# LTC financing & provision in EU

Francesco Paolucci

# Agenda

LTC: definitions and trends in EU

LTC in the Netherlands and Germany

Potential lessons for other countries

# Definitions & Trends

# LTC: Definitions

- Services for people needing help with ***Activities of Daily Living*** (ADL) over an ***extended*** period of time;

- Medical versus non-medical LTC
  - ***Medical***
    - nursing homes
    - residential care homes (elderly homes)
    - home health care
    - care for mentally and physically handicapped
    - long-term psychiatric care
  - ***Non-medical***
    - home help (cleaning, meals)
    - social assistance

# LTC in the EU

- For many decades, EU welfare states did not address LTC as a specific (social) risk, but as **family responsibility**.

- LTC schemes are '**young**' to social protection/security (except for Nordic countries - 1940s - and the **Netherlands** & **Germany** – 1968 & 1994 - most OECD countries have implemented later or are currently considering more comprehensive LTC programmes (mostly NHS-countries in the EU, Australia, U.S.)).

- EC Regulation 1408/71 on the coordination of social security in the European Union, had **no section on long-term care**. Only in the new coordination regulation 883/2004, not yet applicable, long-term care is explicitly mentioned.

- Arguably the social policy area where EU Member Countries differ the most.

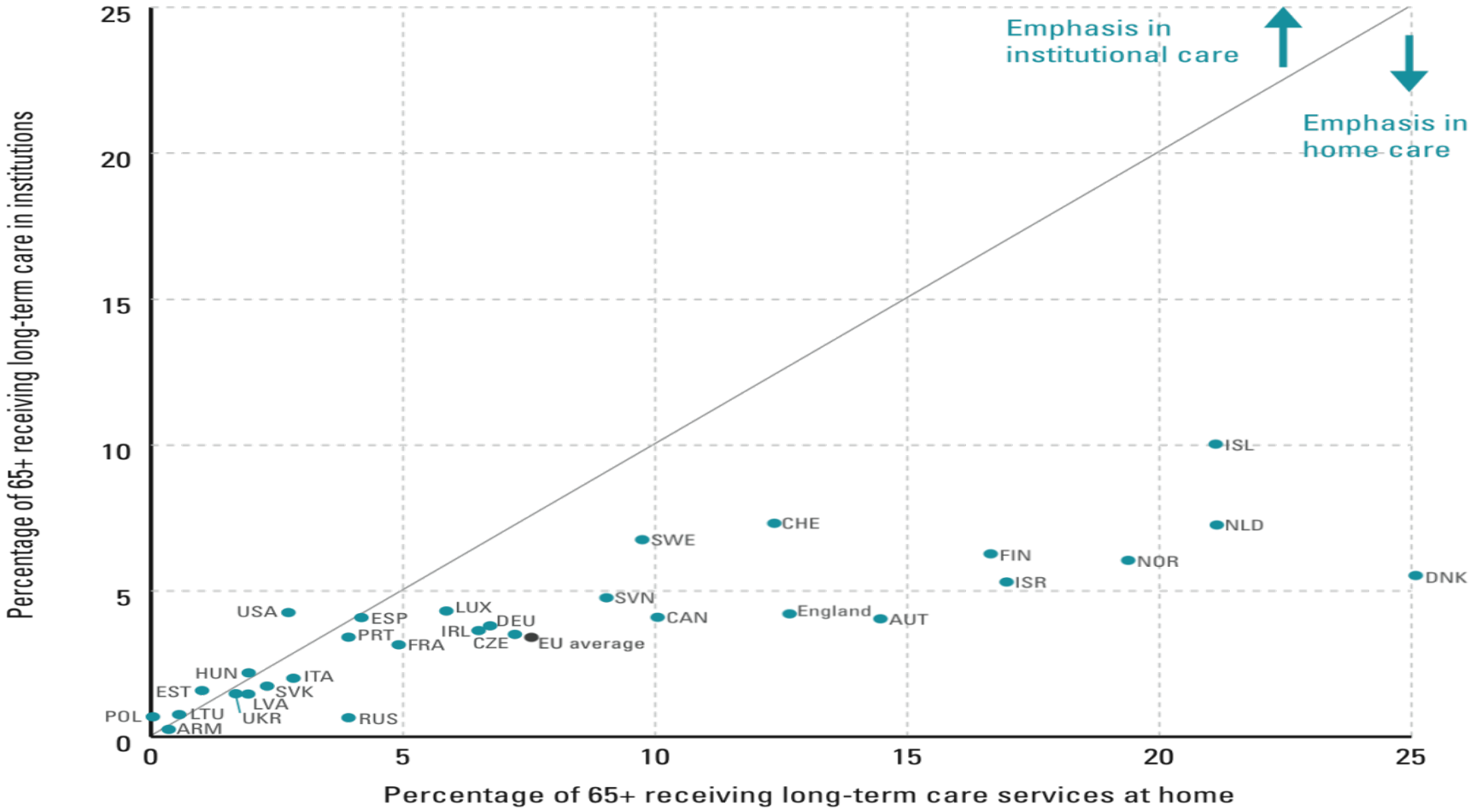
# Relevance of LTC

- LTC relevance will grow as the number of elderly citizens will increase dramatically:
  - Baby boomers approaching retirement, while morbidities & co-morbidities rise.
  - Falling mortality rates, resulting in an increase of life expectancy of **2.5 years** per decade and low fertility rates.

- By 2030 on average 20% of the population will be 65 + in OECD countries and 25.2% by 2050 (compared to a 15% in 2015).

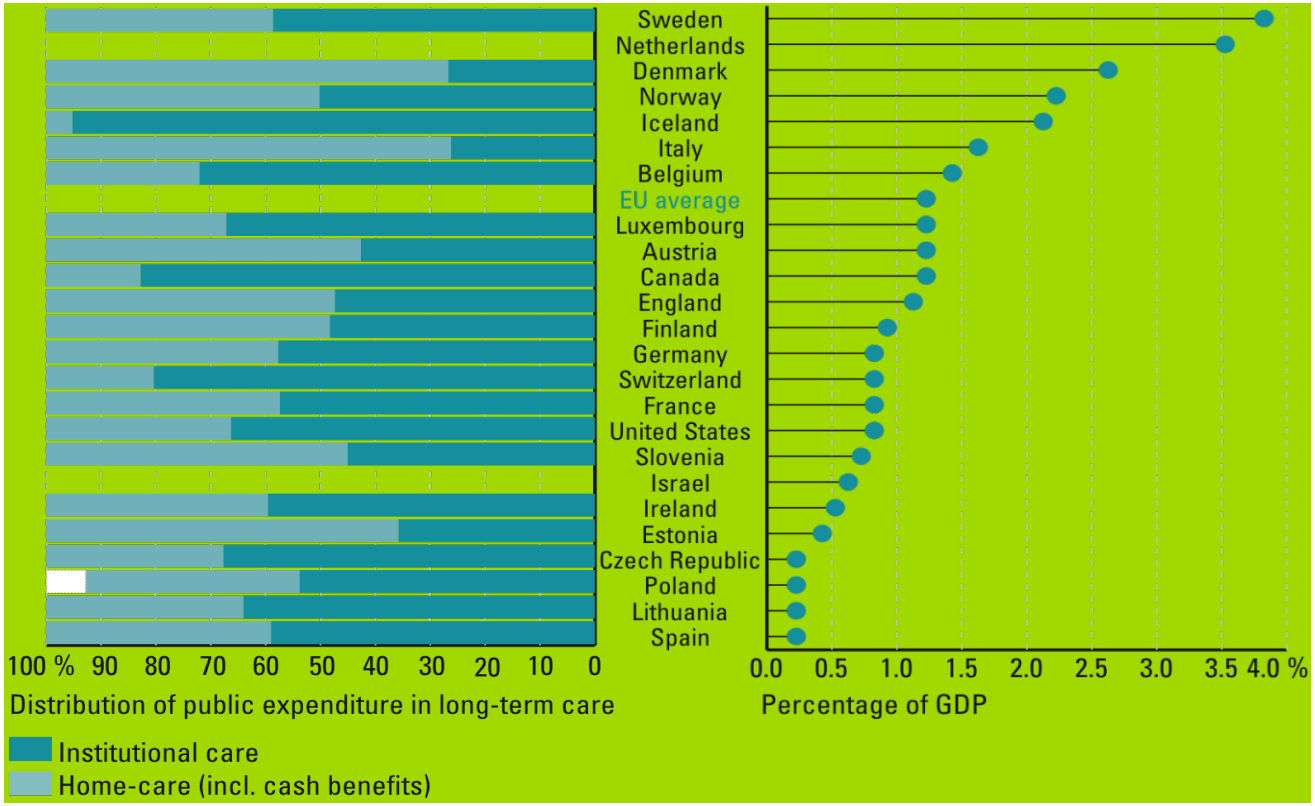
- People aged 85 + will grow the fastest from 2% in 2015 to 3 % in 2030, to 5.2% by 2050.

