Financing long-term care in the future: challenges and policy strategies

3nd International Conference on Evidence-based Policy in Long-term Care

September 1–3, 2014 in London

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For a start

“Everything has been said – but not by everyone”

(Karl Valentin)

For a start

- Four sources of financing
  1. Out-of-pocket: income and/or assets
  2. Private (voluntary) insurance
  3. Social (mandatory) insurance
  4. Taxes

(1–2: private; 3–4: public)

- Questions:
  – What should be used ? → normative question
  – What is (recently) used ? → positive question

Agenda

I. Do we need *public* involvement?

Agenda

I. Do we need *public* involvement? → YES

Agenda

I. Do we need public involvement?

II. Is there a one-size-fits-all solution?

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I. Do we need public involvement?

II. Is there a one-size-fits-all solution? → NO, it has to fit to the specific type of welfare state

Agenda

I. Do we need public involvement?

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III. What are the major challenges for
   a) tax-based and
   b) social insurance systems?

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IV. How can different means of financing be combined?

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V. Summary

I. Do we need public involvement at all?

1. The life-time risk of need of LTC is very high

I.1 Life-time risk of Long-term care

- US figure on risk of nursing home care: 25-40%
  - 24% (Kastenbaum et al. 1973)
  - 26% (Palmore et al. 1976)
  - 39% (Vicente et al. 1979)
  - 29% (Kemper et al. 1991)
- German figures (Rothgang et al. 2012)
  - Nursing home care
    - 16% (men)
    - 36% (women)
  - Any kind of LTC
    - 50% (men)
    - 72% (woman)

➢ LTC is a social risk with high probability

I. Do we need public involvement at all?

1. The life-time risk of need of LTC is very high

2. Costs of formal care, particularly nursing home care, exceed the income of an average pensioner

I.2 Costs of nursing homes

Monthly rates of German nursing homes

	(1)	(2)	(3)	(4)=(1)+(2)	(5)	(6)=(1)-(5)	(7)=(4)-(5)
Level of depend-ency	**Care**	**Room & Board**	**Invest-ment**	**Monthly rate (total)**	**LTCI benefits**	**Out of pocket: care costs only**	**Out of pocket: total**
Level I	**1.369**	**629**	**395**	**2.393**	**1.023**	**346**	**1.370**
Level II	**1.811**	**629**	**395**	**2.835**	**1.279**	**532**	**1.556**
Level III	**2.278**	**629**	**395**	**3.302**	**1.510**	**768**	**1.792**

Data from December 2011 (1, 2, 5) and from 2010 (3).

- For the US
  - the cost of formal care averages USD 75 000 per year in a skilled nursing facility (Gleckman, 2010), nearly three times as much the average disposable income for a person aged 65 years

