

Challenges in healthcare and long-term care financing: Experiences of developed countries

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Structure of the presentation

1. Challenges – demand shift, cost increase and limited resources
2. Expanding the resource envelope
3. Cost rationalization and containment
4. Elderly care - catering for new demands and cost containments
5. Concluding remarks

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1. Challenges – demand shift, cost increase and limited resources

1.1 Changing morbidity patterns

Developing countries

Infectious diseases

<=public health, sanitation, vaccination, primary health care

Middle-income countries

Lifestyle-related / chronic diseases (e.g. hypertension, diabetes, renal failure)

<=prevention, more emphasis on secondary health care

Developed countries

Cancer, lifestyle-related / chronic diseases, mental diseases, age-related interventions

<=prevention, more emphasis on secondary / tertiary health care, living assistance

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1. Challenges – demands shift, cost increase and limited resources

1.2 Cost increase

Basic equation

Total health care cost

= Prevention + Outpatient care + Inpatient care

Outpatient care cost

= (Number of the covered) * (utilisation rate) * (unit cost per case)

Inpatient care cost

= (Number of the covered) * (utilisation rate)

* (average number of bed days) * (unit cost per bed day)

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1. Challenges – demands shift, cost increase and limited resources

1.2 Cost increase (contd.)

- Shift of the interventions in line with the demand shift
=< primary -> secondary -> tertiary care
- higher utilization due to better access both physically (e.g. transport, more facilities / health personnel) and financially (e.g. lower out-of-pocket payment due to social insurance)
- higher unit cost due to technology advancement (e.g. health examination by using CT scan, new drugs,)
- higher utilisation and longer duration due to aging (e.g. social hospitalisation, labour-intensive living assistance)
- longer duration due to chronic diseases

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1. Challenges – demands shift, cost increase and limited resources

1.3 Limited resources

Basic equation

Gross domestic product

= Number of employed (covered) * Productivity

Insurance-base contributions

= Number of contributors * Average contribution base (wages)
* Contribution rate

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1. Challenges – demands shift, cost increase and limited resources

1.3 Limited resources (contd.)

- Slower increase of the working-age population / the number of employed / contributors (e.g. lower fertility / aging) in comparison with the increase of the elderly population
- Slower increase in productivity / wages (in general)
- Developed countries almost reaching the ceiling for the overall public resources (tax plus social security contributions) in the economy

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1. Challenges – demands shift, cost increase and limited resources

1.4 Relation between who pays / who receives

In a simple case of the relation between the inpatient health care cost and the health insurance contributions:

(Health care inpatient cost) / (health care contributions)

$$\begin{aligned} & \text{Number of covered} * \text{Utilisation rate} * \text{Average number of bed days} * \text{Unit cost per bed day} \\ = & \frac{\text{Number of contributors} * \text{Average contribution base (wages)} * \text{Contribution rate}}{\text{Utilisation rate} * \text{Average number of bed days} * \text{Unit cost per bed day}} \\ = & (1 + \text{Dependency rate}) * \frac{\text{Average contribution base (wages)} * \text{Contribution rate}}{\text{Utilisation rate} * \text{Average number of bed days} * \text{Unit cost per bed day}} \end{aligned}$$

=> Control of the dependency rate (as defined by number of covered divided by number of contributors minus 1) is also an important factor to control the cost in relation to resources, as seen in pension financing.

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2. Expanding the resource envelope

2.1 Economic development and political will

- More increase of the working-age population / the number of employed / contributors
 - <= fertility increase
 - labour force participation (e.g. elderly, women)
 - lower unemployment rate
 - Higher increase in productivity / wages
 - Political / societal will to allocate adequate financing for social security / health care
- <=Many factors are exogenous / uncontrollable variable for social security administrators, but worth while paying attentions.

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2. Expanding the resource envelope

2.2 Bigger number of contributors / contribution base / contributions

- More participations of women / elderly as contributors, based on the fact that they have income for contributions (wages / pensions).
 - <= Although contributions of the elderly does not cover the full medical cost for them, cost consciousness of the elderly will be greatly enhanced (educational effects should be appreciated).
 - Increase wage ceiling (or no ceiling) for contributions.
 - Increasing contribution compliance.
 - Increasing contribution rate based on political / societal will.
- <=Not all solved by proposals of social security administrators, but ideas / contributions of social security administrators are essential.

