High medical risks as a social risk

On Friday 26 October the Centre for the History of Health Insurance (VU medical center, Amsterdam) and the Department of Health, Ethics and Society of Maastricht University hosted the symposium *Insuring against high medical risks from an international historical and social political perspective. Symposium on the historical and social political problems of financing long term care, elderly care and care for the disabled.*

Various specialists and the participants discussed how the insurance of high medical risks evolved and interconnected with the development of social security and health care in the EU.

Reforming welfare states and sustainability of care in the EU

Since 1980-1985 the postwar welfare states of Europe are changing from covering the risks of life with stable family structures to new scenarios. The period of full employment and sustained economic growth was over. The combined effect of ageing, changing family patterns and an increasing female labour force, globalization and the political and economical integration within Europe led to an activating rol of the welfare state consumer[1]: *social (self)promotion* in stead of *social protection*.[2]

Restructuring the welfare state by retrenchment did not just mean the ruthless cutting social security, but reforming social politics. The sustainability of services and the financing of care in convalescent homes and residential homes for the elderly, home help schemes, care for the physically handicapped and mental health care is one of the great social and medical problems of the modern welfare states.[3] These forms of care are considered *new social risks*.[4]

All members of the European Union deal with the same problems and challenges of access, quality and sustainability for these forms of care.[5] Demographic and non-demographic factors, leading to *healthy ageing* costs mean higher costs.[6] The growing prevalence of chronic diseases on the other hand causes an increasing demand for services, while government budget deficits, shortage of staff and changing family structures are threats to adequate and sustainable care.[7]

According to the principle of subsidiarity in the EU the organization, implementation and financing of these forms of care belongs to the domains of health and social security of each EU member states.[8] The way these forms of care are organized and financed depends on the economical, cultural, social and historical background of each country.[9] The EU promotes coordination of care to support solutions for these problems at the national level.[10]

There are many EU and non-EU reports and studies about organizing and financing long term care in the member states, but EU wide coordination demands comparative knowledge of how the national systems were formed and functioned from a historical and social political perspective.[11] EU and national government policy workers, health insurers and the healthcare system as a whole confirmed that a lack of historical insight is hampering the formulation of new policies.

Rothgang and Morel studied the development of the international variety on insurance arrangements for long term care from the theoretical perspective of the Bismarckian welfare state classification of Gosta Esping-Andersen.[12] Christensen described the Norwegian long term care system as model of the Scandinavian social democratic welfare regime, with public and private provision of health care.[13] Gleckman wrote an interesting paper about the

development and the problems with long term care financing reforms in the Netherlands, Germany, Japan, France and the United Kingdom with lessons for the US.[14] But this paper was a short sketch and gives little insight in the political and social context in which the described arrangements were formed. A historical and international comparative study into the structuring and financing of care in convalescent homes and residential homes for the elderly, home help schemes, care for the physically handicapped and mental health care is necessary.

Long term care or high medical risks: which is a useful definition?

In social and political debates the services of elderly care, long term nursing care, mental care and care for the disabled are often clustered als long term care, or LTC.[15] The question is whether the term LTC can be used to study these services from an historical and international social political perspective.

LTC has become more and more a catch-all term. The definitions of long term care differ from country tot country.[16] There are wide variations in the identification in the length of staying, the identification of the received care and the definitions of the care services themselves. The distinction between the domains of health care and social care is often blurred, which causes problems for the financing and structuring of care in place and time.[17] The demarcation between curative care and the other mentioned forms of care is often indistinct, which ads to the problems of finance and structure.[18]

The OECD in 2005 defined long term care as an *issue that brings together a range of services for persons who are dependent on help with basic activities of daily living (ADLs) over an extended period of time* or, in short, *care for people needing daily living support over a prolonged period of time*.[19] These include services for[20]:

- activities of daily living (ADL) like rehabilitation, basic medical services, social care, home nursing and institutional care
- instrumental activities of daily living for occupational and empowerment activities *related to independent living*

The OECD-definition focuses on daily care activities and is usable to quantify the need to care.[21] It is more difficult to use the ADL-based definition for qualitative social, political and historical research. It simplifies the care needs of people with complex conditions and the difference between care for chronical physical and mental patients.

