The Rolling Out and Back of Universal Long-Term Care Supports in Europe

Joan Costa-Font, Department of Health Policy London School of Economics, UK.

Bio:

Dr Joan Costa-Font, is an Associate Professor (Reader) at the London School of Economics and Political Science (LSE) in the Department of Health Policy, a fellow of IZA-Bonn and CESIfo-Muncih. He has been Harkness Fellow in Health Policy and Practice at Harvard University, and visiting fellow at Boston College and Oxford University. His research studies the design of health and long-term care programs, and the origins and effects of health disadvantage.

Summary:

I examine the universalization of long-term care services and supports (LTCSS) in the three leading European countries that have reformed their funding for LTCSS in the last 10-15 years. More specifically, I examine the Scottish and Spanish reforms which extended public insurance to everyone needs needing LTCSS, and the Dutch reform, which in contrast rolled back the converge of the older funding system in Europe. I argue that universal systems entail savings to the health system and improve financial wellbeing of families, yet, specific designs can stimulate beneficiaries moral hazard, and weaken government welfare budgets.

Keywords: long-term care services and supports, Europe, Scotland, Spain and the Netherlands.

1. Introduction

Some European countries have moved to universalize the access to long-term care services and supports (LTCSS). This has taken place with a public mandate to the reception of subsidies either in term of residential, home or nursing home care, or in cash with the development of caregiving allowances which in some countries have been conditional which have adopted several formats form personal budgets in the Netherlands, to conditional allowances in the Scotland to unconditional allowances in Spain. The universalization of long-term care refers to access to care, and hence entail partial financing. This means individuals still have to co-finance part of their care except for individuals who fall behind income thresholds

that obtain additional means-tested support. The funding comes from income or payroll taxes and opens an opportunity for insurance markets to contribute to complement public funding such as in France and Germany, or for individuals to self-insure by using their housing assets typically to pay for care typical in Southern Europe (Costa-Font et al., 2010).

The main reasons for the universalization on the first place include making sure that women participate in the labor market, especially in Northern countries, and to support struggling families, mainly in Southern European countries (Costa-Font et al., 2015). In both cases, as we discuss below, that there were significant welfare effect for households financial wellbeing, and savings in the use of health care. However, in the middle of an economic crisis, long-term care subsidies might be seen as an opportunity to increase household income. Hence new subsidy applications can soar and thus, weaken the financial sustainability of the system.

This paper will focus on examining the three main widespread reforms in European that have taken place in the last decade and a half, namely the reforms in Scotland and Spain which universalized the access to the public subsidy for long-term care services and supports (LTCSS), which was means tested before. In contrast, the Netherlands that reduced the public subsidy. Below I will discuss the challenges they are facing and point out what are the mean weaknesses of the specific design that extended and lowered the coverage of for long-term care. This article argues that universal subsidization of LTCSS when it expands the network of services, it reduces the utilization of hospital care, affects caregiving choices, especially when cash subsidies are available for informal care. I argue that the experience of the three countries provides some

lessons for countries that have not yet universalized the entitlement to such supports. For instance, in the US context, some states might consider universalizing Medicaid to support the entire population in need of long-term care. However, these reforms would allow people to purchase additional insurance. I argue that needs tests are the main instrument to monitor demand i. Nonetheless, once a subsidy in place, even though when not working as expected, the Dutch experience shows that is complex to dismantle.

In what follows we briefly describe the Scottish, Spanish and Dutch reforms and we conclude the article with a discussion of the main lessons from such reforms.

2. The Scottish Free Personal Care (FPC)

The funding LTCSS has been at the centre of social policy reforms the Royal Commission on long-term care in 1999 recommended for the UK as a whole a system of free long-term care. The Commission established a clear need to reform and was explicitly concerned with the inequity in the access to LTCSS. However, the recommendation of the Commission was adopted only in Scotland in 2002, two years after health and social care responsibilities were devolved to the Scottish government. Scotland, unlike the rest of the UK, reformed the funding of personal care in the Community Care and Health (Scotland) Act by introducing 'free' personal care (FPC) which meant that all charges for personal care at home were abolished, although charges

continued in place for non-personal care expenses (Glendinning et al., 2004; Bell and Bowes, 2006). An increased flat-rate conditional subsidy (attendance allowance) for personal care was raised (in 2014 it entail a flat rate payment of £169 per week for those at home, and those who receive care in a nursing home receive an additional £77).

