

THE ECONOMICS OF END OF LIFE CARE
WITH THE SPONSORSHIP OF THE SOROS FOUNDATION

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WORKSHOP..... 6

Session Title: Financing Palliative Care - Creating an Evidence Base for Policy Development

Structure

Moderators:

Xavier Gomez Batiste and Guillem Lopez

Workshop Overview:

The workshop will encourage health economists to become engaged in developing the evidence base for palliative care financing including service delivery, professional education, and workforce development.

Expected Audience:

Health economists working in both developed and developing countries who are advising governments on the integration of palliative care into cancer and AIDS programs.

Program Agenda:

1. Financing Palliative Care, Guillem Lopez and David Casado
2. The Catalanian Case, Xavier Gómez Batiste
3. The Hungarian Case, Katalin Muszbek

Schedule:

13:30	Private buffet for the invited participants at UPF
15:00	Openings: Representative of Soros Foundation and Guillem López (IHEA Chair). X. Gómez 15 minutes on the need of building bridges (Economics and EOL Care); Invited participants: 5 minutes on their own research (abstracts to be distributed among attendants)
16:30	Coffee break (aiming for links and joint initiatives)
17:00	Opening the floor to all people attending for Q&A
18:00	Final words from the Chair

Papers related with End of Life to be presented in the iHEA Conference:

End of life:

Kitajima, Tsutomu kitajima@kyorin-u.ac.jp

Demand for home-based terminal care among the cancer patients in a ward in Tokyo

Long term care:

Rothgang, Heinz rothgang@zes.uni-bremen.de

Declining dependency rates for older people in Europe? Implications for long-term care expenditure to 2050

Priez, France priez@email.unc.edu

Long-term care use: does time to death really matter?

Norton, Edward (Structured Session Organizer) edward_norton@unc.edu

*Long-term care and insurance***

Mot, Esther esm@cpb.nl

*Long term care in the Netherlands: strengths and weaknesses **

Moscone, Francesco

*Sources of variations in performance of local English long-term care departments: demand supply and interdependence **

Home-Informal Care

Wilson, Leslie lwilson@itsa.ucsf.edu

The Economic Burden of Home Care for Children with HIV or Other Chronic Illnesses

Van Houtven, Courtney courtney.vanhoutven@duke.edu

*Should we consider caregiver drug utilization when quantifying health care savings from informal care?**

Ogata, Yasuko yogata-ty@umin.ac.jp

Relative Work Values for Home Care Nursing Services and Client Characteristics in Japan

Ogata, Yasuko yogata-ty@umin.ac.jp

*A Study on Relative Work Values for Home Care Nursing Services in Japan**

Norton, Edward (Structured Session Organizer) edward_norton@unc.edu

*Informal Care***

Hall, Jane (Structured Session Organizer) jane.hall@chere.uts.edu.au

*Valuing informal care in economic evaluation***

Bridges, John healthconomics@hotmail.com

Objective measures of team structure and adverse events in home health care

Ageing

Yu, Wei (Structured Session Organizer) wyu2@stanford.edu

*Healthcare Financing for the Elderly: Strategies for Nations with Regional Heterogeneity in Financing Capacity***

Trujillo, Antonio atrujill@mail.ucf.edu

Race and Health Disparities among Elderly in Latin American Countries

Stolpe, Michael mstolpe@ifw.uni-kiel.de

*Health Systems in Aging Societies: Economic Efficiency and Directions for Reform**

Sapin, Christophe CHSA@lundbeck.com

*Obtaining and Explaining EuroQoL utility values in Alzheimer's disease: the LASERAD study perspective **

Rannan-Eliya, Ravindra ravi@ips.lk

Impact of ageing on developing country health expenditure: Actuarial cost model for Sri Lanka 2001-2051

Kehusmaa, Sari

Economic evaluation of a geriatric rehabilitation programme (the AGE-study)

Iglesias, Cynthia cpiu1@york.ac.uk

Ageing Population and Economic Evaluation. Assessing the cost-effectiveness of healthcare interventions in elderly population: the case of the VenUS I Trial

