



Human Development Sector Unit  
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# Reforming Health Social Security Proceedings of an International Seminar

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East Asia and Pacific Region  
Human Development Sector Unit  
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# **REFORMING HEALTH SOCIAL SECURITY**

## **PROCEEDINGS OF AN INTERNATIONAL SEMINAR**

Sponsored by the Global Security Institute, Keio University, and the World Bank

June 27-29, 2005

Tokyo, Japan

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## Preface

### **Reforming Health Social Security: The Proceedings of an International Seminar Sponsored by the Global Security Institute, Keio University, and the World Bank, June 27-29, 2005**

Naoki Ikegami  
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How important is health, and the most visible means to maintain it, health care, important for the security of the society? When Japan legislated its first social insurance program for manual workers in 1922, it was clearly stated that the program had two purposes: to increase the wealth of the nation by maintaining the health of the workers; and to serve as a stabilizing force to prevent a socialist revolution. This rationale was identical to that proposed by Bismarck in nineteenth century Germany. After its introduction, the concept of solidarity within each social insurance pool, whether by workplace or community, and the financial risk protection they provided, turned out to be popular with the voters which resulted in the eventual achievement of universal coverage in 1961.

However, the original arguments for establishing health care as a social security benefit are now less compelling. The threat of a socialist revolution has vanished. The externalities arising from treating communicable diseases are insignificant compared with the amount spent on health care. Most diseases now result from life style, which are more the responsibility of individuals than of society, and their presence is less likely than acute illnesses to cause productivity losses. With the aging of society, solidarity may also be eroding, as under a pay-as-you-go system, a significant proportion of the premiums or of taxes goes towards paying for the care of those who have retired, and not towards the care of those contributing. At the same time, advances in medical technology have greatly increased the availability and use of expensive procedures, leading to cost escalations. Thus, the future of health social security is threatened.

It was in this context that this international seminar on reforming health social security was

organized. About twenty experts from ten countries, Canada, China, Germany, India, Japan, Korea, Malaysia, New Zealand, the United Kingdom and the United States, plus representatives from the World Bank and the OECD, attended the closed seminar. The participants were a mix of academics, bureaucrats and one politician, but all participants had practical experiences in making health policy. Their discipline included economics, political science and medicine. The seminar consisted of six sessions over a three day period. All the sessions except for the last were closed to the public. In the first four sessions, the two papers (except for the second session which also included a short summary from the OECD reports) for each session had been circulated in advance. Each presenter was asked to use their limited time on the major points that he or she would like to emphasize. This allowed for two of the three hours in each session to be spent on questions and answers, and on in-depth exchange. These exchanges were skillfully handled by the chairs who had been asked to prepare the main discussion points in advance.

The first session focused on the crux of the agenda for this seminar. Should the government be responsible for only a “basic package” of health care, leaving the rest to the market for providers to deliver and patients to purchase? The first paper from Japan described how this proposal was vigorously promoted by economists and business leaders who opposed the regulations prohibiting extra billing for uncovered services and balance billing by specialists. However, a political decision was made to not to go down this path, due in part to the opposition raised by the Health Ministry and organized medicine. In contrast, as described in the second paper, Korea did not have these regulations from the time the social insurance

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was implemented. The survey results appeared to show that this had no effect on access to providers but there were no data on health outcomes. Although it could be argued that the services to be covered by the public insurance should be based on cost-effective analysis, what actually becomes covered tend to be mostly determined by fiscal reasons, as has been the case in Korea, and by political consideration. Thus, because of the lack of objective evidence, providers could explain to patients that better outcomes could result if they were to purchase services not covered. However, this would result in serious equity problems and the risk of impoverishment for those who decide to purchase out-of-pocket.

The second session focused on long-term care (LTC), in particular, the projected and actual costs of LTC in the two countries that have recently made it a new pillar of social security, Germany and Japan. Aging of society was the common rationale in both countries but this was not enough to explain why a new program was introduced in the midst of economic stagnation. Pressure on the local government's public assistance program in Germany and the local government's inadequacy in dealing with the rapid increase in the national government's funding of LTC in Japan were part of the reason. This difference may be why the benefit package is more stringent in Germany, with strict fiscal control built into the system, and more generous in Japan, where expenditures were planned to expand. As a result, the future sustainability of the LTC programs will rise from contrasting trends that are occurring in each country: eroding benefit levels in Germany, and rising expenditures in Japan. However, despite these caveats, establishing an independent LTC program should lead to a more efficient distribution of social security benefits since LTC needs would not have to be delivered based on the egalitarian standards of the health care system.

The third session was devoted to the two countries, — the UK and Canada —, that have made an explicit policy decision to increase their health expenditures. The two countries came to this conclusion for the same following reasons. First, their health sectors were under-funded and

were thus perceived to be providing inferior care when compared to neighboring countries, continental Europe in the case of the UK, and the United States in the case of Canada. Second, their expanding economies allowed them to increase funding for health care. Third, the political configurations that acted as a catalyst to this decision. The main difference between the two countries lay in the extent to which the central government had control over how the extra resources are being used. In the UK, although the funds are allocated proportionally to local purchasers, there are significant central directions in the form of requirements to target on particular service areas, such as waiting lists, and in the form of specific contract provisions for providers. In contrast, in Canada, the way in which the funds were to be spent was left almost entirely to the provinces, without even common standards to measure any progress in the areas that had been prioritized such as waiting lists. However, both countries have singled out waiting lists as an area for improvement because they are more visible and of greater concern to the general public than improvements in health outcomes, which have the further disadvantage of having a time-lag between the time of investment and the time of improvement. As a consequence, politicians tend to favor popular concern, but objective measures of health outcomes should also be considered when allocating resources.

The fourth session was on China and India. One reason why social security is being reexamined in developed countries is the competition from these huge two countries that have both shifted from a planned to a market economy. While this shift led to rapid advances in the economy, it has also resulted in the gradual abandoning of a health care system that had been owned and operated by the state. This shift has been more abrupt in China, where the government initially succeeded in delivering services that achieved substantial and widespread health improvements for the population. However, since the dismantling of the public system, health expenditures as a percentage of the GDP have increased more but with little improvement in health outcomes. In India, the shift has been less abrupt because health care has been defined as a regional, rather than a national responsibility.

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However, even in Kerala, which historically had a strong state commitment and had experienced many early gains in health, economic pressures have led to an increasing share of the private sector, largely financed by out-of-pocket spending. Nevertheless, government leaders in both countries have become aware of the need for a greater government involvement in health care. A social insurance based system for urban areas and a community pre-payment based system for rural areas might be a solution for China. The situation in India is likely to be more difficult, partly because of the lower base-line, and partly because the government has less power.

The fifth session began with a short presentation on the abandonment in New Zealand of attempts to remove specific services from the publicly financed system, and the subsequent move towards establishing clinical guidelines. This example was provided as a reminder that all policy decisions must ultimately lead to changes in physician behavior at the clinical level. After the chairs of the four sessions presented the major lessons in each, the discussion then explored two major themes that emerged from the seminar: first, the role of values in health system reform; and second, the challenges involved in the use of technical analysis in policy debates. Values drive all policy decisions, including health care. When specific ideas become the conventional wisdom, it is hard for individuals to swim against the tide to advocate a different approach, because any inconvenient evidence that they may produce is frequently ignored or misinterpreted. This trend raises the question of whether health service research has actually any effect in the policy debate. However, international comparisons and lessons from other countries are the one way to predict both the intended and unforeseeable consequences of policy options. Therein lies the objective of holding this seminar.

The sixth and last session was a public symposium, co-chaired by the Honorable Takemi and Professor Campbell, to present to the informed public the main findings of this seminar. Professor Hsiao began by emphasizing the risk of individual financial impoverishment if reliance were to be placed on private

insurance and charges to patients to finance health care. After which, a digest of one paper from each of the four closed sessions was presented: Professor Kwon on extra-billing and balance billing in Korea, Professor Rothgang on Germany's LTC insurance, Professor Wong on federalism and increased funding in Canada and Professor Wang on the inequity in the financing and delivery of health care in urban China. After which, I presented a summary of the other papers and of the discussion that had taken place in the closed sessions. Finally, there was a question and answer time for the approximately three hundred people who attended the symposium.

This publication is organized in the following order. The papers for each of the five closed session are in the order that they were presented in the seminar. This is followed by the summary of the subsequent discussion written by the chairs of each session. After this, the biographical sketches, followed by the addresses, of all of the participants in the closed session are placed. Since the public symposium covered the material already presented in the closed sessions, we have not included its summary. The power point presentations given in the closed sessions have also been excluded because most were in color and would have been difficult to read in a hard copy version. However, they are available on the web, as are the papers in this volume, with the exclusion of that of Professor Wang's. The website is listed below: <http://www-wds.worldbank.org/WBSITE/EXTERNAL/EXTWDS/0,,menuPK:64187552~pagePK:64187825~piPK:64187925~searchMenuPK:64258546~theSitePK:523679,00.html>

I would like to conclude by first thanking Professor Hsiao for graciously serving as the co-investigator for this project to whom I owe immensely. My thanks also go to the authors of papers who responded patiently to my requests for more details and/or clarifications on the drafts, the chairs of each session who undertook the difficult role of summarizing the heated and complicated discussion, and the participants who contributed to the discussion. I am also grateful to the Global Security Research Institute, Keio University, and the World Bank Tokyo Office,

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which generously sponsored this seminar, and to the Asahi Newspaper, the Japan Medical Association and the National Federation of Health Insurance Societies for supporting the open symposium. Finally, my thanks to the staff

of the Global Security Research Institute, and my staff of Ms Naoko Tomita, Mr Naonori Kodate and Dr Tomoko Shinoda-Tagawa for their tireless efforts.

# Chapter 1: Choosing to Cover Comprehensive or Basic Medical Services under Universal Social Health Insurance

## Should Providers Be Allowed to Extra-bill for Uncovered Services? Debate, Resolution and the Future in Japan

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### Background

Japan has an established universal, compulsory social health insurance (SHI) system for virtually all residents, to ensure that all of its citizens have equitable access to necessary health care and are protected from impoverishment due to medical expenses. Under SHI, employees and their dependents are covered by their employers' plans, while the self-employed and seniors are covered by municipal plans.

These plans can be grouped into three categories according to the level of subsidies that they receive from the government. Each category has enrolled about one-third of the population. The first category, which includes the Mutual Aid Association (MAA), which is the plan for employees of government agencies, and the Society Managed Health Insurance (SMHI), which is for employees of large companies, receives no subsidy from the government. The second category is a single plan managed by the Ministry of Health, Labor, and Welfare (MHLW), the Government Managed Health Insurance (GMHI), which covers those employed in small- to medium-sized companies and which receives a subsidy equivalent to 14 percent of its expenditures. The third category consists of the plans established by the municipalities, which are collectively called the Citizens' Health Insurance (CHI) and which cover seniors and the self-employed. They receive a subsidy equivalent to on average half of their expenditures. In addition to these subsidies, all plans must contribute equally to a central fund that finances the medical

expenditures of the elderly.<sup>1</sup> As a result of these mechanisms, all Japanese are covered for the same medical benefits by contributing about the same ratio of their income as premiums, despite the differences in the income level and age composition of the participants in the various plans.<sup>2</sup>

A key feature of Japan's SHI is its payment system. All health insurance plans pay physician and hospital services and drugs according to the same fee schedule. As Figure 1 shows, the fee schedule serves as the single "pipe" that controls the flow of money from all insurance plans to all providers, with the exception of the subsidies that the government gives directly to public sector hospitals. For patients, the fee schedule defines their benefits package. For providers, the fee schedule specifies the fees and the conditions under which they will be paid.

Biennial political negotiations between the government (MHLW) and the Japan Medical Association (JMA) revise the fee schedule. First, they negotiate the overall revised price rate. By doing so, they implicitly set a global budget for health expenditures since the volume

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<sup>†</sup> The author would like to thank Professor William Hsiao of Harvard University and Professor John C. Campbell of the University of Michigan for their helpful comments and edits.

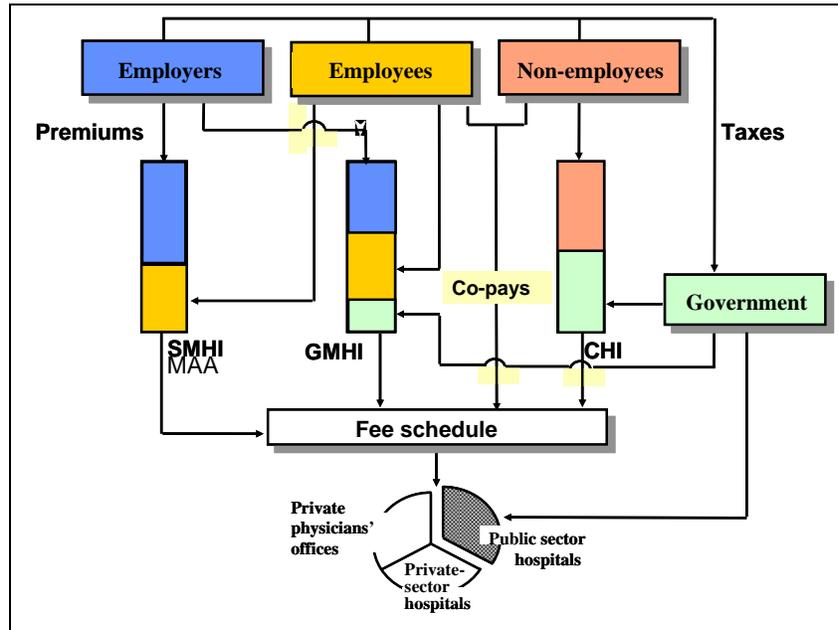
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<sup>1</sup> Each plan contributes an amount that they would pay if the ratio of elderly people enrolled in the plan were the same as the national mean. For example, a plan in which the elderly consist of 3 percent of those enrolled with expenditures amounting to \$2 million must contribute five times this amount, \$10 million, because the ratio of elderly people in the entire population is 15 percent.

<sup>2</sup> Plans in the first tier tend to have more benefits in areas other than direct medical care, such as more elaborate health screening and some reimbursement of any co-insurance that is not covered by the catastrophic program.

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**Figure 1: The Flow of Money in the Japanese Health Care System**



Note: SMHI Society Managed Health Insurance, MAA Mutual Aid Association, GMHI Government Managed Health Insurance, and CHI Citizens' Health Insurance.

Source: Campbell and Ikegami, 1998

of services and drugs will remain essentially the same. Second, they revise each service fee and drug price so that the volume-weighted net effect of these changes will be equal to the overall revised rate. The general rule has been that fees for services that have sharply increased in volume, such as MRIs (magnetic resonance imaging), should be reduced, while fees for those services that the government wants to encourage providers to provide more of, such as home care, should be increased. This micro-management of the fee schedule has helped to contain costs and to favor primary care services over high-tech care to the advantage of both the MHLW and the JMA (Campbell and Ikegami, 1998).<sup>3</sup>

This negotiated fee schedule caused health expenditures to grow at a constant, moderate rate that kept pace with the growth of the economy during the 1980s. However, when economic

growth slowed precipitously beginning in the early 1990s, household incomes became relatively flat, and corporate profits and government revenue declined. As a result, the ratio of health expenditures to GDP increased from 4.6 percent in 1990 to 6.6 percent in 2002.<sup>4</sup> Even the moderate growth in health expenditures became a financial strain, engendering a sense of impending crisis.

To meet this challenge, the government and the JMA have kept price increases to a minimum in the biennial revision of the fee schedule. In 2002, they actually reduced the aggregated fee schedule by 2.7 percent, which resulted in a decrease in total health expenditures for the first time in history (Ikegami and Campbell, 2004). At the same time, patients also had to pay more. The co-insurance rate for employees was increased from 10 to 20 percent in 1998 and

<sup>3</sup> The executive members of the Japan Medical Association tend to be solo practitioners who are mainly concerned with increasing fees in the primary care field.

<sup>4</sup> These health expenditure figures are estimates made by the MHLW (Kokumin Iryouhi) and do not include capital outlays by the public sector. They are about 20 percent below the OECD's figures for Japan's total health expenditures but are more relevant for fiscal purposes.

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from 20 to 30 percent in 2002,<sup>5</sup> and the co-insurance rate for the elderly rose from a modest, flat amount to a fixed rate of 10 percent (20 percent for those with high incomes) in 2002.<sup>6</sup> The government has promised that there will be no further increases in the co-insurance rate, and, in any case, any such increases would not be politically feasible.

