NEWSLETTER
HEALTH AND AGEING

THE GENEVA ASSOCIATION

No. 30, April 2014

The Development of an Aged Care Insurance Market in Spain

By Manuel García-Goñi[+] and Francesco Paolucci[++]

Introduction

In the last years there has been a growing interest on the part governments and researchers in the field of ageing, focusing on how to respond to the evolving needs of the aged population (Costa-Font *et al.*, 2012), and specifically, on whether there should be a market for aged care insurance (Paolucci *et al.* 2013). At the moment, however, the evolution of the market of aged care insurance is marginal and in Europe, only France evidences some developed private LTC insurance market coverage with about 8 per cent of the population subscribed (Costa-Font and Courbage, 2012).

Our concern is that, given the current situation and without the right development of this insurance market, the cost of aged care for the increasing proportion of potential users might impose on them and their descendants a significant burden and welfare loss. First, because of the nature of the cost, which is uncertain and varies greatly within the population and over time. Second, because without aged-care insurance, recipient co-contributions will significantly increase. The relevance of the lack of coverage for aged care is huge if we consider the combined impact of the process of ageing and the fact that 35–50 per cent of the elderly population is estimated to use long-term care in their lifetime (Frank, 2012).

In this article, we take a look at the situation of the long-term care insurance market in Spain, where a "dependency law" was passed by the Spanish Parliament in 2006 and implemented in 2007, granting new rights to citizens in need of LTC personal assistance (Guillén and Comas, 2012). However, currently, not all levels of need are funded, and most beneficiaries receive allowances for the use of family informal care (OECD, 2011).

We analyse the welfare gains in Spain derived from the development of aged-care insurance, whether those risks are insurable and how such an insurance scheme might compare in terms of achieving policy objectives to alternative options. The current context is a challenge, since health expenditures have continuously increased in the last decades and the economic crisis has led Spanish governments in recent years to cut public expenditures, for example, by reducing prices or increasing co-payments, as in the case of the pharmaceutical policy.

The aged-care insurance market in Spain

The Spanish National Health System (SNS) is publicly funded through general taxes. It provides universal coverage, with a benefits package for all inhabitants, and health-care delivery is provided mainly within the public sector. The provision and planning of health services, though, depends on each of the 17 regions (García-Armesto et al., 2010; García-Goñi et al., 2012). With respect to ageing, the decentralisation process has led to regional long-term care (LTC) services (Costa-Font and Patxot, 2005). Before 2006, LTC needs were provided through either regional or local social services, or through programmes for people with disability benefits.

Although there are significant regional differences, the supply of social services for aged individuals has been traditionally limited, and most of the care provision has been private and informal. Law 39/2006 of December 2006 entitled the "Dependency Act" established the basis for a new system of long-term care services granting the right of personal assistance when needed and was recognised as the fourth pillar of the Spanish welfare system

[+] Departamento de Economía Aplicada II, Universidad Complutense de Madrid (mggoni@ucm.es).
[++] School of Health, Community and Education Studies, Northumbria University, Newcastle (f.paolucci@northumbria.ac.uk).

(Guillén and Comas-Herrera, 2012). It gave priority to improving formal care capacity and training caregivers, as well as increasing the quality of care and distributing the burden of LTC financing within society. One goal was to diminish the relative importance of informal care. When an individual becomes eligible, he or she receives a personalised plan based on their degree of inability and can choose between assistance in kind or in cash. The expected cost of the new system was of 1 per cent of GDP (OECD, 2011).

However, only a few years after the application of this law, allocated subsidies are low compared to the expectations created, and recipients show a clear preference for assistance in cash (linked to informal care). As a consequence, informal care is still the main avenue of aged and long-term care provision in Spain, and there has not been a significant effect in the creation of residences, nursing homes or other forms of formal long-term care or jobs related to that activity. In fact, Spain is one of the countries presenting the highest proportion of the population providing informal care to elderly or disabled people and, despite qualification requirements for workers in institutions, the LTC workforce consists mainly of low-qualified workers (OECD, 2011). There is, as a consequence, some more work to be done in order to improve the quality of LTC provision in Spain. This is related to the low allocation of resources together with the huge unemployment rate (26 per cent) and the economic situation of the country (INE, 2013), which induce the high proportion of informal caregivers given the lack of resources to hire private LTC provision.

Why insure aged care in Spain?

Under an insurance contract, the risk-averse individual prefers to pay a small amount, the premium, and avoid the possibility of a large but uncertain loss, while the risk-neutral insurer finds profitable (in expectations) to underwrite many such contracts, the risks of having to make payouts being independent. Therefore, the welfare gain of introducing age-care insurance depends directly on the extent of the insured loss, represented by aged-care costs and driven by the mentioned longevity, morbidity and prices.

