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Kick Off Workshop
Long Term Care: reforms and redistribution

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Introduction

What is so unique about LTC in the NL?

What did we learn from some of our earlier work that led to this new project?

What are some of the policy options considered (in the project) to strengthen the system sustainability ?

What do we take a look at this afternoon?

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Studying LTC insurance in the Netherlands is of interest because

The Netherlands has a fairly unique LTC system

- Separate, comprehensive, compulsory social insurance scheme against long-term care (LTC) since 1968
- High level of public spending but sustainability questioned
- Central assessment of care eligibility criteria
- Relatively generous, rather low copayments
- Reform process has started (WLZ)

The Netherlands has a unique linkage between

- administrative population register data on LTC use and expenditures (CAK), health care expenditures (Vektis), income, pensions and wealth data, hospital admissions, labor force and social security status, mortality register
- As well as (linked) survey data on health and disability, informal care provision and background characteristics (like STREAM, Health monitor, SHARE, etc)

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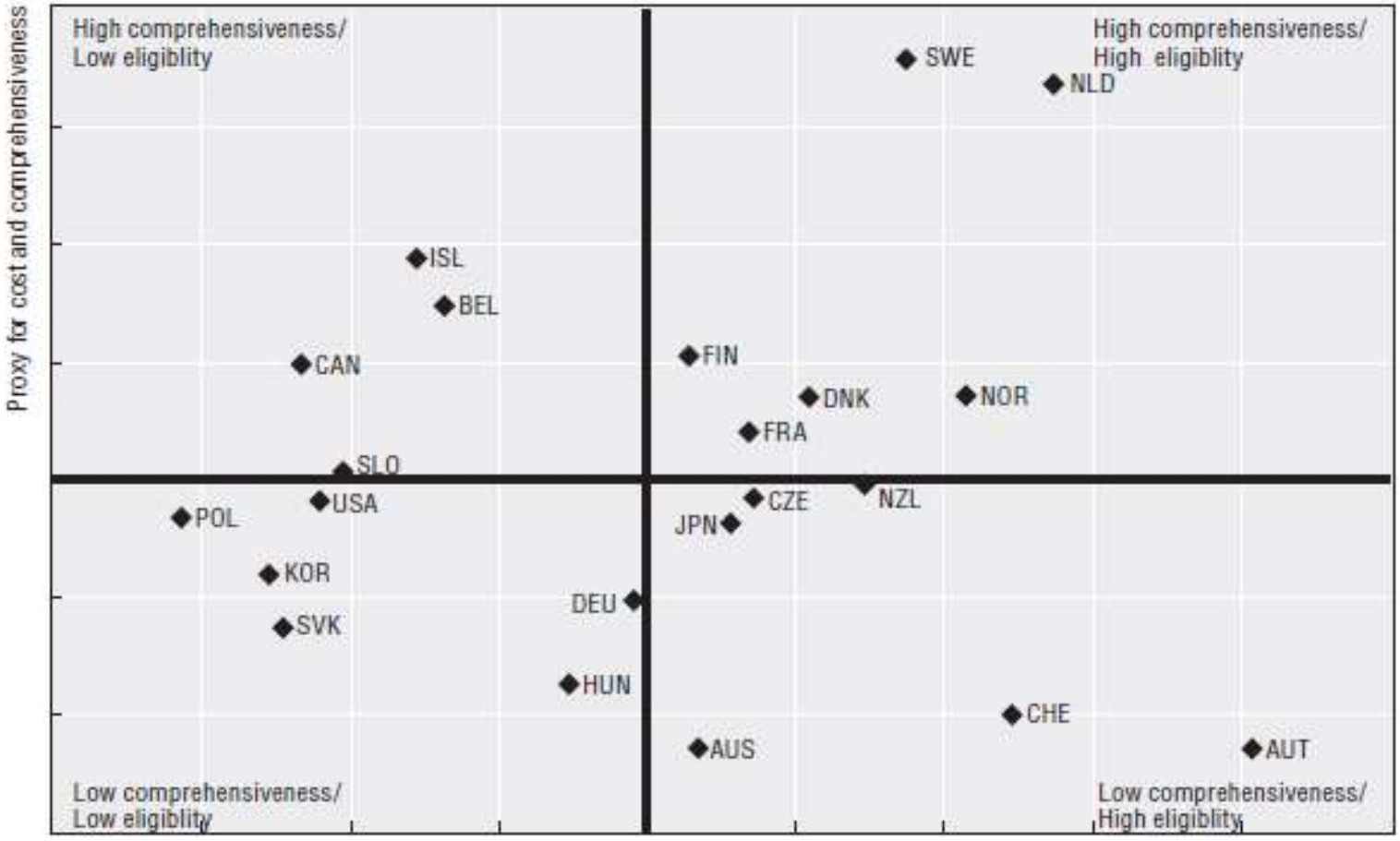
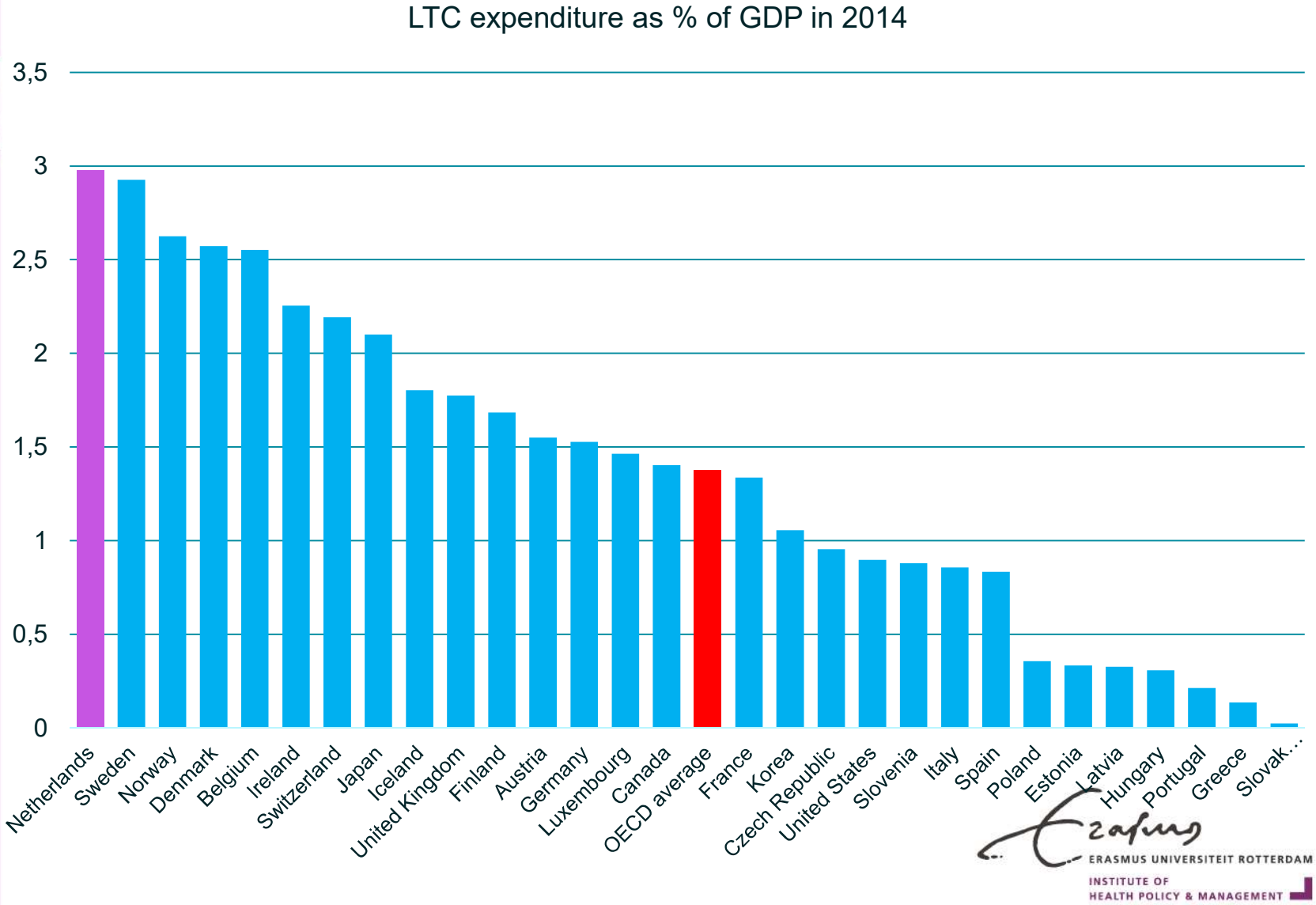
High coverage level