# Institutional & Home care




*Source: OECD, NOSOSCO , WHO, Eurostat and national sources.*

# Public spending in institutional & home care




-Paradox: most people cared for at home, most public resources devoted to institutional care (58% in EU15).

- Public resources: great diversity across EU-countries; modest amounts dedicated to LTC, EU15 spends 7.6% on health and 9.1% on old-age pensions alone.

## Problems in LTC common to most EU countries

- Increasing (projected) expenditure;
- Quality of services, quality assessment/control/assurance;
- Waiting lists, capacity constraints;
- Lack of coordination cure/care/social assistance;
- Lack of incentives for efficiency and innovation;

- Lack of universal coverage (apart from few exceptions e.g. Scandinavian countries and (some) Bismarckian systems);
- Insufficient benefits levels & risk selection.

# LTC in The Netherlands & Germany

# Universal public schemes for funding long-term care are spreading

- Number of countries with universal public schemes to cover long-term care (Austria, Germany, Japan, Luxembourg, Netherlands) is growing.

- ..providing coverage to the whole population.
- ..and reducing the need for social assistance and means-testing.

- Universal schemes are driving forces of growth of private provider markets in these countries.

- Some other countries provide universal coverage through public services (e.g., Norway, Sweden).

# Reforms of long-term care financing in countries with tax-funded services

- Reforms in Australia, New Zealand, Sweden, United Kingdom all aim at targeting more expensive services on those with most severe disabilities…

- ..and adjusting the level of personal contribution to achieve a “fairer” balance of public and private – but in Australia the personal share has gone up and in NZ and UK it has gone down..

- ..Australia, NZ, UK all accept means-testing to set the personal share – Sweden prefers to maintain universal scheme but with much tighter targeting.

# The Netherlands

- 1968: Netherlands first country to introduce universal mandatory LTC insurance (AWBZ);

- Several other countries followed since the 1990s:
  - **Germany** (1995), Luxembourg (1999), Japan (2000)...

- Increasingly comprehensive LTC coverage:

**Initially**:
  - nursing home care
  - institutionalised care for the mentally handicapped
  - hospital admissions exceeding one year.

**Expansion over time:**
  - home health care (1980)
  - mental health care (in 1982)
  - family care (1989)
  - residential care for the elderly (1997)

# Main features of LTC-insurance

- ***Mandatory*** for entire population (currently 16 million);
- Income-related ***contributions***:
  12.15% of taxable income (income threshold: 31,589 euro per year);
- Income-related ***co-payments***;
  max 1800 euro per month for institutional care;

- Legal entitlements defined by **6 "functional categories"**;
- Administered by "***regional care offices***";
- **Needs assessment** by national, independent organization (CIZ);
- For non-institutional care: ***choice*** between "service benefits" and "cash benefits" (personal care budgets).

# Funding of LTC insurance

| Sources of funding | Payments in billion euro | Share of total payments |
|---|---|---|
| Income-related contributions | 13,1 | 68% |
| Co-payments | 1,7 | 9% |
| State subsidy (from general taxation) | 4,6 | 24% |
| Total | 19,3 | 100% |

