older residents over the next 30 years. This will inevitably impact on the costs of long-term care in the future and for that reason, the Panel broadly supports the aims of the long-term care scheme.

The Panel recognises the efforts made by the Social Security Minister to deliver the scheme within the time period. It is noted that the original long-term care proposals outlined in 2011 would have led to an increase in the Social Security contribution rate of approximately 4.6% by 2044, which was considered unacceptable by the current Minister. During 2012 and 2013, detailed research was undertaken by the Department to identify a scheme which would provide assistance to homeowners and those facing high care costs, whilst at the same time setting the long-term contribution rate at an acceptable level.

It appears that one of the key motivations for the scheme has been to spread the costs of care across individuals. Contributions would be collected from everyone who pays income tax via the income tax office. Some expressed concerns with this, believing that the contribution would be seen as an additional tax and therefore would be detrimental to Jersey's reputation as a low tax jurisdiction. Another common theme from those who contacted the Panel was whether the scheme would be affordable in the future and whether it was right to make provision for those that could afford their long-term care.

The Panel's advisor explains that the key question for policy makers is who should pay – should the cost of payment fall mainly on those who need care? Or should the cost be distributed more widely across the community? To what extent should the young be expected to pay for the care of the elderly? How should costs be balanced between costs met by the taxpayer and those using long-term care? How can the less well-off be protected from paying for the increasing costs of care?

The Panel accept that there is no simple answer to these questions and it is ultimately the States who will determine whether the proposed scheme will meet the needs of our community both now and in the future.

Appendix one: Susan Harkness Report

Assessment of revisions to the proposed Long Term Care Law

Prepared for the Health, Social Security and Housing Scrutiny Panel, States of Jersey

Susan Harkness

October 2013

Introduction and Background

As the population ages the funding of long term care (LTC) has become an increasingly pressing policy concern. Jersey, like many countries across the OECD, has recently been reviewing methods of funding and providing LTC. There are compelling reasons for State intervention in the market for LTC, and as the demand for LTC rises the need to address market failures in current provision is becoming increasingly pressing.

The demand for LTC in Jersey, and the cost of its provision, is expected to rise substantially in coming decades. These costs, under the current system of provision, are shared between individuals and the central government, with the majority of state spending routed through means tested benefits. Even if the States of Jersey continues to finance LTC as a means tested benefit to those in greatest need, government spending on care is expected to double by 2026. LTC includes a range of services which provide for the needs of those with long term illness or disability, and includes support for daily living activities – washing, dressing etc – which may be provided to individuals in their homes or in a residential care setting.

A second major concern is that under the current system of provision individuals are unable to protect themselves against potentially “catastrophic” costs. The Dilnot Commission has estimated that one-in-ten adults reaching the age of 65 will spend £100,000 on LTC. This cost representing one of the largest uninsured risks currently faced by individuals. For many this has in the past meant selling the family home in order to pay for care. A key motivation of the 2011 proposals for reform was to protect individuals from having to sell their home in order to pay for LTC in Jersey. The subsequent introduction of a scheme which allows those in LTC to accept a charge against the property to cover the cost of care means that individuals are no longer required to sell their family home in order to finance LTC. Yet while this protects individuals’ assets during their lifetime, it remains the case that those facing the highest costs are unable to protect their assets for their children. As the population ages, and more individuals face the need for LTC, the share that face these costs will rise and policy makers are concerned that people should be able to adequately protect themselves from these costs.

There is widespread support for proposals to share the costs of LTC across the community: funding of LTC by compulsory contributions is supported by 70%[13] of the population. However, opinions on taxation are at odds with this support - there is little support for increased levels of taxation with just 16%[14] supporting a rise in taxation to fund greater spending on health, education or social care. While the introduction of a hypothecated fund to support LTC may be more popular than a rise in general taxation, there is strong competition for government funding with other services provided to the elderly, in particular increased demands for spending on health care and pensions, also requiring substantial increases in funding as the population ages.

This review has been commissioned to assess current proposals for funding long term care (LTC) and in particular to assess the affordability and social and economic implications of setting up such a scheme. In particular the review has been asked to:

1. Make a comparison of what is being proposed in P.99/2013 "Long-Term Care Scheme" compared to what was approved in P.108/2011 "Draft Long-term care (Jersey) Law
2. Determine how the figures within the proposals have been justified
3. Consider the financial implications as a result of the proposed changes
4. Assess the social and economic outcomes of the proposals.

In addition been asked in particular to advise on:

a. The figures set out in the OXERA report
b. How the LTC fund will interact with other healthcare funds, including the Health Insurance Fund
c. Whether the proposed scheme fit for purpose financially
d. What percentage of the population will benefit from the proposed scheme?
e. Whether the proposals are financially viable

[13] R.97/2010 – Long-Term Care Funding: Consultation Paper
[14] R.97/2010 – Long-Term Care Funding: Consultation Paper

The report is structured as follows. Section 2 looks at current provision and compares the 2011 and 2013 proposals for reform. Section 3 examines how costs might evolve over the next 30 years under various forms of provision of LTC and in Section 4 the implications of this for contributions from the taxpayer are assessed. Section 5 looks at the distributional impact of the reforms and in 6 some of the wider implications of financing care are examined. Section 7 concludes and makes some recommendations for further consideration by the LTC review.

1. Current provision proposals for LTC reform (2011 & 2013)

The Current System

The cost of adult social care in Jersey is currently shared between government and individuals. In 2009 total spending on social care amounted to £55 million, with £30 million State expenditure and an estimated £25 million paid by individual contributions[15]. States spending was channelled through both the Department of Health and Social Services (HSS), who spent a total of £16 million on LTC[16], and Social Security (SSD) who contributed a further £14 million[17]. States contributions to LTC are complex, with States spending being significantly (but not fully) dependent on means testing. The level of contributions made by individuals towards their care are dependent on a complex range of factors including age, income, savings, method of care delivery, and level of care needs. HSSD runs nursing care homes for the elderly and for younger adults with special needs and this provision is not subject to means testing. Other provision, including that through charities and parishes, are further important sources of LTC. There is in addition some state support for respite care for carers.

Care in the community is supported through subsidised provision by Family Nursing and Home Care (FNHC) services. Support through the SSD is means tested and received only by those deemed unable to afford care. Those in residential accommodation receiving means tested support are expected to contribute their pension towards their care but are allowed to keep £32.62 a week (2013) as a personal allowance. Those with assets above £13,706 for a single person or £22,718 for a couple are ineligible for mean tested support (2013). Homeowners are able to retain their home, but must accept a charge against the property towards the cost of care home fees payable when the property next changes hands. The breakdown of spending by source and type of care is reported in Table 1.

[15] R.97/2010 – Long-Term Care Funding: Consultation Paper
[16] R.97/2010 – Long-Term Care Funding: Consultation Paper
[17] R.97/2010 – Long-Term Care Funding: Consultation Paper

Table 1: Funding for LTC in Jersey, 2009[18]

£ million	HSSD provision of free or subsidised care	SSD means tested assistance for care & accommodation costs	Client payments towards means tested / subsidised provision	Private clients payments to meet full care and accommodation costs	Total
Nursing home care 65+	8.1	1.6	3.0	8.2	20.9
Residential care home 65+	-	7.2	1.4	11.3	19.9
Under 65 care home	5.3	4.2	0.3	0.2	10.0
Community care, all ages	2.7	0.5	0.7	0.5	4.4
Total	16.1	13.5	5.4	20.2	55.2

Proposals for Reform

The 2011 and 2013 proposals to reform LTC provision in Jersey share a number of common features, in particular in relation to provision. Both suggest creation of a dedicated fund to pay for LTC in the future which would operate on a "Pay as You Go" (PAYG) basis, with current benefits being paid directly from contributions being paid in. It is proposed that contributions to the fund would be collected through the tax office but be held and administered through SSD. This fund would be expected to finance all LTC spending. Contributions towards the fund would be compulsory – there would be no provision for the better off to opt out of the scheme. Further details on the projected costs of the fund are discussed in the following section of this report. Below we discuss the provision of LTC and how individuals will be predicated to contribute towards their LTC costs.

The 2011 proposed reforms and the revisions of 2013 share a number of common features. The key differences between the two sets of proposals relate to how costs are shared between government and individuals, and the mechanism by which individuals' assets are protected against very high costs of care. However many of the features of provision are the same. Entitlements for provision will, under both

[18] R.5/2010 – Long-Term Care Funding: Consultation Paper

proposals, be based on an objective assessment of care needs by professionals and only be available to those with 10 years residency on the Island as an adult and 1 year of residency immediately before making a claim for LTC benefit. Those with more than 5 but less than 10 years eligibility will remain eligible for means tested support as under current system. The criteria for younger adults below the age of 28 requiring LTC will differ such that they can also apply for LTC once they reach the age of 18[19]. Provision of state funded LTC will be through provision of places in approved care homes, or for approved care packages to those receiving LTC at home. Benefit levels are to be set at different levels to reflect different levels of need. In order to maintain choice, an option to top-up state provision to upgrade the available accommodation or facilities was in addition proposed in the reforms, with the proviso that care homes should ensure that care could be afforded for a "reasonable period" without exhausting funds and recourse to means tested support. Top-ups would not be available to those on means tested support or, under the 2013 proposals, count towards the spending "cap" on care.

Both the 2011 and 2013 proposals distinguish between the caring elements of LTC and what are described as "hotel" costs. Hotel costs are those costs that that are associated with everyday living and are payable regardless of whether it is in receipt of care or not – expenses such as accommodation, food, utilities etc. It is proposed that all individuals in receipt of residential LTC should pay these "hotel" costs themselves if they are able to do so (those receiving care at home are not required to fund these costs) in the form of a "co-payment". The proposed value of the current minimum co-payment is currently £300 (and was a similar value in 2011 proposals), although this payment will be greater for those choosing more expensive facilities. This value is just under the median income of a single pensioner after housing costs, which stood at £326 per week after housing costs in 2009/10 according to the 2009/10 Jersey Income Distribution Survey, but is significantly higher than the current state pension for a single pensioner of £193.48 (2013). Individuals are expected to contribute their income to this co-payment, with those with insufficient

[19] For applicants below the age of 28, the first test will be modified so that they will need to have been ordinarily resident continuously in Jersey for a period of 10 years at any age. This will allow a local young person with care needs to apply for the new scheme as soon as they reach the age of 18. Children are not covered by the LTC Law and will continue to receive support directly from Health and Social Services

income to meet this payment, and assets below the disregard, entitled to means tested support. All individuals are entitled to retain a "personal allowance" of £32.62 (2013) per week.