Felder, Stefan stefan.felder@ismhe.de

*Population ageing and health care expenditure: Does the 'red herring' apply to everybody and everything?**

Campbell, Joanna jhcampbe@utmb.edu

Community-Based Programs and the Care of the Frail Elderly

Berman, Peter pberman@hsph.harvard.edu

Health Spending for the Elderly in a Middle Income Country: Recent Results from Turkey

Bos, Antonio abos@tusculum.edu

*The impact of public health infrastructure on elderly health in Brazil **

Other:

Meghea, Cristian cristianm@acr.org

Social Security Income and Elderly Mortality

Ferraz -Nunes, Jose jose.ferraz@spa.gu.se

Prevention of Hip-fractures for people older than 64 year. Good business for Health Care and Community. Improvement in welfare.

Papers from leading participants in the Soros Foundation Pre-conference workshop

Ashton, Toni (Structured Session)--- *Financing long term care for the elderly in the West Pacific*

Original Title: Financing long term care for the elderly in the West Pacific

Organizer:

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Chair:

Philip Davies, Commonwealth Department of Health & Ageing, Australia
Philip.Davies@health.gov.au
Philip Davies joined the Australian Government's Department of Health & Ageing as Deputy Secretary in 2002. He is responsible for acute care, primary care, health services improvement, medical & pharmaceutical services and e-health. Prior to joining the Department Mr Davies worked as a Senior Health Economist with WHO in Geneva, Deputy Director-General in the New Zealand Ministry of Health and a Partner in an international management consultancy firm. Mr Davies holds degrees in Mathematics and Management Science & Operational Research, is an Honorary Fellow of the Health Services Research Centre at Victoria University of Wellington, and has acted as a consultant on health policy to the World Bank and WHO.

Session description:

Financing long-term care for the elderly is becoming increasingly challenging as populations age throughout the developed world. This session focuses on four countries in the west Pacific: Japan, Korea, New Zealand and Singapore. Each of these countries has taken a rather different approach to way in which long term

care is financed, and each faces its own special challenges. There are also some common issues including intergenerational equity, cost, and selecting an appropriate balance between personal and social responsibility.

For both Japan and Korea, the trend towards greater participation in the workforce by women and rapidly changing family arrangements have created an urgent need for formal state-led solutions to the provision of long term care for the elderly. Both countries have opted for a form of social insurance, but the approach being taken by each country is rather different. The financing arrangements are also quite different in Singapore and New Zealand. While Singapore has a compulsory savings scheme, New Zealand has a means-tested taxed-based model. Each of the four speakers will discuss recent developments in the financing of long term care and consider the strengths and weaknesses of the arrangements being taken in their country. The session will then be opened up to debate from the floor.

Ashton T - Financing of long term residential care in New Zealand: swimming against the tide

Presenting author: Toni Ashton, University of Auckland.
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Presenting author bio: Toni Ashton, PhD, is Associate Professor in Health Economics, and Director of the Centre for Health Services Research and Policy at the School of Population Health, University of Auckland, New Zealand. Her research centres on the financing and organisation of health systems from an economic perspective. In recent years the main focus of her research program has been on the reform of the public health system in New Zealand, including the analysis of a series of structural changes, innovations in the primary health care, and development of the mental health workforce. With her co-author, Susan St John, Dr Ashton has undertaken a number of projects relating to the aging of the population, including the provision of superannuation in New Zealand. She is the editor of two new journals: *Health Economics, Policy and Law* and *Australia and New Zealand Health Policy*. Recent publications include articles in *Health Economics, Social Science and Medicine, Journal of Health Services Research and Policy, Health Policy*, and *Applied Economics and Health Policy*.

Co-author: Susan St John, PhD, University of Auckland.