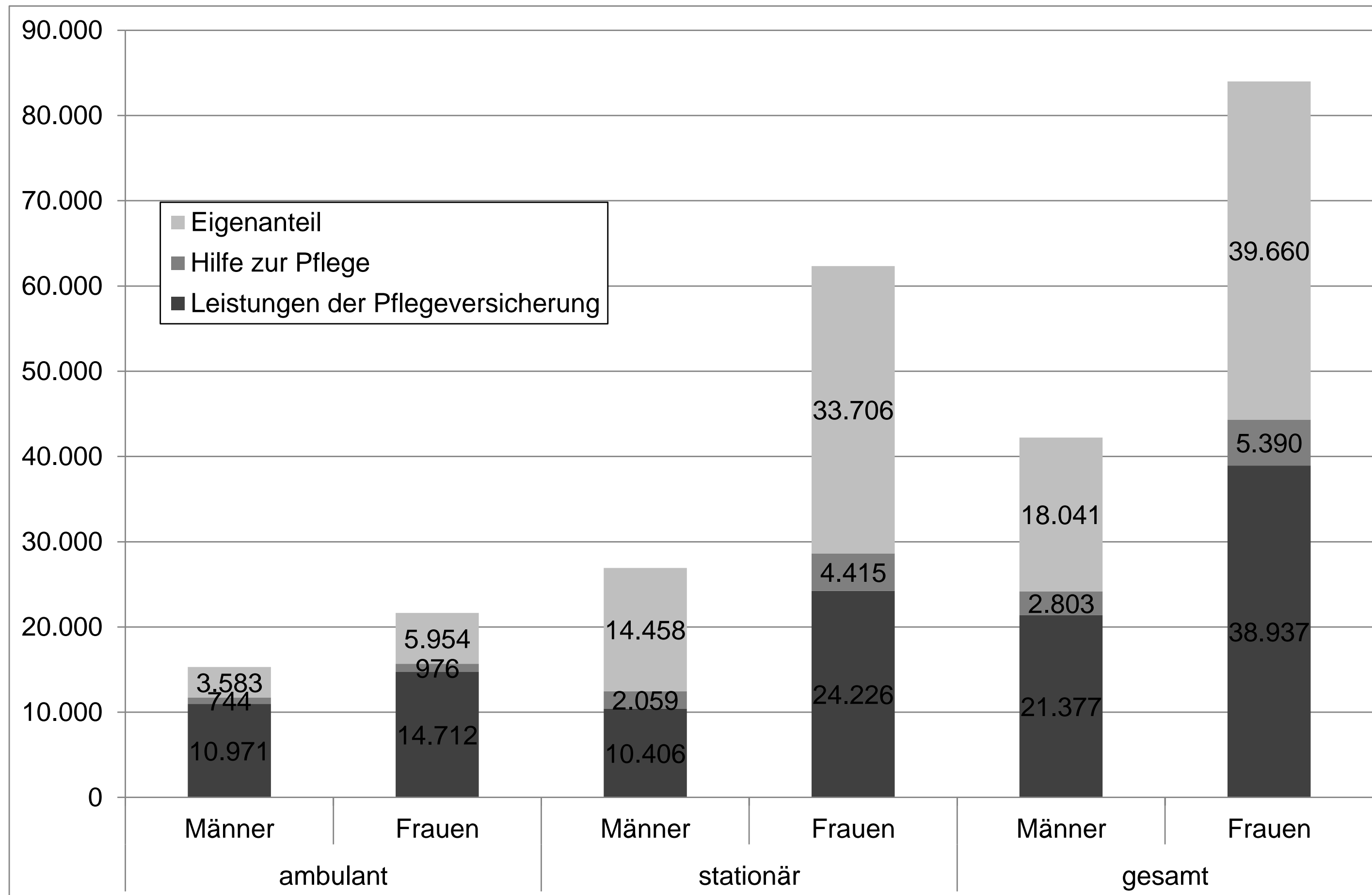
I. Do we need public involvement at all?

1. The life-time risk of need of LTC is very high

2. Costs of formal care, particularly nursing home care exceed the income of an average pensioner

3. Life-time costs may exceed pensions plus accumulated assets

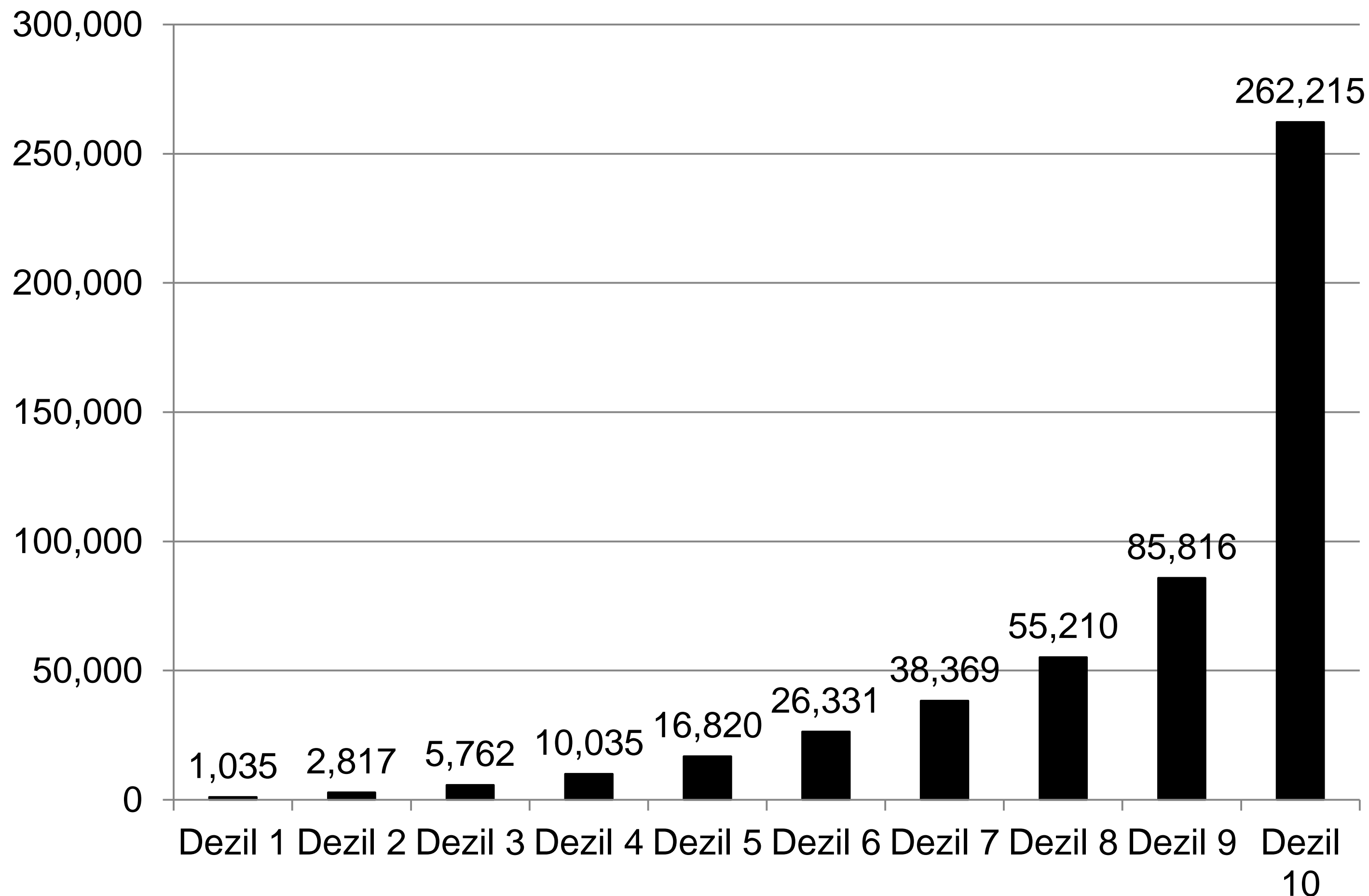
I.3 Life-time expenses on LTC in Germany