There are two key differences between the 2011 and 2013 proposals which drive the difference in estimated costs to the taxpayer. First, the level of asset disregard is significantly higher under the 2011 proposals with a high value of asset disregard being the key mechanism through which individuals assets were protected from high LTC costs. The 2011 proposals suggested that homes worth up to £750,000, together with assets to £25,000 would be disregarded from means testing[20]. For non home-owners a much lower disregard of £100,000 was proposed (the assessment was to be based on assets held by the individual in receipt of LTC and those of any long-term partner). The new scheme proposes a much lower asset disregard value of £419,000, which has been based on the value of a rolling 3-year average of a two bed property (£394,000) plus £25,000 (2013 prices). However, under the new proposals there is more equitable treatment of non-property assets, and the new scheme is therefore likely to lead to fewer distortions in the housing market. Under both schemes regulations will prevent individuals from divesting of their assets to avoid LTC costs by including any assets divested in the previous 10-years in the assessment.

The second key difference between the 2011 and 2013 proposals is the introduction of a cap on the total expenditure that individuals will ever have to make on LTC. This will limit the costs that individuals will ever have to pay on LTC to £50,000 (where LTC costs are evaluated at state approved levels) and is independent of assets held (2013 prices). The introduction of a £50k cap on the costs of care provides protection for individuals against the very high levels of costs that affect 1 in 10 over 65s. However the scheme does not just benefit those incurring these costs but rather acts as insurance against such costs for the wider community, removing financial uncertainty as individuals move into care. However for those that face lower costs will continue to self finance their care if their assets exceed the disregard. Couples

[20] P.108/2011 – Draft Long-Term Care (Jersey) Law 201-

who both require LTC will have a care cost cap set at £75,000, but this is expected to have few cost implications as few couples both require high cost LTC.

Evaluations of the 2011 proposals to reform LTC provision have raised concerns about the high level of contributions that would be required to fund the proposed scheme. The reforms proposed in 2013 are predicted to reduce the cost to the individuals who are required to make LTC contributions by reducing the asset threshold for means testing, and therefore reducing the subsidy paid to better off users of LTC. However the introduction of the cap raises the cost of provision by agreeing to subsidise the finance of LTC for those with the highest costs regardless of their means.

2. The Cost of Care – Projections of Future Costs

The Total Cost of Care

Jersey currently spends £62.2 million on LTC, with individuals contributing £27.8 million and the States £34.4 million. The cost of care is however predicted to more than triple over the next 30 years with cost projections suggesting that by 2044 LTC will cost around £186 million (2013 prices). This projection is based on modelling population parameters, care needs, and costs of LTC provision. Similar trends are observed across OECD countries with spending on social care expected to grow by 150% between 2000 and 2050 (OECD, 2006). A PSSRU report for the UK (Hancock et al, 2012) suggests costs there will rise from 12 billion to 25.5. billion by 2030, more than doubling in real terms over a relatively short period. But while these headline figures are alarming, the rise in costs is much less steep when expressed as a share of GDP, with the UK growth in spending growing from 1% to 1.3%.

Jersey does not produce a measure of GDP, but in 2012 the economy's Gross Value Added was estimated as £3.6 billion, so total spending on LTC amounted to approximately 1.7% of GVA with public spending approximately 0.8%. This level of spending is lower than in many OECD countries (see Table 1 below). Table 1 reports two scenarios that can be considered the upper and lower bounds for predicted expenditures as a share of GDP. In the first scenario of "cost pressure" it is assumed that no policy action is taken to alleviate pressures on public spending. The "cost containment" scenario on the other hand assumes that policy actively seeks to reduce pressures on spending. What these policy measures are not explicitly stated but might include policies to encourage the adoption of new technology or to modify incentives to use health or care services through changes to institutional structures (OECD, 2013: p15 & p36).[21]

[21] OECD, 2013, Economic Policy Papers No 6, "Public spending on health and long-term care: a new set of projections", p15 and Table 8 p36.

Table 1: OECD Projections of Spending on

Table 1.1 **Public health and long-term care spending**

In % of GDP

	Health care			Long term care			Total		
	2005	2050		2005	2050		2005	2050	
		Cost-pressure	Cost-containment		Cost-pressure	Cost-containment		Cost-pressure	Cost-containment
Australia	5.6	9.7	7.9	0.9	2.9	2.0	6.5	12.6	9.9
Austria	3.8	7.6	5.7	1.3	3.3	2.5	5.1	10.9	8.2
Belgium	5.7	9.0	7.2	1.5	3.4	2.6	7.2	12.4	9.8
Canada	6.2	10.2	8.4	1.2	3.2	2.4	7.3	13.5	10.8
Czech Republic	7.0	11.2	9.4	0.4	2.0	1.3	7.4	13.2	10.7
Denmark	5.3	8.8	7.0	2.6	4.1	3.3	7.9	12.9	10.3
Finland	3.4	7.0	5.2	2.9	5.2	4.2	6.2	12.2	9.3
France	7.0	10.6	8.7	1.1	2.8	2.0	8.1	13.4	10.8
Germany	7.8	11.4	9.6	1.0	2.9	2.2	8.8	14.3	11.8
Greece	4.9	8.7	6.9	0.2	2.8	2.0	5.0	11.6	8.9
Hungary	6.7	10.3	8.5	0.3	2.4	1.0	7.0	12.6	9.5
Iceland	6.8	10.7	8.9	2.9	4.4	3.4	9.6	15.2	12.3
Ireland	5.9	10.0	8.2	0.7	4.6	3.2	6.7	14.5	11.3
Italy	6.0	9.7	7.9	0.6	3.5	2.8	6.6	13.2	10.7
Japan	6.0	10.3	8.5	0.9	3.1	2.4	6.9	13.4	10.9
Korea	3.0	7.8	6.0	0.3	4.1	3.1	3.3	11.9	9.1
Luxembourg	6.1	9.9	8.0	0.7	3.8	2.6	6.8	13.7	10.6
Mexico	3.0	7.5	5.7	0.1	4.2	3.0	3.1	11.7	8.7
Netherlands	5.1	8.9	7.0	1.7	3.7	2.9	6.8	12.5	9.9
New Zealand	6.0	10.1	8.3	0.5	2.4	1.7	6.4	12.6	10.0
Norway	7.3	10.7	8.9	2.6	4.3	3.5	9.9	15.0	12.4
Poland	4.4	8.5	6.7	0.5	3.7	1.8	4.9	12.2	8.5
Portugal	6.7	10.9	9.1	0.2	2.2	1.3	6.9	13.1	10.4
Slovak Republic	5.1	9.7	7.9	0.3	2.6	1.5	5.4	12.3	9.4
Spain	5.5	9.6	7.8	0.2	2.6	1.9	5.6	12.1	9.6
Sweden	5.3	8.5	6.7	3.3	4.3	3.4	8.6	12.9	10.1
Switzerland	6.2	9.6	7.8	1.2	2.6	1.9	7.4	12.3	9.7
Turkey	5.9	9.9	8.1	0.1	1.8	0.8	6.0	11.7	8.9
United Kingdom	6.1	9.7	7.9	1.1	3.0	2.1	7.2	12.7	10.0
United States	6.3	9.7	7.9	0.9	2.7	1.8	7.2	12.4	9.7
Average	***5.7***	***9.6***	***7.7***	***1.1***	***3.3***	***2.4***	***6.7***	***12.8***	***10.1***

Source: Secretariat calculations.

LTC

The estimated costs of LTC for Jersey have not however been expressed as a share of output but instead are expressed in real terms. The estimated total spend on care is based on a number of assumptions about demographic changes and the cost of care. Many of the estimates are based on UK models which have been adapted to a Jersey specific context. The OXERA model is based on the existing care population, with some additional (hidden) domiciliary cases included. Future care costs are then increased in line with both stratified population increases and earnings. It is estimated that 1-in-4 adults in the UK that reach the age of 65 will require some form of LTC, with the greatest need demand coming from those over 80. Looking at population projections, and in particular the share predicted to be over age 80, is an important input into modelling the costs. The number of residents that are over the age of 80 is expected to treble over a thirty year period, from 3,567 to 10,024 individuals (Table 2). This trebling of the elderly population is close to the estimated growth in the cost of LTC provision (which is also estimated to treble).

The estimates are based on the assumption that care needs will remain more or less the same. There are arguments that care needs could increase (increased longevity with chronic conditions) or that they could decrease (compressed morbidity). Other estimates of LTC costs have emphasised changes in health as a driver of changing needs among the elderly population (Wanless, 2006; OECD, 2006) although there is no general agreement on the implications for the overall direction of change in costs. In addition it is assumed that the balance between paid (formal) and unpaid (informal) care does not respond to the method of provision although , an allowance for additional domiciliary care cases, over and above existing known care numbers is made in the model Total LTC cost estimates are the same under the OXERA models of provision. In reality there is likely to be some behavioural responses to changes in the way in which LTC is provided – some reductions in care costs are assumed in line with existing plans for improved management of nursing care clients for example, if LTC is heavily means tested the incentives to provide informal LTC are much higher than if LTC is supported more generously with higher asset disregards.

As a share of the population, the projections for Jersey suggest that the share of those over 80, who are most likely to require social care, will make up 10% of the

population by 2036 (up from 4% over 30 years)[22]. The level of migration however plays an important role in determining population trends in Jersey, and estimated population numbers are highly dependent on assumptions about migration patterns. This has potentially important implications for both the demand for LTC and for its finance.