# Main groups of LTC-insurance beneficiaries

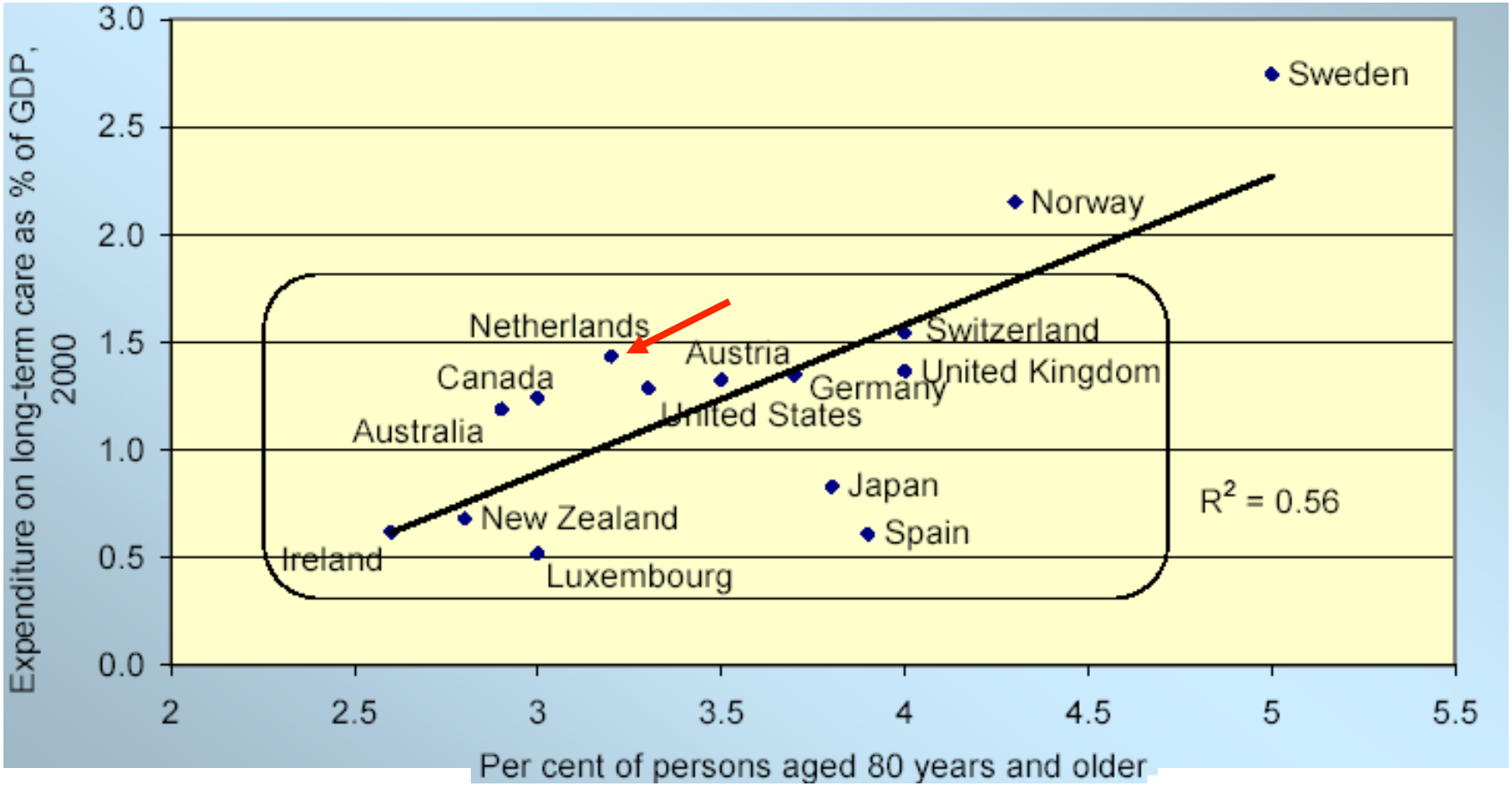
| Type of long term care user* | Number | Share of total number | Expenditure (billion euro) | Total share of expenditure |
|---|---|---|---|---|
| Elderly and chronically ill | 360,000 | 69% | 11,4 | 65% |
| Mentally handicapped persons | 100,000 | 19% | 4,6 | 26% |
| Physically handicapped person | 15,000 | 3% | 0,5 | 3% |
| Chronic psychiatric patients | 50,000 | 9% | 1,1 | 6% |
| Total | 525,000 | 100% | 17,6 | 100% |

# LTC expenditure growth

- Universal and generous public insurance facilitated strong ***growth*** of LTC-services provision and public LTC-expenditure;

- ***Result***: **high LTC expenditure relative to the age composition of the population** (above OECD average).