- Life-time costs are
  - 42 tsd. Euro for men
  - 84 tsd. Euro for women
- About half of it has to be paid by those in need of LTC

Source: BARMER GEK Pflegereport 2012:

I.3 Life-time expenses of Social LTCI in Germany



- For 20% of all beneficiaries life-time expenditures exceed 55 tsd. Euro
- For half of them they exceed even 85 tsd. Euro
- About the same amount is to be paid privately

Source: BARMER GEK Pflegereport 2012:

I. Do we need public involvement at all?

1. The life-time risk of need of LTC is very high

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➢ Out-of-pocket financing won't work!

4. Is voluntary actuarial private insurance enough?

I. Do we need public involvement at all?

1. The life-time risk of need of LTC is very high

2. Costs of formal care, particularly nursing home care exceed the income of an average pensioner

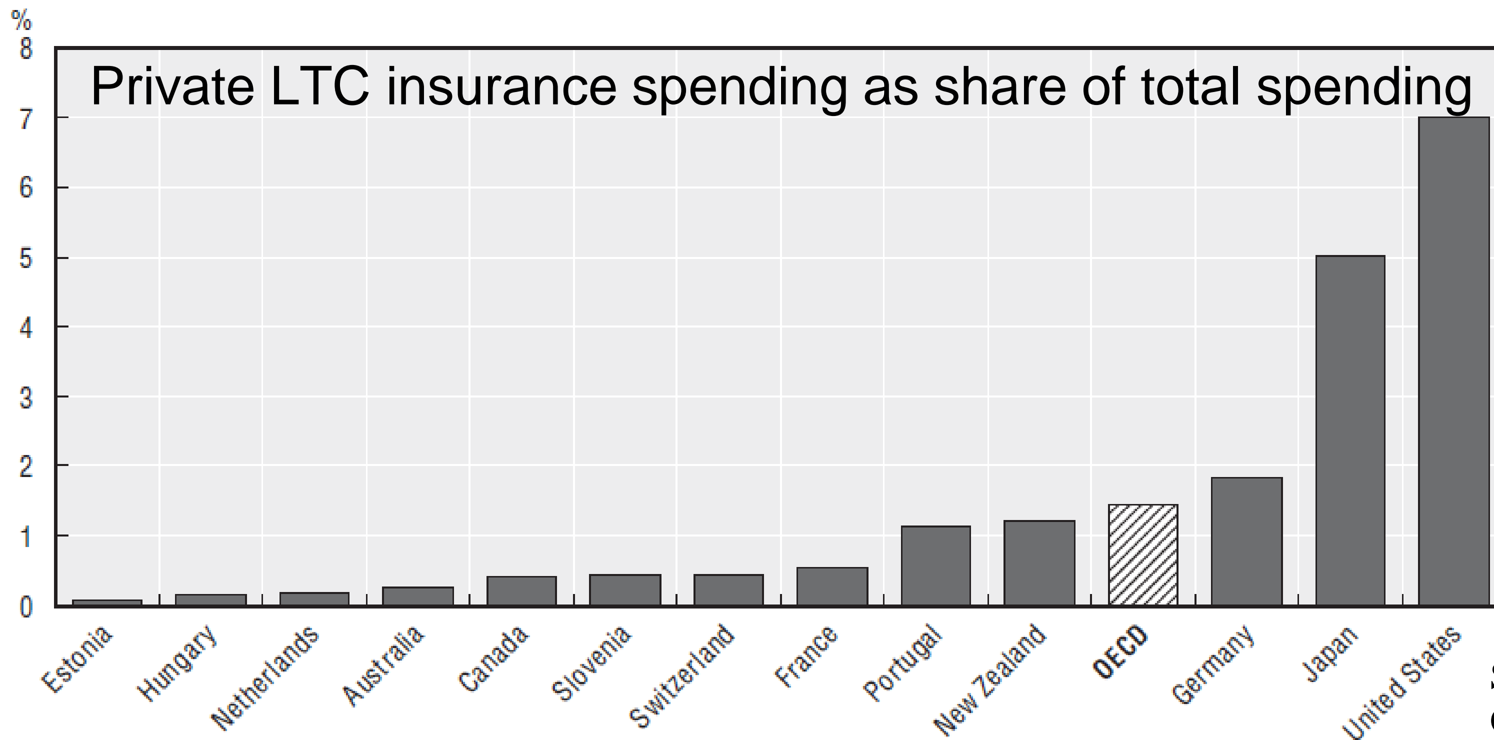
3. Life-time costs may exceed pensions plus accumulated assets