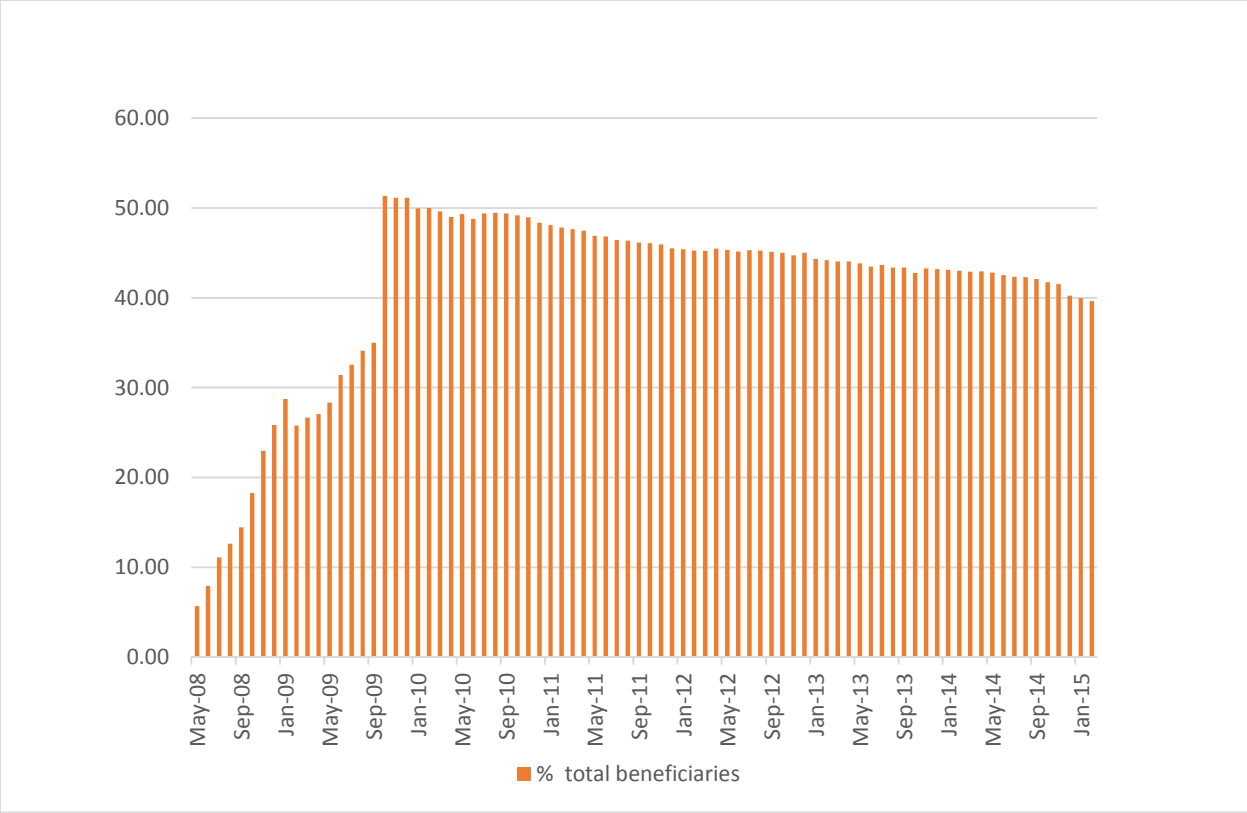
The reform universalised the access to long-term care, but the subsidy was limited, and overall the total costs of free personal care amounted to 0.2 per cent of Scottish GDP (Bell and Bowes, 2006). The reform replaced the pre-existing model, still in place in the rest of the UK, of means-tested care whereby local authorities support only individuals whose wealth does not exceed 23,000 pounds. Additional funds were made available to local authorities on an annual recurrent basis to pay for FPC. The other costs of providing free personal care for the elderly increased this amount by around 10% after the reform (Bell and Bowes, 2006).

Reforms in Scotland took place alongside an incentive to provide informal care as health and social care integration policy focus on enabling older adults to remain in their own homes when possible (Scotish Government, 2016). Hence, the introduction of FPC did give rise to a change in caregiving choices. More specifically, some evidence suggests an increase in informal caregiving by six percental points (Kalsberg-Scaffer, 2015). A recent study using administrative data to evaluate some trends after the introduction of FPC in Scotland and other countries (Bell and Bowes, 2012) finds evidence of a sharp increase in home help demand by 69% between 2002-2010, which was compensated by an increase in the charges for non-personal care, and the intensity of care increased from an average of 6.9 to 7.8.

3. The Spanish universalization of LTCSS

Like Scotland, Spain expanded the public funding of LTCSS in 2007 as the star reform a newly and unexpectedly elected government after it passed the 'Promotion of Personal Autonomy and Care of Dependent People' Bill 39/2006 (we refer to it using the acronym SAAD, in Spanish). Although the central government lead the reform, the design is system is highly decentralised and is funded by matching funds of regional and central governments (similar to the way Medicaid is still funded in the US). Although originally the design contemplates a user co-payment although it is unevenly implemented. Before the introduction of SAAD, the provision of LTC was means tested and funded by local authorities. After SAAD, the subsidy designed in follows the German long-term care system, and applicants are subject to a 'needs test' and classified into one of the three dependency levels ('moderate', 'severe' or major dependency) according to an official ranking scale. An individual's care plan is designed to match the applicant's needs and those of its family. Finally, individuals had a choice between in kinds (some subsidised weekly hours of care at home, or in daycare or nursing homes) or, an unconditional caregiving allowance.