Table 2: Population projections for Jersey and England, 2006 and 2036[23]

	Jersey				*England*			
Age	**2006**		**2036**		**2006**		**2036**	
0-15	15,717	18%	14,264	15%	9,674	19%	14,264	22%
16-64	60,079	67%	54,101	56%	33,003	65%	36,821	56%
65+	13,567	15%	28,563	29%	8,087	16%	14,216	22%
80+	3,567	4%	10,024	10%	2,277	4%	4,959	8%

The second driver of spending is the cost of LTC provision. Current costs vary by need and are reported below in Table 3: Overall numbers in each type of care determine the total cost to the state over the year. The balance of need may change over time in Jersey, and this is a particular risk given that the population numbers using each care type are small.

Table 3: Costs of Care and LTC Numbers 2012/13

	LTC numbers 2013	Of which private care	Weekly rate 2012	Annual rate 2012
Age 65+				
Domiciliary care	211	139	£524*	£27,248
Basic residential care	690	278	£630	£32,760
High Dependency care			£805	£41,860
Nursing Care	269	45	£1281*	£66,612
Under 65 care	139	0	£1,215*	£63,180
TOTAL	1,309	462		

* Weighted averages

A second driver of rising costs is the increased demand for better quality services as the aspirations of those in receipt of LTC grow. There is demand in particular for greater flexibility and choice around provision. This may have important implications

[22] See table 2
[23] R.5/2010 – Long-Term Care Funding: Consultation Paper

for the total care bill. In addition, as more women enter the formal labour market a switch from informal to formal provision of care is predicted. Proposals for reform may also encourage, or discourage, such a switch in provision with more highly subsidised care likely to raise the total cost of providing formal LTC. The Dilnot Commission has also suggested that LTC costs could fall in the future if there was greater investment in social care infrastructure.

How the costs of care evolve is also dependent on technological change and the relative price inflation of inputs into the provision of care. As LTC provision is very labour intensive, with limited scope for technological improvements (unlike health care services) the main driver of costs are wages. While jobs in the care sector are often low-skilled, increased demand for labour in competing service sector industries may drive up costs. The OXERA model is sensitive to variations in the relative price inflation within the LTC sector. This is unsurprising as the cost differentials are assumed to be constant and the cumulative difference in costing is therefore large over a 30 year period. In practise it might be expected that there was less systematic variation in price inflation between the care sector and the rest of the economy over such a period of time. In particular, long term trends in wage inequality in the UK and internationally do not suggest that low skilled workers will see such a significant long term catch up in their relative earnings.

The OXERA model assumes a 1% growth in costs, co-payments, disregard and contributions. Overall, given the uncertainties around population aging, care needs and costs, the estimated total costs of provision in the OXERA and States reports seem reasonable. As with all forecasts, there is always a high degree of uncertainty attached to such estimates. However it provides a useful tool for comparing the implications of different policy designs.

Sharing Costs between Individuals and the State

While it is difficult to precisely estimate the future of LTC costs, what is certain is that there will be not only a significant rise but public spending (to be financed through the LTC fund) will also see a substantial rise. The extent of the cost to the public will depend on the design of the financial package to support LTC. This section reviews

the different levers that are proposed under the LTC scheme that will influence cost sharing between the LTC fund and individuals.

Estimates in the 2011 proposal showed that, even if the government were to do nothing to reform LTC provision, the cost of LTC to the States would double reaching £60 million in real terms by 2026. Individual contributions would similarly double over the period. Alternative scenarios were also considered – first the effect of extending means tested support so that care was only subsidised for those in greatest need, extending the LTC scheme as under the 2011 proposals, and finally providing LTC as a universal free benefit. Under each scenario the cost of State provision will be substantially larger in 2026 than today. Even under a strategy to minimise the cost to the States, where a fully means tested system of LTC provision is adopted, the cost to the States is forecast to rise by 80% by 2026 (Table 4).

Table 4: LTC provision under different scenarios

	2010[24]		2026[25]	
2009 prices (millions)	Cost to States	Cost to individuals	Cost to States	Cost to individuals
Full means testing	27	28	54	56
Current system	30	25	60	50
LTC benefit proposals – 2011	45	10	90	20
Universal free provision	55	0	110	0

The proposals put forward in 2011 have been deemed to be too expensive. The rise in costs was driven by the high level of assets disregard proposed which meant that many homeowners would become eligible for means tested support with LTC costs. Subsequent proposals have examined how altering different elements of the scheme would influence overall costs. The key levers examined in the OXERA report are:

- the level of asset disregard
- the level of co-payment
- the cap on the cost of care
- personal allowance

[24] R.5/2010 – Long-Term Care Funding: Consultation Paper
[25] Extrapolated from R.5/2010

The 2013 proposals will lead to a rise in the cost of care compared to current provision, first because the new capped cost offer provides an immediate subsidy to those not eligible for means tested support with the highest LTC costs, and second because the asset disregard for means tested support will rise substantially. However, compared to the 2011 proposals costs are lowered mainly because the level of asset disregard has fallen and so fewer will benefit from means tested support, although the introduction of a new cap on the cost of care leads to additional costs.

The overall cost to the States of provision will rise with the level of asset disregard; with higher personal allowances; a fall in the value of the cap on cost of care rises and with lower co-payments. Each of these factors are examined in the OXERA report (April 2013).

Updated figures are the impact changes in asset disregards for the LTC contribution rate have recently been updated and show that raising the asset disregard from £219,000 to £419,000 would raise the contribution rate from 2.2% to 2.7%. A further increase to £619,000 raises contributions to 3.4% and to £819,000 to 3.6%.

Raising the asset disregard from £23k to £400k raises the share of the population benefiting from means tested support from 19% to 25% of the population. The co-payments in the base case scenario are however set at a relatively high level (£467 per week). OXERA's analysis also shows that the level of co-payments set makes a substantial difference to how costs are shared between individuals and the LTC Fund – which is perhaps unsurprising given that these make a substantial difference to the net cost of care paid by the fund.

For those on means tested support, there will be support for co-payments when their income falls close to the level of the co-payment (recalling that individuals are to retain a personal allowance (currently £32,62 per week), although this value is not described in the report) *and* the value of their assets falls below the disregard's threshold (£400,000 here).

Finally, the value of the cap on care costs leads to large variations in costs in OXERA's model – a cap of £45k on care costs reduces the net cost to the States by around 20% compared to having no cap; while a £75k cap reduces costs by over 25%. These estimates are based on data of the length of stay in care homes in the UK. At the proposed cap this implies that the cap on care costs will be met 11 quarters of stay (2.75 years) for those in residential care, and will affect 35% of whose going into residential care; those with high dependency care needs meet the cap at 7 quarters (1.75 years) and this is estimated to be reached by 42% of recipients. For those with nursing care needs the cap is met at 4 quarters, or 1 year, and will be reached by 61% of recipients. These calculations of the average length of stay are based on a model developed by PSSRU for a simulated population.

Beyond these thresholds the government will pay for individuals LTC needs. OXERA note that there is evidence that the average length of stay in care in Jersey is greater than in the UK. This is likely to be due to historic evidence regarding early placements into residential care due to the historic lack of domiciliary care provision in Jersey. Over the 30 year span of the model, with support for domiciliary care in place, it is assumed that Jersey average stay will be close to UK values.. The July report produces some sensitivity analysis to assumptions around duration of stay and shows that costs are sensitive to this parameter.

The OECD reports a trend over time towards greater home care (as a share of all LTC) – this would have the effect of mitigating some of the expected increase in cost both as a result of reducing the numbers affected by the cap, but also by reducing expenditure on means tested support. The OXERA model does make some allowance for this by assuming a shift away from institutional nursing care, as included in option three of the KPMG health green paper. The July 2013 OXERA report notes that if such a shift in the balance of care could be achieved it would make a "material difference" to LTC costs. However while the OXERA estimates suggest that the biggest gain will be to individuals whose levels of contributions to LTC will fall from £106 million to £90 million, [26] while the value of States contributions are forecast to fall by less, from £107 million to £101[26] million under the 2013

[26] LTCM 05/07/13 Table 4.7

proposals. However, this may be a function of the models parameters, there is no co-payment payable by those receiving domiciliary care which results in large savings in individuals care costs (although these savings are arguably not real because costs of living still have to be paid), while the estimated costs of care at home are assumed to be on average 90% of those in care homes.

The introduction of a cap on care costs leads to benefits for a much greater share of the population: introducing a cap on the cost of care leaves almost one half of all care users in receipt of "means tested" support. Pensioner income data within the model are based on the 2009/2010 Jersey income distribution survey, the median value of which was £326 in 2009/10. The report does not however discuss how assumptions about pensioners' income impact on the value of state spending on means tested support.

The implications of varying the personal allowance are not discussed in the OXERA report, although variations in this are likely to have a limited effect on costs. The OXERA evaluation of the 2013 proposals show that the share of costs expected to be borne by individuals will rise to £85.8 million and those by the LTC fund to £100.1 million by 2044. Table 5 below shows the numbers expected to receive LTC in each category of need and the total cost to the LTC fund.

Table 5: Costs of Care in 2013 and projections to 2044 under 2013 proposals

	Over 65 nursing care	Over 65 residential care	Over 65 care at home	Under 65	Total
Population 2013	268	690	204	146	1308
Population 2044	529	1819	629	146	3120
LTC Fund Care Costs 2013	£20.0m	£3.9m	£10.5m		£34.4m
LTC Fund Care Costs 2044	£70.9m	£14.8m	£14.4m		£100.1m

It is worth comparing the proposed scheme with those proposed by the Dilnot Commission for the UK. In the UK the Dilnot Commission proposed a cap on the cost of care to be set at £35k and an asset disregard to be set at £100k.

A recent UK government White Paper has proposed a cap of £75k and asset disregard of £123k. Jersey's 2013 proposals suggest a cap of £50k, but a much

higher level of asset disregard, of £419k, than in UK proposals. The Dilnot Commission's proposal for the cap was £35k, although the commission noted that values within the range of £25k and £50k were appropriate. The choice of cap in Jersey falls within this range. This is important because the Dilnot Commission has argued that were the cap to be set too low the principles of sustainability and resilience would be jeopardised. A cap of over £50k would on the other hand do little to protect those on lower incomes or with less wealth. On grounds of equity therefore a £50k cap seems to be appropriate.

