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Contents

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Informal payments in EU Accession Countries

Anant Murthy and Elias Mossialos

Since the announcement of those central and eastern European (CEE) countries about to join the European Union, much attention has been focused on the performance of these nations' health systems. One potential roadblock to successful implementation of reform is the prevalence of informal payments in the central and eastern European region. Informal payments take a number of forms and may exist for a number of reasons. They range from the *ex ante* cash payment to the *ex post* gift in-kind. At their worst they may be a form of corruption, undermine official payment systems, and reduce access to health services. Yet reducing the extent of informal charging is far from straightforward and represents an enormous task for policy-makers.

In the early 1990s, staff salaries in central and eastern European countries were very low and payments were often delayed. Money was instead sought directly from patients and provided to staff. While these informal payments allowed health care staff to remain in facilities and continue providing services during periods of economic difficulty, the demand for payments also resulted in the exclusion of those unable to pay, including the poorest and chronically ill.

Yet to what extent do informal payments exist? Their clandestine nature makes accurate accounting exceptionally difficult, and medical professionals have little incentive to reveal informal charging. Some relatively new evidence has emerged however, and surveys or indirect measures of health service utilisation help to provide valuable insights.*

General Trends

In CEE, informal payments have come to represent a large proportion of total health expenditure as other sources of revenue have collapsed.[1] Payments exist for several reasons, including a general scarcity of financial resources in the public system. A lack of private services may also drive informal payments, as wealthier patients have fewer options outside of the public system. Payments may also reflect a desire on the part of patients to exercise leverage over providers, and cultural traditions may perpetuate informal payments despite attempts to reduce them. Of course, an overall lack of transparency helps facilitate informal charging.

A 1999 World Bank/USAID survey observed that 71% of GP visits in Slovakia involved payments while 59% of specialist visits involved payments. The average payment to specialists in Slovakia was more than 3.5 times the average payment to GPs. The percentage of patients reporting that they had been required to make some payment for a service was 60%, and it is estimated that almost three in ten hospital patients made some kind of informal payments to providers. Between 1993 and 1998, the number of patients who paid for hospital admissions grew by approximately 10%.[2]

According to 1999 data the size of all informal payments in Hungary is roughly 4.6% of total health expenditure.* Informal payments are more widespread in

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gynaecological and surgical hospital services compared to internal medicine and mental health services. GP home visits may get €3–3.5, while a gynaecological service after delivery may receive €40–78 and a cardiac surgeon after operating may receive €117–197. When asked if some informal payment should be made for customary medical interventions, 31% of a sample of 1400 Hungarians answered in the affirmative for a routine injection, 48% for a routine gynaecological examination, and 86% for a house call made at night. Notably, estimates on the overall extent of informal payments made by doctors are lower than those made by the public.[3]

In Latvia, approximately 25% of patients make informal payments sometimes, while 5.7% made payments on almost every visit. A regional breakdown reveals that Riga has the highest proportion of under-the-table payments, with 46.1% of Riga respondents making such payments. In Romania, a recent survey of public perceptions revealed that 39% of people with high incomes paid unofficial fees or gifts for medical services in 2001 while 33% of people with below average income paid unofficial fees or gifts.*

The role of physicians

In many countries, a desire on the part of patients to maintain some control over physicians may drive informal charging. Alternatively, physicians themselves may demand payments to supplement salaries or office budgets. More generally, the status of the profession can shape physicians' attitudes toward accepting payments directly from patients. Evidence on private expenditures in Poland reveals that informal payments nearly double physicians' formal salaries, suggesting overall that managing existing resources poses a more difficult challenge than finding new resources.[4] Indeed, informal payments are not high in the Czech Republic where doctors' salaries have risen above the rate of inflation of average wages. A 2000 survey of health care staff and public officials revealed that only 5% of Czech doctors confessed to accepting "something more" than a small gift.[5]

In Hungary, research in 2000 has provided numerical guides of informal payments. An attempt to calculate the portion of Hungarian doctors' salary comprised of unofficial payments estimated that only 38% is made of official income with the remaining 62% stemming from informal payments.[3] The number of physicians in Hungary may have exacerbated the problem. Despite considerable health care sector downsizing, the number of first-year medical students has increased by 40% since 1990 whilst older doctors have incentives to work after retirement because of low pension income. Salaries in the last decade remained low and were falling in real terms. Also, many doctors come from the working classes, and the emergence of informal payments was strongly related to the low level of respect granted to members of the medical profession. However, in October 2002, the government took steps to raise physicians' salaries.

