

# Financing Long-term Care and Health Care for Older People

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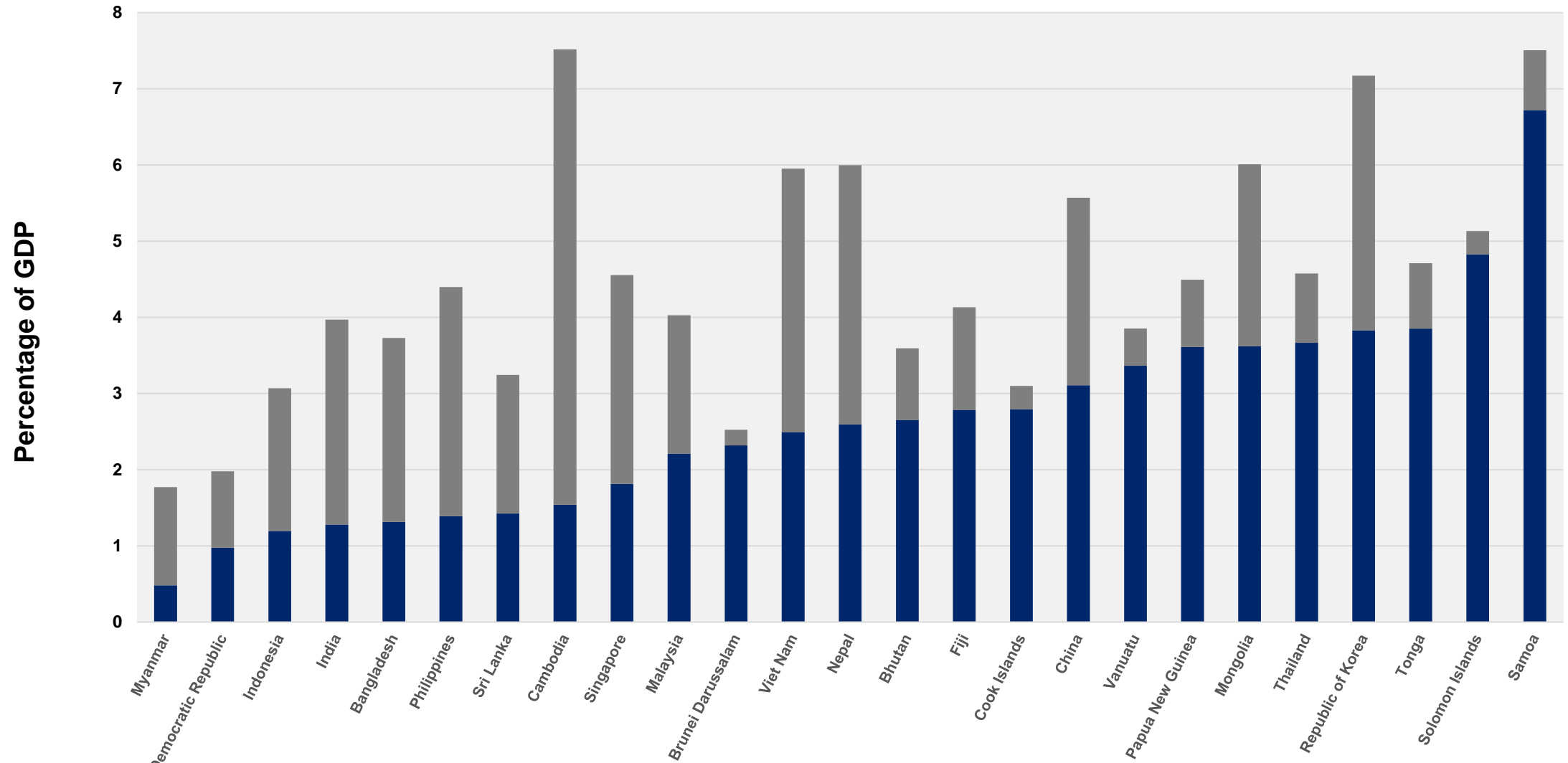
Former Dean, School of Public Health, Seoul National University  
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# **I. Ageing and Health Care Financing**