The level of assets set as a disregard by the Dilnot Commission was based on median property and savings wealth of single women aged 75-84 (which was £124k). The proposals for Jersey set a similar base, with the assets being disregarded equivalent to the median price of a 2 bedroom house plus £25k. Finally, Dilnot proposed a co-payment of £190 per week. Adding to this a modest personal allowance of £22 per week the total cost to individuals comes close to the median pensioner income. Jersey's co-payment is to be set at a substantially higher level of £300, although this too is close to the median income of pensioners (which was £326 in 2009/10).

3. Funding LTC: Implications of the scheme for contribution levels

Under the new proposals the costs of LTC are to be shared between individuals and a new LTC fund. The fund is to be financed from a combination of funding from central government and new funding to be raised from contributions paid through the income tax system. It is proposed that the States will transfer most of the current annual spending on LTC into the fund, which at present stands at £31 million a year. Future anticipated increases in care needs, and additional costs arising from the proposed reforms, are to be met from newly raised revenue from contributions. These contributions will be levied using income tax parameters so that those with the lowest incomes will not pay the contribution and only the best off will pay the full levy. Current proposals suggest introducing a payment of 0.5% of earned and unearned income in 2015, rising to 1% in 2016 and expected to remain at this level for a minimum of 3 years. Applied using income tax parameters, the proposals suggest that the new payment will be an additional £5 to be paid in tax for every £100 paid (1% contribution rate). For those paying tax at the 20% rate the contribution rate is therefore 1% (up to UEL); those paying marginal rate income tax at 15% pay a 0.75% contributions rate; and those paying at 10% will have a contributions rate of 0.5%. As a minority of taxpayers pay at the full 20% rate, the new charge means that for the majority of the population the effective tax rate is below 1%. An Upper Earnings Limit is also to be applied to contributions, with contributions due only on income up to UEL (£152,232 in 2013).

Projections of the required contributions rate needed to fund the scheme in the longer term vary considerably with the policies design, but are also subject to a good deal of uncertainty because estimates of costs and the tax base from which revenues are to be drawn are both sensitive to estimates of these models parameter. In particular, the tax base is sensitive to population estimates of the numbers of working age, and their estimated incomes. For Jersey assumptions about migration trends are particularly important to population projections. In order to ensure a reasonable balance of costs between the working age population and pensioners, pensioners' income is also to be included in the calculation.

The original policy proposals put forward in 2011, which assumed a property asset disregard of £750k, was costed by OXERA in 2013 on the assumption that individuals would make a £300 co-payment, would require a LTC contribution rate of 5.1%[27]. This was deemed to be unaffordable. In comparison the 2013 proposals are expected to require a 2.8%[28] contribution rate by 2044, with a lower initial contribution rate of 1% compared to 1.5% under the old scheme. It is also important to compare these contributions to the levels that would be required if the system (i) continued as it is; and (ii) moved towards a more fully means tested system. If the system were to continue as it is then costs have been predicted to double, and in the absence of a rise in central government funding an additional £30 million will need to be raised by contributions. Under a fully means tested scheme an extra £25 million will be required; the 2011 proposals were estimated to cost an extra £60 million, and free care for all £80 million[29]. Even the do nothing scenario therefore suggests a significant rise in contributions will be needed if central government is not to extend support for LTC.

The interim OXERA report prepared in April 2014 examined the sensitivity of the required LTC contributions to the parameters determining individual contributions; in particular to the level of co-payments, asset disregard and the cap on care costs. The States contribution to the fund through central taxation is assumed to be £31 million, with no growth in the real value of this contribution over time (equivalent to current central government spending on LTC). Some of these results are summarised in Table 6 below.

The OXERA model report (05/07/13) shows that the cost of LTC will reach £66 million in 2014 (assuming the scheme is fully operational and no transitional arrangements are in place) with a total cost to the state of £36.66 million. Given that the States are to maintain the contributions level of £35.5 million, the additional contributions to be raised are small amounting to just 0.2%.[30] In this scenario 36% of the population in care are expected to be in receipt of means tested support. Costs rise over time however – in a decade the required contribution rate rises to

[27] P.99/2013 – Long-Term Care Scheme
[28] P.99/2013 – Long-Term Care Scheme
[29] As reported in R.5/2010 – Long-Term Care Funding: Consultation Paper
[30] LTCM 05/07/13, Table 3

0.9%, by 2034 to 1.8% and by 2044 to 2.9%. This rise in contributions reflects rising needs as the population ages but also the impact of a freeze in States funding towards the scheme (central funding is assumed to have 0% growth). As the results are sensitive to projections about costs the report details the sensitivity of the contributions rate to changes in costs.

In a worst case scenario where costs are 15% higher than predicted the contributions rate is forecast to rise to 3.6% in 2044.[31] However, costs may also be overestimated if costs rise less slowly than predicted in the model. There are wide discussions around how care may be better provided (see OECD 2011) and investment in cost savings measures (such as more suitable housing and technologies to enable people to stay at home for longer) may reduce costs of LTC provision.

The OXERA model does include some conservative estimates of cost savings as a result of reductions in nursing care costs as a result of improvements in health policies Table 6 summarises some of the results from OXERA's April 2013 interim draft report on modelling the costs of LTC. The results, while based on a different set of baseline parameters than the most recent proposals, give a good indication of how sensitive costs to individuals and the State, and contributions to the LTC fund, are to the value of asset disregards, co-payments and cap on the care of cost. The April version of the model did not fully reflect the impact of the asset disregard due to the way in which assets were being treated. This was addressed in later versions of the model, which show a greater sensitivity to the level of asset disregard.

[31] LTCM 05/07/13 Table 4.2

Table 6: Sensitivity of LTC contributions and Share Receiving Means Tested under different parameter estimates, 2014 and 2044

	Cost to State	Cost to individuals	% costs met by LTC fund	LTC contributions rate	% in care receiving means tested support	Cost to State	Cost to individuals	% costs met by LTC fund	LTC contributions rate	% in care receiving means tested support
	2014					2044				
Asset disregard										
£23,000	40,814	23,292	64%	0.60%	19%	116,289	70,796	62%	3.50%	23%
£100,000	40,814	23,292	64%	0.60%	19%	116,289	70,796	62%	3.50%	23%
£300,000	41,083	23,023	64%	0.60%	21%	117,014	70,071	63%	3.51%	25%
£400,000	41,502	22,604	65%	0.60%	25%	117,958	69,127	63%	3.55%	28%
£500,000	42,508	21,598	66%	0.70%	33%	119,990	67,095	64%	3.63%	32%
Co-payment (institutional / domiciliary)										
£467 / £167	41,502	22,604	65%	0.60%	25%	117,958	69,127	63%	3.55%	28%
£300 / £0	49,686	14,420	78%	1.10%	14%	144,796	42,289	77%	4.66%	16%
£187 / £0	54,831	9,275	86%	1.40%	7%	159,874	27,210	85%	5.28%	11%
Cap (with institutional co-payment of £300 / domiciliary care co-payment of £0										
£45,000	33,558	30,548	52%	0.10%	46%	103,611	83,474	55%	2.96%	43%
£60,000	32,355	31,751	50%	0.00%	47%	97,468	89,617	52%	2.70%	45%
£75,000	30,340	33,766	47%	0.00%	48%	94,135	92,949	51%	2.57%	46%

Note: Data from Oxera (April 2013) "Modelling the costs of Long term care in Jersey". The baseline case assumes an asset disregard of £400,000; co-payment of £467 for institutional care and £167 for domiciliary care; no cap on care costs. The benefit level trigger for universal benefit if £0.

The required LTC contribution rate is very sensitive to the level of co-payments and raising the level of co payments can make a substantial difference to the overall cost to the States. The level of the cap too can lever down costs of provision, with a cap of £45,000 raising the contribution rate in 2044 to 2.98% compared to 2.57% with a higher cap of £70,000.

The table also reports the proportion of individuals in care who will receive means tested help. Under the various asset thresholds around 1 in 5 will receive means tested support, with this proportion increasing to 1 in 3 when the asset threshold reaches £500,000. Further increases beyond this level may draw a substantially increased proportion into means tested assistance. The level of co-payments also have a substantial influence on the numbers benefitting from means tested assistance – at low levels few of the care population qualify for means tested support, while at a contribution rate of £467 per week one in four qualify for support. However it is the introduction of a cap in care costs that has the most substantial impact on extending state support to a larger share of individuals in care. Where the cap is set £45,000, 46% of the LTC population will benefit from state support. These proportions rise with the level of the cap by a small share – a surprising result given that a rise in the cap should exclude more individuals from benefitting from support.

4. Distributional implications of reform

It is clear that in the future as more people live for longer the need to spend more on LTC will rise. Even if this is funded through a fully means tested system the rise in funding that will be required over the next 30 years is substantial. The key question for policy makers is who should pay – should the cost of payment fall mainly on those who need care? Or should the cost be distributed more widely across the community? To what extent should the young be expected to pay for the care of the elderly? How should costs be balanced between costs met by taxpayer and those using LTC? How can the less well-off be protected from paying for the increasing costs of care? The answer to these questions is to a large extent subjective. However, understanding how different mechanisms of provision influence the distribution of costs is important.

One of the key motivations for reform to the care system in Jersey and in the UK has been to spread the costs of care across individuals. In the UK the Dilnot Commission has estimated that up to one-quarter of those reaching the age of 65 would spend little on care costs over the rest of their lives; one-half would spend up to £20,000 and one in ten up to £100,000 (with costs for some being much higher). Individuals have no way of knowing what their care costs will be, and no way of insuring against incurring "catastrophic" costs. The introduction of the cap on care costs goes a long way to protecting the assets of those individuals that face the greatest costs. However, those that are relatively well off are the largest gainers – those with very low levels of assets who require LTC will gain little from the cap (although they will benefit from means tested support).

The second major change is the raising of the asset disregard. This too ensures that while those that can pay do, assets are protected for the less well-off. These measures therefore ensure that the costs of care are limited for (i) those with limited assets, and (ii) those facing the very highest costs. In this way costs are redistributed from those facing the highest LTC costs, and for those least able to afford LTC, to the wider community.