# Cross-country correlation between ageing and LTC-expenditure*




* Narrow LTC definition: comprising primarily elderly care

*Source:* OECD

# Policy changes from the 80s'

- To control the growth of LTC expenditure ***cost containment policies*** were introduced in the 1980s:
  - regulation of supply (building license);
  - tight budgeting of LTC-providers;
- As a result:
  - the proportion of GDP spent on LTC remained more or less stable around **3.5%** from 1985 – 2000;
  - Increasing **waiting lists**;

  …However:
  - **Court decisions** that waiting lists were in conflict with "right to care" following from the entitlements of public LTC insurance
  - Growing **public dissatisfaction** discontent about quality and inflexibility of public LTC services;

- In 2000 radical policy change from tight budget controls toward **retrospective reimbursement**.

# In 2004: return to cost control policies

Policy measures to control fast increasing public LTC expenditure since 2004:

- introduction of ***regional budgets***;
- LTC-providers have to negotiate budgets with regional care offices within regional budget constraints;
- increasing ***co-payments***, particularly for home health care.

# Shortcomings of current LTC-policy

- Lack of incentives for cost containment, quality and efficiency:
  - Entitlements are defined too ***imprecisely***;
  - Regional budget constraints are not binding because of ***opting-out*** option of cash benefits (personal care budgets);
  - Fixed provider budgets offer no incentive to meet patients' preferences ("***patients have to follow the money***");
  - Regional care offices have no incentive to contract efficient providers because they are not at risk and have a regional ***monopoly***.

# Reform proposals 2008-14

- Proposal for a structural reform of LTC insurance by Social and Economic Council (SER)
- Main lines:
  - Narrowing the scope of ***entitlements***;
  - Improvement of ***needs assessment*** (protocols, benchmarking, permanent supervision);
  - Replacement of provider-based budgeting by ***client-based budgeting*** ("money should follow the patient", risk-adjustment?) to encourage efficiency and innovation;
  - Replacement of regional care offices by ***individual health insurers*** as purchasers of care, next to individual clients opting for a personal care budget.

# Germany

- Long-term Care Insurance (LTCI) Act 1994 :

  – Until then no comprehensive insurance for financing LTC, i.e. dependent people and their families had to pay for care services, with *only* means-tested social assistance as the last resort.

# Main features LTCI

- Mandatory for entire population with two main components reflecting the design of universal health insurance:
  - ***Social*** LTCI (i.e. SLTCI);
  - ***Private*** LTCI (i.e. PLTCI) with minimum coverage guarantee (i.e. equal to SLTCI).

# Coverage

- ***SLTCI***: employees (and their family members), students, retired people are covered by public sickness funds (about 90% of the pop.).

- ***PLTCI***: people who are not entitled to join public sickness funds or who opted out of social health insurance scheme need to buy equivalent minimum PLTCI (about 10% of the pop.).

# Premiums

- ***SLTCI***:
  - Income-related contributions i.e. 1.95 % of gross earnings with an income ceiling of 3,675 € per month.
  - Employer/employee 44/56%, unemployment insurance and pensioners 100%;

- ***PLTCI***:
  - Risk-related (age/sex) contributions with legally fixed premium caps.
  - Subsidised by employer.

# Entitlements

Legal entitlements independent of age of the dependent person, defined by 3 “dependency categories”.
Benefits can be claimed if the individual needs help with ≥ 2 basic activities of daily living (bADLs) and ≥ 1 instrumental activity of daily living (iADLs) for an expected period of ≥ 6 months.

| | Care required | Duration per day | Care required of which ADLs |
|---|---|---|---|
| Care level 1 | ≥ 1x per day | ≥90 min | ≥45 min |
| Care level 2 | ≥3x per day | ≥3 hours | ≥2 hours |
| Care level 3 | 24/7 availability | ≥5 hours | ≥4 hours |

# Benefits

- LTCI benefits are for home care & nursing homes, legally defined.
- Benefit amounts are ***capped*** - copayments (800€-1300€ p.m. for nursing homes) and means-tested ***social assistance*** still plays a vital role, particularly in nursing home care, where about 1/3 of all residents still receives social assistance.