Yet, poor pay alone may not completely explain the willingness of physicians to accept informal payments. Doctors in Bulgaria, Slovakia and the Czech Republic were more likely than the average government official to have reported a second income, and were also well above average in their reporting of having a "family income" that was enough for a "fair" or "good" standard of living. More significantly, while poor pay increased the willingness to accept gifts, it was those with the highest salaries and the best family incomes who more frequently received such payments, a likely result of the positions of power held by these individuals.[5]

The market share held by private physicians may also impact the pervasiveness of unofficial payments. Private health care organisations have developed significantly in Lithuania, for example, and the number of physicians working in the private sector has increased in recent years. Surveys in that country reveal a decline in informal payments corresponding with the growth of private providers.* This trend seems to follow the Czech experience regarding the role and compensation of providers.

Health system reform

The shift toward market mechanisms in CEE has occurred at a rapid pace, although the impact of informal payments is far from clear. Efforts to reform provider payment mechanisms or improve the efficiency of care, for example, may be mitigated by the perverse incentives caused by informal charging. Equity considerations are equally salient. While there is little evidence from CEE on how informal payments affect utilisation, patients who cannot afford the payments either cannot obtain treatment, cannot access the same level of services or have to wait longer for care. In addition to the financial barriers imposed by fees, patients in some countries are further deterred by the uncertainty about prices caused by informal payments.[6] Nonetheless, there is no evidence as to whether official fees affect equity more strongly than informal payments.

In addition, decentralisation and the shift toward social health insurance may not necessarily reduce the extent of informal payments. While surveys conducted before and after the implementation of a national insurance scheme in Lithuania reveal a decline in the extent of informal payments, no decrease was observed after the implementation of a national health insurance system in Romania, despite the fact that monthly contributions there are compulsory regardless of whether any services are actually received.*

Moreover, informal payments may restrict the growth of private insurance. Patients may be more comfortable paying physicians and other providers directly, while paying third-party entities may be viewed as needlessly meddling with the doctor-patient relationship and reducing assurances of quality care. In Slovakia, for example, informal payments are significant and the market for private medical insurance is not substantial. A 2001 survey observed more than one-third of respondents as being distrusting of the General Health Insurance Company while almost two-thirds did not trust the Ministry of Health.*

The way forward

For CEE countries, a lack of transparency means that tapping informal payments for revenue is difficult in publicly funded systems. Converting informal payments into formalised cost-sharing arrangements requires compliance from providers, many of whom may lose substantial income. Experience from other non-European low-income countries suggests that a successful conversion to formal cost-sharing depends on the ability of government to regulate providers and set priorities or limit the services on offer. Of course, informal payments can abate government efforts to improve accountability and management more generally.[6]

The ability to improve efficiency and quality without jeopardising equity critically depends on a number of policy measures, including the skills and capacity of staff, the development of appropriate incentives and exemption systems, and the existence of suitable information systems to support the accounting and auditing of payments. Governments may also wish to allow some private options for those who wish to pursue them. Health reforms should also target excess capacity, as incentives created by informal payments can lead to inappropriate utilisation. Reducing capacity, especially among physicians, can also help increase wages and the professional status of medical staff, although higher wages alone are unlikely to have long-term effects. In CEE payments can also mitigate the effects of reimbursement reform on hospital efficiency and quality. When such payments exist, managers and physicians will respond less to the financial incentives driven by performance-based payment methods.

Nevertheless, informal payments do represent an important source of revenue for countries in which prepayment systems have collapsed, and phasing them out without developing suitable alternatives may be damaging. The challenges facing CEE countries are great, yet acknowledging the full impact of informal payments would be a significant step forward.

