Abstracts

Mr. J. Draijer (Former Counselor for Health, Welfare and Sport at the Netherlands Permanent Representation to the EU)

Health care in Europe: who cares?

The diversity of health care systems in Europe has been described many times by experts all over Europe. Not only curative care but also long term care. This diversity in such systems can be explained by looking into the history of health care systems in Europe. Doing so, we will see how cultural, social, economic and political determinants have contributed to shape health care system as they are now in all European countries. National health care systems reflect history, values, traditions and culture of the different countries in Europe. This is currently the case as it was in the past: health was and is a national concern. But, does this also count for the future; and, more particular within the European Union (EU)? Are there developments in the EU which may increasingly affect the national competence of governments regarding heath care including long term care?

Health care including long term care is still considered by governments, experts and citizens as primarily a national competence. Indeed it is. Member States of the European Union themselves are responsible for how their health care is organized and financed, as well for which health care performances are to be delivered according to national law. Even in the Treaty on European Union (from the Treaties of Maastricht to Lisbon on) it is stated that any kind of harmonization of health care systems in the EU is excluded. So, who cares?

However, the answer to this question is more complex than we think. There are three developments in the EU which will have a significant impact on the national competence of governments for health care systems: legislation in the framework of the Internal Market of the EU, the intention to transfer sovereign competences from national level (currently 17 euro countries) to supranational ("Brussels") regarding state budgets of EU countries in trouble (as a result of the completion of the Monetary Union by adding a Political Union for the EU), and last but not least the mounting 'jurisprudence' created by Court Rulings of the European Court of Justice(ECJ) regarding health care, long term care, and patients' rights. In particular the ECJ definition for health care as a "service of general economic interest" is very significant because it means that all EU legislation of the EU Internal Market applies for health care: free movements of persons (so also patients), services, goods, capital as well as EU legislation on procurement, state aid and competition.

Only time will tell to what extent these three' irreversible' developments will affect the nature of health care systems in the EU and to what extent sovereign competences for health care will be transferred from national level to 'Brussels". So, who cares in the future?

Dr. K.P Companje (Centre for the History of Health Insurance;
VU Medical Center)

Financing high medical risks in the Netherlands: health care, social insurance and political compromises

The way in which the Dutch social health insurance provides for the insurance of high medical risks has a long history. The social and political definition of high medical risks, exceptional medical costs or uninsurable risks varies in time. Old age, chronic ilness, mental and physical handicaps with limited possibility for curing are risks of which the costs for loss of income and care were covered in various ways.

The first public insurance for high medical risks was the Dutch Exceptional Medical Expenses Act (AWBZ), which dates from 1968. Until the introduction of the AWBZ the costs of care werd covered by a complicated mix of private means: Poor Law provisions (1912), public and private subsidies, subsidies by the Disability Law (1919) and sickness fund insurance benefits (1941). Since 1943 there was political and societal concensus that the arrangements for financing high medical risks were insufficient because of:

- the expected ageing of the population and the increase of chronically ill patients
- shortage of care in convalescent homes
- the lack of organisation and quality regulations for care and lodging of elderly and chronically ill
- the complicated, overburdened, insufficient and out of date system of financial coverage

After years of suggestions and debate the Dutch parliament accepted the AWBZ. The AWBZ is internationally a unique social health insurance, which provides almost entirely in kind for high medical risks. The financial basis is formed by premiums with limited copayment. In 1968 the AWBZ covered uninsurable care as residential nursing care, institutional mental care and care for the physically handicapped. With the AWBZ and the public and private social health insurance every Dutch citizen gained full access to curative care and was covered for high medical risks. For the first time a system of quality standards for the recognition of intramural care also had to be developed.

From the start, the AWBZ had several structural flaws:

- open end financing. Despite many efforts to maximize the AWBZ-budget it was always exceeding the budget.
- no distinct demarcation between social security and insured care
- from 1974 onwards the AWBZ was used to realize political compromises

In 1979-1980 social-democrats, christian-democrats and liberals traded the introduction of housing subsidies against financing home care from the AWBZ. The line between uninsurable and insurable risks was crossed and in 1988 abandoned. In 1987-1992 the AWBZ was used as instrument to integrate the social and private health insurance with the AWBZ into one health insurance.