# 1. Health Expenditure

- Health spending was much lower in developing countries (e.g. Myanmar's 25 USD PPP per capita), compared with developed countries (e.g. OECD average 3,514 USD PPP per capita) (OECD, 2014)
  - Greater proportion of OOP payment
- Growth of health spending has exceeded economic growth in many Asia-Pacific countries (2000-2012) (OECD, 2014)
- "Aging" explains one-third of the health spending growth in developed countries, but it may take greater share in low- and middle-income countries (by increase of health coverage, urbanization) (World Bank, 2016)

# Health Expenditure as % of GDP (Asia), 2013

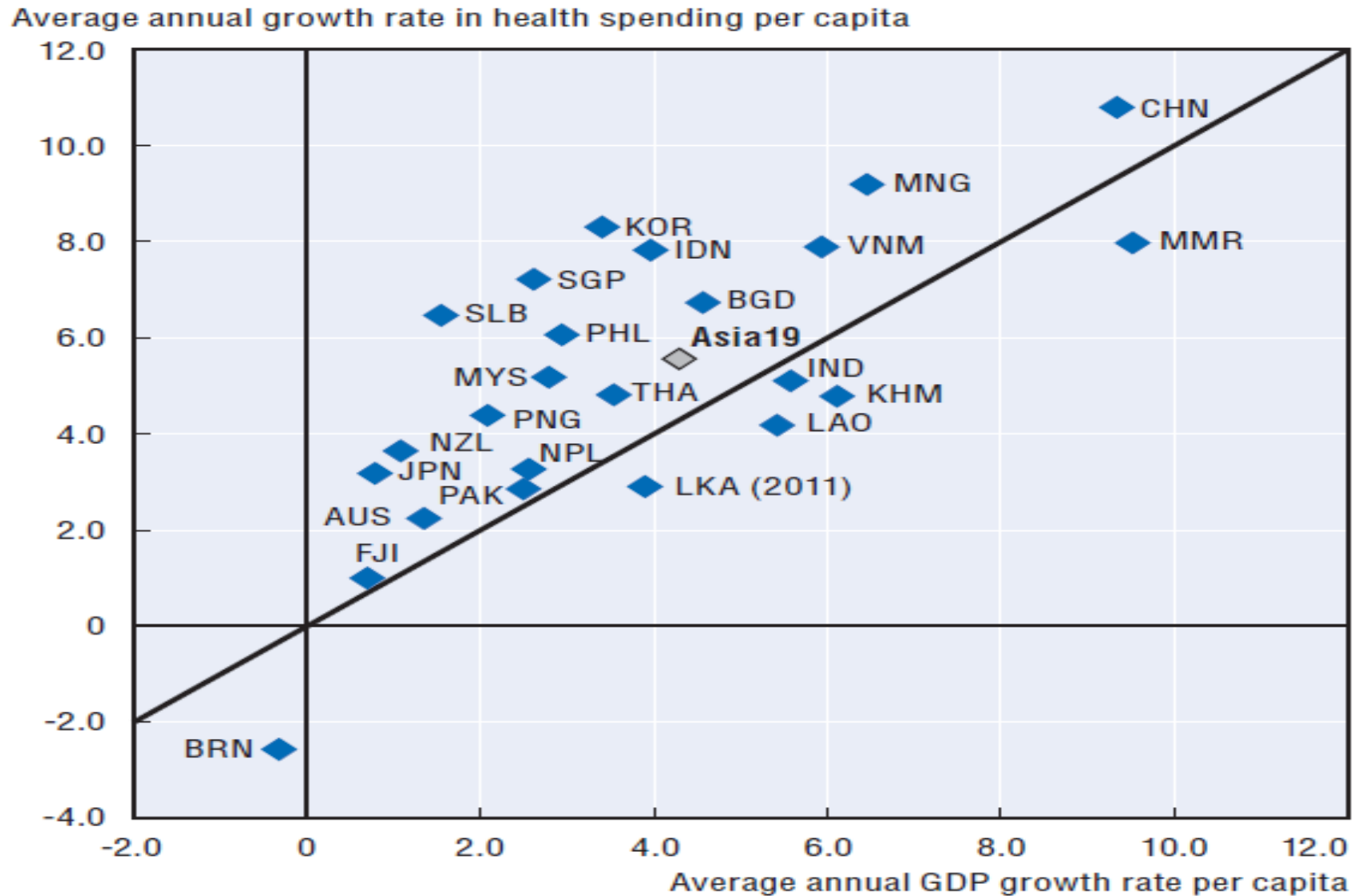


Source: WHO Global Health Expenditure Database (accessed 23 March, 2016)

■ Government health spending
 ■ Private health spending

Kwon: Aging, HC and LTC Financing