However, these measures were insufficient to prevent the premium rate from increasing; the rate for the GMHI had to be raised from 7.2 percent to 8.2 percent in 2002.<sup>7</sup> Employers strongly oppose any further increases in this and other employment-based plans as they must pay at least half of the premiums. They have complained that increases in health insurance and pension contributions have already made labor costs in Japan less competitive than in China and other rapidly industrializing countries. The option of increasing subsidies from the present level of about one-third of total health expenditures is also not viable because of the huge government deficit that has accumulated to nearly 1.5 times GDP. This public debt has become a serious economic burden and is arguably retarding economic growth. With no other way to meet future increases in expenditures, the Finance Ministry finds the notion of limiting benefit coverage and making patients pay more for services outside of the social insurance system very attractive.

### **Current Regulations Concerning the Billing of Services**

Japan's SHI system had been based on the principle of providing a service benefit to ensure

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<sup>5</sup> Thirty percent has been the rate for those enrolled in the CHI so this increase had the effect of equalizing the co-insurance rate, albeit by increasing the rate paid by employees.

<sup>6</sup> These co-insurance rates are applicable up to the catastrophic ceiling, which is about \$700 per month for those with an average income. Those with low incomes and the elderly pay less, and those with high incomes pay more.

<sup>7</sup> The basis for levying premiums was changed from the person's standard monthly wage to all of his or her income, including any bonuses. The new rate of 8.2 percent of all income would be the equivalent of 9.5 percent of monthly wages under the former method of calculation.

equitable access to all necessary medical care rather than a cash benefit to partially defray the costs of such care as in an indemnity type of insurance. Consequently, providers are in principle prohibited from billing patients for uncovered services and drugs that are not listed in the fee schedule (in other words, that are not part of the benefit package) or for conditions that are not specified such as off-label prescribing. Providers are also strictly prohibited from balance billing (in other words, charging additional fees over and above those set by the fee schedule). When providers charge the patient more than the prescribed co-insurance amount, the patient must pay the entire cost of the medical treatment out-of-pocket, not just the uncovered or balance-billed services.

However, Japan established a list of exceptional services for which providers may charge patients. These uncovered services are called the "specified medical costs" (SMC) or Tokutei-Ryoyouhi. The Tokyo District Court ruled on January 23 1989 that, although there are no formal statutes that prohibit providers from billing for uncovered services, this SMC provision implies that providers are prohibited from the uncovered services not specified in the SMC. The SMC list divides these services into two categories: high tech services that are still being developed and services chosen by the patient.

### High-tech Services Still Being Developed

Extra-billing is permitted for a list of specified high-tech services that are currently being developed in 128 designated hospitals. These are mostly university hospitals. In order for a service to be included on this list, the provider must submit a request to start providing this new technical service. After the request has been approved, the hospitals are required to provide data on the effectiveness of the service. Once its effectiveness has been established, it will be listed in the fee schedule and become available for general use. So far, 165 requests to initiate new high-tech services have been approved, of which 58 were proved to be effective and were listed in the fee schedule and 10 were discontinued, leaving 97 currently active. The total cost of these services was 500 million yen (US\$5 million) in 2001 (Takeda, 2003).

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Services Chosen by the Patient

Extra-billing services were limited to extra-charge rooms when the SMC was created in 1984, but the scope has since been gradually expanded. The items below are now classified as extra-billing services with the year in which the service was listed in the SMC is noted in parenthesis:

*Extra-charge Rooms (1984).* The room must meet amenity standards set by the government. As legislated, charges may only be levied if the patient requests an extra-charge room; hospitals are not permitted to charge if the patient is admitted to an extra-charge room because a regular room was not available or because isolation was necessary due to infection, for example. These limitations are not necessarily strictly observed because most patients are not aware of their rights or are not willing to be assertive. However, the number of extra-charge beds constitutes only 16 percent of all hospital beds, of which a majority (53 percent) have *per diem* charges of less than 4,000 yen (MHLW, 2005).

*Special Consultations with Appointments (1992).* Special consultation fees can be levied that allow patients to be seen by physicians with no waiting time. However, since the hospital must maintain an alternate ambulatory service of the same specialty without extra fees, only 97 hospitals provide this SMC service.

*Consultation Fees in Hospitals with 200 or More Beds.* These measures were introduced to encourage patients to visit clinics instead of large hospitals for ambulatory care. Since 1996, consultation fees are no longer covered for initial visits and are extra-billed for an amount set by the hospital if the patient visits the hospital without a referral. However, there is little difference between the extra-billed amount paid by the patient and the co-insurance paid by patients coming with referrals in most hospitals.<sup>8</sup>

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<sup>8</sup> In order to make a functional differentiation between clinics and hospitals, physicians in clinics receive fees for writing letters of referral and those in hospitals for replying. The co-insurance for these fees is about the same amount as the SMC charge that

Since 2002, in the case of repeat visits, the SMC is restricted to situations where the attending physician offers to refer the patient back to a clinic but the patient refuses and wishes to continue to visit the hospital. Thus, very few patients pay the SMC for repeat visits.

*Clinical Trials of Drugs (1996) and Devices (2002).* The cost of the trial is not covered but is paid by the manufacturer. Thus, this measure does not affect the patient and only formalizes what had been the actual practice.

*Surcharge co-payment amounting to 15 percent of bed and board charges when the length of stay exceeds 180 days (2002).* This measure was introduced to discourage patients from staying in hospitals for non-medical reasons. The surcharge is waived if the patient has a diagnosis of, for example, a neurological disease or a spinal accident that would justify a prolonged hospitalization on medical grounds.

*Drugs That Have Been Approved but Not Yet Listed (2002).* This measure was introduced to cover the time lag of several months from when a drug has been approved for use but has not yet been listed in the fee schedule.

So it is clear that, by 2002, the SMC list had remained very restrictive. However, the general public was not aware of the impact of these restrictions or of the rule that, if the provider were to extra-bill them for any services outside of the SMC list, the patients would have to pay the entire amount out-of-pocket. Physicians knew of the restrictions and resented the rigid way in which they are implemented. However, they could sometimes circumvent the prohibitions. For example, in the case of the prohibition on off-label prescribing, which was the restriction most often faced by physicians, they may add a secondary diagnosis of "suspicion of" in the claims form, making the diagnosis not off-label. Alternatively, hospitals sometimes would only bill for the amount that was within the limits set by the directive on usage. Thus, although the restrictions were a source of annoyance, most physicians did not consider them to be a fatal defect of the system.

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is levied in most hospitals on patients who come to be treated without a referral.

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The exception to this may have been hospital specialists treating cancer and other serious diseases. From their perspective, it seemed unfair that new drugs that had produced dramatic results in patients with these conditions were only available to patients who were able and willing to pay the costs of the entire treatment until the drugs had been tested and approved in Japan. However, their grievances and those of their patients were ignored by both society and the media.

**Offensive by Deregulation Proponents**

In 2001, the Japanese government established the Economic and Fiscal Council and the Regulation Reform Council to restructure its economy. The Economic and Fiscal Council is Japan's top policymaking body, consisting of key cabinet members and economists, and is chaired by the Prime Minister. The Regulation Reform Council was given a broad mandate to put forward proposals for deregulation in all sectors of the economy, including transport, agriculture, education, and health with the goal of making the Japanese economy more competitive. The chair of the Regulation Reform Council, Yoshihiko Miyauchi, is the CEO of an aggressively expanding insurance company. Both councils were concerned about the growing fiscal deficit and looked at ways to contain public expenditures. Their primary targets were the ministries that acted in collusion with trade organizations to maintain the status quo by preventing market competition. In the health sector, they proposed that health services be provided through a combination of SHI benefits and private payments under the banner of deregulating Kongou Shinryou.

The Regulation Reform Council's seems to have as its the long-term goal the restricting the benefits package of the SHI to the "basic health services." This would be a major change from the current principle of providing equal access to "all medically necessary services" for all Japanese. The councils reasoned that this change would not only contain public expenditures but would also encourage an infusion of private funding that would better meet the diverse needs of patients. In order to achieve this objective, the Regulation Reform Council did not mount a frontal attack on the SHI system by proposing that its benefits should

become more limited. Instead, they adopted the strategy of focusing on the negative outcomes that resulted from restricting non-covered services to those listed in the SMC. They drew the attention of the public on the following conditions under which patients are currently required to pay for the entire costs of their treatment:

- If a drug or a use for a drug that has not yet been approved in Japan is provided. This becomes particularly contentious when the drug or drug use has already been approved in other countries but not in Japan, due to delays in performing clinical trials and acquiring government approval. The proponents of deregulation summoned cancer patients to the Regulation Reform Council's open forum to testify about the burden of having to pay the full costs of their treatment.
- If more than the prescribed number of treatment courses is provided. The example cited was for the eradication of *Helicobacter pylori* to prevent gastric cancer in which the number of courses is limited to two (if a third was provided, then the patient must pay for all three courses).
- If silicon implants for breast reconstruction are used in conjunction with mastectomy for patients with breast cancer. Silicon implants have not been approved for listing in the fee schedule.
- If a preventative health measure, such as vaccination for influenza, is provided during the course of hospital inpatient treatment. Prevention is not covered by health insurance.
- If interpreters are hired for patients who do not speak Japanese.

By emphasizing the above examples, the council pushed for deregulation that would allow patients to select the services that they want after they have evaluated the extra costs and benefits they will receive, based on the information provided by the physician.

They reasoned that providers would support this proposed reform because it would allow them to extra-bill patients for any service not covered by the SHI system, whereas currently they can only

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extra-bill for exceptional services as defined in the SMC. Those who oppose deregulation are the MHLW officials, who are afraid of losing their power, and the JMA, which mainly represents solo practitioners who fear the emergence of innovative and aggressive competitors. Of course, their self-interest does not preclude opposition on principle as well.

**Critique of the Deregulation Argument**

Proponents of the proposed extra-billing reform claim that its aim is to remedy problems that currently exist in the SHI system, but it also raises a serious equity problem that is not likely to be acceptable to the Japanese public. Public opinion polls have shown that an overwhelming majority of the public is opposed in principle to a system in which a patient's ability to pay determines the quantity and quality of services that he or she receives, even if it may result in a net increase in social welfare (Tamura, 2003). The egalitarian principle in health care, as opposed to the utilitarian principle, appears to be deeply and universally ingrained. As a result, the proponents of the market ideology tend to be limited to the political elite (Schlesinger, 2002).

Aside from these equity concerns, the proponents' argument is based on two assumptions. The first assumption is that patients have sufficient knowledge to decide what medical services they need. The second assumption is that medical care can be purchased in the same way as a consumer chooses options, such as a CD player, when buying an automobile, whereas the two kinds of purchases differ in many obvious ways.

Thereafter, several arguments can be made against the deregulation proposal. First, the safety and effectiveness of drugs cannot be ensured by relying entirely on the approval process in other countries because of the possibility of that drugs may have different outcomes if tested on different ethnic groups.<sup>9</sup>

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<sup>9</sup> For example, the drug for treating lung cancer, Iressa, was first approved in Japan and had some dramatic successes. However, international data have confirmed that it is not effective elsewhere, though perhaps this is not the case for patients in East Asian countries (Asahi, 1.21.05) The reverse situation is equally likely to occur.

The government has been withholding approval for drugs not because of cost considerations but for three other reasons - the postponement of clinical trials by pharmaceutical companies when they have other competing drugs (Li, 2005), difficulties in conducting clinical trials, and the long time required by the government for processing the approval requests. Also, clinical trials have become more difficult because the patient's written approval is now required. One way to shorten the approval time might be to charge pharmaceutical companies user fees, as is done by the Food and Drug Administration (FDA) in the US, but this may also have some adverse effects. It should also be noted that at least some of the restrictions are based on sound evidence. In the case of limiting the number of treatments for eradicating *Helicobacter pylori* to two, increasing the number of treatments to three is no more effective in preventing gastric cancer and actually increases the risk of lung cancer (Nagahara et al, 2002).<sup>10</sup>

Second, it is too optimistic to assume that physicians will provide impartial information to patients concerning the marginal costs and benefits of the uncovered services, especially if they are in a position to gain financially from providing such services. Moreover, the patient is not likely to decline a service if the physician recommends it. Even in the United States, informed consent tends to be more of a formality than a substantive process (Halpern, 2004), and this is likely to be even more prevalent in Japan since Japanese patients are apt to defer to their physicians. It is also inconsistent for the council to trust physicians to provide impartial information to patients when offering uncovered services while simultaneously criticizing the fee-for-service form of payment in the SHI system because it allows physicians to inflate costs. If uncovered services were to become available in principle, there is no guarantee that patients would be able to choose based on their own evaluation of the cost-effectiveness of the service. The evidence needed for monitoring this would also become more difficult to obtain since providers would no longer be obligated to submit such data, as they are now required to do

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<sup>10</sup> As one of the three combination drugs used for eradication, metronidazole, increases the risk of lung cancer, a third treatment might cause more harm than good.

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for the SMC high-tech services currently being developed.

Third, patients with private insurance would not have to pay the extra costs of the uncovered services so they would not be taking costs into consideration when deciding among services. Although virtually all private health insurance is currently limited to cash benefits,<sup>11</sup> it is very likely that such private insurance products would quickly be developed if uncovered services were to become widely available, because people are generally risk-averse and would prefer to pay premiums when they are healthy rather than paying when ill. Moreover, the premiums for the “gap” insurance could be set at low levels since they would only apply to the uncovered services and the insurance providers would not insure those who were a bad risk. Consequently, the inequity that would stem from allowing uncovered services to be provided would be likely to take the indirect form of people not being able to purchase private insurance rather than the more direct form of patients not being able to afford the services.

### **The Political Compromise**

The inconsistencies in the proponents’ arguments for opening up services for extra-billing were not presented to the general public in any coherent way. Rather, their opponents fueled fears that extra-billing would lead to the *de facto* dismantling of the SHI system in Japan and transform it into a system like that in the United States. The JMA took the lead in defending the present system, partly on behalf of the public and partly because allowing extra-billing would divide physicians into those who would be able to charge extra fees and those who would not.

Not surprisingly, the public was confused by the debate and so were the media. On the one hand, the proponents’ publicity campaign raised awareness of the illogical and rigid aspects of the present system. On the other hand, some of the

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<sup>11</sup> Because this would increase moral hazard, private insurance plans are not allowed to cover the co-insurance of the SHI system. Consequently, their benefits usually take the form of a *per diem* cash benefit for inpatient care. However, these restrictions would not apply to uncovered services since they will not be part of the SHI benefit package.

opponents’ accusations struck home with the public and made them feel uneasy about any change. What was also confusing to the public was that the proponents of extra-billing maintained that the reform would *decrease* costs to the patient, while opponents said it would *increase* costs. In reality, the former is true in the short term, since patients would have to pay only for the uncovered service instead of having to pay for the entire treatment. However, the latter is true in the long term, because people would end up having to pay premiums for both SHI and private insurance.

In the end, the following compromise was reached on December 15, 2004 by the two ministers concerned, Hidehisa Otsuji, the Minister of Health, Labor and Welfare, and Seiichiro Murakami, the Minister in Charge of Regulation Reform:

1. A special committee would be formed to decide within three months whether requests for drugs that had not been approved or were currently off-label should be covered. Drugs and drug uses that have been approved in other countries would automatically be subject to deliberation. Since one reason why some drug uses remained off-label was that pharmaceutical companies had been unwilling to incur the costs of performing new clinical trials, physician groups were encouraged to undertake such trials on their own initiative. Approval for listing would be decided within 60 days of the completion of the trial, and during this period, the drug could be extra-billed as an uncovered service.

2. For new high-tech services that were not yet listed, the current limitation applying to designated hospitals would be abolished. The list would also be broadened to include another 100 new procedures that are not high-tech (such as endoscopic resection of small bowel tumor). However, instead of an *across-the-board* deregulation and evaluation *after* the provision of the service, as proposed by the proponents, there would be *specific criteria* for each procedure that hospitals must meet *prior* to being permitted to provide the service in order to ensure quality. In total, about 2,000 hospitals would be permitted to deliver one or more of these services. Hospitals meeting the criteria would be allowed to submit their proposal and,

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except in special cases, such as genetic engineering, which would require more time, would be apprised of the decision within three months. Once approval was given, hospitals would be required to indicate clearly to the public that the provision of the service was subject to the patient's consent and to report their performance to the government.

3. For the provision of more than the designated courses of treatment listed in the directives such as the third course to eradicate *Helicobacter pylori*, extra-billing as an uncovered service would be permitted if patients wished for it and gave their consent.

4. It would be clearly specified that preventive measures, such as influenza vaccination and the use of interpreters for non-Japanese speakers, would not be part of the covered services but would be available to patients as extra-billed services.

5. The SMC would be abolished and replaced by "Medical services under investigation for coverage" and "Medical services agreed and selected by the patient" in a revision of the Health Insurance Act that was expected to be passed by 2006. Some services, such as clinical trials, that had been on the list of "Services chosen by the patient" would now be assigned to the former category.