Figure 7.4. **Comprehensiveness of public LTC coverage across the OECD, 2008**

Share of LTC recipients in the over 65 population (X axis) and LTC spending in GDP (Y axis)



High spending level, mainly from the public purse



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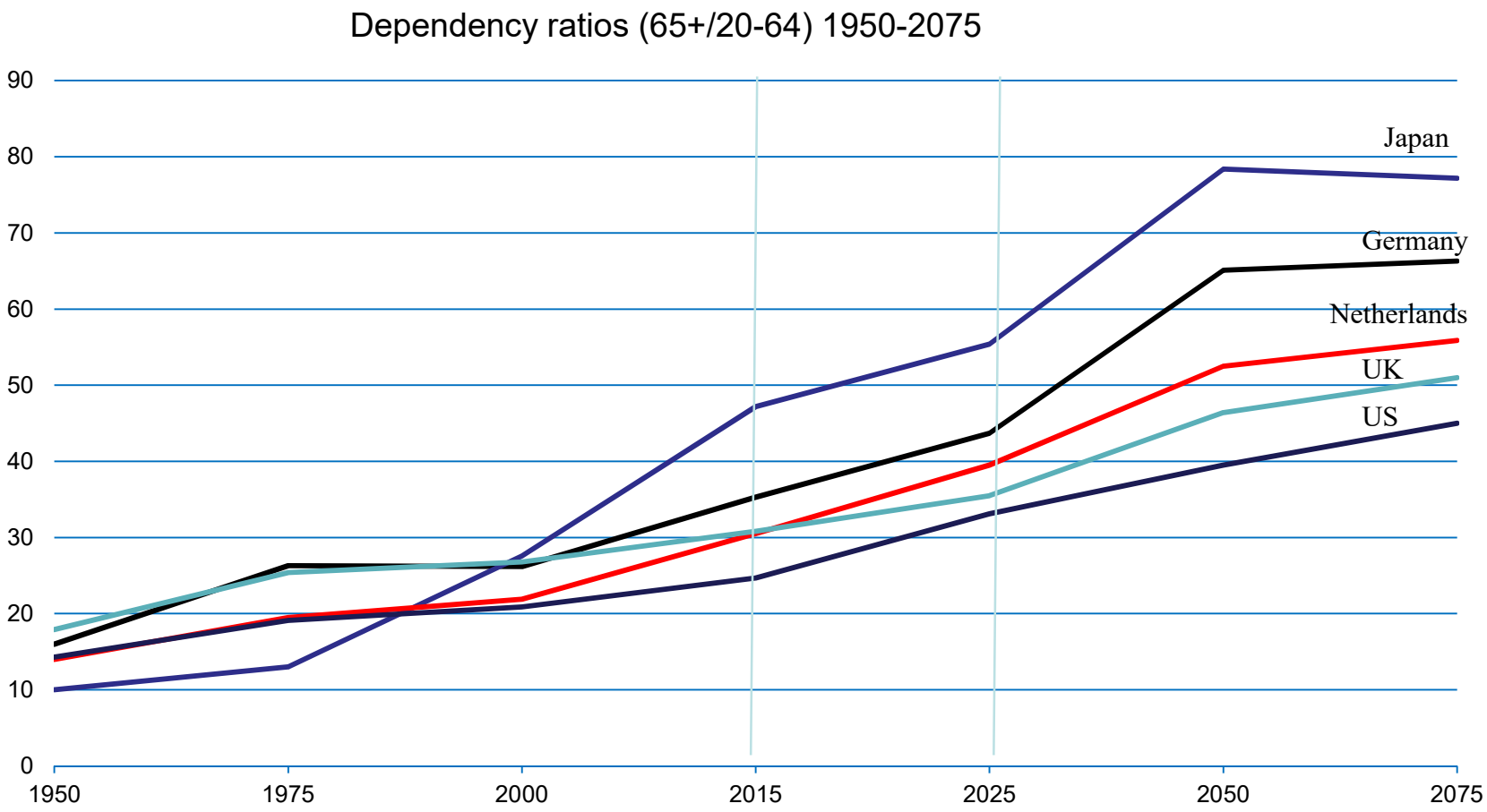
But future sustainability under pressure



Source: OECD, Pensions at a Glance 2015

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What determines LTC use and expenditure? Some lessons from earlier work