The AWBZ became a melting pot of high and low medical risks; from home care, medicine, paramedical and psychiatric health care to instutional nursing and mental care. The demarcationline between curative care, other forms of care and social security became indistinct and causes financial, functional and organizational problems to this day.

Dr. S.O. Daatland (NOVA - Norwegian Social Research)

Sustainable care? Norwegian long-term care in a European perspective

Introduction

Population ageing is a challenge to all modern countries, and to Europe in particular as Europen populations are old and still ageing. European countries have had to cope with ageing populations for some time, and must continue to do so. The similarity of the challenge should make us assume that interventions would be equally similar, but policies have legacies and tend to follow the roads already taken. Countries are therefore attracted to different approaches even when circumstances are similar. Some tend to look for solutions in the (welfare) state, others in the family, and yet others in the market or in civil society. The different policies may have a long history, and may be more or less outdated and resistant to change. This paper will explore the Norwegian case – first through a comparative description of the current model, next via analysing how current policies have come about, and third by discussing their future sustainability.

The current model

Scandinavian countries tend to come out as a distinct model in welfare state typologies, be they based in political ideology (Esping-Andersen 1990) or in cultural characteristics (Castles 1993). Established typologies have, however, been criticized for being more adequate for economic protection than for "the new social problems" (Alber 1995), which are not primarily rooted in the class structure, but are tied to demography, gender, and life-course circumstances. Central among these problems is long-term care, by far new as a problem for individuals and families, but comparatively new as a welfare state responsibility, and representing an expanding component in ageing societies. Long-term care (LTC) refers to personal and instrumental help in the handling of activities of daily living. This paper concentrates on "elder care", i.e. on long-term care to older people.

The paper suggests that long-term care may be analysed with reference to four major dimensions or priorities. Some of these dimensions refer to policy inputs, others to policy outcomes, and some of them may be broken further down into sub-dimensions. The four dimensions are the state role, the mode of financing, the main instruments, and the coverage and benefit levels. These dimensions tend to cluster into a limited number of models, with "the public service model" and "the family care model" as contrasting cases, the former represented by Scandinavia, the latter by Mediterranean countries (Anttonen & Sipilä 1996, Daatland 2012).

The state assumes a larger and more direct role under the Scandinavian model than under the other models. Main instruments are in Scandinavian countries the tax-funded services, usually provided by local governments (municipalities), with universal coverage and comparably generous benefits. Other countries and models tend to give the state a more secondary and indirect role via cash transfers or supplementary services to families, which may be monitored and financed by the state, but are usually contracted out to NGOs or private-for-profit companies. Actual differences are not as clear-cut as indicated by these ideal types. There is in fact considerable overlap between countries and possibly some convergence between them over time.

This section concludes with a description of the major LTC services in Norway with recent trends and cross-country comparisons. Special attention is given to major priorities under the Norwegian model, such as the public-private balance, the financing of services, and their access and standards.

Historical developments

This section provides a general review of developments over time, and the when and why of major policies and drivers of change. Focus is on more general features such as when and why LTC came to be recognised as a welfare state responsibility, the shifting roles and balances between public and private responsibility, and within the public – the division of responsiblities between central (state) and local governments (municipalities). Special attention is given to recent reforms and trends, and discussed as responses to problem pressures, as legacies on the past (path dependency), and as products of more recent political and professional controversies.

Sustainable care?

The concluding section discusses recent reforms in light of their future sustainability. The already established LTC models may be seen as *different approaches to similar challenges*, and to some extent as children of past legacies, which have constrained and channelled the choices taken. Future models are perhaps better seen as *similar approaches to different challenges*, as the same medicine seems now to be prescribed in more or less all countries, however different their policies and populations are. Among such remedies are a priority to home care, a more strict targeting of benefits, and a priority of cash over care (services). Common to all these is a balancing towards (even) more family care, be it in the form of so-called supportive familism, or as familism by default (or omission). Other remedies are found in new technologies, in rehabilitation, in migrant carers, in self-care, and in various forms of privatization. Hardly a treatment that fits all.