This was a political compromise that did not go into the details of how this would work in practice, which were left to be worked out later. Regarding the encouragement of clinical trials under the initiative of physician groups under the first provision, it is unclear how funding and logistical support will be provided. It will also be difficult to speed up the approval process without increasing staffing in the government agency concerned. Regarding the second provision, specialist societies will have to establish the specific criteria that hospitals must meet for each of the procedures that are not currently listed in the fee schedule, which will be a cumbersome process. However, the important fact is that it has been possible to eliminate some of the worst anomalies in the system without wholesale reform. In this compromise, the proponents of deregulation did not achieve any major breakthroughs since the billing of uncovered services will continue to be allowed

only as an exception and not as a general rule.

### **Implications of the Compromise and Future Scenarios**

Although the proponents of deregulation did not succeed in making the billing of uncovered services a general rule, they were able to draw public's attention to the problems inherent in restricting billing to the services listed in the SMC. The resulting compromise reform will broaden both the scope of the uncovered services and the number of hospitals that will be allowed to provide such services. The process for allowing facilities to provide uncovered services will also become more efficient and transparent, which should ultimately lead to more rapid coverage of new services by the SHI system and consequent increases in expenditures.

What is more important, but is a question that has been left unanswered, is the fundamental issue of how to finance even moderate increases in health care expenditures, which are largely due to the rapidly aging population, at a time when the prospects for significant economic growth remain doubtful.

Since the situation has basically not changed, the Regulation Reform Council will continue to press for deregulation and may add a demand to allow balance billing. Regardless of whether or not they decide to take the latter step, it will be difficult to prohibit balance billing once providers are allowed to bill for uncovered services in principle. Balance billing has the potential to raise much more revenue than just providing uncovered services. One reason why it has not become an issue in Japan thus far is probably because, unlike in the UK or Germany, there are no professionally recognized elite groups of physicians;<sup>12</sup> quality is associated with hospitals rather than individual physicians. The problem for balance billing purposes is that these high-quality hospitals tend to be in the public

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<sup>12</sup> This is because hospital vacancies tend to be filled by physicians sent by university clinical departments over which hospitals have little control. Although an organization of the 22 specialties was established in 1981 and two-thirds of all physicians now have qualifications as specialists, only half have undergone formal training programs. The rest have been grandfathered in.

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sector, which is subsidized to offset the low fees charged for services. Because these hospitals are subsidized by tax money, the public would protest if better services were to be provided to those patients who were able and willing to pay for them.<sup>13</sup> Because of this, the affluent have generally satisfied their health care quality demands by giving gifts to renowned physicians in prestigious hospitals. Since these eminent physicians do not declare such gifts to the tax office, they might well prefer this traditional, if somewhat illegal, custom over formalized balance billing.<sup>14</sup>

However, this situation may change. Some public-sector hospitals are currently being privatized as the national and local governments have become increasingly reluctant to provide subsidies. Once subsidies are eliminated, some of these former public sector hospitals may welcome balance billing as a way to survive financially.

Another possibility is that the Regulation Reform Council may yet succeed in achieving its other goal in which investor-owned hospitals play a leading role in the health sector. Since 1948, only the government, non-profit organizations, physician-owned organizations, and physicians have been permitted to open hospitals in Japan.<sup>15</sup> Members of the Regulation Reform Council, which became the Regulation Reform and Opening to Private Sector Council in 2003, believe that allowing the creation of investor-owned hospitals would increase the efficiency of the delivery of health care by

increasing competition and providing alternative examples of operations and management. In its campaign for deregulation, so far the Council has won only a token concession. In 2003, the government decided to allow new investor-owned hospitals only if they confined their activities to high-tech services and if their patients paid for the entire costs of their treatment out-of-pocket. Not surprisingly, no one has applied to open an investor-owned hospital under these circumstances. However, should the Council succeed in both of its goals – allowing extra-billing as a general rule and opening the sector to investor-owned hospitals – the door will be wide open to substantial privatization, including the expansion of “gap” insurance to cover balance billing.<sup>16</sup> In order to avoid this scenario, there are four possible options.

The first option would be to make the system more efficient and less rigid by introducing an inclusive form of payment. The reason that rigid rules, such as the across-the-board restrictions on the off-label prescribing of drugs and on the number of treatment courses, have been necessary is that providers are basically paid on a fee-for-service basis. One possible solution would be to introduce a prospective case-mix based on method of payment, which would give providers more flexibility in choosing an approach to treatment, while having the cost fixed prospectively would tend to discourage and decrease unnecessary expenses in treatment.<sup>17</sup>

Off-label prescribing of drugs could be allowed in cases in which any additional costs could be

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<sup>13</sup> In national and local government hospitals, even for extra-charge rooms that are allowed in the SMC, the ratio of these services to all services provided is less than 10 percent.

<sup>14</sup> It is not clear whether physicians who accept gifts provide better care since their case mixes are likely to vary. Renowned physicians may yield poor outcomes because they attract the most difficult cases. This uncertainty may mitigate equity concerns but it also raises the issue of whether a fair transaction has been made.

<sup>15</sup> Although hospitals that were established by companies for their employees prior to 1948 were allowed to continue to operate, their number has steadily decreased. This demonstrates that investor-ownership does not in itself lead to more efficient management.

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<sup>16</sup> An independent type of insurance is unlikely to emerge in Japan. Unlike the UK, there are no waiting lists; patients are seen on the same day and are referred to affiliated hospitals should they need to be admitted. Unlike Germany, opting out of the SHI system is prohibited in Japan. Social insurance premiums are paid on incomes of up to \$100,000 so those with high income would be likely to opt of the SHI system, which would make its fiscal status worse.

<sup>17</sup> Inclusive payments with no case-mix grouping have already proved to be a failure. A flat rate of payment for ambulatory care was introduced in 1994 but was abandoned in 2002 because physicians billed light care patients at the inclusive rate and billed heavy care patients at the fee-for-service rate.

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compensated for by savings in other services and in which the prescribed use would lead to better outcomes. However, in order to introduce prospective case payment, there would have to be reliable diagnoses, accurate medical records, and standardization of practices. All of these conditions have yet to be met in Japan, which is one reason why the introduction of this payment method was limited to the 82 tertiary care hospitals in 2003.<sup>18</sup> Thus, it is likely to take a long time before prospective case-mix based payment becomes the norm in inpatient care and an even longer time before it becomes the norm in ambulatory care because of the wider variation in practice patterns at that level.<sup>19</sup> The JMA would also have to change its position and stop steadfastly insisting that fee-for-service is the only way to maintain doctors' professional autonomy.

The second option would be to continue cutting the fee schedule. In the 2002 revision of the fee schedule, overall prices were cut by 2.7 percent, which led to a 0.7 percent decline in health expenditures. Another cut in prices could be made to further decrease health expenditures. However, in the 2004 revision, as a result of intensive lobbying by the JMA, a compromise was struck that set the overall revision rate at 0 percent. The effect of this compromise on expenditures is still not clear but, since expenditures have been increasing at an annual rate of 1.8 percent as a result of aging and increases in population, they are likely to rise slightly. It would be unrealistic to aim for a continuous round of cuts that would make it possible to keep expenditures at the present level since, even though population growth is slowing, the population is aging quite rapidly. Moreover, increases in expenditures as a result of advances

in technology will occur, albeit mitigated by the micromanagement of the fee schedule.

The third option would be to increase both the fees and the co-insurance rate for those hospitals that have been evaluated to be of high quality. For example, fees for services (but not for drugs) could be set 10 percent higher than the current fee schedule rate, and the co-insurance rate for that hospital could be increased from 30 to 40 percent. Although the government has promised that there will be no further increases in the co-insurance rate, the number of hospitals affected would be relatively small so it is likely that this idea would be palatable to the public. There is some precedent for this as the initial consultation fees for hospitals with 200 or more beds are not part of the covered services and are listed in the SMC as uncovered services. The threshold for catastrophic coverage could be lowered for those with low incomes. Hospitals would have an incentive to improve quality but with the caveat that higher prices might not necessarily lead to more revenue since volume might decline. This idea has yet to be proposed, but it might be a realistic alternative.

The fourth and last option would be to raise premiums. Although I dismissed this option as untenable at the beginning of this paper, it should be pointed out that premium levels in Japan are well below those in Germany, even when the subsidies from taxes are taken into consideration. Employers should note that, if coverage by the public insurance comes to be perceived as inadequate, they will be forced to take out private insurance on behalf of their employees if they wish to attract high-quality personnel. The combined burden of public and private insurance premiums might turn out to be more than their current level of contributions as the situation in the United States clearly illustrates.

## Conclusion

The decline in Japan's economic growth has prompted some experts to propose deregulation as a way to decrease public expenditures and improve efficiency in many sectors. In their view, the responsibility of the government should be limited to providing basic services, while individual patients should be left to decide where to acquire other services based on their

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<sup>18</sup> Even for these hospitals, there was a two-fold difference in the average length of stay so the case-mix based payment had to be set on a *per diem* basis and with hospital-specific adjustments rather than on an across-the-board per hospital stay basis. Of all hospitals in Japan, only 18 percent use ICD coding (MHLW Survey, 2004).

<sup>19</sup> The task would be particularly difficult in Japan because only 41 percent of all clinics claim internal medicine or pediatrics as their main specialty, the rest being in the specialized areas of, for example, orthopedics, surgery, ENT, psychiatry, and obstetrics and gynecology (MHLW Survey, 2004).

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own evaluation of their marginal costs and benefits. The proponents of deregulation tried to apply these rules to health care, and, as a strategy, they drew the attention of the public to areas where the rigidity of the current prohibition on the billing of uncovered services appeared to be unfair and ridiculous.

Although they did not succeed in their goal of establishing the extra-billing of uncovered services as a general rule, the debate did result in a clarification of the services that are to be covered and of the process for expanding coverage to new procedures and drugs. This increase in transparency is likely to aggravate the conflict between finite resources and infinite demand, which is already strained by the decline

in economic growth in Japan. If ensuring equitable access to all necessary health care continues to be the government's primary goal, then efforts should be made to increase the efficiency of the health care system and to raise premium levels.

The debate in Japan illustrates that, because the general public favors egalitarian principles in health care, pro-market reform is likely to be presented as an attempt to increase the number of choices available to the public and scale back government control of the health sector rather than with the explicit aim of linking the quantity and quality of care to patients' ability and willingness to pay. Whether or not this strategy succeeds will determine the future of health care in Japan and in other countries.

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# The Billing of Medical Services and the Financial Burden on Patients in Korea

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## Health Care System and Policy in Korea<sup>20</sup>

### Health Care Financing

Korea has had social health insurance with universal coverage since 1989. Before the introduction in 2000 of Korea's financing reform (which merged all insurance societies), there were three types of health insurance schemes: (i) health insurance for industrial workers and their dependents, (ii) health insurance for government employees, teachers, and their dependents, and (iii) health insurance for the self-employed. There was no difference in the statutory benefit package among the three different types of insurance societies. Before the merger, health insurance schemes consisted of more than 350 non-profit insurance societies, which were quasi-public agencies and subject to strict regulation by the Ministry of Health and Welfare. Each insurance society covered a well-defined population group, and beneficiaries were assigned to insurance societies based on their employment (employees) or residential area (self-employed). There was no competition among insurance societies to attract the insured and no selective contracting with providers. In the case of industrial workers, employees and employers share the premium contribution equally. In the case of the self-employed, the government provides a subsidy.

In addition to co-payment for insured medical services, the patient pays in full for uninsured services; this amount is substantial due to the stringent benefit coverage. As a result, despite the existence of the national health insurance program (NHI), the role of public financing in health care is still limited in Korea. The social insurance programs related to health care account for only 44 percent of total personal health care expenditure. The majority of

personal health care expenditure, 37 percent, is borne by households through out-of-pocket payments (see Table 1).<sup>21</sup>

### Health Care Delivery

In Korea, physician clinics include inpatient facilities, mostly in surgery and obstetrics. (Most graduates of medical schools get training as specialists, but most of those specialists practice as office-based physicians rather than specialists in hospitals). Those clinics compete with hospitals, which have not only inpatient facilities but also large outpatient clinics. Making a clear distinction between the role of physician clinics and that of hospitals will be a critical step in increasing the efficiency of health care delivery in Korea. Hospitals in Korea are divided into three categories – hospitals, which have more than 30 beds, general hospitals, which have more than 100 beds in total and a given minimum number of specialties, and tertiary hospitals. Most health care in Korea is currently delivered through private hospitals that are, in most cases, owned and managed by physicians. Less than 10 percent of all hospitals are in the public sector. The expansion in demand for medical care that followed the establishment of the NHI has been met by the growth in private providers. Any health care system that is dominated by the private sector will put a very strong emphasis on profits and the Korean system is no exception. Therefore, any attempt by the government to impose policies or regulations is met by resistance from these private health care providers.

### Payment Mechanisms for Providers

The NHI in Korea reimburses providers via the

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<sup>20</sup> See Kwon (2002, 2003a and 2005) for detailed descriptions of the health care system and policy in Korea.

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<sup>21</sup> Private insurance in Table 1 represents medical expenses paid by automobile insurance. Private health insurance is sold as part of life or liability insurance, which pays a fixed amount based on diagnosis (for example, cancer) or *per diem*. As a result, there are no reliable data on medical expenditures reimbursed by private health insurance.

regulated fee-for-service system. The fact that medical services have different profit margins means that physicians may choose to provide more services with higher margins, thus distorting the appropriate mix of medical care given to patients. Any distortion in the relative price of medical services affects the relative supply of medical specialties in the long run. The high fees charged in some specialties such as ophthalmology and dermatology mean that these specialties attract a far greater number of applicants for residency training than those that are paid lower fees. Since 1997, a pilot program has been operating in various health care institutions that volunteered to participate in which a DRG (Diagnosis-Related Group)-based prospective payment is applied to a given number of disease categories. This DRG-based payment system has proved to be effective in reducing lengths of stay, medical expenses, the average number of tests, and the use of antibiotics with no negative effect on quality as measured by complications and the need for further surgery (Kwon, 2003b).

#### Health Expenditure

Korea spent 6.0 percent of its GDP on health care in 2002. Although this expenditure is low compared with other OECD countries, it is partly due to the rapid growth of Korea's GDP in recent years. Since GDP growth in the future will not be as high as in the past, the proportion of GDP spent on health care is expected to increase. An aging population, no incentives for physicians to provide cost-effective care under the fee-for-service system, and the increasing demand for health care will also contribute to inflating health care costs. Increased life expectancy along with the low fertility rate (1.17 percent in 2002) will lead to a rapidly aging Korean population. Fiscal stability is a big and imminent concern for the NHI system in Korea. The NHI as a whole has been in deficit since 1997, but the accumulated surplus delayed the fiscal crisis until 2001. The government's decision to allocate tobacco tax revenues to the health insurance fund has improved the fiscal situation of the NHI system, but fundamental reform is needed to ensure the long-term sustainability of health care financing in Korea (Kwon, 2006).

### **Health Care Reforms in 2000**

#### Merger of Health Insurance Societies

In 2000, all (social) health insurance societies were merged into one single national health insurer. The major driving forces behind the reform were inequity in health care financing and the financial difficulties that were being experienced by many health insurance societies for the self-employed (Kwon, 2003c). Before the merger, social health insurance societies had different methods for setting contributions. The contributions from the self-employed depended on their income, property, and household size, whereas income was the only basis for contributions from employees. These differences among insurance societies in the method of setting contributions resulted in horizontal inequity, in other words, people with the same earnings received similar benefits but paid different social insurance contributions depending on the insurance society in which they were required to enroll. This raised concerns about the unfair burden of social health insurance.

The contribution as a proportion of their income was a bigger financial burden for members of the insurance societies for the self-employed in poor areas than for those in wealthy areas. Many regional health insurance societies in rural areas got into serious financial difficulties. The revenue-sharing mechanism among insurance societies did not rescue these rural health insurance societies from financial insolvency because the problem was structural in that the population of rural areas is always decreasing and in poor health and the proportion of elderly people in the local population is increasing. Before the merger, many health insurance societies had too few enrollees to be able to pool the financial risks of their members efficiently and thus they were unable to take advantage of any economies of scale in management.

Consequently, the merging of all health insurance societies has made it possible to pool risk on a national scale, thus reducing the administrative costs of each insurer. However, in future, it will be necessary to assess accurately the income of the self-employed to increase equity in health care financing across

**Table 1: Public-Private Mix in National Health Expenditures**

(Unit: %)

	1989	1991	1993	1995	1997	1999	2000	2001
Government	8.4	7.9	8.1	9.7	10.5	11.6	11.1	10.9
Soc. Insurance	24.7	26.2	27.0	28.4	32.9	34.2	36.5	43.5
Public Total	33.0	34.1	35.1	38.1	43.4	45.9	47.6	54.4
Household	58.3	57.7	55.7	52.2	47.4	44.6	43.0	37.3
Priv. Insurance	2.9	2.8	2.9	2.6	2.5	2.7	2.9	2.2
Others	5.7	5.4	6.3	7.1	6.6	6.8	6.5	6.1
Private Total	67.0	65.9	64.9	61.9	56.6	54.1	52.4	45.6

Source: OECD Health Data 2004

the entire population. The financial solvency and efficiency of the unified health insurance system hinges on its capability and willingness to use its (monopsonistic) bargaining power over providers as well as its managerial efficiency and responsiveness to consumer needs.