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Hungary: a 'cautious reformer'

Annette Riesberg, Péter Gaál and Reinhard Busse

Since 1999 the Hungarian health care system has experienced resolute cost-containment measures and various initiatives for organisational reform.[1] The country implemented one of the earliest decentralisation reforms in the region by establishing a universal mandatory social health insurance system and a predominantly local government-owned delivery system which began in 1990. However, towards the end of the 1990s, Hungary became perceived as a rather 'cautious reformer', mainly due to its reluctance to further decentralise service provision and financing.[2]

Currently, the single national health insurance fund (HIF) provides comprehensive health care coverage to Hungary's 10 million residents and constitutes the main source of finance (63% of total health expenditure in 2000). The HIF's administration (NHIFA) contracts with all providers accredited by municipal and county (local) governments. Except for most pharmacists and family practitioners, almost all health care workers are public salaried employees – and they are among the lowest paid employees in the Hungarian economy. Family physicians (c. 20% of the physician workforce) are usually paid by weighted capitation and function as gatekeepers. Local government-owned provider institutions of outpatient specialist services receive fee-for-service points, acute hospitals are paid by uniform national DRG base fees and hospitals for the chronically ill receive per-diem charges. Reimbursement does not include depreciation of investments since the NHIFA only finances recurrent expenditures. The financing of investments and the planning of capacities is mainly left to local and national government, both in ambulatory as well as inpatient care.

In 1998, the Orbán government (1998–2002) removed the HIF's autonomy and put its administration under the direct control of the Prime Minister's

Office. Supervision was later transferred to the Ministry of Finance (1999) and then to the Ministry of Health in 2001. This recentralisation measure put the government in a favourable position to assert its financial policies:[1] to reduce total social insurance contributions (49% of gross salaries in 1998) by one quarter, to mitigate the widespread evasion of contribution payment and to contain public health care expenditure.

Revenue and expenditure

On the revenue side, in 1999 the health insurance contribution was decreased from 18% of total gross wage to 14% by reducing the employer's part from 15% to 11%. The employee´s contribution remained stable at 3% of total gross wage. The loss of revenues has been partly compensated by doubling the employers' lump sum hypothecated health care tax to €18 per month. In addition, the HIF's income base was widened further through an 11% proportional tax on the parts of personal income that were previously exempt from health insurance contributions, and by abolishing the ceiling on employees' wage-based contributions in 2000. Finally, in 1999 the National Tax Office took over responsibility for collecting health insurance contributions. As a result, HIF revenues were still reduced, from 7.8% of GDP in 1993 to 5.6% in 2000, despite the fact that the domestic economy and labour market had continued to grow since the severe post-communist economic depression in 1993.

For expenditure control purposes, the Orbán government continued the policy of capping most, but not all, of the 23 sub-budgets of the HIF at national level. The minister of health was given clear responsibility for any overspending of the uncapped pharmaceutical sub-budget, by providing bridging funds from the Ministry's own budget or by cross subsidising from other fixed HIF sub-budgets. Other cost-containment reforms targeted pharmaceutical prices, e.g. long-term price agreements with manufacturers, a decrease in the wholesale and retail price margins of expensive medicines for pharmacists, and an increase in the number of pharmaceuticals subsidised at an absolute rather than relative price limit in order to encourage price-conscious purchasing.

Consequently, the share of public and total expenditure on health declined further. Total expenditure decreased from 8.3% of GDP in 1993 to 6.8% in 2001, thus ranking below countries like Slovenia and the Czech Republic. In fact, Hungary was one of only three OECD countries where the average real annual growth of total health expenditure (2%) developed below real annual growth of GDP (2.7%) between 1991 and 2000.[3] Throughout this period, the role of private sources in funding health care increased from 11 % of total expenditure to 24%, mainly consisting of out-of-pocket payments (especially drug co-payments). According to the recently published National Health Account, other private sources are limited since, for example, private insurance is restricted to supplementary health insurance in the comprehensive social health insurance system.

Efficiency

The current incentives and structures probably encourage technical efficiency (by minimising e.g. expenditure per case and average length of stay in acute hospital care) and productivity (as measured by contact rates) within levels of care, but seem not to be able to ensure efficiency across levels of care. Since the countrywide introduction of DRGs in acute hospital care ten years ago, expenditure per acute hospital case and average length of stay decreased, while admissions increased by 20%. Yet at the same time, contacts with outpatient specialists increased as well: from 10 visits per capita a year to 16 contacts between 1995 and 2001. Family physician contacts remained rather stable at 6 visits annually. In fact, Hungary had not only the highest annual total outpatient contact rate (22 per capita in 2001) among countries in the WHO European region in 2001, but also the highest acute hospital admission rate (24 per 100 inhabitants; the CEE average is18).