First and foremost: demography and epidemiology
(de Meijer et al, *Med Care*, 2009; de Meijer et al, *JHE,* 2011)

- It is not age
- It is not time to death
- It is the degree of disability that determines type of LTC care use (informal vs formal; home versus institutional) and expenditure
- as well as social support – mostly spouse ability to provide informal care
- and type of disease/diagnosis

Second: LTC financing features *do* matter
(Bakx et al, *HE*, 2014; de Meijer et al, *HE*, 2015)

- Eligibility rules for home and institutional care
- Generosity of coverage

Two illustrations using decomposition in Xs (covariates) vs βs (coefficients):

- Differences in formal/informal LTC NL-Germany (based on SHARE data)
- Trends in NL over time (2000-2008)

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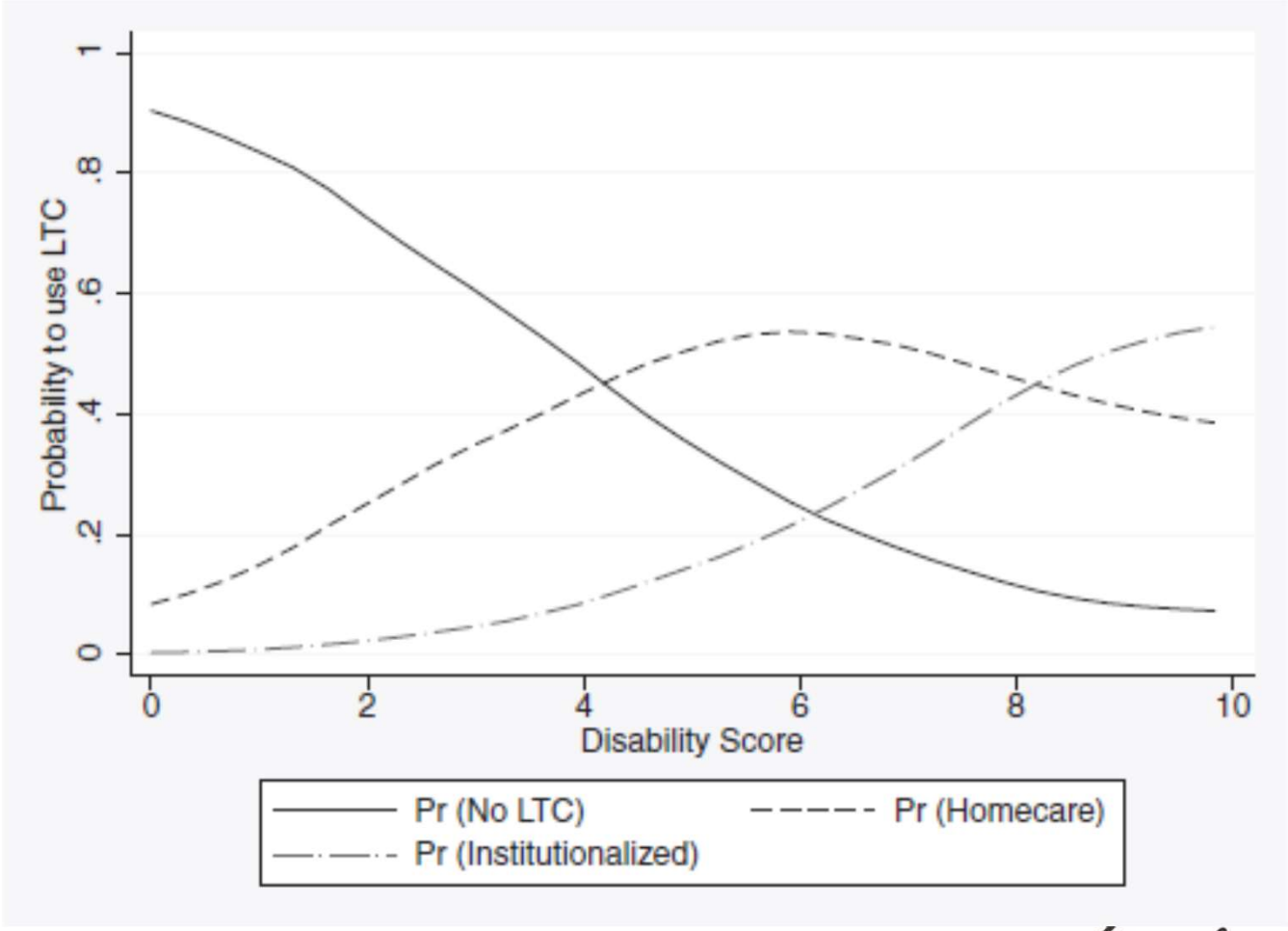
Disability determines use of LTC