In 2010 Kraus, Riedel, e.a., put up an extensive classication of long term care systems in Europe for the EU-project *Assessing needs care in European nations, ANCIEN*.[22] They describe different typologies as:

- the organizational typology, or the distinction between the Beveridge and Bismark systems.[23] The distinction between tax funded and premium based medical and social care does not fit well with the funding of long term care, because in Bismarck typed states as Austria, the Netherlands, France and Belgium LTC is financed by taxes or by a hybrid of taxes and premiums.
- the use and financing typology.[24] Clustering according to the level of public and private spending, the high or low use of formal and informal care and the degree of accessability as a large set of explanatory variables leads to various forms of clustering countries.

For the ANCIEN-project Kraus e.a. concluded that is was difficult to collect *precise quantitative information* on LTC. They combined the two typologies to focus on system characteristics, use and financing of care to derive at a broad classification of organization and funding.[25] This classification differentiates between states in accessability to care, subsidization by the state and attractiveness. This is useful for describing the actual status of LTC in the EU states, but it provides no tools for qualitative research from a historical, political and cultural long term perspective.

Rothgang combines the differentiation in tax- and premiumbased funding of LTC with Esping Andersens notions of decommodification and stratification.[26] He distinguishes for the fifteen 'old' EU states five types or *Pflegeversicherungstypen:*

- the Scandinavian welfare states
- the European countries with a separate LTC insurance (Germany, Austria, Luxemburg and the Netherlands)
- the European states without separate LTC insurance (Belgium, France and Italy)
- the Anglosaxon welfare states (Ireland, the United Kingdom)
- the South European countries as *Rudimentärer Sozialstate* (Spain, Portugal and Greece)

The classifications of the OECD, Kraus and Riedel e.a, and Rothgang are methods to quantify the need of care and to study the contemporary status of long term care in different states. The availability of reliable and sufficient quantitative data to compare national LTC-systems poses a problem for comtemporary research.[27] The question is if LTC is really a usable term to describe the services and the financing of elderly care, long term nursing care, mental care and care for the disabled:

- to characterise the social and medical problems of the welfare state
- to study the social, medical and political context of elderly care, long term care, mental care and care for the disabled as part of the national health care and social systems
- to describe the increasing complexity of the integration of social and care arrangements

An alternative is to consider the services and the financing of elderly care, long term care, mental care and care for the disabled as *risks*. The financing and organization of the mentioned forms of care as problem of the welfare state are earlier characterized as a new social risk, but they are also a medical risk[28]:

- a social risk because it covers the income and social consequences of mental and physical chronical disability
- a medical risk because the way care is provided in quality and quantity depends on the level of care and the capacity of labour and care institutions

To look at these forms of care as risks it makes it possible to study them in historical and in international perspective, like the study of financing and structuring cure as a medical and social risk.[29] In the historical perspective of the welfare state cure is defined as a *low* medical risk because it can be financed by social or private health insurance, copayment and private means.

Forms of care such as care for the elderly, physically disabled and the mentally ill, long term nursing care and rehabilitation programmes can be seen as expensive medical risks. For the major part of the population these risks can only be financed with *state support or by collective social insurance:* they are unpayable or uninsurable *high* medical risks.[30] Defining these care services as high medical risks makes it possible to combine the social and medical domain for research and answers to questions like:

- Which care was in what time considered as high medical risk?
- How developed the debate about recognising forms of care for social means, such as the loss of income and covering costs of disability and chronic care?
- Social needs, economic development and the historical, cultural and political context were the determinating factors for the social status of care services and the way they were financed by collective and private means. Which problems were felt or occurred in time with financing and organizing high medical risks? How did the political and social debate about these problems develop? Which solutions were chosen?

The history of financing health care and high medical risks

The history of financing health care through social health insurance funds, private health insurance companies, and tax-funded systems in the form of National Health Services is described extensively in comparative international studies into financial systems for health such as J. Blanpain, L. Delesie and H. Nys, *National Health Insurance and Health Resources. The European Experience* [31], R.B. Saltman, J. Busse, J. Figueras (eds.), *Social health insurance in Western Europe*[32] and K.P. Companje, R.H.M. Hendriks, K.F.E. Veraghtert en B.G.E.M. Widdershoven, *Two centuries of solidarity. German, Belgian and Dutch social health insurance 1770-2008*.[33] In these studies no clear distinction is made between the coverage of affordable health care with low medical risks such as the care provided by General Practitioners (GPs) and specialists, paramedical care and hospital care, and the coverage of high medical risks.