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3. Cost rationalisation and containment

NB: It is important that medical quality of essential cares should not suffer in the face of the rationalization of cost.

3.1 Demand-side (patient-side) control

- Gradually Increasing co-payment (rate).
- Gate-keeping, home doctors (GPs) and referrals to specialist.
=> additional fees for violations.
- Essential drug list, incentives for using generics (e.g. allow patients' to choose, lower cost reflected in co-payment, maximum insurance payment for drugs).
- General consensus on the package should be built.
- Proper medical educations for general population.

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3. Cost rationalisation and containment

3.2 Supply-side (medical providers' side) control

- Medical provider payment
Fee-for-service
=> (Risk-adjusted) capitation (Primary care / GPs)
Case payments based on Diagnosis-Related Groups (DRGs) (Secondary / tertiary care / Specialist care)
- Standard clinical procedures to follow to be set in regulations based on consensus between Government and medical providers.
- Labour cost of medical care, most expensive in many cases, should be rationalized (e.g. shifting social hospitalization cost from medical cost to general care cost)
- Rationalizing the length of hospitalization (hotel cost containment), medical providers' geographical distributions and hospital beds.¹²

3. Cost rationalisation and containment

3.2 Supply-side (medical providers' side) control (contd.)

- Separation of pharmacies from medical care providers
- IT system for controlling medical provider payments and for recording patient health care history

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4. Elderly care - catering for new demands and cost containments

4.1 New demands

- Population aging
- Living assistance, in addition to medical care, necessary for both physically and mentally handicapped
- Shifting from social hospitalization to elderly care, i.e.:
Reducing social hospitalization necessary in terms of rectifying unmatched needs and of reducing unnecessary medical cost (labour cost, hotel cost)

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4. Elderly care - catering for new demands and cost containments

4.2 System overview

Financing

- Tax-based system: Sweden, UK (means-tested benefits)
 - Insurance system: Germany, the Netherlands
 - Insurance system with substantial tax subsidies: South Korea, Japan
- <= in general, in parallel with health care provisions

Coverage

- All those who needs care regardless of age: Sweden, UK, Germany, the Netherlands
- Mainly the elderly (65+): South Korea, Japan

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4. Elderly care - catering for new demands and cost containments

4.2 System overview (contd.)

Benefits

In principle:

- Home care
- Day care, night care, short stay in care facilities
- Long stay in care facilities

Hotel cost / food cost are not included.

Cash benefits to family care workers:

Germany, South Korea:	included
Japan:	not included

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4. Elderly care - catering for new demands and cost containments

4.2 System overview (contd.)

Benefits level principle

Germany:

To cover partial cost for care to alleviate cost burdens of care (lower benefits)

South Korea, Japan:

To cover full cost of care, with co-payments of beneficiaries (10% in Japan, 15% for home care and 20% for institutionalized care in South Korea)

=>Japanese elderly care will be 'expensive' in the long run due to non-admittance of family care workers' payments and full cost recovery. Reforms cannot not be avoided in the long run.

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5. Concluding remarks

- Changes of the structure of health care and non-health care in different development and demographic stages, e.g. morbidity patterns and population aging, pose challenges to contain cost without sacrificing the quality of care in the essential services.
- Many schemes in developed countries have made efforts to enlarge fiscal envelopes by increasing the contribution base (e.g. participation of more women and elderly in contributions, better contribution compliance, increase in contribution ceilings) as well as cost rationalization and cost containment of health care benefits.

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5. Concluding remarks (contd.)

- Cost containments have been realized through interventions to patients (e.g. gradual increase in co-payment rate, gate-keeping, essential drug list) and to providers (e.g. case payment rather than fee-for-service, rationalization of labour cost, medical facilities and beds).
- Elderly care is introduced in some countries to cater for new demands and at the same time to shift care cost from hospitalization medical cost to cheaper general care cost.
- Cost could be expensive if full elderly care cost by external helpers should be covered by the elderly care scheme.

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5. Concluding remarks (contd.)

- Although family members physical, mental and financial burdens should be alleviated, the extent of the benefits and the modality of participation of family members should be carefully examined and discussed in the establishment of the system.

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