4. Is voluntary actuarial private insurance enough?
   - No, because there will always be a considerable part of the population without insurance due to
     - too high premiums for those with high risks and/or low income
     - Adverse selection (when there is no underwriting)
     - lacking awareness of potential insurees

I.4 Systems based on private insurance

- Holder of private voluntary long-term care insurance
  - France: 15%
  - USA: 5%
  - Germany: 4-5%

  } of population 40 and older



Source:
OECD 2011: 248

I.4 Systems based on private insurance

- Private healthcare in the US (before Obama Care):
  - 40-50 million uninsured (one in six US citizens)
  - equal amount underinsured
- Private subsidized pension insurance in Germany
  - About 12 million out of 80 million
    (=16% of population, about 30% of working population)
- In general: there will always be a considerable part of the population without insurance
  - People are not aware of the need of long-term care
  - Low-income people can't afford it
  - Groups with high risk don't get it (if there is medical underwriting)
  - Adverse selection (if there is no medical underwriting)

I. Do we need public involvement at all?

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3. Life-time costs may exceed pensions plus accumulated assets

4. Is voluntary private insurance enough?
   - No, because there will always be a considerable part of the population without insurance
   - “Private LTC insurance has a potential role to play in some countries but unless made compulsory will likely remain a niche market” (OECD 2011: 32)

➢ We need *public* involvement of some sort!

Agenda

I. Do we need public involvement?

II. Is there a one-size-fits-all solution?

III. What are the major challenges for tax-based and for social insurance systems?

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II. What kind of public involvement?

- As not all citizens can afford necessary LTC, at least a system of social welfare is needed as a last safety net.
- The existence of LTC benefits as part of a social welfare system – though necessary – will further crowd out private insurance and increase the necessity of public involvement
- Is a last safety net enough or do we want more?
- Resulting questions concern
  1. The role of means-testing and other forms of cost sharing
  2. Tax-financing vs. social insurance contributions
  3. Funding vs. pay-as-you-go

II.1 Means-testing

- For people with risk aversion means-tested social welfare is only second-best
- Fiscal federalism: If municipalities or provinces are responsible, this might cause fiscal stress

Germany	**1970**	**1975**	**1980**	**1985**	**1989**
Nursing homes					
Number of recipients	166,050	213,542	236,738	251,875	271,000
Share of 65+ recipients	48.2%	61.2%	68.7%	72.4%	63.8%
Expenditure in Mio. euros	501	1,308	2,197	3,219	4,041
Homecare					
Number of recipients	94,614	189,775	227,135	214,578	265,000
Share of 65+ recipients	53.4%	56.2%	53.8%	49.7%	55.9%
Expenditure in Mio. euros	65	203	361	434	636

Figure: Social Welfare benefits for LTC in Germany

In Germany e.g. fiscal stress was responsible for introducing LTCI.

In Austria we recently observe similar debates

II.1 Means-testing

- Central question: What kind of welfare state do we want?
  - *Liberal welfare state* aims at preventing poverty and insufficient medical (and nursing) treatment
  - *Conservative welfare state* aims at status maintenance: once you have reached a certain position on the social ladder this should be protected against social risk

- Means-testing
  - is perfectly compatible with a *liberal welfare state* as benefits are targeted towards the needy and wealthier people pay for themselves
  - Is *not* compatible with *conservative welfare states* as achieved status should be maintained irrespective of illness, disability or need of LTC

➢ Means-testing is suitable for some welfare states, but not for others depending on the underlying conception and values of the welfare state!