#### The Separation of Drug Prescribing and Dispensing

Before the pharmaceutical reform in 2000, there was no separation of drug prescribing and dispensing in Korea. This meant that physicians and pharmacists could both prescribe and dispense drugs with little system of checks and balances in place to monitor prescriptions. This created financial incentives for both physicians and pharmacists to over-prescribe drugs in ways that might not necessarily be in the best interests of patients. In addition, because no prescription slip was given to the patients, they had no information about the type and amount of medication that they were taking (Kwon, 2003d). Since the fees for medical services were strictly regulated, dispensing drugs was more profitable for physicians than providing their own medical services. Physicians purchased drugs at low costs and were reimbursed by insurers at a much higher rate. This induced physicians to prescribe and dispense more drugs in order to increase their profits. The mandatory separation of drug prescribing and dispensing in the reform of 2000

has meant that these substantial profits from pharmaceuticals are no longer available to physicians and hospitals.

Facing strong opposition from physicians and pharmacists, civic groups consisting mainly of progressive academics and those who used to be active in the democratic movements during the former military regime played a pivotal role in formulating the pharmaceutical reform. They made the reform a major social issue and pushed the presidents of the Korean Medical Association and Korean Pharmaceutical Association to agree on major reform issues after several public hearings. However, there were three nationwide physician strikes before the reform was implemented, which pushed the government into modifying some critical elements of the reform package including eliminating the principle of generic prescriptions. More importantly, the physician strikes pushed the government to raise the fee for physicians' services by more than 40 percent as a compensation for physicians' income losses. Physicians also forced the government to defer implementing the DRG pilot program in all health care institutions. The role of civic groups in promoting policy changes and the veto power of physicians is a very significant change in the health policy process, which had previously been dominated by bureaucrats and vested interest groups (Kwon and Reich, 2005).

### **The Billing of Services**

Social health insurance was first introduced for employees in large corporations in 1977. Coverage was incrementally extended until universal coverage was achieved in 1989. However, this rapid extension of coverage was achieved at the cost of providing low benefits for a low contribution, which was 4.3 percent of employees' salaries in 2005. For services covered by the NHI, the co-insurance rate is uniformly 20 percent for inpatient care. The co-insurance rate is 40-50 percent for outpatient care in hospitals depending on what type of hospital is concerned. Patients pay \$3 per visit to physician clinics when the total expense is under \$15, but when the total expense is over \$15 per visit, the patient pays 30 percent coinsurance. People over 65 years old and those who need long-term treatment due to chronic or catastrophic conditions (such as chronic renal failure, hemophilia, leukemia, and cancer in those under 18 years old) pay discounted copayments for outpatient care. The coinsurance rate is uniform across different income groups, except for those poor people covered by the Medical Aid program. The fee level is highest for tertiary care in hospitals and lowest for care in physician clinics because differential amounts are added to the uniform fee schedule depending on what kind of health care institution is involved. Since 2004, there has been a ceiling of \$2,500 within any given six months on out-of-pocket payments for insured services.

The NHI has allowed physicians to extra bill patients for uncovered services as a compensation for their fees being regulated. Physicians can also extra bill patients for uncovered drugs, which tend to be expensive but whose effectiveness is uncertain (from the insurer's perspective). Patients also pay in full for drugs that are used more than the specified number of times (set by the insurer) or for off-label use. The NHI is a public monopsony (monopoly purchaser) but there is a huge private market in which providers can charge their own (unregulated) price. The aforementioned ceiling on out-of-pocket payments applies only to the copayment for covered services. Since the full cost paid for uncovered services is not taken into account in the ceiling, a patient may have to pay

much more than \$2,500 in total before reaching the ceiling. Different socioeconomic groups probably have different patterns of using uncovered services because these services are essentially private commodities, the consumption of which is affected by the ability of consumers to pay for them. Some physicians may choose to differentiate their fees for the uncovered services that they provide by taking into account their patients' ability to pay, although there is no empirical evidence on this.

In theory, the patient can choose among different types of covered or uncovered services. However, there is asymmetry of information between patients and physicians, and the patients' lack of information is a critical barrier to their ability to make a rational choice, especially as the private market for uninsured services is dominated by physicians. The fact that physicians rely on these uncovered services has been exacerbated by financial incentives under the fee-for-service arrangements and the dominant role that providers play in medical decision-making. As long as there is a big private market for medical care (in other words, uncovered services) and the practice of extra billing, government policy has a limited impact because health care providers can easily substitute uncovered services for covered ones.

The government has extended the coverage of the benefits of the NHI over time. However, this extension of benefit coverage has been accompanied by the rapid introduction by providers of new services that are not covered by the NHI. Health care providers prefer providing uncovered services because they can charge (monopolistic) prices for them and avoid having their fees regulated by the government. Therefore, providers have always been opposed to the extension of benefit coverage because it means that more services are subject to fee regulation. Physicians can easily persuade consumers to use more uncovered services by giving them distorted information on the cost-effectiveness of different treatment and drug options. The rapid introduction of new services has led to extensive use of those uncovered services. As a result, patients have to pay copayments for NHI-covered services and full payment for uncovered services within the same

medical episode. Patients are also required to pay a 100 percent copayment for a very limited number of covered services for budgetary reasons.

Typical payments required for uninsured services are for meals, extra charges for rooms with fewer than six people, for uncovered high-technology care (for example, ultrasounds)<sup>22</sup>, and for specialist care. Many patients, especially in tertiary care or teaching hospitals, are forced to pay extra charges for rooms because standard rooms with six patients are short of supply. Patients should pay specialist charge to specialists in hospitals who have more than 10 years of clinical experience after the certification of specialist board. Hospitals can charge a specialist fee of up to 55 percent of their consultation fee, 50 percent of their test fee, 100 percent of their anesthesiology fee, and 100 percent of their surgery fee. In theory, patients have a choice of doctors. However, patients in tertiary care hospitals usually end up paying a significant amount of specialist charge because most physicians in those hospitals are eligible for the specialist fee.

### **Empirical Evidence on Out-of-pocket Payments by Patients**

#### Data

The National Health Insurance Corporation recently collected data on out-of-pocket payments made by patients in Korea (Kim and Chung, 2005). In theory, insurance claims made by health care institutions include information on the total medical expenses associated with each treatment episode. However, the information on the patient's out-of-pocket payments for uncovered services in the claim data is not reliable. So a separate survey was needed to estimate the amount that patients pay in out-of-pocket payments. From data on all patient cases (both inpatient and outpatient) during March 2004, a national representative sample of 357 health care institutions was selected using stratified sampling. This yielded data on 1,214,823 cases from 173 health care institutions (response rate 48.5 percent), which

is the largest database of its kind in Korea. Since the data were reported directly by health care institutions, it was necessary to check the reliability of the data. A sample of 1,922 patients, who were randomly selected from among all discharged patients, was interviewed by phone. In the case of 94.8 percent of those patients, there was no difference between their actual out-of-pocket payments and the amount reported in the survey.

#### Out-of-pocket Payments by Type of Health Care Institution

A patient's average<sup>23</sup> out-of-pocket (direct) payment as a percentage of his or her total medical expenses per case is 43.6 percent, which consists of a copayment for covered services (22.3 percent), full payment for uncovered services (20.2 percent), and full payment for covered services (1.1 percent) – see Table 2. The direct payment percentage is lower in medical care institutions than in dental care institutions and in traditional medical institutions because the major expenditures in those cases (for example, prosthodontics and traditional drugs) are not covered by health insurance. In medical care, the larger the health care institution, the higher the percentage of a patient's total medical expenses that consists of the out-of-pocket payment. In tertiary care hospitals, patients pay 56 percent of their total medical expenses out of their own pockets. Since physician clinics do not charge specialist fees and rely less on high-technology services than hospitals do, the share of patients' payments that applies to uncovered services is much smaller in physician clinics than in hospitals.

The average direct payment percentage is slightly higher in the case of inpatient care (45.1 percent) than of outpatient care (43.1 percent). However, focusing specifically on medical care (excluding dental and traditional medical care), the out-of-pocket percentage is higher in outpatient care than in inpatient care. The composition of the direct payment differs

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<sup>22</sup> MRIs have been covered since 2005.

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<sup>23</sup> This is a weighted average, adjusted for medical expenditures of different types of health institutions.

**Table 2: Out-of-pocket Payments by Type of Health Care Institution** (Unit: %)

	Type of Health Care Institution	Paid by the Insurer	Out-of-pocket Payment by the Patient			
			Subtotal	Copayment for Covered Services	Payment for Uncovered Services	Full Copayment for Covered Services
All	AVERAGE	56.4	43.6	22.3	20.2	1.1
	Tertiary Care Hospital	43.8	56.2	20.8	32.7	2.7
	General Hospital	51.7	48.3	22.6	23.9	1.8
	Hospital	51.6	48.4	22.8	24.0	1.6
	Clinic	67.5	32.5	24.3	8.1	0.1
	Dental Hospital	22.2	77.8	16.9	60.9	0.0
	Dental Clinic	38.3	61.7	15.6	45.8	0.3
	Trad Med Hosp	20.6	79.4	9.4	69.7	0.3
	Trad Med Clinic	66.4	33.6	19.5	14.1	0.0
Inpatient	AVERAGE	54.9	45.1	16.3	26.5	2.3
	Tertiary Care Hospital	48.0	52.0	14.0	34.7	3.3
	General Hospital	57.0	43.0	17.5	23.4	2.1
	Hospital	54.3	45.7	18.8	25.3	1.6
	Clinic	72.1	27.9	17.8	9.6	0.5
	Trad Med Hosp	31.4	68.6	11.4	57.2	0.0
Outpatient	AVERAGE	56.9	43.1	26.0	16.7	0.4
	Tertiary Care Hospital	36.0	64.0	33.5	28.9	1.6
	General Hospital	40.1	59.9	33.6	25.0	1.3
	Hospital	48.7	51.3	27.2	22.6	1.5
	Clinic	66.4	33.6	25.9	7.7	0.0
	Dental Hospital	22.2	77.8	16.9	60.9	0.0
	Dental Clinic	38.3	61.7	15.6	45.8	0.3
	Trad Med Hosp	14.2	85.8	8.1	77.3	0.4
	Trad Med Clinic	66.4	33.6	19.5	14.1	0.0

Source: Kim and Chung, 2005.

between inpatient and outpatient care. In inpatient care, the direct payment for uncovered services is much bigger than the copayment for covered services (with the exception of charges in physician clinics), while in outpatient care, the former is slightly lower than the latter. The huge payments for uncovered services in inpatient care are partly the result of extra room charges and charges for meals.

#### Break-down of the Payment for Uncovered Services

In the case of inpatient care, more than 55 percent of the patient's total payment for uncovered care consists of extra charges for rooms with fewer than six people (23.5 percent), payments for meals (20.7 percent), and charges for specialist care (13.1 percent) – see Table 3. In tertiary care hospitals, charges for non-standard rooms and extra charges for specialist care are the major elements of the patient's direct payment for uncovered services. In general hospitals and in hospitals, payments for meals and extra charges for rooms account for half of the patient's payment for uncovered services. In the case of outpatient care, the largest slice of patients' direct payments for uncovered services consists of charges for medical technology (ultrasounds and MRIs) – see Table 4. Payments for tests also account for a significant share of patients' direct payments for uncovered services. Patients' payments for outpatient care in tertiary care hospitals are heavily affected by charges for specialist care because most doctors in those hospitals are eligible for the charge.

#### **Effects on Equity**

##### Financial Risk Protection

Due to high out-of-pocket payments for medical care, the NHI in Korea may not be providing full financial risk protection for the insured. Lee et al (2003) analyzed the catastrophic impact of medical expenditure on households and its impact on poverty using data from the Urban Household Expenditure Survey fielded in 2000. The researchers found that 21 percent of the households surveyed spend more than 5 percent

of their consumption expenditure on health care, and 10 percent [6 percent] of the households spend more than 10 percent [15 percent]. The concentration index of headcounts is negative (in other words, occurs among the poor) when the threshold level is 5 percent, but it turns positive (in other words, occurs among the rich) when the thresholds are 10 percent and 15 percent. This implies that having high expenditure on health care as a proportion of total consumption expenditure may not necessarily have a catastrophic financial impact on households. Since food expenditure is essential for survival, the above analysis was also performed for consumption expenditures excluding food. This analysis showed that 28 percent of the households spend more than 5 percent of their consumption expenditure on health care and that 16 percent [10 percent] of the households spend more than 10 percent [15 percent]. Moreover, the concentration index of headcounts is negative for all three threshold levels (5, 10, and 15 percent), which implies that having high expenditures on health care as a proportion of total consumption expenditure (excluding food expenditure) may indeed have a catastrophic impact on poor households.

Similar conclusions can be derived from the same researchers' analysis of the impact on poverty of health care expenditure. When the poverty line is set at one-third of average daily expenses (the relative poverty line), 5.1 percent of the households are below the poverty line even before spending on health care. This increases to 5.2 percent after medical care spending, which implies that medical expenditure does not impoverish households. However, this particular poverty line may be unreasonably low. When the poverty line is set at the level of the minimum expenses of living (the national poverty line), the proportion of households below the poverty line increases from 10.8 percent to 12.5 percent after spending on medical care, implying that household expenditure on health care impoverishes some households to some extent. Heavy out-of-pocket payments at the point of service contribute to the potential catastrophic financial impact of medical care on households.

The reasons why medical care expenditures do not lead to widespread impoverishment despite

**Table 3: Payments for Uncovered Services in Inpatient Care (Unit: %)**

	Extra Charge Rooms	Meals	Injection	Surgery	Test	MRI	Ultra sound	Materials	Specialist Charge	Other	Total
AVERAGE	23.5	20.7	6.7	3.6	5.2	5.4	11.0	5.1	13.1	5.8	100.0
Tertiary Care Hosp	28.8	9.9	6.2	2.3	5.6	6.4	5.4	6.0	25.4	3.8	100.0
General Hospital	23.4	27.3	8.0	3.1	3.5	5.9	5.3	6.9	10.2	6.5	100.0
Hospital Clinic	22.3	33.8	6.6	8.2	7.2	6.2	2.2	3.1	0.0	10.3	100.0
Trad Med Hospital	9.2	19.5	4.9	3.0	5.9	0.0	54.9	0.5	0.0	2.1	100.0
Trad Med Hospital	17.1	23.7	1.0	3.5	0.6	0.7	0.1	0.2	6.8	46.4	100.0

Source: Kim and Chung, 2005.

**Table 4: Payments for Uncovered Services in Outpatient Care (Unit: %)**

	Medi cation	Injection	Test	Radiology	CT	MRI	Ultra sound	Materials	Specialist Charge	Others	Total
AVERAGE	5.1	10.3	18.8	3.3	3.7	5.6	24.4	9.3	3.2	16.3	100.0
Tertiary Care Hosp	0.9	4.5	11.1	1.6	0.3	18.3	25.1	5.9	23.3	9.	100.0
General Hospital	1.0	3.5	11.7	1.4	1.9	27.1	34.3	5.3	4.3	9.6	100.0
Hospital Clinic	0.3	13.2	21.3	2.0	1.8	18.3	20.4	0.9	5.3	16.4	100.0
Dental Hospital	1.6	15.6	27.4	5.1	5.9	0.0	30.6	0.9	0.0	12.8	100.0
Dental Hospital	0.0	0.0	0.0	0.1	0.0	0.0	0.0	76.6	0.0	23.2	100.0
Dental Clinic	0.0	0.0	0.0	0.0	0.0	0.0	0.0	84.5	0.0	15.4	100.0
Trad Med Hospital	62.8	0.0	1.8	0.0	0.0	0.0	0.4	0.0	3.8	31.0	100.0
Trad Med Clinic	43.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	10.9	100.0

Source: Kim and Chung, 2005.

the existence of high out-of-pocket payments need to be explored in the future. Although the percentage of out-of-pocket payments in total household expenditure is high, this may not be a great financial burden on patients in absolute terms thanks to the regulation of fees (for insured services) by the government. Social protection for the poor may also reduce the extent to which medical expenditures have the potential to impoverish households. Poor people (3-4 percent of population) do not pay any contributions. Half of them pay no copayments for insured services, and the other half pay discounted copayments. Although the poor have to pay in full for uncovered services, physicians are unlikely to provide many of these uncovered services to the poor.