(de Meijer et al, Med Care, 2009)



Unraveling shifts in LTC determinants and policies

(de Meijer et al, HE, 2015)

A= example of demographic determinant shift: disability rises due to ageing populations

B= example of policy shift: stricter eligibility criteria for institutional care

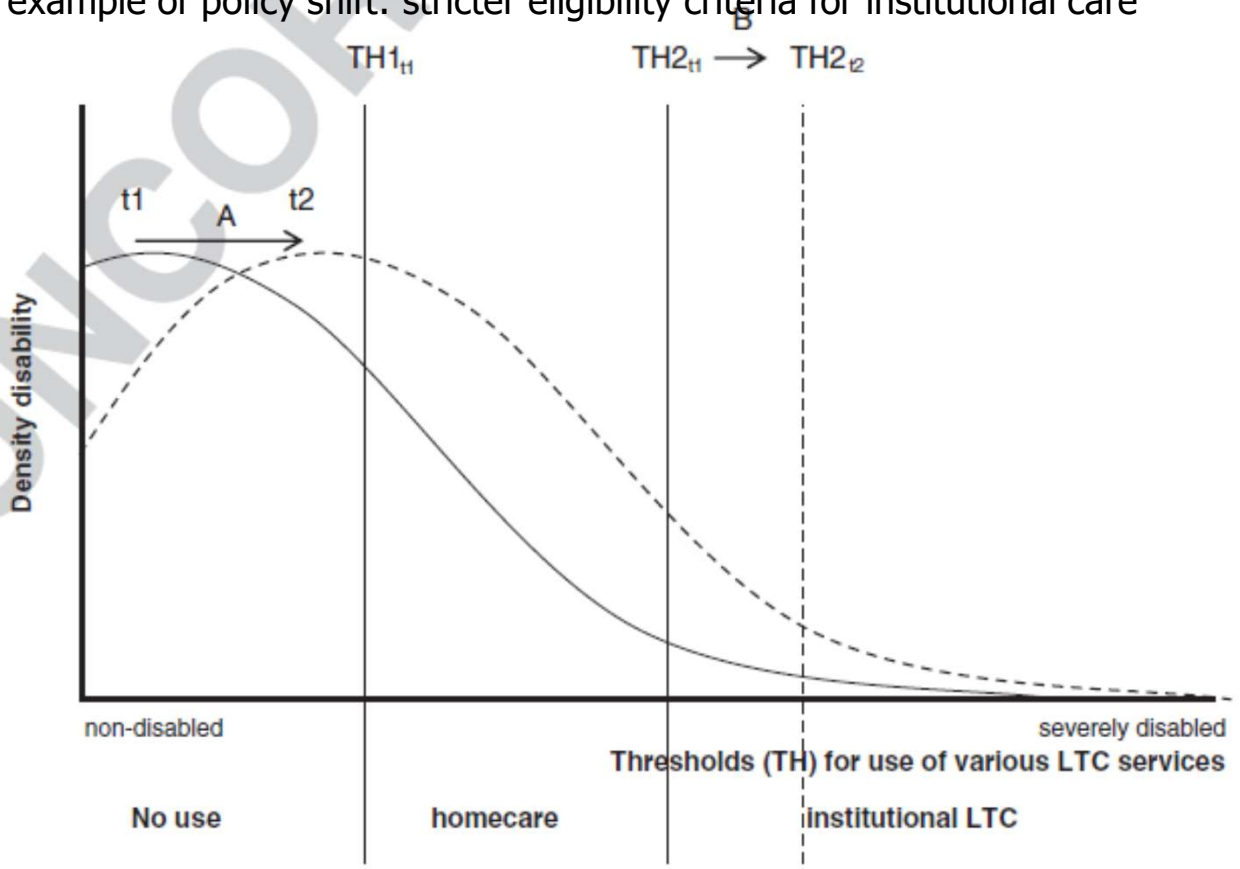


Figure 1. Sources of change in long-term care (LTC) use rates (hypothetical illustration)

Residential LTC admission probability is falling, given disability
(de Meijer et al, HE, 2015)