Under the current proposals the largest gainers are those with assets between £23,000 and £419,000 who will become entitled to means tested support. Those with initial assets just above this level will also benefit if their care costs reduce their asset level to £419,000 (those with assets up to £469,000 in this particular scenario). Those with care costs of over £50,000 will also benefit significantly from the cap even if they have substantial

assets. Analysis of the distribution of costs by wealth quintile in the OXERA report (05.07.13) shows that the schemes design is progressive with wealthier individuals paying a greater share of their care costs from their own income, largely as a result of the provision of means tested support.

A key objection to the 2011 reforms was that the costs to the taxpayers would be very high with the proposed contributions to the LTC being deemed unfair to younger generations who would have to pay an increasing share of their income into the fund. This disparity in contributions across generations has, in the UK context, been seen as particularly unfair because of the vast disparity in housing wealth between the older generation and the young. In order to preserve intergenerational fairness pensioners will also be liable for the LTC contribution, with payments liable on all earnings and other income. However many pensioners are asset rich but income poor, and as a result only between one-third and half of all pensioners are expected to be liable for the contribution. Using income tax parameters to determine contributions mean that over one-half of contributions come from those with an annual income of at least £50,000 (15% of the adult population) and so the proposed method of collecting contributions is progressive.

5. Wider economic implications

Reforms to the provision of LTC must be seen in the wider context of competing demands for government funding. In particular, the aging population is predicted to lead to increased pressure on healthcare services and spending on pensions. In comparison with both health and pension spending, expenditure on LTC comprises a relatively small share of government spending - in 2009 the Social Security Fund spent £132 million on pensions; the comparable figure for States spending on LTC was £30 million. By 2036 pension spending is predicted to reach £201 million (after accounting for an increase in the pension age)/ One means of addressing this cost would be to raise social security contributions (which is a useful way of comparing these costs with those of LTC) and it is estimated that this would require a 4 percentage point rise in social security contributions (up from 10.5% today); LTC spending by 2036 under current proposals is forecast to reach £72 million requiring a contribution rate of 1.8% by 2034. The Health Insurance Fund (HIF) is similarly facing pressures from an aging population. Currently funded by social security contributions of 2% up to the SEL, the HIF's break-even contribution rate is estimated to increase from 1.5% in 2007 to approx 2.4% in 2027. Together these predictions suggest that tax payer contributions will rise significantly to fund these areas in the future.

Recent reviews of LTC in the UK and OECD have emphasised the need to improve the integration between health and social care in order to improve service delivery and better meet needs. These reforms tend to favour single budget holders to encourage cooperation across service providers. Such steps are also likely to be cost saving in aggregate. The development of the LTC benefit in Jersey has involved very close co-operation with the HSS Department and this is expected to continue with an integrated, client-centred approach to care.

There has been concern raised about withdrawal of money, from the economy during a period of economic slack. The phased introduction of a higher rate of LTC should help mitigate against these short-term effects. In the longer term a review by the Economic Unit confirmed that the scheme to put in place funding for the future cost of the ageing society was a positive development as it encouraged long term planning (both by individuals and the States) and would help to keeps the States' finances on a more sustainable footing.

The 2013 proposals improve in many ways on the old scheme. The introduction of property bonds to finance LTC has already meant that the elderly no longer need to sell their homes in order to pay for LTC. This has mitigated the need to base asset levels on property values, and the new proposals asset disregard levels do not differentiate between homeowners and others. This is a positive move as previous proposals distorted incentives, for example discouraging downsizing which has been argued to be potentially beneficial for the elderly and may delay the time of entering care.

6. Conclusion

The cost of LTC is to rise in the future and States spending will increase in the future. The proposals for reform will take LTC provision in Jersey in a direction similar to proposed reforms in the UK and across OECD countries where a fully means tested system is becoming increasingly seen as unacceptable with more individuals living for longer and facing “catastrophic” costs of care (a risk which is, at present, uninsurable).

The proposed LTC fund will require additional contributions from taxpayers. While the amounts are relatively modest, increased demands for resources to fund pensions and health care (both of which face the same pressure from an aging population) mean the cumulative effect on taxation may be substantial in the next 30 years. Current funding proposals for LTC however assume that the States contribution to the LTC fund will be frozen in real terms from 2012. If the States contribution to the LTC fund were to grow, in real terms, at the same rate as the other costs and payments in the model (the OXERA model assumes care costs, asset disregards, co-payments and the contributions base grow at 1% per year in real terms, while the States departmental contribution is assumed to have 0% real growth) the effect would be to reduce the required levels of contributions in the future. This is not considered in the OXERA report. In addition this assumption implies that funding for LTC will comprise a shrinking share of central government spending in the long term and this could leave scope for reduced general taxation.

The proposed reform to LTC also assumes that income will be assessed on the basis of an individual and their partner’s incomes. How much income a partner will be allowed to retain when their partner enters LTC is unclear. The UK abolished the liability of relatives (including partners) for co-payments in 2009. While this would raise costs the equitable treatment of those whose partners enter LTC merits further consideration.

Younger people (those under 65) in receipt of LTC are treated in the same way as pensioners in the proposals. The Dilnot Commission in the UK proposed that younger adults should not be subject to means testing but that provision should be free as their ability to save or plan for their care is limited. In Jersey 11% of those in receipt of LTC are under 65 but figures suggest they account for almost ¼ of expenditure (2012). It is unlikely that costs associated with provision for this group will rise in the same way as those for the elderly.

Appendix two: Boyle Report, appendix one

Appendix 1: Organisation and financing of primary care

This appendix considers the organisation and financing of primary care in other relevant jurisdictions and the role of community health services. In particular we look at the role and extent of co-payments for primary care services in these systems.

1 Introduction

We understand that there is some concern that the White Paper will establish community health services (CHS) as yet another layer of healthcare. It is not uncommon in other healthcare systems for CHS to be run separately although often it is co-located within GP practices.

2 Co-payments in the health system

The spread of co-payments in healthcare systems throughout the world is well-documented (see for example Tambor *et al.* 2010). Over half of the systems in the expanded EU (EU27) have some form of co-payment; for many countries these co-payments have been introduced since 2000. The purpose of such payments varies from a desire to contain public health costs by shifting cost to the individual, to providing incentives for more efficient consumer behaviour and hence increasing allocative efficiency by for example encouraging appropriate use of healthcare facilities. It is the latter that would appear to drive the proposal in Jersey to introduce charges for inappropriate A&E attendances.

Most formal reviews of co-payments have concentrated on four aspects of healthcare delivery: GP appointments, specialist appointments, inpatient hospital care, and pharmaceuticals. While there is some information available on other aspects of the healthcare system eg physiotherapy sessions, diagnostics, community nursing care, co-payments in these sectors have not been the subject of any major systematic study of which we are aware. This may be a shortcoming when drawing conclusions as clearly there is interaction between most elements of the healthcare system and thus different payment mechanisms should be looked at in the round.

Nevertheless, in this appendix we consider co-payments mainly in the context of general practice. We also provide information on the organisation of primary and community health services, and where available additional information relating to co-payments in other sectors.

We have surveyed a range of countries (including the ones suggested by the Panel). It is less easy to get a view of what is happening in some of the smaller jurisdictions as these are not well-reported. On the other hand size is unlikely to be a key consideration when assessing co-payments.

2.1 Reviewing co-payments in a selection of countries

In this section we review the organisation and system of payment for general practice in the following countries: Switzerland, Sweden, Norway, Finland, Denmark, the United Kingdom, New Zealand, France, Germany, Ireland, and Luxembourg. Much of what we report is based on Thomson *et al.* (2011). Also we draw on the results of a recent review of payment mechanisms in the EU (Tambor *et al.* 2010).

Payments by Individuals in addition to what is provided through public funding (often referred to as cost-sharing) may take three forms: co-payments where the individual is expected to pay a fixed amount for accessing the service; co-insurance where the individual is expected to pay a proportion of the cost of the service, and usually this can be offset against voluntary health insurance (VHI); and, extra fees where the provider charges some form of extra in addition to what is paid from public funds, often for some additional aspect of service or increased quality.

Table 1 provides a summary of the primary care systems in the selected countries. There is a mix of ownership, payment systems, population registration requirements and gatekeeping.

Table 1: Primary care organisation and payment in 11 selected countries

Country	Ownership	**Primary care payment**	**Registration with GP required**	**Gatekeeping**
Switzerland	Private	Most FFS, but some capitation	No	In some insurance programs
Sweden	Mixed	Most salaried; private - mix capitation/FFS	Yes (not Stockholm)	Some incentives
Norway	Private	Mix FFS/capitation	Yes	National incentives
Finland	Mixed	Mix FFS/ capitation/salary	Yes	Yes
Denmark	Private	Mix FFS/capitation	Yes (98% population)	Yes (98% population)
UK	Mixed	Most mix capitation/ performance-related; some salaried	Yes	Yes
New Zealand	Private	Mix capitation/FFS	Yes (96% population)	Yes
France	Private	FFS	No	National incentives
Germany	Private	FFS	No	In some sickness fund programs
Ireland	Private	Mix capitation/FFS	No	Mixed
Luxembourg	Private	FFS	No	No

Based mainly on Table 4 of Thompson et al. (2011). Note: all descriptions are approximate. No health system accords with a single model; all are hybrids.
FFS is fee-for-service.

Table 2 shows the population in millions in 2011 for the 11 countries that we consider below and the proportion of people aged over 65 years in each. This proportion varies between 13.3% in New Zealand and 20.6% in Germany. Jersey currently lies in the middle of this range.

Table 2 also shows per capita spend on healthcare in each of the 11 countries and the proportion of this that is out of pocket. Again there is considerable variation: in out-of-pocket spend, from 7.3% in France to 30.9% in Switzerland, and in spend per head, from £2,018 in New Zealand to £5,036 in Luxembourg. However, looking at spend as a proportion of GDP, Luxembourg is at the bottom of the range at 7.9% with Germany and France at the top on 11.6%. Luxembourg has very high GDP per head.