#### Equity in Health Care Utilization

High out-of-pocket payments can also prevent some people from accessing medical care. Kwon et al (2003) analyzed equity in the use of medical services using a Health and Nutrition Survey fielded in 1998. Following van Doorslaer et al (2000), they measured equity in the use of medical care as the difference between the concentration of the use of medical care and the concentration of medical care needs among different socioeconomic groups. This is known as the HIwv index, measuring equity in terms of equal treatment for equal need. They concluded that the use of outpatient care in Korea seems to be equitable (in other words, favorable to the poor even after taking into account medical care needs and health status, meaning that the value of HIwv is negative), or at least less inequitable than in other OECD countries (see Table 5). Health care use in terms of the number of inpatient days is equitable for the poor too. The finding that health care use benefits the poor disproportionately after controlling for medical care needs was a bit unexpected given that out-of-pocket payments at the point of service is rather high in Korea.

However, it is necessary to examine health care expenditures to find out if there are any variations in the quality or intensity of medical care use between different socioeconomic groups. Despite the fact that the poor use more medical care than the better-off, the rich spend more on medical care, resulting in an inequitable distribution of medical care

expenditures in favor of the rich (positive values of HIwv in the case of medical care expenditure in Table 5). This is the result of the high out-of-pocket payments for the many services that are not covered by health insurance. It is likely that different socioeconomic groups utilize different “types” of medical care. For example, the relatively poor use more insured services whereas the relatively rich use more uninsured services, resulting in the greater health care expenditure by the rich despite the fact that the poor use more visits or patient days of medical care. More research is needed into how the use of different types of medical care affects health outcomes.

#### **Policy Implications**

Extra billing for uncovered services has contributed to the rapid introduction and use of new medical services in Korea. The expansion in the provision of uncovered services that has been the result of extra billing and limited benefit coverage has put a serious financial burden on patients. Although the problems of extra billing are manifold, it does not seem politically feasible to limit the extra billing of uncovered services. When so many services remain uncovered, banning extra billing would limit consumers’ access to necessary care. Consequently, public debate has focused on extending the coverage of social insurance rather than on limiting extra billing. The NHI needs to increase its contributions and extend its benefit coverage to cover all medically necessary services. Alternatively, the NHI could restructure its benefit package and reduce cost-sharing for minor cases and increase cost-sharing for catastrophic cases.

The government needs to take policy measures to reduce the financial burden on patients caused by the requirement to make full payment for uncovered services. For example, it could increase the basic consultation fee for physician service in return for the elimination of the specialist charge. It could also upgrade the specifications of a “standard” hospital room (for example, to accommodate only four instead of six patients) and increase the fee for using the standard room based on this new specification. Introducing case-based payments (such as the

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DRG), inclusive of more services covered, might extend benefit coverage and put a limit on extra billing. In the pilot program of the DRG payment system, the level of compensation to providers has been increased (compared to the current level of fees under the fee-for-service

system) in return for a ban on extra billing except for meals, sonograms, extra room charges, and specialist charges.

**Table 5: Equity in Use of Health Care Services**

	Unstandardized Cm	HIwv standardized for age, sex, and	
		Self-assessed Health	Chronic Diseases and Self-assessed Health
Number of Outpatient Visits	-0.106	-0.011 (Cn: -0.096)	-0.002 (Cn: -0.104)
Number of Inpatient Days	-0.187	-0.168 (Cn: -0.019)	-0.162 (Cn: -0.025)
Medical Care Expenditure	0.016	0.058 (Cn: -0.042)	0.064 (Cn: -0.048)

*Notes:* Cm = concentration of medical needs, Cn = concentration of medical care utilization, Positive/ negative HIwv means the rich use or spend more/ less than the poor.

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## Summary of the Discussion

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### Summary of the Two Papers

Naoki Ikegami's paper addressed a fundamental issue that is relevant to any developed economy with a social insurance (SI) system: what would be the consequences if Japan shifts from providing comprehensive SI coverage to covering only basic health services? Japan currently has a universal social insurance program with a fairly comprehensive benefit package and a high co-insurance rate. Ikegami argued that, under the SI as currently structured, the Japanese people have reasonably equal access to health services, the cost burden is equitably distributed, and health care cost inflation has been contained.

However, Japan has suffered from economic stagnation while health care costs have been rising because the population is aging and more expensive new medical technology is available and widely used in the health care system. As a result, health care costs are taking up a growing share of Japan's GDP. The government has taken significant measures to hold down medical prices, and further reductions may not be possible. If not, then the SI premium rates may have to be raised to maintain the financial soundness of the current SI system. The Regulation Reform Council has recommended that the government should reform its SI to cover only basic health services. Doctors and hospitals would be allowed to bill for any services that are not covered in the basic benefit package (called extra billing) and the price and quality of the uncovered services would be left to the marketplace (largely unregulated). Furthermore, doctors and hospitals would be allowed to bill patients above and beyond what the SI pays them for those services (called balance billing). In fact, the Council's recommendation would shift health service delivery from a regulated SI system to a largely unregulated market system. It would shift the health care costs to the patients and use prices to ration health services (through extra billing and balance billing). Private insurance schemes could emerge to offer insurance to cover the

services not covered by SI, and those who could afford it would purchase such private insurance. The Council seems to believe that market competition works fairly well in health sectors and that providers would compete with each other to provide the highest quality services at minimum cost to the benefit of the consumer.

Ikegami argued against the Council's recommendation on four grounds: it would reduce the equity of Japanese health system; more Japanese people would be impoverished by their medical expenses since the risk protection would be reduced; it would reduce the safety and efficacy of medical treatments and drugs because many of them would be provided as part of the uncovered services that would not be regulated; and patients may not be sufficiently well-informed to be prudent buyers of services and drugs, particularly if doctors do not give them objective information.

Soonman Kwon presented the second paper on South Korea, which has a similar social health insurance system as Japan and also has high co-insurance. However, South Korean's benefit package is less comprehensive than Japan's. Moreover, South Korea allows extra billing and balance billing. Kwon's study examined the equity of the South Korean SI system using a medical care concentration curve that measured the differences in the use of medical services among different income groups. He found that utilization rates are quite equal after controlling for health care "need." However, Kwon was unable to establish definitively whether extra and balance billing in South Korea had resulted in an increase in the number of South Koreans living in poverty.

### Discussion

The discussion centered on several topics: the effects of reducing the benefit coverage of SI with extra and balance billing, how to decide on what should be included in a basic benefit package, and the politics involved in reforming SI.

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Peter Berman highlighted the direct connection between Ikegami and Kwon's papers. Ikegami argued on equity grounds against changing Japan's SI program to cover only basic health services and allowing extra and balancing billing. But Kwon's analysis of South Korea's SI showed that the extra and balance billing had no measurable impact on equity among difference income groups. Berman asked the question: if we assume the findings from Kwon's study were correct and that they can be generalized to Japan, then what would be the objection to Japan reducing the benefit coverage of SI and shifting to more private financing of health services?

In the debate, several points were made against a shift. Participants pointed out that Kwon studied the equal utilization rates of health services but not health effects. Naoki Ikegami argued that basic benefit package could exclude clinically effective services and negatively affected health status and he pointed out that Kwon's study did not examine the health status issue. Furthermore, the excluded medically efficacious services would be rationed by price. Patients who could afford them would receive these services while others would not. Such a system would not be equitable. Another participant argued that allowing for extra and balance billing would reduce the risk protection offered by SI, and more Japanese would be impoverished. William Hsiao pointed out that Japan's single-payer system had held down the health cost inflation rate. Legitimizing extra and balance billing would create a multi-payer system and lead to greater cost inflation. The experience of the United States is an indication of what could happen in Japan. Peter Berman pointed out that Kwon's paper did not assess how changing SI into a basic benefit package with extra billing and balance billing would affect both the allocative and the technical efficiency of health services. It is possible that this kind of change would increase the inflation rate of total national health expenditures. The United States has a so-called market system and is spending the largest share of GDP on health of any developed country but this expenditure has not yielded commensurate benefits.

In the debate, various participants offered several arguments in favor of a shift. One argument was that increasing patients' direct

payments for health services would reduce the demand for "unnecessary" health services (in other words, the traditional moral hazard argument). Keizo Takemi diplomatically put forward an argument that reducing the SI benefit package would remove the need to increase premium rates and relieve a difficult political problem for the Japanese government. Another argument in favor of the shift was made from the neo-classic economic perspective. Reducing the benefit coverage of a compulsory SI system would give people more choice in that they could either buy private insurance or pay for medical expenses out-of-pocket. This argument was further extended by the proposition that the promotion of private insurance and unregulated medical care and drugs may also enhance economic development, particularly in encouraging the development of drugs and medical technology. Other participants, however, questioned whether industrial development should be a goal of a national health system.

Alan Maynard argued that there has to be rational process to decide what health services would be covered in a basic benefit package and that a boundary should be drawn based on the purpose of the national health system in question. The method used to decide what to include in the package should be cost-effective analysis. This assertion stimulated a lively debate. One participant questioned what should be the criterion for the cost-effectiveness studies. Maynard and others argued that the purpose of a national health system is to produce health gains so these should constitute the effectiveness criterion. However, many participants disagreed. They argued that a national health system has several purposes and that health gains are only one dimension. For example, people value risk protection as much as health gains. Current cost-effectiveness studies, however, do not incorporate risk protection as an effectiveness criterion. Moreover, we do not have a method for ascertaining the trade-off between health gains and risk protection.

Another shortcoming of the cost-effectiveness is that the benefit package that lawmakers choose to be covered by SI has to be politically acceptable. Yet cost-effectiveness analysis usually ignores political factors including public satisfaction. Michael Reich and Joseph White

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succinctly summed up the dilemma inherent in the cost-effectiveness method: “You can be happy but unhealthy, or you can be healthy but unhappy.” In other words, how useful can cost-effectiveness be in determining the basic benefit package of SI? Soonman Kwon observed that in South Korea the services included in the basic benefit package were mostly determined by fiscal criteria rather than by some technical method such as cost-effectiveness.

The discussion then turned to the politics of social insurance reform. Michael Reich suggested that the process of shaping the benefit package was likely to be dynamic rather than confined to a single time period. Services were likely to be added or deleted over time as socioeconomic and political factors changed. He pointed out that South Korea originally excluded MRI and now included it in the coverage. The participants then focused on the political forces that are influencing the current Japanese reform. Seven million Japanese people signed a petition against the Regulation Reform Council’s proposal, which they found unacceptable regardless of the technical argument in its favor. As a result, the

government withdrew its proposal in December 2004 and accepted a compromise that involved making only several modest changes to the existing SI.

**Themes Connecting the Four Sessions of the Seminar**

Some participants thought that this seminar covered disparate topics. However, William Hsiao pointed that there are overlapping themes and issues among all sessions. He argued that Sessions 1 and 2 (on long-term care) addressed two common issues: risk pooling and the role of government in subsidizing the poor. Sessions 1 and 3 (on the public financing of health services in UK and Canada) shared a common theme: how much should the public sector invest in health services and what would be the consequences if the public sector under-funded health? Sessions 1 and 4 (on health care financing and provision in China and India) addressed a common fundamental issue: what are the socioeconomic and political consequences when countries shift to private financing for health and turn over the provision of services to an unregulated market?

## Chapter 2: Financing Long Term Care

### Financing Long-term Care: Lessons from 19 OECD Countries

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This paper in its current form does not necessarily reflect the views of the OECD or of its member countries.

#### Introduction

Governments in OECD countries are faced with the growing expectations of their populations that they should be able to access high-quality long-term care services at affordable costs. When the baby-boom generation grows old over the next three decades, demand for services will rise steeply. In the meantime, consumers of long-term care are already more reluctant to accept the variability in the quality of care and the wide differences in access to services that currently prevail across OECD countries.

Long-term care is a cross-cutting policy issue that brings together a range of services for people who need help with the basic activities of daily living over an extended period of time. Such activities include bathing, dressing, eating, getting in and out of bed or a chair, moving around, and using the bathroom. These services are often provided in combination with rehabilitation and basic medical services. In OECD countries, most people in need of long-term care are the oldest age groups in society who are most at risk for long-standing chronic conditions that cause physical or mental disability.

This paper begins with a brief overview of the demographic trends in these aging populations. It then reviews the evidence about cross-country differences in long-term care programs and expenditure and identifies key national differences and drivers. An overview is given of the need to improve the quality of care in many instances. A final section discusses lessons from

recent reforms of long-term care financing and how to sustain these reforms financially in the future.

This paper is a rearranged and abbreviated version of an OECD study that reports on latest trends in long-term care policies in 19 OECD countries – Australia, Austria, Canada, Germany, Hungary, Ireland, Japan, Korea, Luxembourg, the Netherlands, New Zealand, Norway, Mexico, Poland, Spain, Sweden, Switzerland, United Kingdom, and the United States (OECD, 2005). This study was one of the major components of the OECD Health Project, which was carried out between 2001 and 2004 to explore key issues involved in improving the performance of health and long-term care systems (OECD, 2004b). It was conducted with the invaluable assistance of a network of national experts nominated by the countries taking part in the project.

The following box (Box 1) brings together the key definitions and concepts used throughout this paper and the OECD study.<sup>24</sup>

#### Demographic Trends and Informal Care-giving

The rising number of very old people in OECD countries is causing concern about how these countries are going to finance the care that will be needed by this large cohort. In response, policymakers have begun considering different policy options for providing and paying for this long-term care. However, future demand for long-term care will be driven not only by growth in numbers in relevant age groups but also by a number of other factors that may be susceptible to being influenced by social and health policies in ways that may reduce this heavy demand.

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<sup>24</sup> Methodological and data work on long-term care at OECD is ongoing during 2005. See, for example, Huber (2005a, b, and forthcoming).

## **Box 1: Definitions and Glossary of Terms**

The terminology used in long-term care policy and statistics varies widely between countries. This box presents various working definitions compiled with the aid of the group of experts who supported this study.

### **Activities of daily living (ADLs)**

*Activities of daily living* are self-care activities that a person must perform every day, such as bathing, dressing, eating, getting in and out of bed or a chair, moving around, using the toilet, and controlling the bladder and bowels.

### **Allowances**

*Allowances, cash allowances, and cash benefits* are all payments that may be either liable for income taxation or exempt from income taxation.

### **Care**

The term *care* is frequently used in the study as a synonym for *long-term care*.

### **Consumer direction**

The term *consumer direction* refers to arrangements whereby public programs enable people who need care or their families to purchase their own care, sometimes by employing a care assistant.

### **Disabled or dependent older people**

Older people whose overall level of functioning is substantially impaired to the extent that they are likely to need help from a third party or various aids and adaptations to fulfill the normal activities of daily life.

### **Formal long-term care services**

Long-term care services are supplied by the employees of any organization, in either the public or private sector, including care provided in institutions like nursing homes or care provided to people living at home by either professionally trained care assistants, such as nurses, or untrained care-givers.

### **Home care**

Home care refers to long-term care services that can be provided to patients at home, including day care and respite services. It also includes long-term care received in home-like settings such as assisted living facilities.

### **Informal care**

*Informal care* is the care provided by informal care-givers (also called *informal carers*) such as spouses/partners, other members of the household and other relatives, friends, neighbors, and others, who usually but not always have a previously existing social relationship with the person for whom they provide care. Informal care is usually provided in the home and is typically unpaid.

### **Institutional care**

Institutional care is long-term care provided in an *institution* that, at the same time, serves as the residence of the care recipient.

### **Long-term care**

Long-term care is a range of services needed for people who are need help with basic ADL. This care is frequently provided

in combination with basic medical services such as help with changing wound dressings, pain management, medication, health monitoring, rehabilitation, or palliative care.

**Long-term care institutions**

*Long-term care institutions* are places of collective living where care and accommodation are provided as a package by a public agency, a non-profit, or a private company. Residents may or may not be charged separately for care services and accommodation.

**Older people**

All those aged 65 or over.

**Nursing home/Nursing home care**

These terms are used in this study as synonyms for long-term care institutions providing nursing and personal care to people with ADL restrictions.

**Respite care**

*Respite care* is a short-term care arrangement with the primary purpose of giving carers a short-term break from their usual care commitments.

*Source:* OECD (2005a)

An individual's demand for long-term care grows exponentially with age. Therefore, most demand comes from people aged 80 years and older. A number of recent national and international studies have looked at how trends in disability among older people affect future demand for long-term care, and we provide an overview of their findings in this section. Although a number of studies agreed that favorable disability trends in the future could substantially reduce future demand for long-term care, the fast-growing number of very old people, in particular relative to the population at working age, is nonetheless expected to increase care needs – and related spending – by a substantial amount in the future.