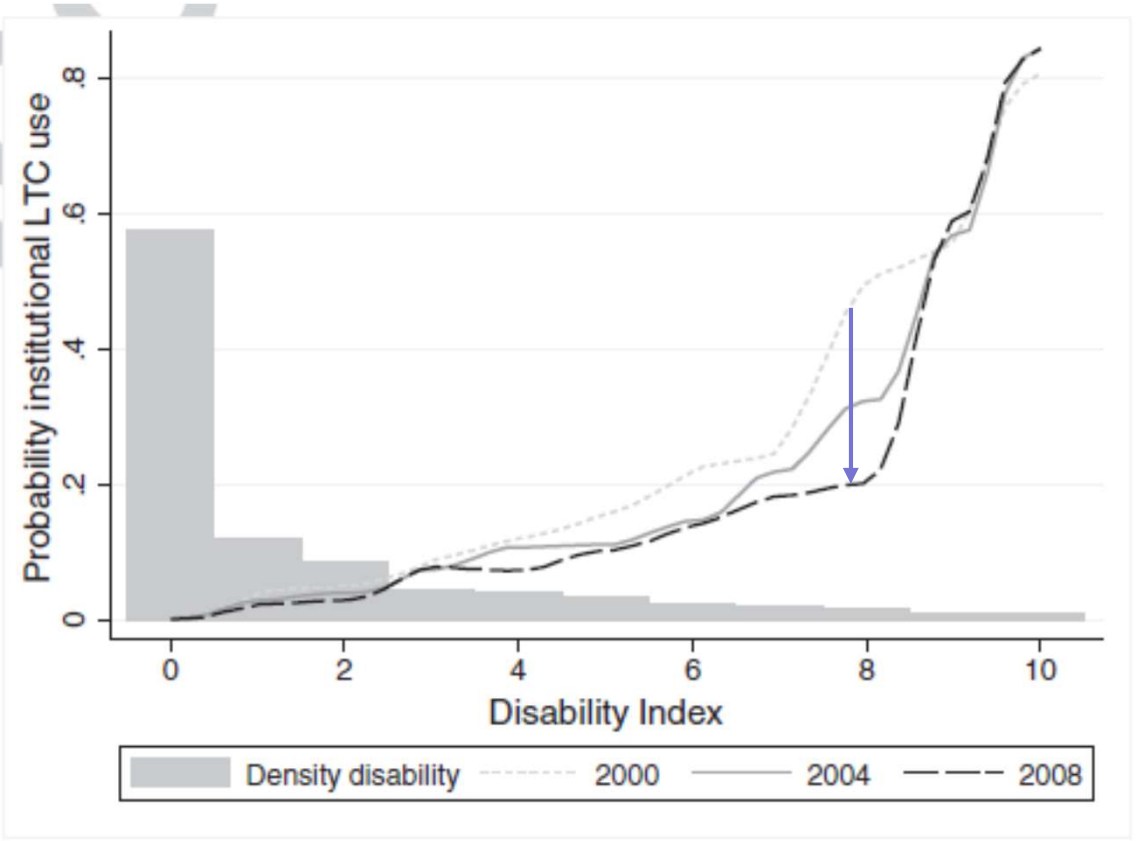
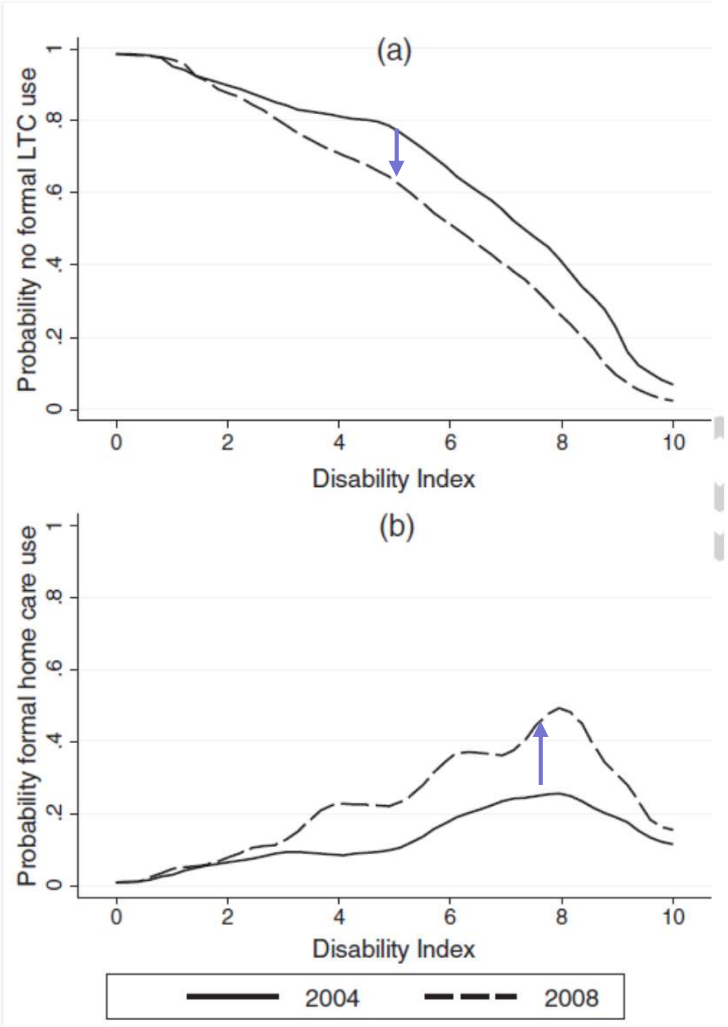