**Table 2: Amount of LTCI Benefits (Major Types of Benefits) in 2009**

| in euros per month | Home care | | Day and night care | Nursing home care |
|---|---|---|---|---|
| Level | Cash benefits | In-kind benefits | In-kind benefits | In kind benefits |
| I – moderate | 215 | 420 | 420 | 1,023 |
| II – severe | 420 | 980 | 980 | 1,279 |
| III – severest | 675 | 1,470 | 1,470 | 1,470 |
| Special cases | | 1,918 | | 1,750 |

# Administration

- Administered by different LTCI funds, which are responsible for **contracts** with care providers (including admission to the market), prices (for in-kind care), and cash benefits.

- Needs assessment by the national Medical Review Board.

# LTCI sources of funding

| Sources of funding | In million euro | Share of total spending |
|---|---|---|
| SLTCI | 17,860 | 56.8% |
| PLTCI | 0,550 | 1.7% |
| Social Assistance | 3,200 | 9.2% |
| Sub-Total | 21,610 | 68.7% |
| OOP Nursing Home Care | 7,660 | 24.4% |
| OOP Home Care | 2,180 | 6.9% |
| OOP Total | 9,840 | 31.3% |
| Total | | 100% |

# LTCI expenditure & contribution growth

- From 2000 – when the introductory phase was over– to 2007, the growth rate of nominal expenditure has exceeded 2 percent only once (in 2002), and the average annual growth rate of nominal expenditures was 1.4 %.

- The deficits have rather been caused by slow growth rates for *contributions*. From 1997 to 2004, the average annual growth rate of nominal contributions was 0.8 percent. In 2003, contributions actually declined and in 2004, they remain practically unchanged.

# Cost containment policies

- To control the growth of LTC expenditure cost containment policies were introduced:
  - Tight definition of dependency;
  - Entitlement for LTCI benefits is based on rigorous assessment by the Medical Review Board (not by providers to prevent ex-ante moral hazard);
  - All benefits are capped and have not been adjusted, not even for inflation.

- As a result, while the assessments have prevented any explosion of the number of beneficiaries, the benefit caps have controlled expenditure per beneficiary.

# LTCI: Shortcomings

- Cost containment at the expenses of quality and efficiency?

- ***Incomplete needs assessment*** (benchmarking, cost of living, permanent supervision): e.g. under compensation and poor quality of care for individuals with dementia.

- ***Increasing co-payments***, particularly due to benefits caps.

- Tendency towards nursing home care and within home care towards ***formal care***, driven by higher benefits in formal care, and particularly in nursing home care:
  - Burden for ***financial sustainability*** of LTCI.
  - Potential conflict with ***consumers' preferences*** towards home care.

# Reforms 2009-15

- Long-term Care Further Development Act.

- Main lines:
  - New instruments for informal carers (e.g. “nursing care time”), promotion of rehabilitation, case management and counselling;
  - Quality inspections;
  - Adjustment of benefits and financing: adequate, sustainable?

# Potential lesson for other countries

- ***Improvement of needs assessment***: 3 too little 7 too many? Also they need to explicitly look at behavioural and cognitive patterns that cause dependency and the need for surveillance.

- ***Over-institutionalisation***: proportion of beneficiaries who receive institutional care has been increasing, including many who require only low levels of care.

- ***Universal coverage***: important achievement in both countries but the lack of choice and the existence of local monopolies (NL) and a dual system (GER: SLTCI/PLTCI where the risk structure between the two pillars greatly differs) raises questions about efficiency and fairness.

- **Potential lessons for other countries**:
  - (Nearly) Universal and Integrated Mandatory LTCI ***necessary*** first step to prevent market failure in the financing and delivery of LTC and to provide a coherent regulatory and incentives framework to achieve efficiency, fairness, contain costs and deliver quality of LTC.

- **But not sufficient**:
  - ***Choice of third-party purchasers*** crucial to increase responsiveness to consumers' preferences and to trigger efficient contracting with providers.
  - ***Fine-tuning of needs assessment*** to specific and evolving needs.
  - Introduction of income- and risk-adjusted ***subsidies***.
  - ....