Abstract

In New Zealand, long term residential care for the elderly is financed through a mix of general taxation and private payments. Subsidies are available for residents over the age of 65 years, subject to an income and asset test. Anyone with assets above a threshold level must pay for their care in full up to a maximum of NZ \$636 per week. Once the asset threshold has been reached a subsidy is payable to the extent that there is insufficient income to meet this charge. In 1999, the incoming government promised to remove asset testing, but the new Bill did not appear until 2003 with implementation not expected until 2005. The stated intention is to "ultimately remove" the asset test by gradually increasing the threshold of assets to which the test applies. Increasing the threshold will be very costly in the longer term as the population ages. The policy also introduces a number of inequities, fails to address some underlying inefficiencies, and ignores the need for a sustainable solution to the question of

how to finance long term care. We argue that this is a political solution to an economic problem. As such it is unlikely to be sustainable in the longer term either politically or fiscally. Thus the "problem" of long-term care has been deferred, rather than resolved. An important opportunity has been lost to introduce a longer-term insurance-based solution which is fiscally sustainable, and which integrates long term residential care with care provided in the home.

Bos A - *The impact of public health infrastructure on elderly health in Brazil*

Original Title:

The impact of public health infrastructure on elderly health in Brazil: An application of the household production model

Introduction

Demographic trends indicate the importance of studying the health problems facing the elderly in Brazil and Latin America. The household production of health model is a useful approach for this task, especially in the context of multigenerational households.

Methods

Based on a sample from Southern Brazil, this model was used to estimate a health production function and four health input demand functions. The health inputs studied were choice of health care provider (public, private or no health care), smoking, alcohol abuse and physical exercise. The dependent variable for the production function was self-assessed health. Of particular interest was to assess the importance of public health resources in determining utilization by different income groups and whether the orientation of the public health system meets the needs of the elderly population.

Results

The results indicate that the elderly who live in cities with more extensive public health infrastructure tend to use the public system to a higher degree, either over the possibility of using the private system or not seeking health care at all. The impact is more significant for the elderly with low individual and family income. There is also clear indication that the elderly who use the public system have worse health outcomes than those who use the private system. This result occurs even after controlling for demographic variables, number of chronic conditions under treatment and the endogeneity of the health inputs.

Conclusions

Policy recommendations include further investments in the public health infrastructure, full implementation of the National Plan for Elderly Health and developing new programs that enhance the opportunities for an effective geriatric

consultation at the primary care level. Further research efforts on elderly health are urged and for this purpose the household production of health model was found to be a useful framework.

Bridges, J, McDonald, M, Scharpf, T, Peng, T and Feldman, P. - *Objective measures of team structure and adverse events in home health care*

Abstract:

Rationale: In recent years there has been much interest in the determinates of adverse events in all forms of health care services, however, the majority of the academic literature has focused on acute hospital care. This paper focuses on the under researched, yet increasingly important, area of home health care.

Objective: To examine possible relationships between objective measures of organizational structure and risk adjusted adverse events in the context of home health care in the US. Eighteen possible organizational measures that could be measured using existing administrative data were identified using qualitative methods and literature review.

Methodology: Adverse event were defined by using an index of the 13 CMS defined adverse events (Y=1 if any adverse event, Y=0 otherwise), and risked adjusted using a comprehensive set of patient, economic and environmental factors. The resulting risk adjustment model was used to construct two quality scores for each team (the organizational unit of interest), the first using an econometric fixed effects method and the second a more traditional zscore ranking. The resulting quality scores for each team were then regressed on the 18 objective measures using both bivariate and multivariate ordinary least squares. Data comes from a large metropolitan home health care agency that has 87 different teams with natural variation in structure. Data was collected for a six month period, amassing 56,346 episodes of care.

Results: Fixed effect bivariate analysis identified the number of core nurses ($p=0.032$) and the Herfindahl – a measure of concentration of work load among nurses – ($p=0.065$), while fixed effect multivariate analysis identified the number of HHIC admissions ($p=0.132$), the average age of the nurse ($p=0.126$), the number of core nurses ($p=0.141$) and year at the organization ($p=0.138$). The corresponding results for the z-score identified the exact same variable for both the bivariate and multivariate analyses (with slightly different p values).