Table 2: Some population and healthcare expenditure figures for selected countries

	2011			2010		
	Population Millions	Proportion > 65 years	GDP per head	Healthcare spend: % GDP	Healthcare spend per head	Proportion spend out-of-pocket
Denmark	5.57	16.9%	£36,743	11.1%	£3,953	13.1%
Finland	5.39	17.8%	£30,406	8.9%	£2,453	18.8%
France	65.44	17.1%	£26,088	11.6%	£2,888	7.3%
Germany	81.73	20.6%	£26,896	11.6%	£2,874	13.0%
Ireland	4.49	11.9%	£29,810	9.2%	£2,611	15.2%
New Zealand	4.41	13.3%	£20,081	10.1%	£2,018	10.5%
Norway	4.95	15.0%	£60,394	9.4%	£4,981	15.3%
Sweden	9.45	18.6%	£35,045	9.9%	£2,900	17.0%
United Kingdom	62.64	16.8%	£23,897	9.6%	£2,156	10.0%
Switzerland	7.91	17.0%	£49,490	11.4%	£4,809	30.9%
Luxembourg	0.52	13.9%	£70,820	7.9%	£5,036	11.4%

Based on World Bank 2012, and this appendix.

Table 3 shows a selection of data on co-payments in the 11 countries. We find that 8 of the 11 have systems of co-payment for GP consultations. Unfortunately these data are for a range of years making comparison difficult. However we do find some considerable variation: Ireland stands out with the highest levels of payment for GP consultations. KPMG reported an average co-payment for GP consultations in Jersey in 2009 of £32 at the surgery and £55 for a home visit (KPMG 2011, p108). We also note that 5 of the 11 countries have payments for visits to emergency rooms although some of these are more akin to visits to what we would term walk-in centres in the UK.

Table 3: Co-payments and GP utilisation, selected countries, various years

	Range of co-payments			Annual Limit on co-payments	GP visits per head per year
	GP		Emergency		
Denmark	None		None		4.6
Finland	£8.80	£17.70	£12.10	£26.50	1.7
France	£0.80	£18.50	£32.10	£40.20	6.9
Germany	£8.00		None		8.2
Ireland	£40.20	£64.20	£48.20		
New Zealand	£5.10	£30.60	None		4.3
Norway	£19.40	£31.20	£23.50	£202	
Sweden	£9.40	£18.70	£18.70-£28.10	£84.30	2.9
United Kingdom	None		None		5.0
Switzerland	None		None	£464	4.0
Luxembourg	£16.00	£27.60	None		

Based on World Bank 2012, and this appendix.

Annual limits are often placed on co-payments as a way of alleviating excess costs for individual payers, and we see that these can vary substantially. Finally we provide some evidence of the variation in the annual use of GP services between the 11 countries, from 1.7 visits per head in Finland to 8.2 in Germany. However we urge caution when considering these figures as, although

based on OECD and World Bank published comparators, these sources do not always manage to compare like with like.

We go on now to provide some more detail on the systems in each of these 11 countries.

Switzerland

Each individual must buy statutory health insurance (SHI). The government provides subsidies based on income to individuals or households to help cover premiums; the process varies by local area (canton). The maximum income level for a single adult household to be eligible for subsidies varies by canton from around £16,570[32] to £26,700 (CHF 25,000 to CHF 40,300). Approximately 30% of all residents receive individual premium subsidies. Local government covers health insurance expenses for individuals on social assistance or supplementary old age and disability benefits. In addition individuals may buy voluntary health insurance (VHI) and also pay out of pocket.

Insurers must offer a minimum annual deductible of £167 (CHF 300), though individuals can choose a higher deductible and hence a lower premium. There is a 10% co-insurance for almost all services including those provided by GPs. There is only a co-payment for inpatient care, and this is relatively small. Maternity services and a few preventive services are exempt from deductibles but not from co-payments. Individuals < 19 years are exempt from all deductibles and from co-payments for inpatient care. There is an annual maximum limit on co-payments of £464 (CHF 700).

SHI covers most GP services, physiotherapy (if referred by a doctor), and some preventive measures. Individuals have free choice of GPs and access without a referral to specialists in private practice (unless the individual is enrolled with a gatekeeping managed care plan). Most private medical practices have just one doctor. Apart from some managed care plans, where groups of doctors are paid on a capitation basis, ambulatory doctors are paid on a national fee-for-service, negotiated between insurers and providers or their organisations. The cantons are responsible for out-of-hours care, and arrange provision through a range of public and private organisations. There is an agreed additional payment for out-of-hours care.

Long-term care

Two-thirds of the costs of long-term inpatient care (nursing homes and institutions for disabled and chronically ill people) are funded by contributions from private households (out-of-pocket and cost sharing). The remainder is funded by SHI (15% for nursing care) or state subsidies and disability insurance. SHI also covers the cost of home nursing care – the nursing component of community long-term care; however, support and household services are paid for by individuals or through state subsidies.

SHI only covers 'medically necessary' services for long-term care. Since January 2011, SHI pays a fixed contribution to cover long-term care; the individual pays at most 20% of the non-covered costs, and the remainder is financed by local government. The total cost of long-term inpatient care is £6.63 billion (CHF 10 billion) or 17.1% of all healthcare costs, two-thirds of which (66%) is paid for by private households, 15.4% by SHI, and the rest by government subsidies and disability insurance.

Out-of-pocket expenditure accounts for 30.5% of total health expenditure, 5.7% of which consisted of co-payments in 2009. Public spending accounted for 60% of all healthcare spending in 2009, which was 11.4% of GDP. Healthcare expenditure per capita in 2009 was £5,190 (CHF 7,833). This account is mainly based on Thomson *et al.* (2011).

[32] Sums up to £1000 are rounded to the nearest £1, over £1,000, rounded to the nearest £10. Throughout this appendix, all figures in £ sterling are based on the exchange rate at 18 September 2012.

Sweden

All residents are entitled to healthcare funded by the state. There are co-payments for most publicly-financed services. Patients pay £9.40 to £18.70 (SEK 100–200) per visit to a primary care doctor, and £18.70[33] to £28.10 (SEK 200–300) to access emergency care. There is a limit on the amount to be paid out of pocket for publicly-financed care in a 12-month period of £84.30 (SEK 900).

In January 2010, the population was given greater choice of GP; also, the privatisation of primary care providers was introduced (Anell 2011). Registration with a primary care provider is required in all local areas (county councils) except Stockholm, where it is optional. Payments to providers are based on risk-adjusted capitation which varies by council, but is usually not less than 80% of total payment. In addition, GPs receive fee-for-service, and pay-for-performance schemes, the latter accounting for 2-3% of total payment. The pay-for-performance schemes are mainly financial incentives for preventive care and to promote rational use of prescription drugs.

GPs generally work in groups of three to six doctors; there are hardly any single-handed GPs. They do not have a formal gatekeeping role. However, although patients can access hospital outpatient departments or specialists directly, they are encouraged to get a referral from their GP by having higher co-payments for visits to hospitals and specialists without such a referral. Primary care providers must provide out-of-hours care within the general payment framework. They collaborate on a voluntary basis to fulfil this responsibility.

In addition there are health centres, mostly owned and operated by county councils with GPs and other staff as salaried employees, although the number of private providers is increasing. Roughly one-third of all providers are private, and in some areas more than 50% are private. About half of private providers are self-employed and the rest are local, regional, or national chains.

Community health services

There are nurse-led clinics for chronic diseases e.g. diabetes, asthma, COPD organised within larger health centres and not as separate entities. The Government encourages a coordinated approach to care with multi-disciplinary teams comprising GPs, district and specialist nurses, physiotherapists, and psychologists, as well as coordination between primary care, hospital care, and nursing home care.

Total household out-of-pocket payments accounted for 16.7% of total health expenditure in 2009, most of which was private household out-of-pocket expenditure for pharmaceuticals and dental services, although there were some user charges for other services. This account is mainly based on Thomson *et al.* (2011).

Norway

All residents are entitled to healthcare funded by the state. In 2011 there was a co-payment of £19.40 (NOK 180) per visit for GP consultations. There were also co-payments for physiotherapy visits (which vary), and radiology and laboratory tests – £23.50 (NOK 218) and £5.10 (NOK 47) respectively. There is a maximum limit on total co-payments per year which was £202 (1,880 NOK) in 2010. However, this limit does not include payments for long-term care.

Some groups are exempt from co-payments: children < 16 years receive free treatment, children < 18 years receive free psychological care and dental care, pregnant woman receive free medical examinations during and after pregnancy, and residents eligible for minimum retirement pension or disability pensions receive free essential drugs and nursing care.

[33] These are rounded to the nearest £0.10.

Almost all residents are registered with a GP; those not registered pay higher co-payments – an additional £11.80 (110 NOK) for GP consultations.

Local areas (municipalities) contract with private GPs, who receive a combination of capitation, fee-for-service, and out-of-pocket payments from patients. Most GPs are self-employed although there are some salaried employees. GP practices are typically comprised of two to six doctors, nurses, laboratory technicians and secretaries, depending on the size and interest of the practice.

Long-term care

There are co-payments for home-based and long-term institutional care for older or disabled people with levels of payment income-tested. The municipalities are responsible for providing long-term care in nursing homes, long-term psychiatric homes, and homes for severely disabled children and youth. Home nursing is also provided. A few of the nursing homes are privately run, but services are provided mainly through contracts with the municipalities. Very few patients pay individually for full-time nursing home care. Out-of-pocket payment for institutionalised care can be up to 85% of the patient's income.

In 2009, out-of-pocket payments were 15% of total healthcare expenditure. However, for GP services, patient co-payments accounted for 37% of total costs. This account is mainly based on Thomson *et al.* (2011).

Finland

All residents are entitled to healthcare funded by the state. Local areas (municipalities) must provide primary care and public health services to their residents in provider organisations known as 'health centres'. In Finland this is not necessarily a single building or location; it can be several locations. Health centres are not-for-profit, and are publicly owned and run. They can offer a wide range of services including outpatient and inpatient care, and employ a range of health professionals: GPs, nurses, public health nurses, midwives, social workers, dentists, physiotherapists, psychologists and administrative personnel.