One important factor that will influence the demand for care services is the level of health and disability of future generations of elderly people. If the elderly in the future are more able to provide for themselves and in less need of services than the present elderly cohort, then demand for services will be less than purely demographic projections would suggest. Equally important will be the supply of informal

care in the future. Currently, over half of all long-term care in all OECD countries is provided through informal care arrangements. Unless informal care can expand to keep up with demand from elderly people, then the higher demand for formal care services will rise.

The future level of informal care provision will itself be a response to a number of factors, including the living arrangements of elderly people, the longevity of elderly husbands and wives, and trends in the labor market participation of those groups in the labor force that currently shoulder most of the burden of informal care, especially women aged over 45.

Any decisions today on how to organize the provision and financing of long-term care for older people have to be taken in the context of aging populations in the OECD countries. Current population projections assume, first, that the gains in life expectancy that have been observed in the past will continue in the future, second, that patterns of declining fertility will not be reversed rapidly, and third, that future international migration will make only limited

changes to current population trends.

Under these assumptions, absolute numbers of older people and their shares in the populations of the OECD countries will increase rapidly over the next 20 years when the post-war baby boom generation will reach the age of retirement in many OECD countries. By the year 2040, one person in four may be 65 years or older in OECD countries on average (Table 1). In Italy, Switzerland, and Japan, this number could come close to one in three if current demographic trends prevail. As the populations of OECD countries age, the oldest cohort of the population will grow the fastest. Over the past 40 years, the increase in the number of those aged 80 and over contributed around one-third to the total increase in the share of older people in these populations as a whole. It is this group of the population that has the most pronounced care needs. Table 1 brings together population projections that suggest that the share of the oldest-old in the population will double over the next 30 to 40 years.

In 1960, only one out of seven older people (aged 65 and over) belonged to the oldest age group (80 and over) across all OECD countries on average. Today, this figure is more than one in five, and this share is expected to increase to around one-third in some OECD countries by the year 2040 (Table 2). The demand for long-term care is therefore likely to grow in all OECD countries in future decades. This is a major concern for policymakers as it implies that any decisions made about extending the supply of services or reducing the financial costs of users could add significant additional costs to public budgets in future decades.

However, there are large differences across countries. In several countries (for example, Sweden and Norway), the number of oldest-old people among the elderly already come close to the average that is likely to prevail in all countries by the year 2040. Several countries that today have relatively “young” populations (such as Mexico, Turkey, and Korea) are likely to experience the fastest aging among all OECD countries in the decades to come.

Demographic projections of aging populations

crucially depend on the reliability of forecasts of future trends in life expectancy, in particular of remaining life expectancy at higher ages as most of the additional years added to life in the past few decades of the 20<sup>th</sup> century were at higher ages (Cutler and Maera, 2001). Increases in life expectancy for those in higher age groups are a major reason for the growing dependency ratios in the population, and long-term gains in life expectancy in the past have been consistently underestimated by demographers and actuaries (for example, Wilmoth, 1998). Demographers are divided in their opinions as to the extent to which life expectancy will be further prolonged in the future (Tuljapurkar et al, 2000). The factors driving mortality decline, in particular at higher ages, are currently poorly understood. Consequently, there is an ongoing scientific debate about whether or not past trends will prevail and can be extrapolated into the future.

From the perspective of fiscal policy and of the question how to ensure the financial sustainability of long-term care services, trends in demographic dependency ratios are crucial. The ratio of older people to the number of those of working age is projected to roughly double over the next 40 years assuming current demographic trends (see OECD, 2005a, TableA.4). This raises difficult questions about the future financial sustainability of a range of publicly funded old-age benefits such as pensions, health care, and long-term care benefits.

The fiscal outcome of this major demographic change will crucially depend on how many people of working age will be in gainful employment, which is an argument in favor of reversing of past social trends towards earlier retirement. In addition, there will be fewer adult children to care for the baby boomers when they begin to require long-term care in 20 to 30 years' time.

One broad indicator that is used to show the trend in the potential within societies to provide care for older people is the “old-age dependency ratio.” This is normally expressed as the number of people aged 20 to 64 as a proportion of those aged 65 and over. Expressed in this way, the

**Table 1: Share of Older People in the Population, 1960-2040**

	65 and over					80 and over				
	1960	2000	2040	Change in % points		1960	2000	2040	Change in % points	
				1960 - 2000	2000 - 2040				1960 - 2000	2000 - 2040
Australia	8.5	12.4	22.5	3.9	10.1	1.2	2.9	7.3	1.7	4.4
Austria	12.2	15.5	29.6	3.3	14.1	1.8	3.5	8.2	1.7	4.7
Belgium	12	16.8	27.4	4.8	10.6	1.8	3.6	8.6	1.8	5.0
Canada	7.5	12.5	24.6	5	12.1	1.2	3.0	8.1	1.8	5.1
Czech Republic	8.7	13.8	28.8	5.1	15.0	1.2	2.4	8.5	1.2	6.1
Denmark	10.6	14.8	24.1	4.2	9.3	1.6	4.0	6.9	2.4	2.9
Finland	7.3	14.9	26.2	7.6	11.3	0.9	3.4	9.0	2.5	5.6
France	11.6	16.1	26.6	4.5	10.5	2.0	3.7	9.1	1.7	5.4
Germany	---	16.4	29.7	---	13.3	---	3.7	8.7	---	5.0
Greece	8.1	17.3	28.2	9.2	10.9	1.3	3.5	7.9	2.2	4.4
Hungary	9.0	15.1	25.7	6.1	10.6	1.1	2.6	7.1	1.5	4.5
Iceland	8.0	11.7	22.6	3.7	10.9	1.1	2.8	7.1	1.7	4.3
Ireland	11.1	11.2	20.5	0.1	9.3	1.9	2.6	5.5	0.7	2.9
Italy	9.3	18.1	33.7	8.8	15.6	1.4	4.0	10.0	2.6	6.0
Japan	5.7	17.4	35.3	11.7	17.9	0.7	3.8	14.1	3.1	10.3
Korea	2.9	7.2	27.8	4.3	20.6	0.2	1.0	7.1	0.8	6.1
Luxembourg	10.8	14.2	24.0	3.4	9.8	1.6	3.0	7.4	1.4	4.4
Mexico	4.2	4.6	15.4	0.4	10.8	0.5	0.6	3.7	0.1	3.1
Netherlands	9.0	13.6	25.5	4.6	11.9	1.4	3.2	7.6	1.8	4.4
New Zealand	8.6	11.7	22.8	3.1	11.1	1.5	2.8	7.0	1.3	4.2
Norway	11.0	15.2	26.3	4.2	11.1	2.0	4.3	8.6	2.3	4.3
Poland	6.0	12.2	24.1	6.2	11.9	0.7	2.0	7.5	1.3	5.5
Portugal	7.9	16.3	24.0	8.4	7.7	1.1	3.4	6.2	2.3	2.8
Slovak Republic	6.9	11.4	23.2	4.5	11.8	1.0	1.9	6.3	0.9	4.4
Spain	8.2	16.9	30.7	8.7	13.8	1.1	3.8	8.5	2.7	4.7
Sweden	11.7	17.3	25.2	5.6	7.9	1.9	5.0	7.9	3.1	2.9
Switzerland	10.2	15.3	33.1	5.1	17.8	1.5	4.0	11.1	2.5	7.1
Turkey	3.5	5.7	14.3	2.2	8.6	0.3	0.6	2.6	0.3	2.0
United Kingdom	11.7	15.9	25.4	4.2	9.5	1.9	4.0	7.3	2.1	3.3
United States	9.2	12.4	20.4	3.2	8.0	1.4	3.3	6.9	1.9	3.6
<b>OECD Average</b>	<b>8.7</b>	<b>13.8</b>	<b>25.6</b>	<b>5.0</b>	<b>11.8</b>	<b>1.3</b>	<b>3.1</b>	<b>7.7</b>	<b>1.8</b>	<b>4.6</b>

Source: OECD Health Data 2004 for 1960 and 2000; 2040 projections: Eurostat (15 EU countries); national sources (Canada and the United States); United Nations (2002).

Note: Germany 1960 (before reunification) not comparable with 2000 data

**Table 2: Share of Very Old People among the Elderly, 1960 to 2040**

Country	Change in % points				
	1960	2000	2040	1960 to 2000	2000 to 2040
Australia	14.3	23.6	31.8	9.3	8.2
Austria	14.4	22.8	28.1	8.4	5.2
Belgium	15.4	21.3	31.9	5.8	10.6
Canada	15.8	23.6	32.9	7.8	9.3
Czech Republic	14.0	17.1	30.4	3.1	13.3
Denmark	15.3	26.7	28.9	11.4	2.2
Finland	12.7	22.5	35.1	9.8	12.6
France	17.2	23.3	34.6	6.1	11.3
Germany	---	22.3	29.9	---	7.6
Greece	16.0	20.5	30.1	4.6	9.6
Hungary	12.3	17.5	28.7	5.2	11.3
Iceland	14.3	24.2	31.6	10.0	7.3
Ireland	17.5	23.0	26.7	5.5	3.7
Italy	14.6	22.2	30.6	7.6	8.4
Japan	12.6	22.0	41.1	9.5	19.1
Korea	8.1	14.2	26.1	6.1	11.9
Luxembourg	14.7	21.0	26.9	6.3	5.9
Mexico	12.0	14.0	23.5	2.0	9.6
Netherlands	15.2	23.5	30.0	8.3	6.5
New Zealand	17.1	23.8	30.5	6.8	6.7
Norway	18.0	28.3	32.7	10.4	4.4
Poland	12.2	16.2	31.9	4.0	15.7
Portugal	14.4	20.6	25.8	6.2	5.2
Spain	14.5	16.5	28.3	2.0	11.8
Slovak Rep.	14.0	22.3	27.6	8.3	5.3
Sweden	15.9	29.0	31.5	13.1	2.5
Switzerland	15.0	26.0	34.9	11.0	8.9
Turkey	8.5	11.3	18.2	2.8	7.0
United Kingdom	16.4	25.4	29.1	9.0	3.7
United States	15.2	26.4	33.3	11.2	6.9
OECD average	14.4	21.7	30.1	7.3	8.4

Source: OECD Health Data 2004 for 1960 and 2000; 2040 projections: Eurostat (15 EU countries); National sources (Canada and the United States); United Nations(2002).

Note: Germany 1960 (before reunification) not comparable with 2000 data

aging of OECD societies means that the ratio will become significantly lower in future decades, possibly shrinking to about half the 1960 level by 2030 in the United States.

This may be the most appropriate indicator for assessing the trend in social protection schemes that are financed by the working population and received by older people, such as pensions and health care in many countries. However, it is not obvious that this is the best way to look at the potential for care. Knickman and Snell (2002) have shown that re-conceptualizing the dependency ratio changes the potential for care in the United States in future decades markedly. They argue that reductions in the number of children with care needs will offset some of the increase in older people needing care. Moreover, relatively few people in the 65 to 74 age group require long-term care and an increasing share of people in that age group contribute to caring for and supervising both young people and the very old. This increases the ratio of potential carers to those needing care.

### **Disability in Older Age**

The share of older people with functional limitations increases exponentially with age and is highly concentrated in the oldest age groups. Since women have a longer life expectancy than men, they are also more likely to be in need of long-term care. There is some evidence that care needs are becoming increasingly concentrated in the oldest age groups, but making comparisons across time is fraught with problems. Data on the prevalence of disability among older people are often available for only few points in time and are rarely entirely comparable. For example, it is difficult to compare take-up rates of certain services over time when these figures are derived from the administrative data from public programs as the care assessments for these programs may have changed over time.

Until the late 1980s, there was little longitudinal data that would enable direct measurement of the trend in the level of disability among the elderly

over time. There is now some evidence that there has been a general improvement in the health and well being of the population in OECD countries, leading to a longer average lifespan. This began to be seen as a significant trend in OECD countries around 1980. However, there has been much debate about the potential impact of this increase in lifespan in old age. Additional years of life in very old age could in principle lead to any of these three outcomes:

Elderly people may continue to become sick and disabled at the same ages as previously, leading to additional years of disability at the end of life. Exponents of this view associate extended lifespan with extended morbidity.

The extension of lifespan has an upper limit. If poor health and disability tended to appear at later ages on average, this would lead to a “compression of morbidity.” First propounded by Fries (1980), this thesis has been the subject of lively debate ever since.

The third possibility is that both average lifespan and age of onset of poor health or disability would continue to extend, leading to the deferral of disability. Whether the average length of years of disability would grow, decline, or stay the same would depend on the relative rate of extension of lifespan and onset of disability. This argument has led to a further change in the way disability in old age is perceived. It is now seen as “end-of-life” disability rather than inevitably associated with passing a particular age, in which case its onset might be deferred at the same rate as the rate of extension of lifespan.

The emerging trends in international data up to the mid-1990s are described in Waidmann and Manton (1998), Jacobzone et al (1999), and Lagergren and Batljan (2000). These reviews suggest that the observable trends in the data concur with the third of these possible scenarios. With some exceptions, there has been little support for the “extended morbidity” thesis. Finally, there has been evidence from reviews of a number of countries (Canada, France, Japan, the Netherlands, Sweden, the United Kingdom, and the United States) that the prevalence of

disability rates in old age is declining.

This reduction was found mainly among the 65 to 80 age group and was more striking in the case of males than of females (males having poorer health at similar ages as women but a shorter lifespan in old age to begin with). This decline was partly offset by an increase in disability in the institutionalized population. However, these trends were far from homogenous across countries.

More recent data have continued to indicate that levels of disability in old age are decreasing. In particular, the US National Long-term Care Survey (NLTC) has added 1999 data to the data from 1982, 1989, and 1994. Manton and Gu (2001) examined the data from the 1999 NLTC and confirmed that the decreasing trend in disability in the United States is not only continuing but is growing. The average drop in disability prevalence had been higher between each round of the NLTC and was over 0.56 percent per year between 1994 and 1999. In addition, it could now be concluded that the older black population, which had not shown any declines in disability in the earliest waves of the NLTC, was now benefiting from this trend as well. To counter the response that this may have been a single exceptional result for one generation, Manton and Gu cited work by Fogel and Costa (1997) using records of medical assessments of US army veterans from 1912 to the 1990s that showed a long-term trend of a similar magnitude.

Some (for example, Cutler, 2001) have seen this as “clear, overwhelming evidence that the average health of the elderly population is improving.” Others, however, such as Freedman et al (2002), have urged caution as comparing different sources yields different findings about which ADL or IADL functions have improved, and there remains little if any sign of a decline in the underlying conditions. In addition, to the extent that the measured reductions were in IADL functions, the improvement might be environmental, arising from improved housing conditions and use of assistive technology as much as from improved bodily function. Nonetheless, even if such environmental

improvements do explain part of the trends, they still mean that the need for care services has declined.

Recent evidence from other countries mostly supports the overall conclusions of Jacobzone (1999) and Manton and Gu (2001) and supports the “deferral” thesis. Most of the available evidence from Canada, France and Sweden suggests that prevalence of disability among elderly people has declined over time. In some other countries, for example, Finland, Italy, the Netherlands, Switzerland, and the United Kingdom, there is as yet no consensus in the data about whether the level of disability has declined, but there is no evidence of an increase. In one of these countries, the United Kingdom, Jarvis and Tinker (1999) have re-analyzed the main longitudinal data set and concluded that the health status of older people in the United Kingdom is improving but is still lagging behind the improvements seen in the United States by several years.

However, the trend is not clear for some countries. In fact in one country, Australia, there has been a measured increase in disability rates among the elderly, although at least half of this increase can be attributed to changes in the measurement instrument (AIHW, 2003). Also, because the national disability scales and the estimation methods used for this indicator can vary substantially across countries, the numbers in Table 3 should mainly be analyzed with respect to trends over time but are less suitable for inter-country comparisons.

Researchers are only just beginning to study the factors that might explain changes in disability rates among older people over time and across countries, so they are not yet well understood. Available evidence shows that there is a strong socioeconomic gradient of disability in older age (Kjoller and Rasmussen, 2002). Improvements in education, health-related behavior, socioeconomic status, and the treatment of chronic disease are probably some of the factors that drive disability rates in older age (Cutler, 2001).