In health care systems that are financed through taxes, i.e. the Beveridge systems such as the British National Health Service and the Scandinavian healthcare systems, the financial set-up does not play a major role in the distinction between high and low medical risks.[34] However, this distinction is crucial for the way in which health care is paid for in healthcare systems in countries as Germany, the Netherlands, France and Austria where the financial set-up consists of a mix of social and private healthcare insurance companies, government contributions and personal contributions: the Bismarckian type of welfare states.[35]

Coverage of low medical risks in the Netherlands, Belgium, France and Germany is provided by basic insurance policies for health care and social health insurance funds. The history of these insurance schemes is described extensively and also comparatively from an international perspective.[36]

The insurance against high medical risks is much less uniform and very few details of its history have been documented.[37] In 2004, De Roo, Chambaud and Güntert presented the first ever comparative study of long term health care as a high medical risk in EU member states.[38] In 2005, the Commission for Public Health and Healthcare in the Netherlands [De Raad voor de Volksgezondheid en Zorg] published a recommendation for reforms to the

Dutch AWBZ, an official act governing special medical expenses. It contained country studies on long term health care.[39]

Rothgang published in 2009 his study *Theorie und Empirie der Pflegeversicherung*. As earlier mentioned, he made a classification of the coverage of long term care according to Esping-Andersens typology of welfare states. He described the German *Pflegeversicherung* in the way long term care is covered as new social risk in the Western European states and Japan. Rothgang analysed the long term development of the *Pflegeversicherung* in the tension between state, market and corporatism and the problems with financing and coverage.

In 2011 Costa-Font and Courbage published the study *Financing long-term care in Europe. Institutions, markets and models.*[40] Various authors compared the financing of long term care of the EU member states fromn a institutional point of view. The ageing of the European population is described as a new financial risk, which calls for a response from the market, the states and society. The authors describe the way long term care is financed, with the institutional mechanisms for financing old age. The objectives are to try to understand the *institutional, economical, cultural and behavioural constraints* of the development of coverage of long term care, specific for the problems with ageing.

The book illustrates how long term care is financed in Europe and the problems the EU states face in terms of risk management of LTC. *Financing long term care* is valuable for its international comparative perspective of the risk of ageing and its contemporary problems.

The international perspective of contemporary and future problems of high medical risks

In the most of the EU member states it has been concluded that the current systems and regulations governing high medical risks are inadequate.[41] Soaring costs, the lack of functional descriptions for health care, complex financing structures and the distribution of authority over different ministries and regional and local authorities meant that the countries listed above increasingly view these systems as problematic. Various solutions are sought[42]:

- stimulating price/quality ratio by introducing regulated competition between careproviders and free choice of provider for the care client[43]
- more efficient and better quality of care by improved coordination or creating a continuum of care[44]
- substitution of expensive instutitional care by less expensive forms of formal and informal home care[45]
- introducing private insurance complementary to compulsory public insurance or public financing schemes as in France[46]
- using housing wealth, pensions and savings as self insurance against the risk of ageing[47]

The political and social debate about resolving contemporary and future problems with high medical risks aims at evolutionary development of the existing institutional and financial frameworks. It is important to gain insights into the way the financial basis and the structure of insurance against high medical risks evolved in order to fully understand the current problems. A comparative study into how the insurance of high medical risks has been structured and financed can go a long way into addressing this need. In the Netherlands and Germany high medical risks are covered by various forms and mixes of public and private health insurance and social security schemes. In addition to these countries who are financing

high medical risks by insurance, Norway is added as a model of a state where these risks are part of the tax financed benefits of the welfare state.

The first public insurance for high medical risks was the Dutch Exceptional Medical Expenses Act, the AWBZ, which dates from 1968. The AWBZ is still a unique social health insurance which provides almost entirely in kind for high medical risks. Premiums with limited copayment formed the financial basis.[48] 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 high medical risks. For the first time a system of quality standards for the recognition of intramural care 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.
- from 1974 the AWBZ was used to realize political compromises. In 1979-1980 social-democrats, christen-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 demarcation between curative care and other forms of care became indistinct and causes financial, functional and organizational problems to this day.