II.1 Other forms of cost sharing

- There are also other forms of cost-sharing
  - Capped benefits, cost sharing as residual
    (e.g. Australia, Austria, France, Germany)
  - Flat-rate cost sharing
    (e.g. Belgium, Japan, Korea)
  - Income- and/or asset-related benefits
    (e.g. Canada, Czech Republic, Finland, Hungary, Ireland, Netherlands, New Zealand, Norway, Poland, Slovak Republic, Spain, Sweden)
- Cost sharing is a means to
  - limit public expenses
  - prevent moral hazard
- When excessive, however, other forms of cost-sharing have similar effects as means-testing

II.2 Taxes vs. social insurance contributions

- Financing can be based on
  1. Private out of pocket payments → does not work
  2. Private voluntary insurance → does not work
  3. Taxes
  4. Social insurance contributions

- Taxes
  - include direct taxes (in particular income taxes) and indirect taxes (in particular VAT)
  - generate no claim for specific benefits → willingness to pay is limited

- Social insurance contributions
  - are earmarked and not part of the general state budget
  - contain some element of redistribution as otherwise they cannot be mandatory → mandatory private insurance must be regarded as some kind of social insurance

II.2 Taxes vs. social insurance contributions

- Taxes
  - Advantage:
    - Levied on whole population, all kinds of income
    - Potentially redistributive
  - Disadvantage:
    - Instability: Revenue may decrease in times of budget crises.
    - Decreasing redistribution as direct taxes are replaced by indirect taxes
  - Relation to welfare state conception:
    - Particularly compatible with liberal welfare states and means-testing.

II.2 Taxes vs. social insurance contributions

- Social insurance contributions
  - Advantage:
    - Earmarked → saver in economic crises
    - Higher willingness-to-pay
  - Disadvantage:
    - Potentially not levied on the whole population (Germany)
    - Negative labour market effects when only levied on wages and salaries
  - Relation to welfare state conception:
    - Close fit to conservative welfare state as
      - benefits are based on contributions
      - benefits may guarantee status maintenance.

➢ Depending on the normative conception of the welfare state taxes or social insurance contributions are more suitable

II.3 Funding vs. pay-as-you-go

- Advantage of pay-as-you-go
  - flexible to changing environments (e.g. German unification)
  - immediate benefits
- Advantage of funding:
  - less vulnerable to demographic change, but not independent (age wave-, asset meltdown-debate)
  - Intergenerational redistribution may be reduced
- Disadvantages of funding
  - Funded systems can only guarantee a certain amount of cash for those in need of LTC, but not the necessary services
  - To provide substantial benefits from the beginning premiums must be extremely high → unattractive for politicians

➢ We hardly see universal systems based on funding. Funding is more likely as a supplement to a pay-as-you-go system

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V. Summary

Demographic change leads to more people in need of LTC

- How to control expenditures
  - Eligibility criteria
    - Definition of long-term care, particularly coverage of dementia
  - Moral hazard
    - Assessment process
    - Co-payments
  - Economics of LTC
    - Care arrangements, role of informal care and migrant care
    - Price setting for LTC
- How to secure willingness to pay – and to pay more?

III.1 Challenges for social insurance systems

When being introduced:

- Premiums: risk-related, income-related, flat
  - Risk-related premium effectively excludes elderly from insurance
  - Flat premiums
    - Are used in healthcare in Switzerland, Netherlands, (Germany)
    - afford subsidies for the poor
  - Income-related contributions (vs. capitation) provides another element of redistribution additional to imperfect redistribution via tax systems

When in place

- Secure a broad financial base
  - Inclusion of the whole population
  - Contributions levied on all kinds of income
- Secure substantial benefits and proper adjustment (capped benefits) →Political support for increasing contributions

III.3 Challenges for tax-funded systems

- Which kind of care should be means-tested (medical care, personal care, social care) and how can they be separated from each other?
- How to guarantee sufficient benefits in case of economic crisis?
- How to uphold re-distributional effect of taxation when we envisage a shift from progressive income-tax to regressive consumption tax as VAT?