*Financing Long-term Care: Lessons from 19 OECD Countries*

**Table 3: Relationship between Care Recipient and Informal Care-giver**

Country (source)	Year	Relationship	Total	Male	Female	Country (source)	Year	Relationship	Total	Male	Female
Australia (ABS Survey of Disability, Ageing and Carers, 1998)	1998	Partner	43	19	24	Korea (Survey on long-term care needs of the elderly, 2001)	2001	Partner	32	7	49
		Parent	22	3	19						
		Child	24	6	19						
		Other	11	2	9						
		Total	100	30	71						
Austria (Microcensus 2002)	2002	Partner	18	7	11	Spain (Survey on impairment, disabilities, and handicaps)	1999	Partner	23	6	32
		Child	38	14	24						
		Other	43	12	32						
		Total	100	34	66						
Canada (Survey on informal caregivers to adults in British Columbia)	1995	Partner	20	7	13	Sweden (Survey of aged care, 2000)	2000	Child	46	13	33
		Child	35	9	26						
		Others	45	11	34						
		Total	100	27	73						
Germany (Schneekloth and Müller, 2000)	1998	Partner	32	12	20	United Kingdom (General household survey, 2000)	2000	Partner	15		
		Parent	13	2	11						
		Child	28	5	23						
		Other	27	1	26						
		Total	100	20	80						
Ireland (Survey of older persons, 1993)	1993	Partner	22	5	17	United States (National long-term care survey, 1994)	1994	Partner	23	10	13
		Parent									
		Child	48	13	35						
		Other									
		Total									
Japan (Comprehensive survey of living conditions, 2001)	2001	Partner	36	12	25			Child	41	15	27
		Parent	1	0	1			Other <sup>2</sup>	35	11	24
		Child	60	11	48			Total	100	36	64
		Other	3	1	3						
		Total	100	24	76						

Note: definition of carers and care recipients may differ between countries. The number of informal carers is usually higher than the number of carers receiving support under public long-term care programmes (e.g. as cash allowances)

1. National data on the shares of care-recipients in the different categories, which include persons receiving care from more than one care-giver, have been recalculated to add up to 100.

2. Missing values are included in the category "Other".

### **Living Arrangements of Older People**

Older people with care needs who live with their family or partner are more likely to receive informal help than those living alone (Sundström, 1994). Given the importance of partners, in particular, in providing care, the fact that the number of older people living alone is increasing will itself increase the demand for formal care services in the future. Living alone has become a much more frequent experience for elderly people in the OECD area. During the decade of 1990 to 2000, the proportion of elderly people living alone grew in most OECD countries, other than New Zealand, the United Kingdom, and the United States. Northern European countries, including the Netherlands, Norway, and Sweden, which started with a high proportion of one-person elderly households showed the highest rates of living alone in 2000. Mexico, Japan, Korea, and Spain had the lowest rates (see OECD, 2005a, Figure 3).

Living alone becomes more frequent as people age, mainly due to the death of their spouses. For example, around half of all people aged 75 and over live alone in Canada, around 42 percent in New Zealand and Sweden, and 44 percent in the United Kingdom. Women aged 75 and above are the most likely to live alone. It is estimated that almost 60 percent of elderly women aged 75 and over in Canada, Sweden, and the United Kingdom live alone.

Several studies have forecast that this trend towards living alone may change. A modeling exercise for the United Kingdom, for example, suggested that, between 1996 and 2031, the numbers of dependent elderly people living with others will increase faster than the numbers living alone, largely due to higher marriage rates and increased male longevity. In turn, the proportion of dependent elderly people living alone is projected to fall slightly, from 43 percent in 1996 to 38 percent in 2031 (Pickard et al, 2000). Wolf (1995) has projected that the percentage of older women living alone in eight countries would decrease sharply around by 2010 and then would climb again.

### **Informal Care-giving and Trends in Labor Market Participation**

In each of the 19 countries that we studied, informal care-giving is an indispensable component of care for older people with long-term care needs. Surveys that explore the living situation of older people and available time-use studies consistently show that the majority of care – 80 percent or more – is provided informally (see, for example, Lamura; 2003; Sundström/Johannson/Hassing, 2002; and Zukewich, 2003). However, most of this time is spent on lower-level care, such as help with instrumental activities of daily living (Romoren, 2003). However, some informal carers also care for many older people with the greatest care needs, such as dementia patients, for whom informal care is often the most important source of support (Moïse et al, 2004).

Most informal care is provided by women, although with marked differences across countries (Table 3). Men are more likely to take over the role of care-giver for their spouses than for other family members. Because more elderly people are living as couples and for a longer time, this has led to a slight increase in the number of men providing informal care over time (Sundström et al, 2002). There are, however, some gender differences in the level of care provided, which are not shown in Table 3. Women are predominant among those informal care-givers with the heaviest commitments. They are more likely to be the main carer than an additional carer. The more demanding that personal care services become, the more likely it is that women provide them. The share of men providing domestic help rather than personal care is correspondingly higher than the share of women.

Across countries, there seems to be a peak in care-giving by those aged between 45 and 65. This is the age group that frequently has multiple care responsibilities for elderly parents or for a spouse or partner with age-related health problems. In addition, policymakers have crafted fiscal and labor market policies to try to reverse trends towards early retirement. It will be important to ensure that their caring

responsibilities can be combined with employment in this age group.

### **Long-term Care: Program Design and Eligibility Criteria**

Long-term care services are financed from different sources in OECD countries. Table 4 lists various long-term care programs in OECD countries by type of program, source of financing, eligibility criteria, and the use of private cost-sharing. Most programs in most countries provide in-kind services for both home care and institutions, but there are a growing number of programs that offer cash allowances or allow consumer demand to influence the budgets. Most long-term care programs serve all age groups, except for those in Korea and Japan as well as the US Medicare program.

In most countries that we studied, the main source of public financing is taxation. For example, Norway and Sweden both provide universal coverage of long-term care services funded from general taxation, but they differ in terms of the amount of cost-sharing required for services provided in nursing homes. A few countries (such as Germany, Japan, the Netherlands, and Luxembourg) have set up a universal social insurance scheme specifically to cover long-term care. Austria has a universal system funded from general taxation and governed by similar regulation. In other countries, the main health insurance program finances a limited amount of care in hospitals in the absence of other programs, but the total involved is quite small (for example, in Hungary, Korea, Mexico, and Poland).

Besides those countries that provide universal access to long-term care services, there are those that have a largely means-tested system in which the user is expected to bear all or most of the cost above a certain level of income. In means-tested schemes, users face very high costs if their income is above the means-test level, especially if they have to go into a nursing home. This has generated pressure on governments to reform these schemes. One common feature of long-term care programs is that nursing home residents have to pay an accommodation charge

unless they are in the social assistance category. In some countries with a public scheme, this is indexed to their retirement income, for example, 80 percent of the public pension in Norway, whereas in others users have to pay the actual cost of their accommodation unless they meet a low-income test.

As Table 4 shows, even under universal public programs, the requirement for private cost-sharing usually is substantial, although it tends to be spread more evenly among beneficiaries than in means-tested programs. Cost-sharing in universal systems is either calculated as a fixed percentage of cost or as the difference between the benefit and actual spending.<sup>25</sup> The implications of these various cost-sharing regulations for the public-private mix of financing are discussed in the following sections on expenditure trends.

### **Differences in Spending Levels for Long-term Care Services**

Total expenditure on long-term care in the 19 OECD countries covered in this study ranges from below 0.2 to around 3 percent of GDP. Most countries, however, are clustered in a range between 0.5 percent and 1.6 percent of GDP, with only Norway and Sweden spending a proportion that is well above that level (Figure 1 and Table 5).

Comparing spending levels across countries reveals that the many different ways of organizing and funding long-term care (as can be seen in Table 4) have actually led to very similar overall spending levels. For example, Australia, Canada, Germany, the United Kingdom and the United States all spend within the narrow range of 1.2 to 1.4 percent of their respective GDPs..

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<sup>25</sup> The borderline between means-tested programs and “universal” programs can be blurred. If cost-sharing under universal programs is high, then some households will not be able to cover the cost of the care needed by their older members. They may then become eligible for means-tested social assistance to fill the financial gap, for example, to cover the cost of accommodation in nursing homes.

**Table 4: Major Public Programs Covering Long-term Care in Selected OECD Countries, 2003**

Country	Type of care	Programme	Source of fund	Type of benefits	Eligibility criteria	Private cost-sharing
<b>Australia</b>	Institutional care	Residential care	General taxation	In-kind	All ages	There is a standard charge plus a means-tested charge based on income
	Home care	Community Aged Care Packages (CACP)	General taxation	In-kind	Generally 70+ Means-tested	Users are charged according to ability to pay
		Home and community care(HACC)	General taxation	In-kind	All ages Means-tested	Users are charged according to ability to pay
		Care payment	General taxation	Cash	All ages Means-tested	-
		Carer Allowance	General taxation	Cash	All ages Universal	-
<b>Austria</b>	Home care	Long-term care allowance	General taxation	Cash	All ages Universal	Users are expected to pay the difference between the benefit and the actual cost
	Institutional care	Long-term care allowance	General taxation	Cash	All ages Universal	Users are expected to pay the difference between the benefit and the actual cost
<b>Canada</b>	Home care	Provincial programmes	General taxation	In-kind	All ages Usually means-tested	Means-tests vary between provinces
	Institutional care	Provincial programmes	General taxation	In-kind	All ages Usually means-tested	Means-tests vary between provinces
<b>Germany</b>	Home care	Social Long-Term Care Insurance	Insurance contribution	In-kind and cash	All ages Universal	No cost-sharing required but out-of-pocket to pay for additional or more expensive services than covered by public insurance was on average 130 Euro per month
	Institutional care	Social Long-Term Care Insurance	Insurance contribution	in-kind	All ages Universal	Board and lodging is not covered (on average 560 Euro per month); plus service-charges in excess of statutory limit were 313 Euro on average; (these private cost can be covered by means tested social assistance) (1)
Source: replies to OECD questionnaire for the <i>Long-Term Care Study</i> .						
(1) Cost-sharing in 1998, according to Schneekloth-Müller (2000)						

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Country	Type of care	Programme	Source of fund	Type of benefits	Eligibility criteria	Private cost-sharing
<b>Mexico</b>	Institutional care	Specialised services in Geriatrics	General taxation	In-kind	All ages, all people who are insured	
	Home care	Day centres for pensioners and retired	General taxation	In-kind	Insured pensioners and retired people	
<b>Netherlands</b>	Home care	AWBZ	Insurance contributions	Consumer-directed budget(1)	All ages Universal	Income-related co-payments are required
	Institutional care	AWBZ		In-kind	All ages Universal	Income-related co-payments are required
<b>New Zealand</b>	Home care	Carer Support	General taxation	In-kind	All ages, means-tested	
		Home Support: home help	General taxation	In-kind	All ages, income tested	
		Home Support: personal care	General taxation		All ages, universal	
	Institutional care	Long-term residential care	General taxation	In-kind	Aged 65 and over, and 50-65 with early onset age-related conditions Means-tested	
<b>Norway</b>	Home care	Public long term care	General taxation	In-kind	All ages Universal	Home nursing care is free of charge. Home help is based on an optimal user-payment (usually NOK 50 per time)
	Institutional care	Public long term care	General taxation	In-kind	All ages Universal	Residents in institution are charged approximately 80% of their income.
<b>Poland</b>	Home care Institutional care	Social services	General taxation	Cash/in-kind	All ages Means-tested	
Source: replies to OECD questionnaire for the <i>Long-Term Care Study</i> .						
(1) By April 1, 2993, the Consumer directed budget has been changed in a cash payment						

<sup>1</sup> These were contributions to health insurance not long-term care.

The first lesson from this comparison is, therefore, that one broad type of program is no more associated with a particular expenditure outcome than any other.

Moreover, countries with similar spending levels may face different challenges. This is illustrated by Figure 2, which plots overall spending levels against the percentage of people aged 80 years and older in the population, this age group being the largest group of users of long-term care programs.<sup>26</sup> Spain and Ireland, for example, have similarly moderate spending levels and a comparable split between spending for home care and spending on institutional care. However, Spain has almost 40 percent more very old people in its population than Ireland. In addition, financing for this significantly older population in Spain comes predominantly from private sources. For Ireland, private spending accounts for only one-sixth of total spending on long-term care.

A second conclusion is therefore that countries with significantly different shares of very old people often have similar spending levels. This is mainly due to differences in the design of their programs, differences such as the varying mix of public-private funding, and, more generally, differences in the division of labor between formal and informal (unpaid) care-giving.

Norway and Sweden spend substantially more on long-term care than any other OECD country. Although these countries also have the highest population shares of very old people, their high spending is also due to the generosity of the programs in both countries. This can be seen in the generous services that both countries provide for residents in nursing homes. Both countries offer more amenities, such as single rooms and

well-equipped housing, than other countries (see Table 8 below). Higher cost-sharing in Norway may explain part of why its expenditure ratio is lower than Sweden's.<sup>27</sup>

Aspects of the quality of care may explain part of the differences observed in Table 5 and Figure 1 between other countries as well. The proportion of single and double bed rooms in nursing homes has obvious cost implications for all countries. The number of these small rooms is currently much lower in countries like Japan and Korea, which explains part of the lower expenditure levels for these countries.

### **The Public/Private Mix of Funding for Long-term Care Services**

Private households in most countries share the burden of care, not only by providing informal, unpaid care but also by making substantial co-payments and/or paying out-of-pocket for care provided under public programs, both at home or in institutions. Even under universal social insurance systems, long-term care services provided in institutions are usually only partially covered by public programs, and households may be required to contribute to the cost of board and lodging. In most countries, users are also charged for nursing and personal care at a rate decided by the results of a means test. Moreover, some households who can afford it may decide to buy additional services directly from private providers over and above those provided under public programs.

In general, private spending plays a more important role in funding long-term care provided in institutions than for home care. Because these private expenditures are concentrated on a relatively small number of households, they can represent a heavy financial burden on the individual households concerned (see, for example, the cost-sharing rates for

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<sup>26</sup> The prevalence of functional limitations grows exponentially with age, which leaves room for different cut-off points for analytical purposes. Most of the research literature chooses to use 80 and over as the cut-off point. However, other age limits have been proposed. *Residential Aged Care in Australia*, for example, has observed that the availability of care places increases in line with the number of people aged 70 and older.

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<sup>27</sup> The case of oil-rich Norway (with the third highest per capita GDP of OECD countries) is also a reminder that in comparing expenditure ratios one should not forget the large differences in GDP among these countries.

Germany, Ireland, and Spain in the last column of Table 5).

The burden of private expenditure on nursing home care and accommodation can be substantial for individual households and is an important source of funding for these institutions, contributing 30 percent or more of total spending in several countries (Australia, Germany, New Zealand, the United Kingdom, and the United States). Countries with different overall spending levels on care in institutions can vary widely in the share of private spending contributed by households (and, in the case of the United States, by private insurance).<sup>28</sup>

Substantial private cost-sharing, in particular for nursing home care, and the availability of informal care as a major source of support are two of the main reasons why some countries have been able to contain costs and spend similar amounts on long-term care as other countries with different program designs and lower shares of old people in their populations.

### **Public Expenditure on Long-term Care Services: No Place like Home?**

This section looks in more detail at the differences in the way in which public money is spent on home care versus institutional care. Over time, policymakers in many countries have been shifting a larger share of resources to support home-care services in a number of ways by financing a larger supply of home-care providers in the community, by providing more support services, such as respite care and counseling, to families who care for close relatives, and finally by introducing consumer choice in various forms such as care payments or personal budgets. As a result, home care now accounts for more than 30 percent of public resources in half of the countries for which data are available (Figure 3).

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<sup>28</sup> This is also the case when demographic differences are taken into account, for example, by standardizing expenditure levels by the share of very old people (aged 80 and older) in the population, relative to an OECD average share of about 3 percent.

Behind these aggregate numbers, there are big differences in the way in which access to home care is granted. Countries with similar spending levels may either spend small amounts on a large number of cases or may targeted their spending to those with the highest levels of care needs.

While even universal long-term care programs currently consume only around 8 to 20 percent of health and long-term care spending (taken together), several countries have a much lower level of resources to meet the demand for long-term care. This is especially the case in those countries that are only just beginning to develop unique long-term care programs within their health and social services sector. Moreover, public programs that cover home care are, in many countries, less developed than programs for long-term care in institutions.

Public funding is the most important source of financing for long-term care services in all countries where data on the public-private mix of funding are available (with the exception of Spain and Switzerland). Nonetheless, public spending on long-term care is still relatively low as a proportion of GDP compared with other aging-related expenditures such as pensions or acute health care that are also heavily concentrated on older people (OECD, 2004b).

In all of the countries that we studied, spending on care in institutions accounts for more than half of all public spending on long-term care (Figure 3). However, public programs that provide home care have begun to be developed as this is the preferred option for most people with care needs. The majority of home-care recipients, in particular older people, have family or friends who support them by providing additional services (mostly unpaid) in addition to any care they receive from the public program. This makes home care a lower-cost alternative to care in institutions in many cases.

### **Trends in Public Expenditure on Long-term Care**

There is a widely shared perception that expenditure growth will accelerate over the next

20 to 30 years, mainly as a result of larger numbers of older people and a steep increase in the numbers of the oldest-old. However, as we have discussed, the empirical evidence suggests that differences in program design (such as generosity of funding and level of cost-sharing, quality of services, and whether services are targeted or not) play a more important role in explaining differences in current spending levels than demand for services measured simply by population age structure. The caveat here is that data on time trends are even scarcer than for cross-sectional analysis, making it even more difficult to make comparisons over time.