Some services are free of charge eg attendance at a maternity or child health clinic, appointments with a public nurse, and laboratory and radiological examinations at a health centre. A health centre may charge a single or annual payment to see a doctor. Thus, there is a co-payment of £8.80 (€11) per GP consultation. There is a maximum limit on total co-payments per year of £26.50 (€33). Alternatively a patient can choose to pay an annual fee of £17.70 (€22). The fee for a visit to the health centre emergency clinic (out-of-hours care) is £12.10 (€15). Individuals aged ≥ 15 years may have to pay a penalty charge of £21.70 (€27) for unattended appointments. A maximum of £8.80 (€11) per home visit is charged for occasional treatment by a doctor; £5.60 (€7) is charged for a visit by other types of healthcare professional. There is a monthly fee for continual treatment which depends on the quality and extent of the service.

The GP payment system varies between municipalities. The traditional payment method, which applies to 45% to 50% of health centre doctors, is a monthly salary with some extra fee-for-service payments. In health centres where the 'personal doctor system' has been introduced, doctors are paid a combination of a basic salary, capitation payment and fee-for-service payment for visits. Around half of doctors work in health centres that are in a 'personal doctor system'. In this system, a person is assigned to a specific health centre doctor usually based on place of residence. Doctors organise their practice so that patients on their list are able to see them within three days. They determine their own working hours, but not that of other personnel, and they are public employees. In some areas the size of the population covered is so small that the principle of a personal doctor system already exists without a specific system.

There are also firms, mainly owned by doctors, that provide doctors to public-sector primary care. Doctors are employees of the firm with salary negotiated with the firm. Municipalities use these services mainly when it is difficult to recruit doctors, especially for out-of-hour duties, although also for in-hour care. These firms often offer better salaries and more flexible working conditions than municipalities. In 2004 about 5% of Finnish doctors worked in such firms.

Physiotherapy and rehabilitation services are also available in health centres. Physiotherapists mainly see patients who are referred by a health centre doctor. Health centres also often employ social workers to deal with various problems related to illness, such as helping patients to apply for benefits or arranging home help and other services needed by patients discharged from inpatient care.

Health centres were intended to cover a population of at least 20,000 people. A health centre doctor is responsible for 1,500 to 2,000 people. In 2005 there were 1.7 patient contacts to health centre doctors and 3.0 contacts to other health centre personnel per person. Home visits by GPs are not very common; more often nurses visit people in their homes. Nurses, in addition to assisting GPs, have their own consulting hours for giving injections, removing sutures and measuring blood pressure. The role of nurses is currently also expanding in acute care and in assessing new patients. Nurses do not act as formal gatekeepers to the doctors, but in practice, seeing the nurse first has become a common route to a doctor appointment.

Long-term care

A maximum of 80% of a patient's monthly income can be charged for long-term hospital or institutional care. Fees for care provided at home depend on whether the care is occasional or continual.

Out-of-pocket payments were 18% of total expenditure on healthcare in 2005. This account is based on Vuorenkoski (2008).

Denmark

All residents are entitled to healthcare funded by the state and mainly free at the point of use. There is almost no cost-sharing for hospital and primary care services.

GPs are self-employed and are paid through a combination of capitation (30%) and fee-for-service. They act as gatekeepers to secondary care. The structure is gradually shifting from single-handed to group practices. The number of practices with specialised nurses performing for example diagnostic tests is increasing. Everyone who chooses the Group 1 public service option (98% of the total population) is required to register with a GP primary care doctor. The alternative is Group 2 coverage, which provides direct access to practising specialists and free choice of GP but requires a co-payment (this is the only element of co-payment and in a sense it is by choice).

Out-of-hours care is organised by larger local areas (regions) and is mainly provided by GPs at clinics co-located with hospital emergency departments. GPs are paid higher fees for out-of-hours and their participation is voluntary. GPs are supposed to act as coordinators of care, and to develop a comprehensive view of individual patient needs, in terms of both prevention and care.

Long-term care

Long-term care is organised and funded by smaller local areas (municipalities). There are no co-payments. There is a market for home care services that includes private and public providers but around 90% of care homes are in the public sector.

The proportion of total expenditure on healthcare that was private was 14.9% in 2008, and most of this was out-of-pocket payments. This account is based on Thomson *et al.* (2011).

United Kingdom

All residents of the United Kingdom are entitled to healthcare free at the point of use. There is no cost-sharing for primary care services. Primary care is delivered by GPs, who have lists of registered patients, and are normally the first point of contact for patients. Walk-in centres also offer primary care services; no registration is required. Most GPs are private contractors, operating under a national contract and paid through a combination of capitation, and fee-for-service. There are also financial incentives for achievement of clinical and other performance targets.

GPs increasingly work in multi-partner practices employing nurses and other clinical staff with consulting rooms for visiting specialists. Around 20% of GPs are employed in practices as locums or on a salaried basis. Some private providers of GP services set their own fee-for-service rates. Out-of-hours care is the responsibility of the local NHS which commissions a range of providers, including GP cooperatives and private companies, to provide urgent primary care outside office hours.

Long-term care

There are co-payments for home-based and long-term institutional care for older or disabled people with levels of payment means-tested based on assets and income. A distinction is made between nursing care needs and social care needs with nursing care being paid for by the NHS. Local areas (councils) are responsible for ensuring the provision of long-term care in nursing and residential homes, although most of this is provided in private-sector homes. In addition individuals can organise their own institutional care.

England spends about 10% of GDP on healthcare of which about 84% is public expenditure. Private expenditure, mainly on over-the-counter drugs, dentistry, and hospital care, accounts for the remainder. Out-of-pocket spending amounted to 10% of total health expenditure in 2009. This account is mainly based on Boyle (2011).

New Zealand

All residents are entitled to publicly-financed healthcare. There are co-payments for GP and general practice nurse primary healthcare services, prescription drugs, private hospital or specialist care, and adult dental care. Subsidies are available for people (96% of the population) who belong to Primary Health Organisations (PHOs). Thus, with these subsidies, co-payments for GP and nurse primary care services vary between £5.10 and £30.60 (NZ$8 and NZ$60) depending on the income and health needs of individuals.

GPs are usually self-employed providers who manage their own practice, and are paid through a mixture of fee-for-service, co-payments and PHO capitation payments. They receive additional payments from PHOs for health promotion, care coordination, and chronic disease management. GPs act as gatekeepers. Patients are not required to register with a GP but there is a financial incentive through subsidies for co-payments.

In cities GPs provide out-of-hours care often in purpose-built, privately owned clinics that they partly own. PHO subsidies are provided for out-of-hours care but patient charges are high and well above the government subsidy. In rural areas and small towns, GPs work on call.

Long-term care

Subsidies for long-term care for older people are means-tested based on income and assets. Most care homes are in the private sector.

Out-of-pocket payments, including co-payments and private expenditure on healthcare, accounted for 14% of total national healthcare expenditure in 2007. Private health insurance accounted for

around 5% of total expenditure on healthcare. This account is mainly based on Thomson *et al.* (2011).

France

All residents are entitled to publicly-financed healthcare through a system of statutory health insurance (SHI). Different forms of cost-sharing operate in the French healthcare system: co-insurance, co-payments, and extra billing.

Co-insurance payments can be reimbursed by voluntary health insurance (VHI) schemes. A co-insurance rate of 30% is applied for GP consultations if the patient is part of a voluntary gatekeeping system (médecin traitant), and attends the gatekeeping GP. But visits to other GPs are subject to a co-insurance rate of up to 50%, and the difference between the two rates cannot be reimbursed by VHI. Registration with a GP is not a legal requirement but this voluntary gatekeeping system for people aged ≥16 years (*médecin traitant*) provides financial incentives encouraging patients to have coordinated care. There are higher co-payments for visits and prescriptions without a referral from the gatekeeper. More than 85% of the population is registered in this way with a GP.

In addition to cost-sharing through co-insurance, which can be fully reimbursed by VHI, a non-reimbursable co-payment of £0.80 (€1) per doctor visit is applied. There is a maximum limit per year of £40.20 (€50) that covers all forms of co-payment.

Some people are exempt from co-insurance: individuals with any of 32 chronic illnesses (8.6 million people); individuals who benefit from either universal medical coverage (CMU, 2 million people) or means-tested vouchers for VHI (CMU-C, 4 million people); and individuals receiving invalidity and work-injury benefits. Also children and people with low incomes are exempt from paying co-payments. VHI covers statutory cost-sharing (the share of healthcare costs not reimbursed by SHI), and applies only to health services and prescription drugs listed in the publicly financed benefit package. Most people obtain VHI through their employer. People with low incomes are entitled to free or subsidised VHI (CMU-C) and free eye and dental care, and cannot be billed extra by doctors.

GPs tend to be self-employed and paid on a fee-for-service basis. In 2011, the payment to the doctor per visit of £18.50 (€23) was the same for specialists and GPs, based on negotiation between the government, the public insurance scheme, and the medical unions. Doctors can charge above this level depending on the duration of their medical training. There is no limit to what may be charged but medical associations recommend restrained fee levels. In addition to fees, doctors are paid for providing coordination of care for chronic patients (£32.10 (€40) per patient) and, as of 2009, may opt for additional payment through a pay-for-performance system. Doctors are office-based or based in private, for-profit clinics (or both). Office-based doctors are self-employed. Around 68% of GPs are self-employed. The majority of GPs are single-handed. Single-handed GPs do not employ nurses.

GPs in group practices usually do not share a common patient list but aim to ensure continuity of care. About 40% of self-employed doctors are involved in such practices. Self-employed nurses provide care to patients at home. As a rule, nurses do not work in doctors' practices but are self-employed and paid by fee for service.

Long-term care

In 2004, a pool of funding of over £12 billion (€15 billion) per year was created to provide services for older people, both community care at home and care in nursing homes. In addition local government provides over £1.6 billion (€2 billion) per year for home-based support for older people. Nevertheless out-of-pocket payments for care in nursing homes are around £14,500 (€18,000) per person per year.

In 2009, out-of-pocket spending was 7% of total health expenditure. This account is mainly based on Thomson *et al.* (2011).

Germany

Each individual must have health insurance, either in a statutory health insurance (SHI) scheme or in a private health insurance scheme. All employed citizens earning less than £39,750 (€49,500) per year (in 2011) must be part of the SHI scheme, and their dependents (non-earning spouses and children) are covered free of charge. If an individual earns more than this, there is a choice between the publicly financed scheme (SHI) on a voluntary basis (75% of people do this) or private health insurance.