The relatively bad, but slowly improving health status of the Hungarian population is unlikely to be the main reason for these trends. In fact, the incentives to provide definitive care at the lowest possible level of care are weak although formally, family physicians have gate-keeper functions (except for direct access to 7 medical specialities) and bypassing involves co-payments. The interaction between capitation payments for family physicians, and the various performance-based payments in secondary and tertiary care do not prevent unnecessary referrals but rather encourage high contacts rates (of short duration) in specialist care, particularly when taking into account the (only partly pre-determined) floating point values under sectoral spending caps. Furthermore, alternative forms of care like home care and longterm care, which may be better and more efficient in meeting the needs of the ageing population, are still underdeveloped.

Recent reforms and challenges

The Orbán government considered three main options for organisational reform: introducing multiple competing health insurance funds, enhancing the NHIFA´s purchasing and control function and decentralising at provider level. After a long political debate, the government dropped the initial plan for insurance competition and opted instead for the other more cautious options. It launched (yet another) regional pilot managed-care project and again decentralised planning of capacities. In 2001, the National Assembly also passed a law which created health care-specific rules for the corporatisation of health care providers but excluded e.g. for-profit investors. However, most of these restrictive clauses were suspended when the Medgyessy government came into power in April 2002.

Amongst its first measures, the Medgyessy government increased the influx of financial resources to the health care system. It introduced a long awaited pay rise for public sector employees, including all publicly financed health workers, even those family physicians working in 'functional privatised'

(ie. partly privatised) practice. Monthly salaries were increased by an average of 50% from autumn 2002. In addition, nurses who had worked for more than four years were granted a loyalty bonus worth an annual salary. The government also recently introduced a bill to the National Assembly which would allow for privatisation of health care institutions, including ownership by for-profit investors, as well as pharmaceutical companies. The much debated bill also plans to guarantee a 'fair' return on capital and depreciation for private investors through the NHIFA. In addition, the government has decided to extend the existing regional managed care pilot project, but has not yet ruled out the introduction of competition among multiple insurance funds.

The tasks facing policy-makers and stakeholders in Hungary are complex. They will have to transform the health care system towards adequately responding to the health needs of an ageing population with one of the worst health status records in Europe, while still struggling with the legacies of the past, and attempting to minimise the adverse effects of recent reforms. Furthermore, this delicate balancing act has to be seen in light of the challenges of the European internal market. In terms of reforming the delivery system, it seems that instead of taking it one step at a time, the government has decided to jump in headlong. As an old Hungarian saying goes, 'let's hope there is water down there'.

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Recent developments in France

Valérie Paris, Dominique Polton and Simone Sandier

According to the WHO World Health Report in 2000, the French health care system has been characterised as the 'best in the world'. Yet, consecutive governments have attempted to reform it to improve its performance. Since the early 1990s, public policies have been pursuing several (sometimes conflicting) objectives, including reducing geographical and social inequalities in access to care, improving the quality of health care and containing health expenditure. We will focus on two major changes that have occurred in the last few years: the extension of statutory health insurance coverage and the attempt to contain health expenditure growth through the setting of national expenditure targets.

Universal health insurance

Since 1946, the French health care ystem has been built up as an employment-based statutory health insurance system. Initially developed for salaried workers, it has been progressively extended. However, up to 1999 a very small part of the population (0.5%) remained without statutory health insurance, and was covered only through social assistance provided by local communities (*départements*) or by the state. This segment of the population represents the poorest in France and previously, the extent of coverage and the income thresholds for entitlement varied across the country.

Taking effect from 1st January 2000, the Universal Healthcare Coverage Act (*Couverture Maladie Universelle*, CMU), introduced a right to statutory health insurance coverage on the basis of residency in France. In addition to this basic statutory coverage, the CMU Act also reformed complementary voluntary health insurance (VHI), which covers the cost of statutory co-payments (the *ticket modérateur*). All individuals whose income is below a certain threshold are entitled to free complementary VHI (about 10% of the population). CMU beneficiaries are thus exempt from all statutory co-payments. Additionally, the CMU Act precludes providers from charging beyond the official tariff when delivering medical goods or services to CMU beneficiaries, making access to care formally free of charge. Finally, CMU beneficiaries do not have to pay for services at the point of use and then request reimbursement from their statutory insurance fund, as is the case with those covered by statutory health insurance, because the statutory insurance fund pays the provider directly. In 2000, 86% of the population was covered by complementary VHI, which financed about 12% of current expenditure on health. In addition, as at 31 December 2002, complementary VHI applied to 4.1 million CMU beneficiaries, bringing the proportion of the population covered by complementary VHI to about 92%.