Because Spain is one of the countries with the highest proportion of informal caregivers, it is difficult to estimate the annual average age-care cost. However, total public expenditures for long-term care were estimated to be 0.6 per cent of the GDP in 2008, and overall expenditure (public and private) was 0.8 per cent (0.5 per cent of GDP for institutional care, and 0.3 per cent for home care) as shown in Colombo *et al.* (2011). Therefore, the extent of loss seems to be important enough to derive a gain from insurance. Nevertheless, in Spain in 2009, only 0.3 per cent of the population over the age of 65 years received long-term care in institutional settings and medical facilities, while 1.2 per cent of this population group received care at home. The expected trend for the extent of loss is increasing: Comas et al. (2006) present projections for various European countries including Spain and find that the proportion of GDP devoted to LTC will more than double by 2050.

Regarding longevity, the Instituto Nacional de Estadística (INE, 2013) reports that life expectancy at birth between 1992 and 2011 has increased from 73.9 to 79.2 years for males and from 81.2 to 85.0 years for females, and conservative estimations indicate that, by 2051, life expectancy at birth could reach 86.9 years for males and 90.7 years for females. But the welfare gain from aged-care insurance depends also on the ability to pay or the socio-economic status of the insured, and in Spain, there is recent evidence that the correlation between socio-economic status and the mortality rate of the elderly Spanish population is weak (Regidor et al., 2012), increasing the gain from the insurance market.

With respect to morbidity, in Spain there is a consensus on the increasing importance of chronic patients' use of the National Health System and health expenditures, and the pathways that should be followed to link supply and demand in a more appropriate chronic-care system (García-Goñi *et al.*, 2012). Besides, the prevalence of chronic disease and related health problems is increasing in the older population. Hence, extended survival could expose individuals to an increasing risk of disability and age-related functional loss.

Lastly, the price of aged-care services also determines the extent of loss to be insured and, because aged-care services are and will likely remain labour intensive, that relative price seems set to rise, as working-age cohorts account for a smaller share of the population.

Obstacles for developing the age insurance market in Spain

The gains of developing the age insurance market are clear. However, if the aged-care insurance market were constituted as optional and non-mandatory, its enrolment would depend on the choice of individuals, and that, on the rationality in buying insurance. We know that consumers may act with some sort of state-dependent utility, with erratic rationality or myopically, postponing the purchase of aged care insurance until it is too late. Mental disorders, for example, condition and threaten that choice. And in Spain, Ayuso-Mateos *et al*. (2008) estimate that about 5 per cent to 10 per cent of the total Spanish population faces one major depressive episode in a lifetime. Even so, it is reasonable to think that individuals weighing the potential high care scenario will recognise that income transfers through insurance would allow them to meet the costs without drastically compromising their own and partners' living standards and the value of bequests to descendants.

The asymmetries of information both on the demand side and on the supply side are the main obstacles to developing the aged-care insurance market. With respect to adverse selection, consumers with "hidden attributes" make competitive markets for voluntary insurance non-efficient, and inferior to a compulsory pooling. Also, the scarce market for aged care insurance is not perfectly competitive, and there is evidence of a lack of price competition (Brown and Finkelstein, 2007 and 2009). Although, as far as we know, there is no evidence for Spain supporting this, adverse selection is potentially an effective obstacle to the development of the voluntary aged-care insurance market at late-life stages in Spain, as the likelihood of observing private information increases.

Moral hazard refers to "hidden actions". *Ex ante* moral hazard refers to the tendency of insured not to invest sufficiently in precautionary measures, and *ex post* moral hazard, to the situation in which the insured event has already occurred, and the insured individual has no incentives to make an effort to mitigate the loss. However, we do not expect to have moral hazard-induced inefficiency in the aged care insurance market, as many of the insured services have little value to those who are not ill. And for other services, with discretionary use, they might not be suitable for risk pooling in this market.

Supply-side moral hazard refers to the way in which providers are reimbursed. Usually, when fostering incentives for efficiency, we also promote incentives for risk selection. In Spain and under the National Health System, there are no incentives for risk selection, but there is very complete and universal coverage (only the last economic crisis has led to increased co-payments and limit coverage); there is also a lack of incentive for efficiency. For the case of the aged-care insurance market in Spain, private voluntary aged-care insurance might result in problems arising from the nature of the required coverage. Narrow coverage (only residential care for example) would be inefficient by not covering care subject to increasing cost of innovation in health technology. Conversely, wide coverage would be exposed to adverse selection and particularly moral hazard.

Although there is concern about the cost of information gathering with a view to development of the aged-care insurance market, it seems that transaction and verification costs are sufficiently low and thus do not distort the accuracy of decisions (Grignon and Bernier, 2012).