SHI covers a wide range of services including GP care, preventive services, and rehabilitation. There are co-payments for office visits for ambulatory care (GPs, specialists, and dentists) for adults aged ≥ 18 years of £8 (€10) for the first visit per quarter or subsequent visits without referral, and £8 per inpatient day for hospital and rehabilitation stays (up to 28 days per year). This amounted to 2.85% of total SHI revenue (£141 billion or €175.6 billion) in 2010, mostly for drugs (£1.4 billion or €1.7 billion) and ambulatory physician care (£1.2 billion or €1.5 billion). Individuals may also receive a proportion of their annual contribution payment back if they have not used services in that year. Co-payments are limited to 2% of household income; for chronically ill patients, the limit is 1% of income.

Ambulatory general practice and specialist care is delivered by doctors who by law are members of regional associations which negotiate contracts with sickness funds: these funds are responsible for organising care and acting as financial intermediaries. GPs and specialists work in their own practices — around 60% single-handed and 25% with one other. Most doctors employ doctors' assistants. In addition other professionals such as physiotherapists have their own premises.

Registration with a GP is not required; individuals have free choice of GP. GPs have no formal gatekeeping role. However, sickness funds must offer their members the option to be part of a 'family physician care model' which often offers a bonus for complying with gatekeeping rules. In January 2007 about 4.6 million people subscribed to such schemes.

Doctors in ambulatory care, both GPs and medical specialists, are usually reimbursed on a fee-for-service basis with the fee schedule negotiated between sickness funds and doctors. However, payments are limited to pre-defined maximum numbers of patients per practice and reimbursement points per patient. Sickness funds annually negotiate aggregate payments with the regional associations of physicians.

Out-of-hours care is organised by the regional associations. GPs must provide out-of-hours care although regulations vary across local areas. In a few places eg Berlin, out-of-hours care is provided by hospitals.

Long-term care

Long-term care is covered by a separate insurance scheme that is mandatory for the whole population. But benefits are limited to a maximum amount depending on the level of care, and are not usually sufficient to cover institutional care completely; hence individuals often buy supplementary private long-term care insurance. The contribution rate for the mandatory scheme is 1.95% of gross salary shared between employers and employees. People without children pay an additional 0.25%. Everybody with a physical or mental illness or disability who needs help (and who has contributed for at least two years) can apply for benefits. Home care and institutional care are provided almost exclusively by private providers.

In 2009, SHI accounted for 57.8% of total health expenditure. All public funds combined (including the long-term care scheme and taxes) accounted for 77% in 2009. In 2009, private health insurance accounted for 9.3% of total health expenditure, and out-of-pocket expenditure was 13.5% of the total amounting to £30.1 billion (€37.5 billion) or around £370 (€460) per capita. Major items of out-of-pocket spending are pharmaceuticals (around £5.2 billion or €6.5 billion), nursing homes (around £4.8 billion or €6 billion), and medical aids (around £4.6 billion or €5.7 billion), while expenditure in doctors' offices was only around £2.8 billion (€3.5 billion). This account is mainly based on Thomson *et al.* (2011).

Ireland

There are two levels of entitlement to healthcare, depending on income and other eligibility criteria. People in Category I qualify for the 'Primary Care Reimbursement Scheme' and receive 'Medical Cards', which means that all services other than long-term care ie GP care, dental and ophthalmic services, pharmaceuticals, and hospital care are free at the point of use. The rest of the population is in Category II: these people have free access to publicly-funded secondary care services subject to some charges, but they pay the full cost of GP consultations out of pocket and there are also contributions to the cost of most other primary and community-based services. Dependants are usually assigned the same category status as their guardians; hence only those children whose parents qualify for Medical Cards also have access to care that is free at the point of use. In December 2007, just over 30% of the population were Medical Card holders ie had Category I coverage. In addition, there are people who qualify for a 'GP Visit Card' allowing free GP visits but the income guidelines to qualify for this are 50% higher than those for Medical Cards.

All Medical Card patients can choose a private GP so long as that GP has entered into a Primary Care Reimbursement Scheme contract with the central government body known as the Health Services Executive (HSE). Most of the rest of the population (Category II) have to pay out of pocket for GP and other primary care services (unless they qualify for the GP Visit Card, in which case GP consultations are paid for by the HSE). Expectant mothers are entitled to a number of free GP examinations during pregnancy, and after birth. Mothers are also entitled to free inpatient and outpatient care in respect of the pregnancy and birth. Around 50% of the population also subscribe to VHI schemes; these are mainly supplemental schemes providing more rapid access to services or a greater degree of privacy for patients seen within public and voluntary hospitals.

GPs are self-employed, working in single practice or joint practice. In 2001 approximately 51% of GPs were single-handed, 26% in partnerships with one other, and 23% in partnerships with three or more partners. Most GPs treat both private patients and public-sector patients. Medical Card and GP Visit Card holders must register with a specific GP; most of the remaining population do not need to register and can use any GP subject to payment of a fee. The majority of GP practices have at least one practice nurse.

GPs that provide public-sector services contract with the HSE; fees are based primarily on weighted capitation plus additional fees for services such as out-of-hours care and home visits. In 2006, capitation fees ranged from £39.50 (€49.13) for a male between the ages of 5 and 15 years living within three miles of the practice to £192.60 (€239.84) for a woman aged 70 years living over 10 miles from the practice. GPs are paid on a fee-for-service basis for private patients. VHI provides only limited coverage for primary care services. There are no set charges for GP services and fees vary between £40.20 and £64.20 (€50 and €80) per visit. Private health insurance typically only offers a payment of between £16.10 and £24.10 (€20 and €30) for each GP visit (often up to an annual limit); the patient pays the difference out of pocket.

GPs are usually the first point of contact for healthcare. Informally they act as gatekeepers to hospital care. It is possible to access specialist care directly, but, for example, a standard fee – £48.20 (€60) – is charged for a non-emergency visit to an A&E department in acute public hospitals. Consultations are free if the individual has a letter of referral from their GP or is a Medical Card holder.

Long-term care

Social care is not automatically covered. There are charges for long-term care for older people. These charges depend on the level of nursing care. Where nursing care is provided on a 24-hour basis, the maximum weekly charge for care is £102.30 (€120), or the person's weekly income minus £29.80 (€35), whichever amount is lower. Where nursing care is not provided on a 24-hour basis, the maximum weekly charge is £76.70 (€90), or the person's weekly income minus £46.90 (€55), or 60% of the person's weekly income, whichever of the three calculations is the lowest.

There is only a limited supply of HSE-owned long-term care facilities which means that many people use long-term care provided by the private sector, with a small number of private care homes also being contracted by the public sector. The government contributes to the cost of care in private nursing homes – the maximum weekly contribution is £256 (€300) – but this does not usually cover the full cost and it is subject to means-testing. Access to community care is also means-tested, and individuals may have to contribute towards the costs of services, such as home helps. The HSE provides community nursing services including home helps and healthcare assistants providing assistance and care for people within their own homes.

In 2006, 78.3% of total health expenditure (both public and private) was raised from taxation and pay-related social insurance. The remaining components of total expenditure on healthcare were private, in particular out-of-pocket household expenditure on GP visits, pharmaceuticals and hospital stays, as well as payments to VHI providers. Gross expenditure on healthcare in 2010 was around £11.7 billion (€14.6 billion). In 2007 just over 30% of the population held Medical Cards entitling them to most services free of charge. The rest of the population makes some out-of-pocket payments for both hospital and primary care services. Out-of-pocket spending was 15% in 2010. This account is mainly based on McDaid *et al.* (2009).

Luxembourg

Healthcare is provided through a statutory health insurance system that includes all residents. Primary healthcare is provided mainly by self-employed GPs who mostly work in single-handed practices. However, GPs have no gatekeeping role; they are in competition with specialists to whom patients can go directly even for primary care. Thus patients have free choice of all healthcare providers including primary care. Primary care providers charge the fees negotiated between their professional representatives and the Union of Sickness Funds. Patients pay GPs directly, on a fee-for-service basis, and are later reimbursed by their compulsory (or voluntary, where applicable) sickness fund. However, most medical consultations are subject to a non-reimbursable co-insurance payment by patients.

The patient is reimbursed 80% of the fee for a home visit by a GP ie there is a 20% co-insurance for the first visit in any 28-day period. This co-insurance decreases with subsequent visits which are reimbursed at 95%. Visits to the doctor's surgery by the patient, or to any specialist, are also reimbursed at a rate of 95%. Pre- and post-natal care is reimbursed at a rate of 100%. When doctors are called out by emergency services the cost is 100% reimbursed. There are limitations on the number of GP visits within certain time periods. In 1999, the fee for a GP consultation was £16 (805 LUF), and for a GP home visit was £27.60 (1,385 LUF).

In 1999, the fee for a nurse to take a blood sample was £1.40 (70 LUF), and for a nurse to install a drip £6.90 (349 LUF). Most treatments by nurses are reimbursed at 100% of the cost to the patient. The first eight physiotherapy sessions per year are reimbursed at 80%; sessions exceeding that number, and any session as part of inpatient hospital treatment, are reimbursed at 100%. Speech therapy is reimbursed at 100% as long as treatment is undertaken within the time limit specified; sessions exceeding eight per year require prior authorisation. The cost of laboratory analyses performed at Luxembourg's National Laboratory of Health, or in the laboratories attached to hospitals or in private laboratories, are 100% reimbursed by the sickness funds.

Primary care nursing is mostly provided by ‘medico-social centres’ on contract to national and local authorities. These centres are administered jointly by the Luxembourg Red Cross and the Luxembourg League for Prevention and Medico-Social Action. Centres are spread throughout Luxembourg and provide child health clinics, school health services, assessment of handicapped children and health education and antenatal advice. ’Social nurses’ from the centres combine the role of health visitors and social workers.

Out-of-pocket payments accounted for 11.4% of total healthcare expenditure in 2010 (World Bank 2012). This account is mainly based on Kerr (1999).

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