The CMU Act was passed in spite of its likely consequence of increasing demand for care, demonstrating that the objective of equity took precedence over that of controlling health spending. In addition to the universalisation of coverage, two other elements have been driving the French insurance system towards a national health service-like system:

– Statutory health insurance contributions by the insured, which were initially based on wages have been progressively replaced by an earmarked tax levied on all income, which now represents one quarter of the statutory insurance funds' sources of revenue. However, no change has occurred to employers' contributions which remain equal to 12.8% of payroll costs.

– Since 1997 the French Parliament has set an annual Social Security Financing law and thus plays a more active role in determining policy directions and expenditure targets for statutory health insurance.

Failure of expenditure targets

Cost-containment has been a policy goal since the mid-1970s. Health expenditure in France in recent years has risen faster than GDP, and the sustainability of statutory health insurance financing has often been questioned. Until the late 1980s, controls over prices and the level of supply (eg. number of health professionals and number of hospital beds) tended to be the main cost containment measures. However, new tools were progressively implemented, namely: (1) in 1983, the method used to pay public hospitals shifted from per diem payments to prospectively set global budgets; and (2) during the early 1990s national expenditure growth targets were negotiated with some independent health care professionals (eg. ambulatory nurses, physiotherapists). The principle of national expenditure growth targets (the ONDAM) was also extended to all areas of the health care system by State Ordinances in 1996 (under the *Réforme Juppé*).

Since 1997 a national target for the growth of statutory insurance funds' expenditure is set annually by Parliament. This national expenditure growth cap is then further broken down into four areas; for 2003 the overall growth rate target is 5.3%, broken down to: 5.6% for ambulatory care, 4.8% for public hospitals, 4.0% for private hospitals and 6.7% for social care. Within ambulatory care, a national expenditure growth target is also defined for pharmaceuticals (+4% for 2003).

In practice, the national expenditure growth targets have never been adhered to and they have always been exceeded by real expenditure growth.

Although the 2003 expenditure growth target is significantly higher than that of previous years, and was supposed to be more realistic, official forecasts in May 2003 estimate that statutory health insurance expenses will exceed the cap (growth estimated at 6.4%). The difference between the actual rate of growth and the 2003 target is mainly attributable to expenditure growth in ambulatory care and in pharmaceutical spending.

The medical profession has always been strongly opposed to the principle of putting a cap on expenditure. Moreover, the threat to impose overspending penalties has never been applied in practice, except in the pharmaceutical sector (the pharmaceutical industry is required to pay rebates to sickness funds if expenditure exceeds the annual target). Overall however, this limited implementation of expenditure caps has not been adequate in meeting the original objective of cost containment.

Future prospects

The current Government (in power since June 2002) has put less emphasis on macro-economic constraints, concentrating instead on avoiding unnecessary care and expenses. New agreements have been signed between statutory health insurance funds and health care professionals to increase the use of generic drugs and reduce unnecessary home visits. The benefits package covered by the statutory health insurance scheme is also under scrutiny. Recently, the reimbursement rate for pharmaceutical products classified as 'moderately useful' has been reduced, and in the near future it is expected that pharmaceuticals classified as 'insufficiently useful' will no longer be reimbursed (although this measure has been announced several times before without actually being implemented). Finally, a new classification of medical procedures is expected soon and will serve as a basis for determining the payment of health care professionals.