Figure 1 Evolution of the percentage of beneficiaries of SAAD claiming caregiving allowances 2008-2015



Source: Costa-Font et al (2017) Data retrieved from http://www.dependencia.imserso.es/dependencia_01/index.htm

Caregiving allowance is designed to compensate informal caregivers (including social security contributions), yet the allowances in 2011 for major dependency could amount 530€ in 2011 and 300€ for severely disabled which compare to a minimum wage of 641.40 €/month. Hence, there was a strong moral hazard incentive, and as we show in Figure 1, a few months after the implementation of SAAD, about 50% of its beneficiaries were claiming caregiving allowances. Costa-Font et al. (2017a) show that SAAD incentivised informal caregiving as in Scotland, and lead to an increased to transfers to help children amidst an economic recession and, Costa-Font and Vilaplana-Prieto (2017) shows that it lead to changes on saving decisions (reduced savings).

However, part of the above results can be explained by the fact that a year after the SAAD Spain underwent into an economic recession, (increasing the country's public deficit to 8.9% of GDP in 2012). It only in July 2012 that the system was adjusted to reduce the strong moral hazard incentive spending cuts (amounting 15-25% of the subsidy) as well delays in the SAAD entitlements in July 2012 (Royal Decree 20/2012, 13 July 2012), and more stringent needs tests by some regional governments. However, the implementation of SAAD reduced the so-called 'bed blocking' and admission in hospitals which is estimated to have reduced hospital health care costs by an average of 11% (Costa-Font et al., 2018). Hence, as with the Scottish reform, evidence from Spain suggests mixed evidence of success, which depended on its design.

4. The Netherlands: fragmentation and tighter budgets

The final country reform we examine is that of the Netherlands stands out as a contrasting example to the previous two reforms. The Dutch long-term care system is the oldest in Europe, and up until 2015 it was the most generous in Europe after Sweden, in part because it relied too heavily on residential care, and (Alders et al., 2015). As some other European systems, is funded by a single payroll contribution, eligibility of benefits is determined by an assessment of care need. As in the Scottish and Spanish case, the system offers both benefits in kind and cash, but in the latter case, they refer to conditional allowances that follow a detailed personal budget. However, in the aftermath of the economic downturn, the escalating costs of LTC as well as concerns about moral hazard in the system, in January 2015, the Social Support Act 2015 created a new more restricted funding scheme where the old statutory insurance (AWBZ) becomes WLZ with more las limited to funding and restricted to residential care and provides

personal budgets that are heavily surveilled (Maarse et al., 2016). Nursing care was integrated into the statutory health insurance scheme, and non-residential services are now managed by a new less generous fund (WMO), the responsibility of which is shifted to the municipalities.

Although the reform mas a major restricting of the funding of LTC in the Netherlands, it was significantly softened in part because reform gives rise to strategic behaviours – as the Scottish and Spanish example show- altering caregiving decisions. This is because elderly individuals often would not have adequate housing to receive care at home and, in part because the new fragmented system opens up new coordination problems that were not present in the old system (von Ginneken and Kroneman, 2015). The net effect of the reform reducing coverage has not resulted in significant savings to the system because, although 30% savings were originally envisaged, the system required additional funding (Maarse et al., 2016).

5. Lessons for the US

The universalization of long-term care services and supports (LTCSS) in Scotland, Spain and the Netherlands contains some lessons for countries that have not yet universalized the entitlement to such supports. More specifically, the Scottish and Spanish reforms extended public insurance to everyone, hence universalising the access to LTCSS. However, the funding was limited, and its designed did alter caregiving decisions, especially in Spain where the reform coincided with an economic downturn. Another lesson from both the Spanish and the Scottish reforms is that it has shifted the balance of care towards care at home, rather than residential care which explains in part why it has been affordable. Finally, there were clearly important

knock-on effects on the health system, and improvements in the financial wellbeing of households that carry the burden of caregiving. In contrast, in the Netherlands, concerns about the escalating costs lead to a reform increasing the fragmentation of the system which although it was supposed to bring some savings, they failed to materialise. The system became after the reform harder to navigate albeit decentralisation made it more accountable to local demands.

Altogether European evidence suggests that in extending public insurance for LTCSS, one needs to pay particular attention to the micro-design of the system, and especially the incentives that changes in caregiving allowances entail. However, a system that has an integrated form of funding like a 'universal Medicaid' with limited subsidies depending on need would have in the US context. It would reduce the fragmentation of the system and could be designed to reduce health care costs, alongside allow for the development of a market for complementary or supplementary insurance (e,g., Medigap for LTCSS). As always, cross country lessons should be taken with a 'pinch of salt' and some imagination.

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