# Growth in Health Spending and GDP per capita, 2000-12



## 2. Medical Cost towards the End of Life

Proximity of death has bigger impact than demographic change  
(medical cost does not rise uniformly with increasing patient age)

- Health expenditure at the end of life decreases with age  
(Kuriyama, 2008; Seok, 2012; Shin, et al., 2012)

Hospitalization (vs. dying in hospice or LT care institutions) and clinical decision on treatment (intensity of care) at the end stage of life has a crucial impact on medical cost of the elderly:

End-of-life care and long-term care matters

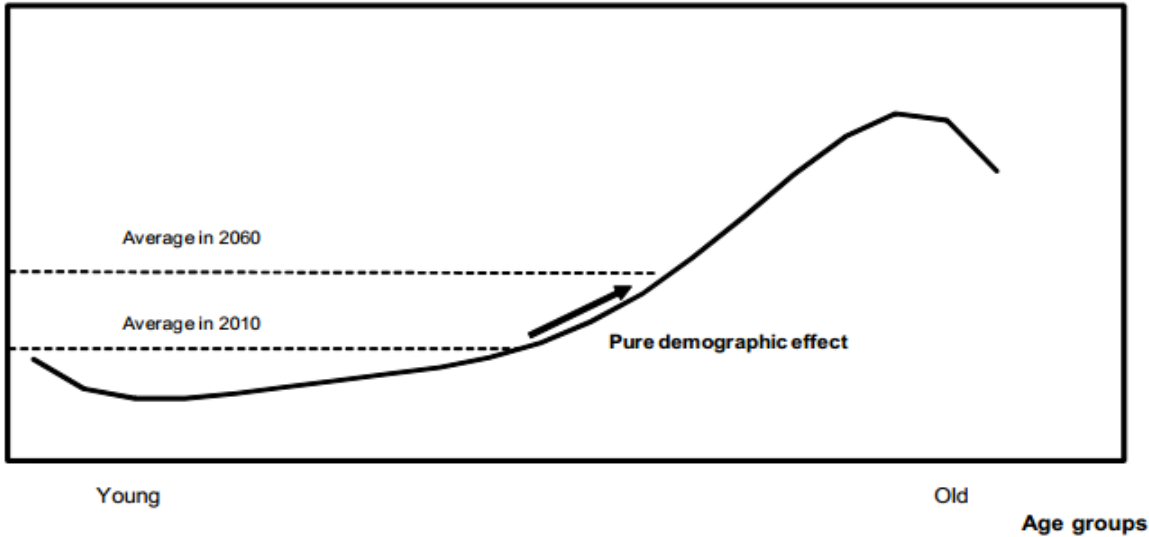
Prevention and health promotion is important: People who were healthier when young consume fewer resources in later life

(Gandjour and Lauterbach, 2005; Daviglus et al., 2005)