As far as financial targets are concerned, a commission was recently mandated to recommend a new approach to setting the ONDAM, turning this into a 'medical-oriented' target. The underlying idea is to define realistic targets consistent with both the needs of the population and the resources available within the statutory health insurance scheme. The Commission's report has just been issued and it recommends that growth targets should take into account factors driving health expenditures (such as ageing, epidemiology, economic growth, population demand and health technology) as well as any potential savings that will accrue from "corrective measures" adopted to increase productivity within the health care system. The report also recommends a more inclusive approach to setting growth targets, arguing in favour of involving all major stakeholders in order to make the growth target more widely acceptable. Finally, the Commission recommends that expenditure targets should be set over a period of 3–5 years instead of annually and that they be applied differentially across regions. Notwithstanding new target-setting methodology, it is still unclear what tools would be necessary to meet such targets once they have been defined. The government is expected to respond to the recommendations next autumn.

Despite persistent demand for health care services, it is highly unlikely that future policies will work towards increasing the resources available to the statutory health insurance scheme. However, since health expenditure appears to be difficult to constrain, the solution probably will be to modify the role of the statutory health insurance scheme by increasing the role of out-of-pocket payments through supplementary VHI, whatever the consequences for equity.

This article is based on the Health Care Systems in Transition profile on France (forthcoming), written by S Sandier, V Paris and D Polton, and edited by S Thomson and E Mossialos.

Pharmaceutical Study

A new study entitled *Regulating pharmaceuticals in Europe: Containing Costs while Improving Efficiency, Quality and Equity*, edited by the Elias Mossialos and Monique Mrazek (Observatory/ London School of Economics) and Tom Walley (University of Liverpool) is in it's final stages of completion. Part of the European Observatory series, published by Open University Press, the book examines how countries in Europe regulate their pharmaceutical markets in an attempt to contain drug expenditures while improving resource allocation. As part of the study process, a workshop was held in London on 14–15th February 2003, bringing together all the book's lead authors, representatives from many of our partner organisations, as well as key government decision-makers and other interested stakeholders from across Europe. The diverse mix of workshop participants provided a lively and rich forum that has enhanced the relevance and accuracy of the study. The book is due to be published in early 2004.

The future of long-term care expenditure in Europe

Adelina Comas-Herrera, Raphael Wittenberg, Linda Pickard and European long-term care finance study team*

As the numbers of older people rise throughout the world, long-term care has become an increasingly important issue. The expected increase in the numbers of care users has highlighted the issue of how best to provide and finance long-term care. Throughout Europe the debate has concentrated mainly on the extent to which long-term care is an individual, family or state responsibility with key questions focussing on how to finance long-term care, the balance between care provided by families and by service providers, whether to provide care in-kind or cash payments, and the boundaries between health and social care.

New Study

A recent comparative study of long-term care expenditure[1] has investigated the key factors that are likely to affect future expenditure on long-term care services in Germany, Spain, Italy and the United Kingdom. The approach involved investigating how sensitive long-term care projections are to assumptions made about future trends in different factors, using comparable projection models. The main factors investigated include demographic changes, trends in functional dependency, future availability of informal care, the structure of formal care services and patterns of provision, and the future unit costs of services.

The study's first challenge was how to produce comparable analyses for four countries with different patterns of long-term care and different funding arrangements. Germany has introduced a social insurance scheme for long-term care which provides specified benefits for people assessed as meeting national eligibility criteria. The UK funds long-term care from a combination of central and local taxation and user charges levied under a means test. Spain and Italy have decentralised arrangements for formal care and greater reliance on informal care.

A second challenge was how to produce comparable analyses for countries with different data and different existing projections models. To make the long-term care projection models available in each country as comparable as possible, the main adjustments were to their coverage, to ensure that the all the models covered the same population group and included both public and private long-term care services.

A further task addressed how to develop a common set of base case scenarios on trends in the key drivers of demand for long-term care. There are two main reasons for using a common core set of assumptions. The first is to provide a plausible central projection that can be used to compare the likely impact of demographic and other pressures between countries. The second is to have a set core of projections that can act as a reference case against which the effect of changes in the different assumptions can be investigated. The key base case assumptions are set out the Box.

CENTRAL BASE CASE ASSUMPTIONS AND VARIANTS

Numbers of older people and their characteristics

Older population by age and gender changes in line with Eurostat 1999-based central population projections. *Variants test Eurostat high and low projections.*

Prevalence rates of dependency by age and gender remain unchanged. *Variants test declining prevalence rates.*

Demand for services

The proportion of older people receiving informal care, formal community care services and residential and nursing home care remains constant for each sub-group by age, gender and dependency. *Variants test changes in the balance between formal and informal care and between community care and residential care.*

Supply of services

The supply of formal care will adjust to match demand, such that demand will be no more constrained by supply in the future than in the base year.