Conclusions: This study sheds some light on the explanation of variation of risk adjusted adverse events across teams. Consistent results were given across both econometric and traditional methods of risk adjustment. Some caution has to be

made for policy interpretation of the results given that a number of issues (such as the need to include possible subjective measures of team structure) but offers a more sound basis for future research focusing on organizational factors and home health care.

Disclosure information:

Research funded through a grant to the Visiting Nurses Service of New York titled 'Working Conditions & Adverse Events in Home Health Care', Feldman PI, from AHRQ (Grant Number R01 HS11962).

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Courtney Harold Van Houtven - *How does informal care affect formal care expenditures?*

Co-authors: Edward C. Norton, University of North Carolina at Chapel Hill,
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Abstract: Informal care by adult children is a common form of long-term care for older adults and can reduce medical expenditures because it substitutes for formal care (Van Houtven and Norton, forthcoming in JHE). In this new study we address how informal care by all children affects formal care expenditures, which is critically important given obvious demographic trends and the trend in the United States to having more formal care arrangements, which are more costly than informal care. Our research helps frame the relative cost-effectiveness of policies enacted to support informal caregivers such as through tax credits. Such programs to support caregivers exist in California, Missouri, and Hawaii, and have been considered at the national level. We examine Medicare Claims data from 1990 to 1998 linked with the 1993 and 1995 Asset and Health Dynamics Among the Oldest-Old Panel Survey and the 1998 Health and Retirement Survey using two-part expenditure models. In addition to informal care provided by all children, we also examine informal care from all sources in order to frame policy simulations on the cost-effectiveness of tax credits to caregivers, which are provided to eligible spouse as well as adult child caregivers.

We ask the following questions. Does informal care reduce Medicare expenditures that are common to the elderly (home health, skilled nursing, hospice, and inpatient costs)? If so, what kinds of expenditures does informal care affect among home health, skilled nursing, hospice, and inpatient costs? Finally, is informal care endogenous in determining formal health care expenditures of older adults? Informal care reduces home health care expenditures and nursing expenditures. Modest tax credits for caregivers would be cost-effective depending on the labor market assumptions of caregivers.

Courtney Harold Van Houtven, Michele R. Wilson, Elizabeth C. Clipp - *Should we consider caregiver drug utilization when calculating health care savings from informal care?*

Objectives. To quantify how the intensity and type of informal care provided to a national sample of veterans with progressive dementia affect caregiver drug use, controlling for caregiver health, demographics and economic resources. If there is a strong association, not including informal caregiver's drug costs leads to overstating estimates of savings to the health care system from informal care.

Methods. Survey data was collected in three consecutive years from caregivers of a nationally representative sample of elderly veterans clinically diagnosed with vascular dementia or Alzheimer's disease. Ordinary least squares and two-stage least squares estimation of number of drugs taken by the caregiver on caregiver intensity was conducted. Two-stage least squares is used to control for the fact that intensity of informal care may be endogenous. Three measures of intensity were examined—total caregiver hours, hours spent assisting with tasks of daily living, and hours spent providing companionship.

Results. Rather than the total number of hours spent assisting a patient with activities of daily living (i.e., ADLs and IADLs), the total time spent caregiving and intensity of companionship time are associated with small increases in the number of drugs consumed by caregivers. We find no evidence that endogeneity exists between intensity and drug utilization.

Discussion. The intensity of informal caregiving is associated with slightly higher drug consumption for this sample of caregivers of elderly veterans with dementia, particularly the total caregiving hours and the total hours spent providing companionship to the care recipients. The small magnitudes indicate, however, that, in this application, it is not important to consider caregiver drug utilization when quantifying the net savings of informal care to the health care system. Nevertheless, it is possible that such costs may be important in other, generally healthier, caregiver populations such as adult child caregivers of elderly parents or parent caregivers of children with special needs. Examining their drug or other utilization use could alter estimates of net savings to the health care system from informal care. The strong association between depression and caregiver drug use

has important cost because depression affects the quality and duration of informal caregiving.

Elvira, David --WTP for home basic health services for future minor dependent elderly in Spain

David Elvira. Universitat Autònoma de Barcelona

TITLE:

WTP for home basic health services for future minor dependent elderly in Spain in comparison with the preference of other relevant home services and residential dimensions.