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1. Tax-financing in social insurance schemes
2. Funding in PAYGO-systems: The German case
3. Private Insurance and public schemes

V. Summary

IV.1 Tax-funding in social insurance systems

- Tax-financing in social insurance
  - in form of social welfare as a last safety net
  - in systems with flat contributions (Netherlands, Switzerland healthcare system)
  - to compensate for benefits that are not regarded as purpose of insurance (e.g. family benefits). In Germany
    - Pensions insurance
    - Healthcare insurance (since 2004)
    - LTC: not yet

- Chances of supplementary tax-financing
  - "Invisibility"
  - Levied on all kinds of income

- Dangers of supplementary tax-funding
  - Political instability of revenue

IV.2 Funding in a PAYGO System: The German Case

- Until 2013:
  - Mandatory social LTCI: 88% of the population
  - Mandatory private LTCI: 12% of the population
  - Additional supplementary insurance: 2-3 % of the population

- Two new mechanisms for introducing funding in LTC
  - 2013: Supplementary subsidised voluntary LTC insurance (“Pflege-Bahr”)
  - 2015: Collective provident fund within Social LTCI (“Pflegevorsorgefonds”)

IV.2 Funding in a PAYGO System: "Pflege-Bahr"

What is the "Pflege-Bahr"?

- Tax-financed subsidy of 5 Euro per month on contracts
  - with a premium of at least 10 Euro / month
  - benefits of at least 600 Euro in care level III
  - obligation to except every applicant not yet in need of LTC
  - no medical underwriting, but age specific premiums
  - Waiting time no longer than 5 years

Effects and problems of the new subsidy (“Pflege-Bahr”)

- Number of insurees will be limited
  - For 2013: Government put 90 million Euro aside → 1.5 million contracts
  - By the end of 2013: < 400,000 contracts (about 1% of working population)
  - In the long run: < 10% of working population
- Due to social welfare: insurance is unattractive for households with low income
- Redistribution from the bottom to the top as those with lower income will finance tax-subsidy for better off households that buy insurance

Effects and problems of the new subsidy ("Pflege-Bahr")

- Benefits are insufficient

Monthly „financing gap" in nursing homes with and without „Pflege-Bahr

	Financing gap		„Pflege-Bahr"	Remaining gap	
	Care costs	total		Care costs	total
Care level I	346	1.380	120	226	1.260
Care level II	532	1.566	180	352	1.386
Care level III	768	1.802	600	168	1.202

Source: own calculation using the „Musterkalkluation" of private insurance companies

Effects and problems of the new subsidy (“Pflege-Bahr”)

- adverse selection
  - New insurance is particularly attractive for those who could not buy “normal” insurance
  - Due to this risk selection premiums must be higher
  - In the US a respective programme (CLASS Act) was stopped as “unworkable” and then withdrawn
  - Insurance companies are safe as waiting time works as a safety net for the first five years and premiums may be raised thereafter
- Biggest danger: “Pflege-Bahr” might legitimize insufficient adjustments in Social LTCI

IV.2 Funding in a PAYGO System: “Pflegevorsorgefonds”

What is the “Pflegevorsorgefonds”?

- Starting in January 2013 contribution rate is increased by 0.1 percentage point → revenue of about 1.2 m Euro
- This additional contribution rate is collected until 2033 and managed by the Deutsche Bundesbank
- From 2035 onwards a maximum of 1/20 of the capital reached then is given to Social LTCI to prevent increasing contribution rates
- Once all is spent the fund will be closed

Effects and problems of the “Pflegevorsorgefonds”?