Figure 2. Probability to be institutionalized as a function of disability. LTC, long-term care

While use of home care in NL was rising 2004-2008



At given disability level,
probability of <u>not</u> using any LTC has fallen

while probability of using home care use has risen

Pushing patients into LTC but out of institutions has driven up the use of home care, especially at disability index levels 4-8

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Some lessons from two decomposition analyses of
- trends over time in the Netherlands (de Meijer et al, 2015)
- comparison with Germany (Bakx et al, HE, 2014)

1. Trends not due to changes in disability distribution but to changes in LTC policy:
   a. a sharp budget increase in 2001-2002 to reduce waiting lists and
   b. encouraged substitution of home care for institutional care (Ageing in place)
2. Drop in institutional care use primarily among mild disabled (and rise among most disabled). Stricter eligibility rules can explain this.
3. Drop in institutional care use (minus 6.3%) more than compensated by higher home care use (plus 50%). Possible "woodwork" effect?
4. In absence of changed responsiveness of LTC use to disability, institutional LTC use would have risen, not fallen.
5. Comparison with Germany suggests that financing arrangements do matter:
   a. Different formal/informal care mix is due to financing rules, not demographics
   b. Equal LTC use for equal need, irrespective of income in NL, not Germany, driven by generosity and equal application of eligibility rules

Both studies suggest that LTC policy *can* mitigate consequences of population ageing.

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Options for improving sustainability

The private co-financing share of LTC can be raised by considering five possible sources:

1. Income related cost sharing
2. Pension wealth
3. Housing wealth (e.g. reverse mortgages)
4. Other assets (savings, stocks,..)
5. Contributions of children (in cash or in kind)

Project aims to assess consequences, both costs and benefits – and their (life cycle) distribution – of alternative options.

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Examples of sources of exogenous variation in financing arrangements

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Source of exogenous variation	Behavioral response to	Potentially affects
Level of co-payments adjusted for asset holding (2013)	An increase in the price of formal care	The type and amount of LTC use; saving behavior (including housing); health status
Cutbacks in public expenditures on domestic care and housing adaptations (2007-2015)	An increase in the price of formal care	The type and amount of LTC use; saving behavior; health status
Increases in the statutory retirement age and eligibility for early retirement	Changes in the amount of expected pension benefits	Labor supply; amount of informal care provided; health status of the potential caregivers
Adverse health events: parents and spouses	An increase in the demand for informal care	Labor supply; amount of informal care provided; the health of the potential caregivers

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Project goals

1. Exploit natural experiments (incl recent reforms, e.g. in cost sharing arrangements) to estimate behavioural responses to policy/institutional changes
2. To identify effects of financing changes on LTC use, on LTC expenditure on LTC public and private payments, and on health/dependency of users and carers
3. Use 1-2 to simulate distributional consequences across the life cycle of planned reforms of increased private share in public-private financing mix

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This afternoon's session

1. Jon Skinner (Dartmouth): Inattentive households and consumption decline during retirement
2. Arjen Hussem (PGGM/CPB): Life cycle paths of LTC costs: alternative consequences for income and wealth
3. Pieter Bakx (EUR): Estimating the health effects of a nursing home admission in the NL

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