# Determinants of Health Expenditure for Older People

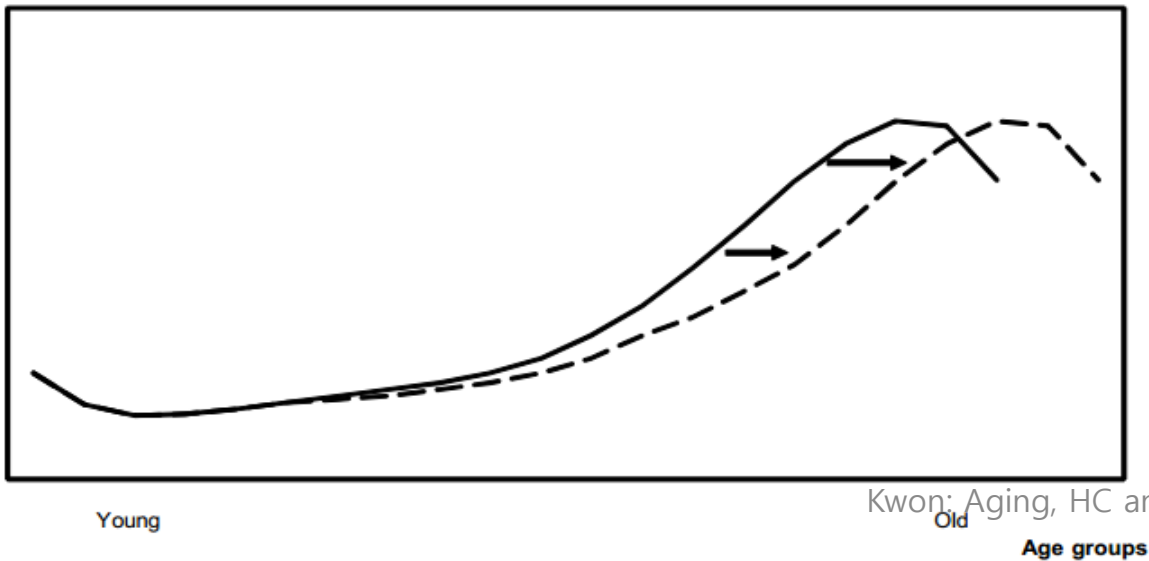
(1) Pure ageing effect

Health expenditure per capita



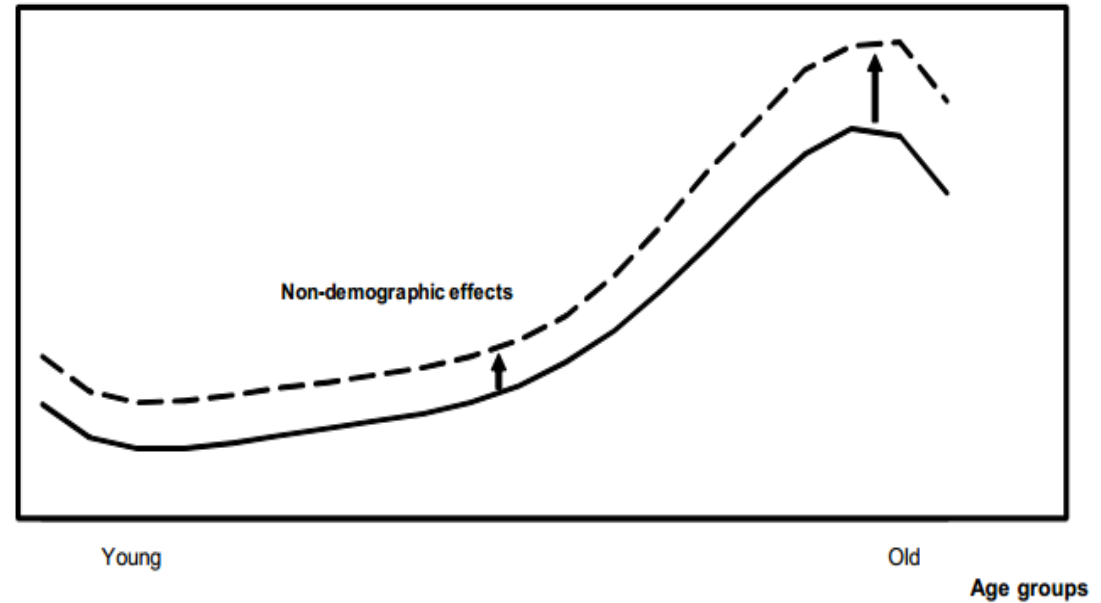
(2) Ageing effect adjusted for death-related costs and healthy longevity