After twenty years of discussion in 1994 in Germany the premium based *Soziale* and *Private Pflegeversicherunge* was introduced as *Pflege-Versicherungsgesetz, PflegeVG.*[49] The *Plegeversicherungssystem* is a mandatory, universal social health insurance, introduced as fifth pillar of the social security system. The insurance provides partial cover for long term, residential care. Services such as domestic support, care for the mentally ill and the physically handicapped and rehabilitation programmes are financed in different ways by the state and the *Gesetzliche* and *Private Krankenversicherung*.[50] The benefits are mostly in cash and partly in kind. The German *Private Pflegeversicherung* is unique: it is the only mandatory private long term care insurance in Europe which guarantees the same benefits as the *Soziale Pflegeversicherung.* It concerns 10% of the population who are not covered by compulsory social health insurance.[51]

The Dutch and German insurances can be compared with the more divergent system of of Norway. In Norway the public care system is tax funded and organized by the municipalities, but with growing influence of private health care providers.[52] Copayment rates are high: for institutional care they amount to 85% per income. [53] The various forms of long term care and rehabilitation care are provided by the municipalities and the regions by contracting public and private care providers.[54]

In Norway social care, primary health care and long term care are strongly integrated, because they are combined at the level of the municipality. Services available in the municipalities and political choices in how to allocate funding is under debate.[55] Services for elderly care can vary per municipality. Emphasis on cost containment also varies considerably. The system is changing because of the increasing number of commercial service providers for home based and institutional care.[56] This may have an impact on the public

provisions of health and care services to make the public more able to choose between competing care providers. Private insurance of high medical risks does not exist.

According to the principle of subsidiarity in the European Union, covering high medical risks belongs to the domains of health and social security of the member states. The development of social protection systems in the old and new member states aims to guarantee coverage against illness and dependence in cure and in care. Social protection in each state is under pressure because of ageing. In line with the gains of life expectancy the number of dependent persons will increase by 31% in 2050.[57] The member states have to deal with the problems of growing demand in funding and providing care themselves[58], but they agreed that the EU will coordinate the national long term policies concerning access, organazation and sustainability.[59] However, this can interfere with the national priorities, such as the coordination of different levels of government budgets and between health and social care to strengthen sustainability.[60] The tension between the coordination of Brussels and the autonomy of the national levels poses the question: *Health care in Europe: who cares?*

Research and primary objectives

Coverage of high medical risks is not a new social risk. Like in the Netherlands it was part of the postwar debate about social health insurance. The way in which insurance coverage and financial arrangements were developed and implemented differed in each state, depending on the systems of social insurance and health care and the outcome of the social and political debates. A research question can be formulated as follows:

How does insurance coverage for high medical risks link up with the development of social security and health care in the Netherlands, Germany and Norway from 1945 onwards?

In each country social health insurance, of which insurance against high medical risks is an integral part, belongs to both the domains of social insurance and health care.[61] The core of the historiography of social insurance regulations consists of the following elements:

- a description of the social and political framework
- a description of the risks
- the segment of the population which is covered by the insurance scheme
- an explanation of the legislation and regulations developed
- the organisation responsible for implementing the legislation
- an assessment of how the insurance is worked out

These elements can be used for a systematic and historical description of financing and insuring high medical risks in the European countries and the US by reformulating them as:

- the development of the social, health care and political framework during the period 1945-2012
- a description of the risks to cover
- the development of the political and social debate about the need and way to finance high medical risks as public or private insurance arrangements
- the results of these debates: public or private arrangements, premium- of tax-financed arrangements or mixed-systems
- how the tension between state and private parties influenced the results?

- the segments of the population that werd insured
- the arrangements that were implementated and administrated
- the benefits, premiumsettings and cost
- the way the development of health care and social security influenced the need, use and expansion of the arrangements
- the problems that evolved or were felt
- the political and social reactions to these problems
- the solutions that were decided?
- the relation between the arrangements for insuring and financing high medical risks and other forms of health insurance. How did they fit in the social security systems?
- the influence of EU-regulation influence on insuring and financing high medical risks
- what were the similarities and differences between the arrangements in the states as they developed in time?

These questions and elements will give insight in the way how and why these arrangements were initiated and developed in each state, linked with social security and care. The presentations, papers and the results of the discussions of the symposium will be published in 2013.

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