RATIONALE:

Elderly population in Spain is increasing and the future dependence level of the senior population will need creative solutions to combine health and long term care services. Home services are one of the most preferred solutions among senior population in Spain observing previous surveys on this matter.

OBJECTIVE:

Our purpose was to compare the preference intensity among relevant dimensions of residential design solutions for elderly using the perceptions of Spanish citizens of over 55 years old. The dimensions we were interested to compare, as a result of the conclusions of a previous survey, were: basic home health services, basic home social services (basic health services not included), and the degree of aversion to be institutionalized in any residential solution. We developed a contingent valuation-WTP survey (based on a contingent framework of minor dependence level) to investigate how senior Spanish people value the three relevant dimensions analyzed.

DATA AND METHODS

Data from a telephonic survey (March-April 2003) on Spanish population over 55 years old that that were previously contacted in order to ask them about general perception of the residential needs for elderly. Total sample size was 739 (geographically representative of over 55 years old Spanish population). Effective respondents (who accepted to be asked about WTP) were 48% of the total sample. They described their preferences on residential characteristics in a minor dependence contingent framework and they answered the WTP for 3 relevant residential dimensions / services (home basic health services, home general care services, and institutionalization aversion). For WTP questions we used a

dichotomous approach with open ended follow-up. For the estimation we used a Maximum Likelihood Probit Estimation. We also studied the “zero-protest” answers of the survey.

RESULTS:

Median/Mean WTP estimation for home basic health services, home basic care services (health services not included) and for avoiding the institutionalization at a residence or similar were 69€, 207€ and 291€ monthly, respectively.

CONCLUSIONS:

WTP for home basic health services is quite lower than the WTP for home general care services or for avoiding the institutionalization of minor dependent elderly. Furthermore, while the “zero-protest” behavior was low when we asked about home basic care services and the institutionalization aversion (about 2%-7% justified the zero answer on the basis of budget restrictions to pay); the major zero answers for home basic health services were justified on “protest” bases (68%). The major explanation for the health services protest answers is based on the fact that the interviewees considered that home health services must be provided by the state. Deeper analysis of the “zero-protest” behavior shows that it is deeply and statistically conditioned by the level of income of the interviewee and it is not conditioned by the gender or the age.

DISCLOSER INFORMATION:

This research was carried out on behalf of Edad&Vida. Edad&Vida is an independent association of companies worried about the quality of life of elderly.

Fassbender, K - Evidence-Based Performance Measures in Palliative and End of Life Care Service Delivery

Title: An Inventory of Evidence-Based Performance Measures in Palliative and End of Life Care Service Delivery

Authors: Konrad Fassbender PhD, Carleen Brenneis, RN, MHSA, Donna Wilson, RN, PhD, Pam Brown, RN, MSN, Linda Slater, MLIS

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Abstract: Our objective was to provide decision makers with appropriate tools to facilitate improvements in the quality of care provided to dying Canadians, their families and caregivers. We systematically reviewed over 7,000 references obtained from academic journals, government reports and the internet. A total of 50 performance measures were identified as pragmatic and oriented toward service delivery. An inventory was constructed which contains eleven descriptors for each measure. 86% of measures rely on prospective questionnaires, 12% on chart review and 2% use administrative data. The vast majority of these measures were not validated. We conclude that performance measures for palliative and end-of-life care are in the early stages of development and therefore require substantial investment by all levels of government.

Disclosure Statement. The authors gratefully acknowledge funding from Health Canada (Contract No. H654910-34). The opinions expressed in this abstract are

those of the authors and do not necessarily reflect the official views of Health Canada, provincial ministries of health or regional health authorities in Canada.

Howard, David - *End of Life Care and Spending*

Title: The Impact of Mortality Risk on End-of-Life Costs

Presenting Author: David H. Howard, Emory University, Department of Health Policy and Management, david.howard@emory.edu

Presenting Author Bio: David Howard is an Assistant Professor at Emory University. His research focuses on using economics to better understand medical decision-making. Currently Dr. Howard is studying the impact of life expectancy on the early detection and treatment of cancer. Dr. Howard received his doctorate from Harvard University in 2000.