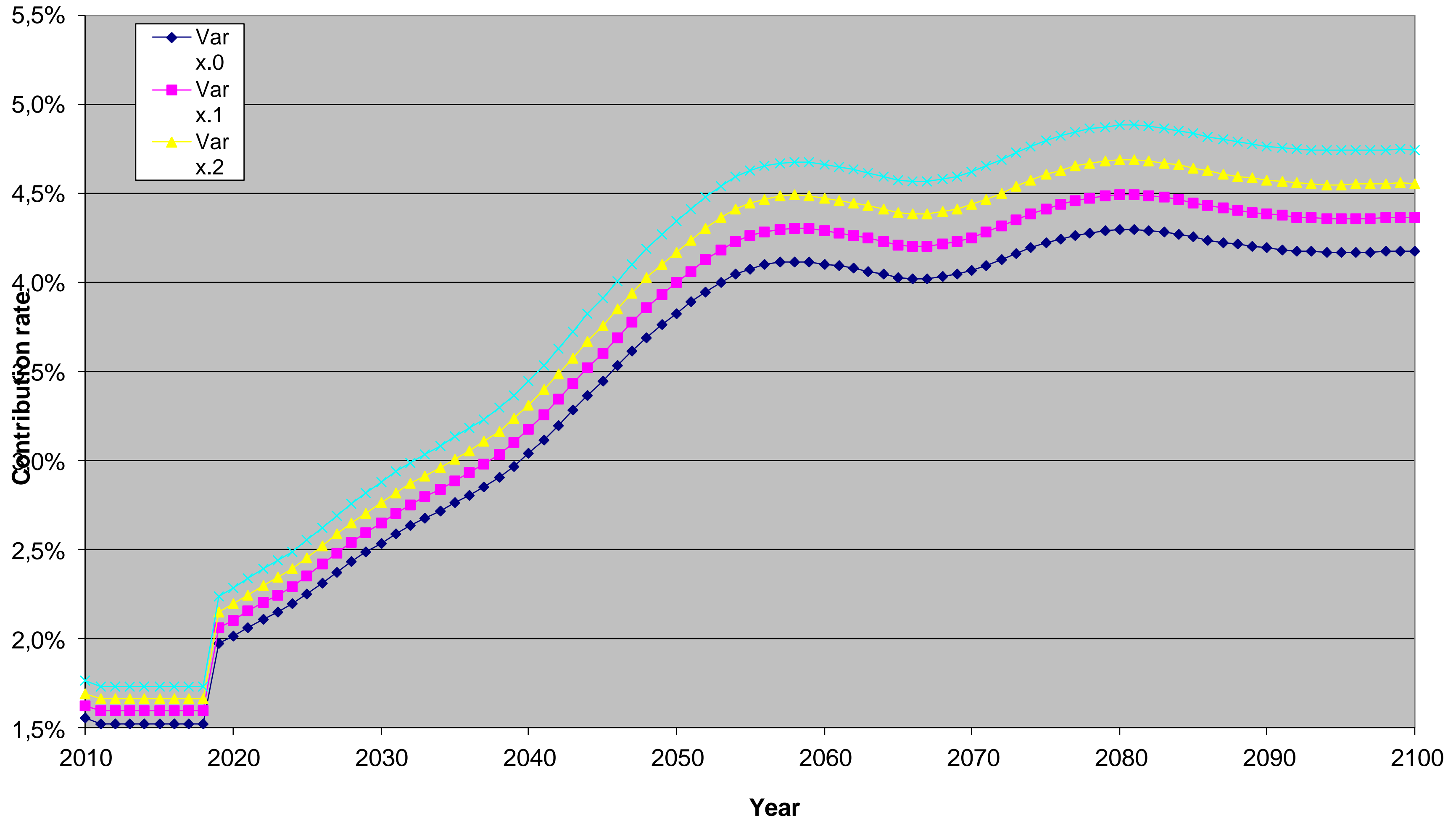
1. The effect is very small
   - For 20 years the contribution rate is increased for 0.1 percentage point
   - For another 20-25 years the contribution rate is then reduced by 0.1 percentage points

2. It is difficult to protect such a fund against politicians once there is a fiscal crisis

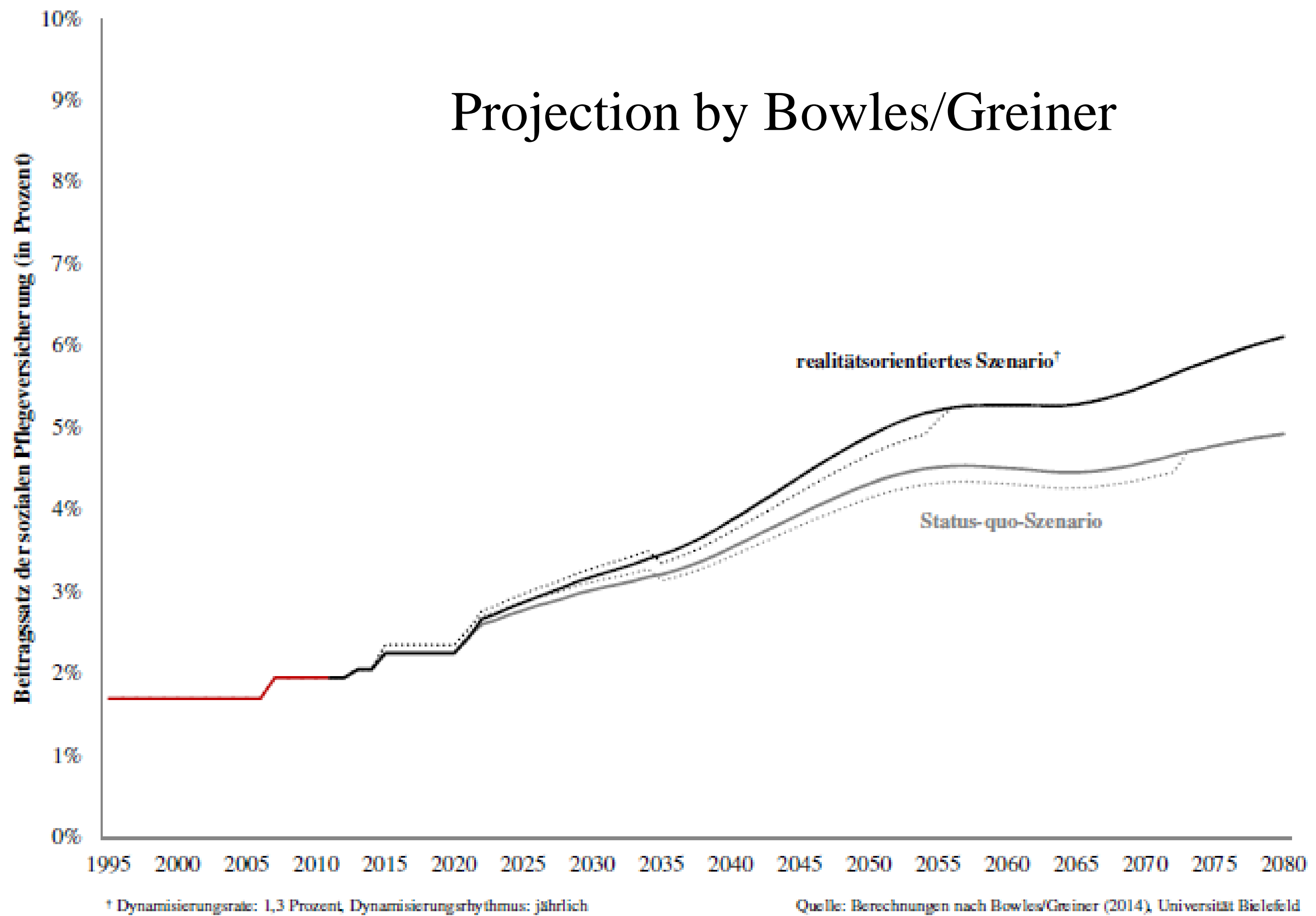
3. The fund will be empty when we have the highest number of LTCI beneficiaries. While number of beneficiaries will decrease then, contribution rate will not.

