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Abstracts

Financing Long-Term Care

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J. Merrill, A test of our society: how and for whom we finance long term care. *Inquiry*, **29**, (1992), 176–87.

A major policy area to be faced by the incoming Clinton administration in the United States is the future funding and provision of health care across the country. Problems of rising health care expenditures, coupled with poor access to services by large sections of the population are seemingly endemic characteristics of the US system, even though different policy solutions have been widely debated and tried over the years. Within the health care debate the particular issues surrounding the funding and provision of long-term care need more careful exposition. Merrill's paper aims to do this. Even though there is widespread concern over the issues, no consensus has been reached on a workable approach to the financing of long-term care. He believes there are several reasons for this. First, there has been a failure to define long-term care. As a consequence attempts have been made to try to address solely through health care funding a problem that straddles the medical and social service systems. To acknowledge the realities of what a long-term care system should provide would, however, require a shift away from a system that appears to be more concerned with paying health care providers and towards one that cares for people.

The second reason for the lack of resolution of the funding issue has been the polarisation between those seeking a private sector answer and those who advocate a public sector response. The absence of successful models to show how the two sectors can form a successful partnership has led, he believes, to a lack of vision. Merrill argues that the present system is a reflection of the two sectors competing to avoid their responsibilities, rather than trying to find ways to complement each other. The last impediment to the financing problem is the lack of a coherent service infrastructure for it to support. Merrill questions whether there are adequate systems to manage care, assure quality, or whether there would be sufficient service capacity to maintain people in the community if the funding was available. Viewing an apparent lack of infrastructure in this manner, however, begs the question as to

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how a comprehensive and integrated service system could have developed and been maintained without an adequate funding base.

The current funding system for long-term care is briefly described. It has five components: *Medicaid*; private insurance; a variety of social and human service programmes, including income support and housing assistance; family and voluntary caregiving and personal expenditures. The contribution of each is described. In doing so Merrill emphasises the relative weaknesses of *Medicaid* and private insurance in ensuring access to care for all those in need and points to the problem of the impoverishment of the elderly as a consequence of high insurance premiums, the need to spend savings before being eligible for *Medicaid* and the high out-of-pocket expenditures needed to finance care. *Medicaid* has the added problem that before a person is eligible, he or she has already begun to be cared for in a nursing home setting and has exhausted their own asset base. This makes it unlikely that they would ever be able to return to a community setting for their care. The general point is also made that even with the growing acceptance of care management as a means of coordinating services across different agencies, this process is hampered by the different funding and eligibility criteria of different programmes.

Merrill sets out some basic principles for a reform of the funding of long-term care. Three of these would apply to any system of funding: being clear as to what is meant by long-term care; defining the roles of the different care agencies and the requirement that funding should not dictate demand but that the reverse applies. A British audience would substitute the concept of need for demand as the criterion for funding. Two principles shape Merrill's later proposals and set these in the context of United States health care. They are that there is a role for both the private and public sectors in the financing of long-term care, and that more prospective and comprehensive payment systems must be developed. The latter views the financing of long-term care as a disability benefit where funds are available to clients prospectively. Merrill argues that the current uncoordinated fee-for-service system is inefficient and confusing, produces gaps in service, and often leaves the responsibility for coordination with the individual receiving care.

A solely public sector financing approach is rejected for political reasons: Americans look to the private sector as the principal means of addressing a problem. Also the current federal budget crisis makes unlikely the creation of new federal programmes with substantial expenditure implications. Complete reliance on the private sector would also be unacceptable. Private long-term insurance has increased in popularity but still represents only a small proportion of the total

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market, with large sections of the population unable to afford coverage. More people are taking out coverage at earlier ages, but inflation protection makes such policies expensive. Lapse rates are very high: Merrill cites Firman and Polniaszek (1991) who estimate that the probability of a purchaser of insurance at 65 years still being covered at age 85 may be as low as 0.04. High lapse rates are partly due to the practices of some insurance firms which, through large premium increases, termination following failure to make a premium payment due to illness, restrictive payment policies, or misleading information, cause policies to be discontinued or to be terminated by the insurer.

Three options for funding long-term care are set out. These are: a private programme with public subsidies, 'front-end' public coverage, and 'back-end' public coverage. Each of these options would be designed to expand the pool of people with coverage and reduce the cost of private insurance. The first option would offer subsidies to the purchasing of private insurance. The second would pay for the care of an individual up to a set amount. When that point was reached they would then look to private insurance or *Medicaid* to offer further protection. Back-end public coverage would let individuals self-insure up to a specific dollar amount or level of care, at which point the public programme would assume financial responsibility. Each option would reduce the private cost of insurance. The options are briefly discussed, with reference to a five State demonstration project that uses *Medicaid* to provide back-end coverage to private insurance. Merrill concludes that whichever option is chosen, the current system should be changed as a large proportion of people at the age of retirement are faced with the spectre of impoverishment or premature institutionalisation.

COMMENT

Merrill offers a timely paper on a serious problem which needs to be faced by the United States executive and legislature. It usefully sets out the issues pertinent to long-term care, although some are common to other aspects of health care financing. The proposals he puts forward are sensible given the premise that private health insurance does have a role to play. The paper also raises other issues related to the provision and coordination of long-term care. The author admits that these are not solved by any of his proposals, but argues that by debating what is meant by long-term care and the need for such care as part of the debate on financing, these can also be addressed more sensibly.

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Conceptions of Intelligence

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Cynthia A. Berg and Robert J. Sternberg, Adults' conceptions of intelligence across the adult lifespan. *Psychology and Aging*, **7**, (1992), 221–31.

Robert Sternberg's earlier studies have shown that both expert psychometricians and lay people agree surprisingly well in their definitions of 'intelligence'. Very few follow recent suggestions by Eysenck (1986) and Jensen (1982, 1985) that it must be treated as an abstract global property of the human central nervous system (CNS) which determines the efficiency with which any cognitive task can be performed; that, consequently, the 'biological basis of intelligence' must be discussed in terms of factors that determine the maximum rate at which neural networks can transmit information, and that, if defined in this way, 'intelligence' must inevitably decline as the brain ages and becomes less efficient (Salthouse 1982, 1985, 1991). Most people and psychologists define 'intelligence' pragmatically as the ability to solve the problems encountered in everyday life. Zoologists tend towards similar definitions and have difficulty comparing the 'intelligence' of species of different animals with equally successful, albeit intensely specialised, adaptations to diverse ecological niches. In this conceptual framework, intelligence is 'what works best' for an animal or a person. The specialised survival adaptations of academics, aborigines and artists can be regarded as equally valid manifestations of 'intelligence', in the sense that they can all be successful ways of coping with different, complex life demands. In terms of this contextual model of intellectual development, intelligence is defined as 'the mental ability involved in successfully adapting to one's environment'. In the sense that as people age they must adapt to radically altered environments, problems and life-roles, it may be more appropriate to say that their intelligence must certainly qualitatively alter as they grow old but does not necessarily decline.

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