Co-authors: Benjamin Druss, Emory University, bdruss@emory.edu; Steven Culler, Emory University, sculler@sph.emory.edu

Abstract: Numerous studies have documented the high costs of medical care in the final months of life. While the magnitude of spending on end-of-life care is striking, it is difficult to determine if expenditures are wasteful or simply reflect the inherent uncertainty facing decisionmakers. Costs may appear excessive in hindsight, but, prospectively, clinicians do not always know which year will be a patient's last. Among decedents, some will have had pre-death characteristics indicative of short-term mortality. Others will have had characteristics that suggested they were at low risk of death. In this study, we analyze whether the health care system treats these types of patients differently. Specifically, we examine whether mortality risk influences end-of-life costs. We also examine whether decedents consume a disproportionate share of resources after controlling for comorbidities.

The data consist of a random 5% sample of Medicare beneficiaries in 1999 living in eleven cities and states. We measured costs in the year before death for decedents (N = 8,279) and costs in the 1999 calendar year for survivors (N = 132,016). For both groups, we measured comorbidities from claims filed in the year prior to the annual cost observation period. We estimated a logistic model of death at one year as a function of age, sex, and comorbidities. Using the model, we predicted mortality risk for each subject.

Our main results are: 1) The difference in annual costs between decedents and survivors matched on mortality risk – i.e. the “marginal cost of death” – is

\$15,000, or 78% of total decedent costs. 2) Baseline mortality risk is positively related to costs among survivors but inversely related to costs among decedents. Put another way, decedents whose characteristics were most strongly predictive of short-term mortality incurred the lowest costs. This result is inconsistent with the widely-held view that the health care system squanders resources on patients near death.

Lim M-K - *Financing long term care in Singapore: the State as last resort.*

Presenting author:

Meng-Kin Lim, National University of Singapore. coflimmk@nus.edu.sg

Presenting author bio:

Dr. Meng-Kin Lim is Associate Professor of Health Policy and Management at the Department of Community, Occupational and Family Medicine, National University of Singapore. He was Chief Executive Officer of the Health Corporation of Singapore and has served on numerous government committees and hospital boards. He is currently on the WHO Western Pacific Advisory Committee on Health Research, the Editorial Advisory Board of *Health Policy Research*, and the Board of Advisors to the Singapore Medical Association's Centre for Medical Ethics and Professionalism. He consults extensively for the WHO, World Bank and Asian Development Bank in China, Indonesia and the Middle East, and has conducted numerous World Bank Flagship Training courses and seminars throughout Asia on health policy, health care finance and health care management. He is a recipient of the Public Service Star and Public Administration (Silver) Medal, as well as the National University of Singapore's Special Commendation Award for Teaching Excellence.

Abstract

Singapore has one of the fastest ageing populations in the Asia-Pacific region. Since 1982, five high-level governmental committees have reviewed the problems associated with this worrisome trend. Adhering to an ethos that emphasizes individual and family responsibility over dependence on the state for welfare, Singapore became the first country in the world to legally oblige grown-up children to care for their parents, under the *Maintenance of Parents Act of 1996*. More recently, the 1999 *Report of the Inter-Ministerial Committee on the Ageing Population* reaffirmed the principle of primary reliance on the family for care-giving, with institutional care as a measure of last resort. Government remains committed, however, to working closely with voluntary welfare organizations, religious institutions and ethnic-based clan associations, offering tangible support in the form of funding (e.g. 90 per cent of capital costs and 50 per cent of operating expenditures in the case of nursing homes), land leases at special rates, training of staff and guidance in programme planning. There is acknowledgement that the existing health care financing mechanisms – notably