IV.2 Long-term projection of contribution rate

Demographic projection: income, prices and benefits are kept constant



IV.2 Long-term projection of contribution rate



What can be the role of supplementary private insurance schemes?

- Supplementary private insurance plans are an instrument for the better off (e.g. immediate LTC annuity plans) for covering gaps in public schemes.
- For those they might be helpful, but we must make sure politicians don’t cut public schemes and refer to private insurance instead.
- If we (no longer) want to rely on means-tested social welfare, social insurance is superior to private insurance

V. Summary

1. We need some sort of public involvement as neither out-of-pocket-payments nor voluntary private insurance suffice

2. Distinct welfare state conceptions demand distinct means of financing long-term care

3. There are specific challenges for social insurance and tax-based systems particularly securing sufficient benefits

4. In LTC Funding can at most supplement PAYGO

5. Private insurance might supplement public schemes. However, this contains the danger of
   - substitution effects
   - inequity in benefits
   - reversed redistribution (when subsidised)

The end

Thank you for your attention!

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Steinbruch

- Hotelkosten und andere Kostenarten differenzieren
- Washington folien prüfen
- (“Hotel cost” scheint zu gehen)
- Ad “combination”: asset protection by Versicherungen, die erst im Risikofall zahlen (s. OECD bericht)

Steinbruch

- Services through the healthcare system (Belgium) or as separate systems
- Contributions also by pensioners
- Catastrophic costs
- Means-tested safety net: US with medicaid
- UK: The Disability Living Allowance and Attendance Allowance are non-contributory, non means-tested and tax-free benefits, the former paid to severely disabled people who make a claim before age 65, the latter paid to those who claim from age 65.

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- Means-testing in England (OECD, S. 229):
  By targeting public funds to the poor, this approach can be effective at limiting costs, even though the cost per eligible user can be high. But it may also create inequities and incentives to use health care for LTC purposes, particularly where there are universal health-care services and targeted social-care services as in England. Means assessment can also be administratively expensive. These systems can result in unmet needs and leave families above the assets/income threshold vulnerable to high LTC expenditure (Fernandez *et al.*, 2009).

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Steinbruch

- Means-testing (OECD, S. 229):
  Safety nets face similar challenges to those confronting poverty programmes and social-assistance systems. For example, they can leave elderly and disabled people impoverishing to become eligible for care. Setting thresholds is hard, particularly as it always implies creating a group not poor enough to qualify for public funding, and yet not rich enough to pay for care costs. When people are required to sell their homes and use such proceeds before being eligible to public coverage, the system can be seen as unfair, particularly given older people attachment to their homes. If there are no uniform criteria for eligibly across different jurisdictions, this can also lead to confusion over eligibility for public funding and reduce transparency.