Costs and economic context

The real unit costs of care rise in line with the EU Economic Policy Committee[2] assumption for the growth in productivity in each country, while GDP also rises in line with EPC assumptions. *Variants test higher and low rises in unit costs.*

Results

The four models project that, under these base case assumptions, the proportion of Gross Domestic Product (GDP) spent on formal long-term care services for older people would more than double between 2000 and 2050. The Figure overleaf shows that the highest increase in expenditure as a proportion of GDP would be in Germany, followed by Spain, Italy and the UK. It should be stressed that these findings are projections on the set of assumptions described: they are not forecasts. They take no account of possible policy

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THE EUROPEAN OBSERVATORY ON HEALTH CARE SYSTEMS IS A UNIQUE PARTNERSHIP:

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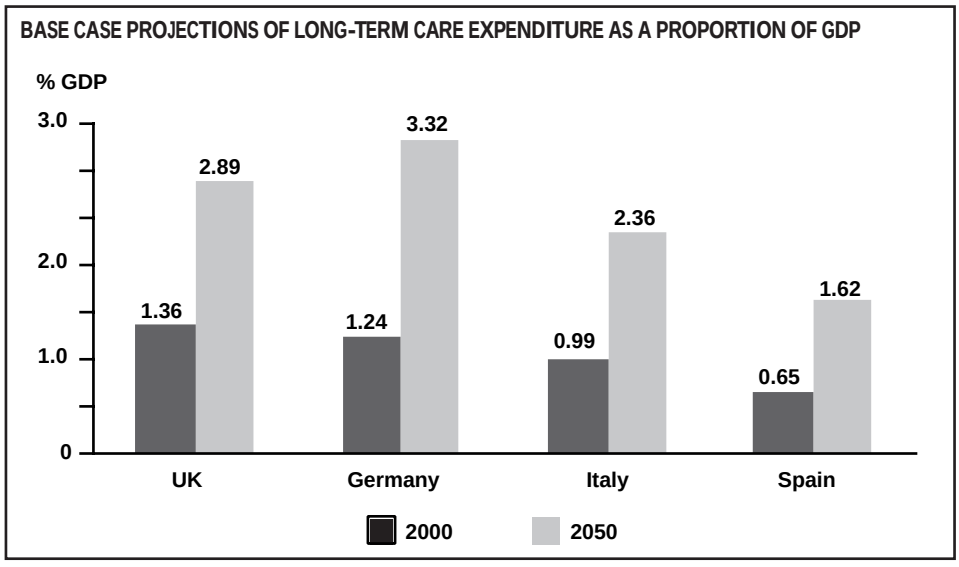

changes or of the potential impact of rising expectations. They are rooted in current patterns of care and current policies.

The key aim of this study was to investigate how these base case projections varied under alternative assumptions about the key drivers of demand. The sensitivity analysis shows that projections of long-term care expenditure are sensitive to assumptions about future mortality and dependency rates. If improved health care or other measures were to have the effect of reducing dependency rates, this could at least partially offset expected demographic pressures from rising numbers of older people.

The projections of long-term care expenditure are also highly sensitive to assumptions about future real rises in the unit costs of care (such as the cost of an hour's home care). They are sensitive to scenarios involving a relative decline in informal care where this results in greater use of residential care. They are somewhat less sensitive to assumptions about changes in the balance between residential care and home care.

A final challenge was to draw policy implications from these projections that would be relevant for European Union countries. One key implication is that there is a need to promote measures that are likely to reduce dependency in old age and to promote healthy ageing. There is also a need to increase support for family carers and to increase non-residential services, if a policy of promoting home-based care is to be successfully achieved.

The models project that the proportion of GDP required to fund long-term care services will rise significantly between 2000 and 2050. This is not to suggest that these rises are unaffordable or that there is a looming demographic 'time-bomb' or crisis of sustainability of long-term care expenditure. It does suggest, however, that the achievement of cost-effectiveness in long-term care will be important. Policy makers need to recognise that there is a wide degree of uncertainty about future demand for long-term care services for older people.

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