medical saving accounts (Medisave), catastrophic insurance (Medishield), and a government-backed safety net (Medifund) -- are insufficient to meet the long-term care needs of the vast majority of post-war baby boomers. The reason is these schemes were designed with acute care hospital expenses in mind. In 2002, the government introduced ElderShield, a severe disability insurance that provides lifetime coverage of S\$300 per month, up to a maximum of 60 months, with premiums payable from Medisave. But the opt-out scheme did not meet with the resounding success that was hoped for, even though no underwriting was involved and individuals with pre-existing conditions were automatically covered. The response was lukewarm and 30 % those eligible opted out of the scheme. Earlier in 2001, the government had set up Eldercare Fund (funded from budget surpluses) to help defray the cost of long-term care for the elderly. The fund currently stands at 750 million and is expected to reach \$2.5 billion by 2010. Another approach taken was to periodically top up (again from budget surpluses) the Medisave and Medishield accounts of the elderly. Thus in 2001 the government, in a one-time gesture, paid two years' worth of MediShield premiums for all Singaporeans aged 61. In 2004, the Government again topped up the Medisave accounts of 770,000 Singaporeans aged 50 and above, totaling S\$98 million, and further injected S\$100 million into Medifund to help the needy. While these measures have helped the older and needy Singaporeans, their *ad hoc* nature suggests that a comprehensive, long-term financing solution to the long-term care needs of all Singaporeans remains elusive.

Soonman Kwon - *Future of Long-term Care Financing for the Elderly in Korea*

Author: Soonman Kwon, Seoul National University, South Korea, kwons@snu.ac.kr

Author Bio: Soonman Kwon is Associate Professor and Head of the Department of Health Policy and Management, School of Public Health at Seoul National University in South Korea. He received Ph.D. from the Wharton School of the University of Pennsylvania and was assistant professor at the University of Southern California. Previously he was visiting at Harvard University (as a Fulbright Scholar and Takemi Fellow), London School of Economics and Political Science, University of Bremen in Germany (DAAD scholar) and Hosei University in Japan. He received Article-of-the-Year Award from the Korean Association for Health Policy and Administration in 2003. His recent publications include those in *Journal of Risk and Insurance*, *Medical Care Research and Review*, *Social Science and Medicine*, *Health Policy and Planning*, *International Social Security Review*, *International Journal of Social Welfare*, *Social Indicators Research*, and *International Journal of the Economics of Business*. He is currently conducting several research projects funded by the Ministry of Health and Welfare, including the economic impact of the new long-term care insurance for the elderly.

Coauthors: N/A

Abstract: With rapid aging, change in family structure, and the increase in the labor participation of women, the demand for long-term care has been increasing in Korea. Inappropriate utilization of medical care by the elderly in health care institutions, such as social admissions, also puts financial burden on health insurance system. The widening gap between the need for long-term care and the capacity of welfare programs to fulfill that need, along with a rather new national pension scheme and the limited economic capacity of the elderly, calls for a new public financing mechanism to provide protection for a broader range of old people from the costs of long-term care. Many important decisions are yet to be made, although Korea has decided to introduce social insurance for long-term care rather than tax-based financing, following the tradition of social health insurance. Whether it should cover only the elderly long-term care or all types of long-term care including disability of all age groups will have a critical impact on social solidarity and the financial sustainability of the new long-term care

insurance. Generosity of benefits or the level of out-of-pocket payment, the role of cash benefits and the relation with health insurance scheme all should be taken into account in the design of a new financing scheme. Basic coverage of long-term care cost for all age groups with an option of cash benefits seems more efficient than other schemes in preserving consumer choice and the role of family and improving the financial sustainability in the long run. Lack of care personnel and facilities is also a barrier to the implementation of long-term care insurance in Korea, and implementation strategy needs to be carved out carefully.

Mot E, Douven R, and Folmer K - *Long term care in the Netherlands: strengths and weaknesses*

Authors: Esther Mot (e.s.mot@cpb.nl), Rudy Douven (R.C.M.H.Douven@cpb.nl) and Kees Folmer (C.Folmer@cpb.nl), Netherlands Bureau for Economic Policy Analysis

Title:

Rationale: In the Netherlands costs for long term care are relatively high. Even so there was dissatisfaction concerning the strict budgeting of long term care in the 1990s. Tight budgets created both waiting lists and poor customer orientation. Under the influence of changes in policy the costs have increased fast from 2000 on (by one third between 2000 and 2002). Adhering to the EU Growth and Stability Pact in the current economic situation means that further large costs increases are very difficult to accommodate. In the near future ageing is going to play a larger role, which will increase costs further. Therefore it is important to analyse the organisation of long term care to see whether efficiency can be improved.