Health expenditure per capita



(3) Non-ageing drivers

Health expenditure per capita



Source: OECD, 2013

## **II. Ageing and Long-term Care Financing**



# 1. Need for Investment in LTC System

Need for LT care

- Proportion vs. Number of older people
- Change in the attitude toward caregiving for older people

Long-term care system can reduce the (unnecessary) social admissions in health care/acute care hospitals -> Reduce health cost

Quality long-term care improves prevention and promotion (and reduces the need for health care)

-> Decreases the need for health care of older people

e.g., 1% increase in LTC expenditure leads to 0.5% decrease in HC expenditure in Korea (Kim, Kwon and Kim, 2013)

## 2. Financing for Long-term Care: Tax or Public Insurance

Relative performance of tax-based (supply-side) financing and insurance-based (demand-side) financing?

### **Tax-based financing for LT care**

- Usually based on public delivery
- Often target the poor
- Or use income-related cost sharing in case of universal coverage  
(different from tax-financing for health care)

## 2. Tax or Public Insurance (continued)

Insurance: Is long-term care insurable risk?

### Public insurance for LT care

- Mix of public and private delivery
- Eligibility based on need (through a formal assessment process),  
not on capacity to pay:

Q: Why should support those elderly who have capacity to pay?:

Universality vs. targeting

- Ceiling on benefits, cash benefits.

Health insurance – LT care insurance – Pension

- Crucial role of the purchaser (insurer)

# Institutional Stickiness

- Similarity between health care and LT care system

e.g., Same insurer for HC and LTC:

path dependency, save administrative costs

- > Sickness funds in Germany, NHIS in Korea,  
Local governments in Japan

- Difference: generosity of benefits, eligibility

### 3. LTC Insurance in Germany, Japan, Korea

#### 1) Public insurance for long-term care, separate from health insurance

##### a. Pros: Foreclose

- the spillovers of medicalization
- dominant role of physicians
- cost-increasing practices of health care financing

##### b. Cons

- Transfer beneficiaries to the other fund
  - > Coordination between health care and social care can be more difficult
- De-medicalization of LTC can lead to potential coordination problem between HC and LTC

## 2) Population Coverage

Germany: all types of disability regardless of age

Japan: long-term care of the elderly (+65) and  
age-related LT care for 40-64 years old

Korea: Long-term care for the elderly (+65), and  
age-related long-term care of the younger (<65 years)

Political compromise: Everybody should pay contribution, and  
everybody is eligible when he/she has LT care needs due to  
age-related health problems

### 3) Type of Benefits: Cash Benefits

E.g., Cash benefits in Germany, no cash benefits in Japan

#### a. Pros

- Preserving the role of family and consumer choice (competition among formal and informal care givers)
- Potential cost savings (level of cash benefits lower than the value of service-in-kind)
- Without the option of cash benefits, perverse incentive for formal care-giving or institutionalization is possible

#### b. Cons

- Potential abuse, low quality of care, gender perspective?
- Against the philosophy of socialization of care?

### III. Coordination of HC and LTC

Coordination of various policies and programs

- Coordination among the MoH and MoSW

Policy priority between health care vs. long-term care financing:

should consider catastrophic expenditure due to health care vs. long-term care, availability of family care givers, government fiscal capacity, etc.

Coordination between health care and long-term care

- > Continuum of care: overcome discontinuity and fragmentation among service providers (HC, rehabilitation, LTC, community care, etc.)

- Role of gate-keeping: need to empower primary care