Finally, risk-neutrality in insurers is based on the uncertainty attached to each individual's risk within the insured cohort, but in the aged-care insurance market, we find uncertainty attached also to the *average* level of aged costs driven by, among others, the evolution of prices. As a consequence, risks associated with long-term care may not be independent and would limit the scope for intra- and inter-generational risk pooling, influencing the choice of either a pay-as-you-go (PAYG) or a funded system.

The challenge

The policy objectives of economic efficiency, equity, stability and fiscal sustainability are in danger in the case of aged care. The absence of an aged-care insurance market makes the ageing population bear a huge loss in case of need. Although Spain has made some effort in the last years to assure LTC through the Dependency Act, most of the effort has ended up in subsidies to informal and unprofessional care, which might not be the best solution.

This private market will not develop spontaneously, given, among others, the existence of adverse selection. Nevertheless, regulation might help. If it were mandatory early enough in life to avoid selection, the market would be feasible. Although there is still work to be done, the inter-generation problem might be improved following a PAYG or funded system, or a combination of them, so that neither the first nor second generation are worse off. Also, the choice between a universal public insurance plan with full coverage based on need (Grignon and Bernier,

2012), or a safety net with minimum coverage through subsidies (Blomqvist and Busby, 2012) and with more or less private provision may depend on idiosyncratic preferences.

Spain, unlike other countries, has no marked tradition of developing private insurance markets, and the interaction with the National Health System would most likely complicate the developing of the private aged-care insurance market. Our suggestion for Spain, therefore, is to promote a mixture of public and private financing and provision with strong regulation on coverage, quality and transparency as a complement to the public universal coverage provided under the National Health System. There is room, however, for different models of relationships between individuals, insurers and providers.

References

Ayuso-Mateos, J.L., Gutiérrez Recacha, P., Haro, J.M., Salvador-Carulla, L., Vázquez Polo, F.J., Negrín Hernández, M.A., Chisholm, D. (2008). *Reducing the burden of mental illness in Spain. Population-level impact and cost-effectiveness of treatments in depression and schizophrenia*. Bilbao: Fundación BBVA.

Brown, J.R., and Finkelstein, A. (2009). The private market for long-term care in the U.S.: a review of the evidence. *The Journal of Risk and Insurance* 76(1): 5–29.

Brown, J.R. and Finkelstein, A. 2007. Why is the market for long-term care insurance so small? *Journal of Public Economics* 91(10): 1967–1991.

Blomqvist, A., and Busby, C. (2012). Long-term care for the elderly: challenges and policy options. C.D. Howe Institute Commentary No. 367. Available at SSRN: http://ssrn.com/abstract=2182774 or http://dx.doi.org/10.2139/ssrn.2182774 (accessed on 28 March 2014).

Colombo, F., Llena-Nozal, A., Mercier, J. and Tjadens, F. (2011), Help wanted? Providing and paying for long-term care, OECD Health Policy Studies, OECD Publishing.

Comas-Herrera, A., Wittenberg, R., Costa-Font, J., Gori, C., Di Maio, A., Patxot, C., Pickard, L., Pozzi, A. and Rothgang, H. (2006). Future long-term care expenditure in Germany, Spain, Italy and the United Kingdom. *Ageing & Society* 26(2): 285–302.

Costa-Font, J. and Patxot, C. (2005). The design of the long-term care system in Spain: policy and financial constraints. *Social Policy and Society* 4(1): 11–20.

Costa-Font, J., Karlsson, M. and van den Berg, B. 2012. Redesigning long-term care finance and delivery. *Applied Economic Perspectives and Policy* 34(2), 215–19.

Costa-Font, J. and Courbage, C. (eds). (2011). *Financing long-term care in Europe: institutions, markets and models*. Basingstoke, U.K.: Palgrave Macmillan.

Frank, R.G. (2012). Long-term care financing in the United States: Sources and institutions. *Applied Economic Perspectives and Policy* 34(2): 333–345.

Garcia-Goñi, M., Hernández-Quevedo, C., Nuño-Solinís, R. and Paolucci, F. (2012). Pathways towards chronic care-focused healthcare systems: evidence from Spain. *Health Policy* 108(2–3): 236–245.

Grignon, M., Bernier, N.F. (2012). *Financing Long-Term Care in Canada*. IRPP Study No. 33. Montreal: Institute for Research in Public Policy.

Guillén, M., Comas-Herrera, A. 2012. How much risk is mitigated by LTC protection schemes? a Methodological note and a case study of the public system in Spain. *The Geneva Papers on Risk and Insurance—Issues and Practice* 37(4): 712–724.

Paolucci, F., Sowa, P., García-Goñi, M., Ergas, H. (2013). Mandatory aged care insurance: a case for Australia. *Ageing & Society*. Forthcoming.

Regidor, E., Kunst, A.E., Rodríguez-Artalejo, F. and Mackenbach, J.P. (2012). Small socio-economic differences in mortality in Spanish older people. *European Journal of Public Health* 22(1): 80–85.