Objectives: to analyse and evaluate the organisation of long term care and to discuss possible improvements, especially regarding efficiency.

Methodology: We describe the goals of Dutch health care policy and the institutions in Dutch long term care. Next, we analyse the roles, responsibilities and incentives of the different actors in long term care. We determine to which extent goals can be reached with the current organisation. Since there is often a trade-off between goals the analysis is in terms of strengths and weaknesses. We describe the policy reactions to the current problems with long term care, and confront them with our analysis. We end with a discussion of possible changes in the organisation of long term care in the Netherlands.

Results: because of the policy changes from 2000 on the influence of patients on long term care has increased and access to care has improved. However, the possibilities for cost containment have decreased. In the current setup there are insufficient incentives for an efficient execution of long term care; this concerns the determination of the appropriate amount of care for patients as well as the

procurement of long term care. There is not enough information about the quality of care but the information that is available, suggests that the quality is substandard for parts of long term care.

Conclusions: incentives for efficiency can be improved. There are possibilities for improvement within the current organisation as well as promising routes for more radical system change. Regulated competition between health insurers will improve incentives for efficiency but there are risks for the quality of care and for access. The characteristics of different types of long term care have to be considered carefully in designing solutions.

Ogura -*The Long Term Care Insurance of Japan after Four Years*

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Presenting author bio: Dr. Ogura is Professor of Economics and Director of Hosei Institute on Aging, Hosei University in Tokyo, Japan. He received a Ph.D. in economics from University of Pennsylvania, and taught at SUNY at Albany where he was a tenured associate professor. He has worked in many aging related issues in Japan, such as population projections, public pension reforms, public health insurance reforms, etc. During 1990's, as chief economist of the Japan Center for Economic Research, he coordinated the research on the Japanese side in the NBER-JCER Joint Research on Aging, while Professor David Wise of Harvard University coordinated the NBER side. His English publication includes the two co-edited NBER-JCER conference volumes published by Chicago University Press (*Aging Issues in the United States and Japan*, 2001, and *Labor Markets and Firm Benefit Policies in Japan and the United States*, 2003). Since 2003, the Hosei Institute on Aging, which Dr.Ogura has founded in 1999, is designated as one of the national frontier-research centers by the Ministry of Education, Science and Technology for its five year Joint International Research on Aging in Japan, China and Korea

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Abstract

In this paper, we provide a detailed description of the Japanese Long-Term Care Insurance introduced in 2000, an evaluation of the objectives of the system based on its four year experience, and a projection of the future of the system. Following almost a decade of intense public debate, the Long Term Care Insurance was finally introduced in 2000 with multiple objectives. For the general public, it was to remove the increasing uncertainty in the last phase of their life. For a large number of "stressed out" households that had been providing informal long-term care to its elderly members, it was to bring an immediate relief to them. For the public health insurance programs, it was to remove the so-called "social hospitalization" cases from hospital beds and their benefit costs. For women's activists, it was to free women from the risk of having to give informal care to their parents, parents-in-law, or husbands, and help them to keep their

jobs and careers. For policy-makers, it was to improve the care the elderly receive by providing formal care in a competitive process.

After four years of operation, as we examine individual benchmark figures, most of these objectives seem to have been accomplished. At this moment, however, the insurance is threatened by the problem of financial sustainability. The rapid increase in its cost far exceeds the costs that were expected at the planning stage. The overall cost of the system, which was 4 trillion yen in 2000, will reach 6 trillion in 2004, and is expected to continue to dimb as the aging process continues. We provide estimation on the extent of the sustainability problem and evaluate possible reforms through simple financial simulation analyses.