Drs. R. Götze and Prof.dr. H. Rothgang (University of Bremen, TranState Research Center, Linzer Str. 9a, D-28359 Bremen (Germany), +49 (0) 421/218-56632, ralf.goetze@sfb597.uni-bremen.de)

Fiscal and social policy: financing long-term care in Germany

This paper deals with the coverage of long-term care (LTC) in Germany since the post-war period. Until the 1990s long-term care was mainly a task of the family with means-tested, tax-financed social assistance as a last resort. In 1994, after two decades of political debate, the German parliament approved the LTC Insurance Act. This path-breaking reform act introduced a two-tiered mandatory long-term care insurance (LTCI) for virtually the entire German population. We will capture the genesis of the so-called »fifth pillar« of the social security system from the initial stage of problem recognition to the agenda-setting period and the decisive implementation phase. We also shed light on recent reforms of the original LTCI Act. We argue that the introduction of the LTCI can be explained in terms of an interplay between fiscal and social policy. In order to conceal their financial interests, municipalities and charities acted as advocates for the elderly in need of LTC and their families.

Summarizing the effects of the LTCI and comparing them with the initial estimations and targets we identify unsolved issues and further need for reform. Even todays reform debates, however, can be understood as rooted in the tension between fiscal and social politics and policy, but overshadowed by a revival of ideological debates about private vs. public provision and strongly tied to the veto-ridden institutional setting of the German political system.

Drs. A.A.M. Spoor (Group Strategy Achmea, the Netherlands)

Health, pensions and housing wealth. Towards a multi-pillar approach of health care finance

The question whether health care expenses in the Netherlands are financially sustainable is a cause for growing concern, as they systematically increase faster than GDP. This trend may result in a growing financial burden for future generations.

In the Netherlands long-term care is regulated – for all age groups - in the Exceptional Medical Expenses Act (AWBZ, Algemene Wet Bijzondere Ziektekosten). The finance system is P(ay)A(s)Y(ou)G(o). This raises the question whether a funded multi-pillar system may contribute to a more robust finance of long-term elderly care. From the macroeconomic point of view there does not seem to be a necessity for a funded finance. Funding however may be useful in a scenario of growing demographic pressure. On the micro level precautionary savings for long-term elderly care do make sense, when households are confronted with both rising out-of-pocket health expenses and increasing uncertainty of pension benefits.

When considering the funding of finance of long-term elderly care, several options come into view. In the Dutch context two possible models deserve special attention. In the first model the mandatory Dutch (funded) second pillar pension system is used as a vehicle to organise savings for elderly care. The second model is a funded – mandatory or voluntary - long-term care insurance or a long-term care fund. If the Netherlands would consider a funded system for financing elderly care, this preferably should be realised by an insurance system rather than by pure savings, because health expenses of the elderly are highly skewed. In addition to the aforementioned savings and insurance solution we may think of other options, such as pension benefits in kind and the use of accumulated wealth in housing equity.

What measures can be expected from Dutch politics, if at all? The budget of Dutch households feels the pressure of the financial crisis. Consequently, at this moment any step towards additional mandatory savings for elderly care seems highly unlikely. This raises the question whether there is room for the introduction of a voluntary long-term care insurance in the Netherlands. However, experiences in other countries show that starting and developing a market for long-term care insurance is extremely difficult. In the short term the use of housing equity for the finance of long-term elderly care seems more promising, as this does not require additional savings. This solution poses challenges as well, such as the development of more transparent financial products for releasing home equity.

One of the general observations is the following. The worries about the financial sustainability of the Dutch health care system have triggered a debate on the question whether the domains of pensions, health finance and housing may work more closely together to create a more solid base for financing the needs of the elderly. It is likely that, sooner or later, from this debate new finance models for the provisions for the elderly will emerge.