In some long-term care systems that have been operating for many years, public spending has remained fairly stable as a share of total public expenditure on health and long-term care in several countries since 1990 (Figure 4). Any growth in long-term care spending took place while Germany, Japan, and Luxembourg were setting up their new social programs. However, in those countries where a system has been in place for a longer period of time, there has been no “cost explosion” in long-term care spending relative to acute care spending.

### **What Needs to be Done to Improve the Quality of Long-term Care?**

There are wide variations in the quality of long-term care services for older people. Consequently, the quality of these services often does not meet the expectations of the public, the users of services, and their families. Examples of inadequate care in institutional and community settings are numerous and can include inadequate housing, poor social relationships, and lack of privacy in nursing homes as well as inadequate treatment of chronic pain, depression, bedsores, or the inappropriate use of chemical or physical restraints. Improving quality in long-term care will require an increase in public spending and better regulation of long-term care services by establishing quality assessment mechanisms and by monitoring outcomes. Governments in many countries are now taking a more active role in this respect, but long-term care still lags behind acute health care when it comes to measurement

and quality improvement. To improve the situation, more investment in measurement instruments is needed. Countries already set quality standards for infrastructure and process, but now they also need to measure improvements in outcomes and to disseminate this information to clients, both actual and potential.

There is also a case for making information on the quality of care and the prevalence of adverse outcomes more transparent and accessible to the public on a regular basis. Making information on quality assessment at the level of the provider available to the public is likely to increase consumer protection and create a climate of competition in quality, especially if consumers are also given greater choice in terms of providers.

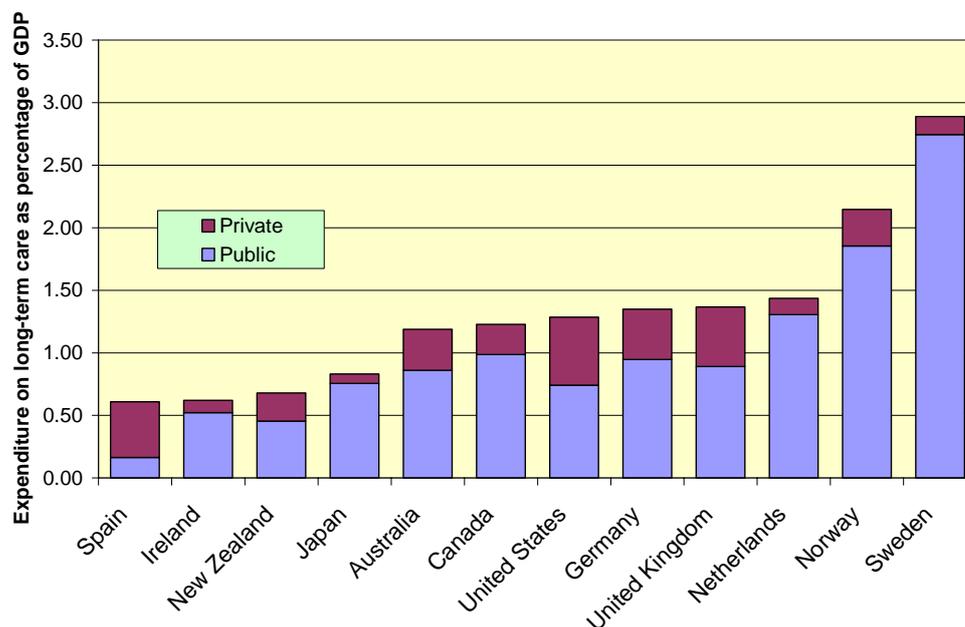
It is unlikely that better quality care will be sustainable in the future if current staffing levels in long-term care stay the same. According to the responses given to the OECD questionnaire, staff shortages and staff qualifications are the number one concern of long-term care policymakers in OECD countries (Tables 6 and 7). Therefore, it is important to address the issue of staff shortages now in order to prevent the situation from worsening in many countries.

Countries also differ widely in terms of the privacy and amenities available to residents in nursing homes. The number of people residing in single or double rooms, for example, can range from less than a quarter to almost a 100 percent (Table 8). In those countries where many people have to share larger rooms, only substantial investment in new buildings will change this situation for the better.

### **Paying for Long-term Care: Current Reforms and Issues for the Future**

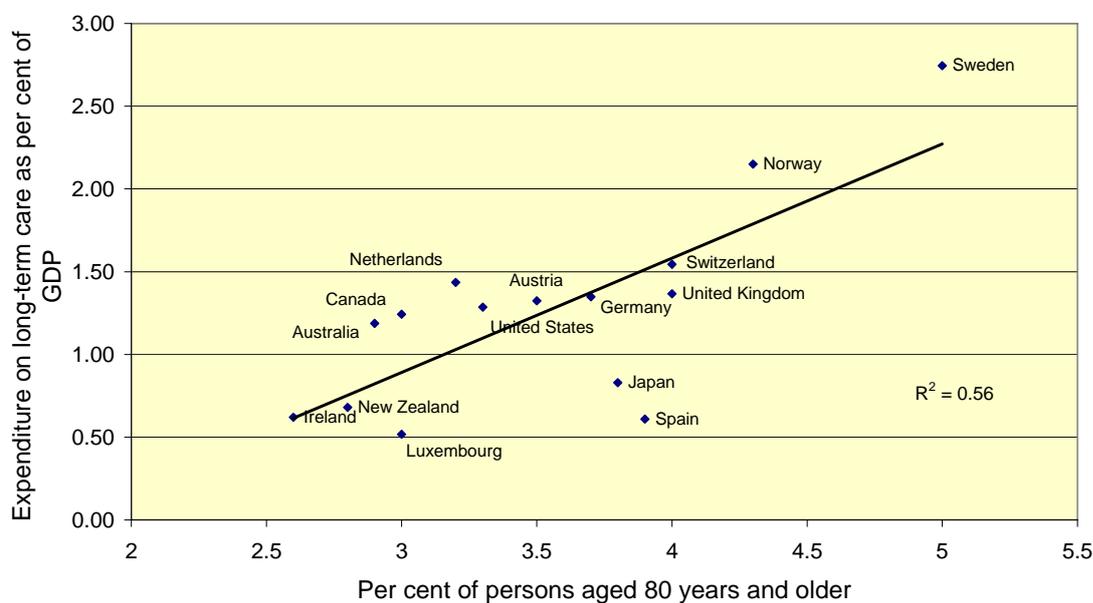
The large variations in the public coverage of long-term care costs across the OECD countries reflect the differences in the way long-term care is financed and provided. A number of countries have introduced new forms of public programs for long-term care. This has increased overall coverage and consolidated previously

**Figure 1: Public and Private Expenditure on Long-term Care as Percentage of GDP, 2000**



Source: Table 5, this report.

**Figure 2: The Correlation between Long-term Care Spending and Aging is Weak, Suggesting that Other factors Play an Important Role**



Source: Table 5 of this report.

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**Table 5: Public and Private Expenditure on Long-term Care as Percentage of GDP, 2000**

Table 1.2 Public and private expenditure on long-term care as percent of GDP, 2000

	<i>Total expenditure</i>			<i>Public expenditure</i>			<i>Private expenditure</i>		
	<i>Home care</i>	<i>Institutions</i>	<i>Total</i>	<i>Home care</i>	<i>Institutions</i>	<i>Total</i>	<i>Home care</i>	<i>Institutions</i>	<i>Total</i>
<b>Australia</b>	0.38	0.81	1.19	0.30	0.56	0.86	0.08	0.25	0.33
<b>Austria</b>	n.a.	n.a.	n.a.	n.a.	n.a.	1.32	n.a.	n.a.	n.a.
<b>Canada</b>	0.17	1.06	1.23	0.17	0.82	0.99	n.a.	0.24	0.24
<b>Germany</b>	0.47	0.88	1.35	0.43	0.52	0.95	0.04	0.36	0.40
<b>Hungary</b>	< 0.10	< 0.20	< 0.30	n.a.	n.a.	< 0.20	n.a.	n.a.	< 0.10
<b>Ireland</b>	0.19	0.43	0.62	0.19	0.33	0.52	n.a.	0.10	0.10
<b>Japan</b>	0.25	0.58	0.83	0.25	0.51	0.76	0.00	0.07	0.07
<b>Korea</b>	n.a.	n.a.	< 0.30	< 0.10	< 0.10	< 0.20	n.a.	n.a.	n.a.
<b>Luxembourg</b>	n.a.	n.a.	n.a.	0.15	0.37	0.52	n.a.	n.a.	n.a.
<b>Mexico</b>	n.a.	n.a.	< 0.20	n.a.	n.a.	< 0.10	n.a.	n.a.	< 0.10
<b>Netherlands</b>	0.60	0.83	1.44	0.56	0.75	1.31	0.05	0.08	0.13
<b>New Zealand</b>	0.12	0.56	0.68	0.11	0.34	0.45	0.01	0.22	0.23
<b>Norway</b>	0.69	1.45	2.15	0.66	1.19	1.85	0.03	0.26	0.29
<b>Poland</b>	0.35	0.03	0.38	0.35	0.03	0.37	n.a.	0.00	0.00
<b>Spain</b>	0.23	0.37	0.61	0.05	0.11	0.16	0.18	0.26	0.44
<b>Sweden</b>	0.82	2.07	2.89	0.78	1.96	2.74	0.04	0.10	0.14
<b>Switzerland</b>	0.20	1.34	1.54	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
<b>United Kingdom</b>	0.41	0.96	1.37	0.32	0.58	0.89	0.09	0.38	0.48
<b>United States</b>	0.33	0.96	1.29	0.17	0.58	0.74	0.16	0.39	0.54
<b>Average <sup>(1)</sup></b>	0.38	0.88	1.25	0.35	0.64	0.99	0.06	0.19	0.24

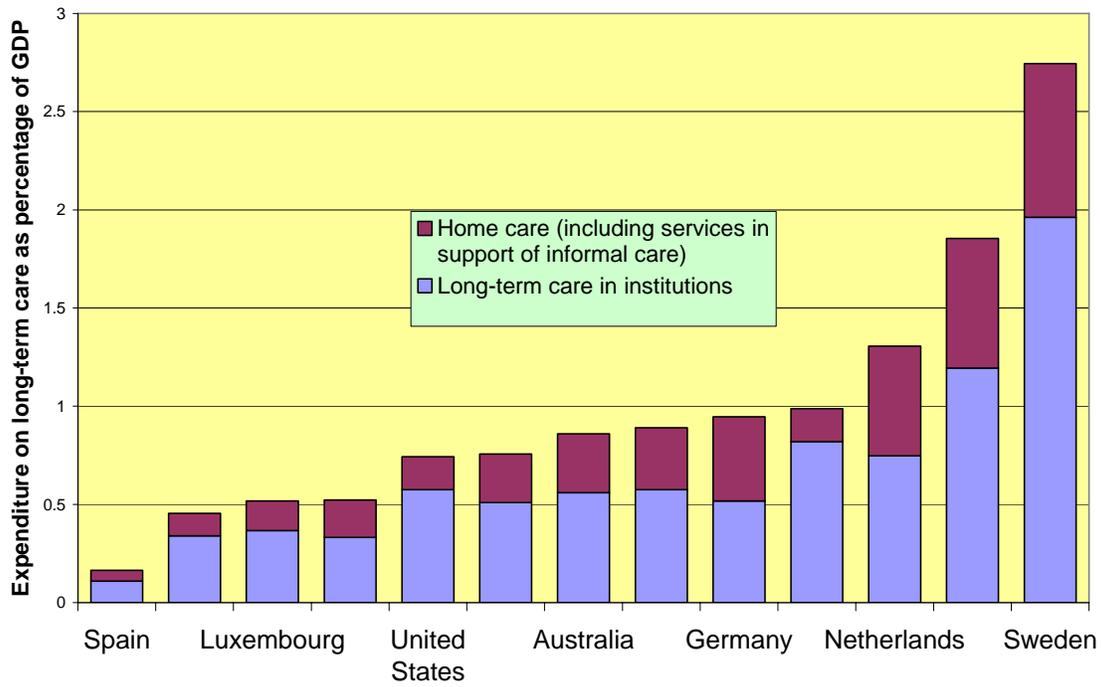
Sources: Canada, Germany, Hungary, Norway: OECD Health Data 2004; Australia: Prod. Commission (2001); Poland: Kawiorska (2004); Spain: Marin/Casanovas (1998); Austria, Ireland, Japan, Korea, Luxembourg, Mexico, Netherlands, New Zealand, Sweden, Switzerland, United Kingdom, United States: Secretariat estimates (see OECD (2004c) for a documentation of sources and methods).

Note: Data for Hungary, Korea, Mexico, and Poland are rough indications of magnitude; n.a. = not available.

The notion of "long-term care" used in a national context can be substantially broader, e.g. by including residential homes for older people (e.g. the Netherlands, Nordic countries)

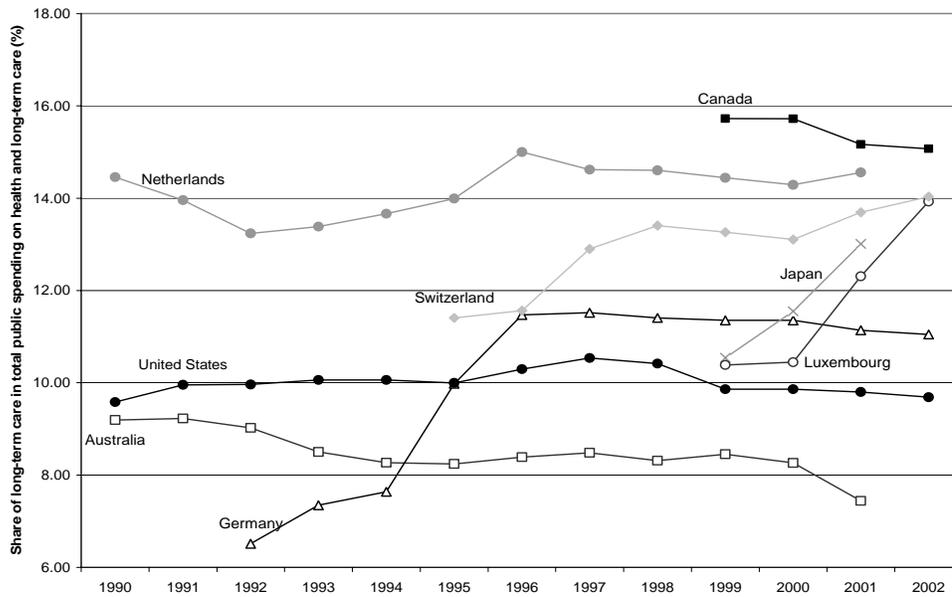
<sup>(1)</sup> Average excludes Austria, Hungary, Luxembourg, Korea and Mexico

Figure 3: Public Expenditure on Long-term Care as Percentage of GDP, 2000



Source: Table 5 of this report.

Figure 4: Trends in Public Spending on Long-term Care, 1990-2002



Source: OECD Health Data 2004

Note: Australia, USA: expenditure in institutions only;

fragmented health and social services systems. Other countries have opted for reforming their existing long-term care systems while maintaining the basic design of a tax-based system with set budgets.

The issue of sustainability arises in relation to private as well as public expenditures. While existing levels of public contributions may be unsustainable in the future, putting these costs onto the backs of private households is likely to drain the resources of many middle-income families. This is already a major issue in a number of countries. For the user, the costs of long-term care are potentially very high (“catastrophic” in health insurance terms) unless they are at least partly covered by a public program or private insurance.

While policymakers in all countries are concerned about the sustainability of their system of funding long-term care, some have seen this as a reason to levy extra contributions, while others have seen this as a reason to limit expenditure by increasing targeting or raising user payments. Different strategies have been followed in different countries, which has widened the differences between OECD countries in how they treat long-term care within their social protection systems.

Of the 19 OECD countries considered in the OECD long-term care report, seven – Austria, Germany, Japan, Luxembourg, the Netherlands, Norway and Sweden – provide comprehensive coverage, treating long-term care in broadly the same way as they treat other health-related needs in their social protection system. Of the seven countries in the first group, four have introduced universal funding for long-term care within the past decade. The Netherlands introduced universal funding for long-term care as part of their health insurance system in 1968. This has been modified several times since its introduction, most recently in 2003 in that all home-care users now have the option of paying in cash to purchase their own care.

Neither Norway nor Sweden is considering making any structural changes to their system for funding long-term care as a universal service.

However, there have been considerable modifications in Sweden to target the services to the sickest and most disabled older people.

Of the 12 countries in the second group, two – Hungary and Korea – have in recent years discussed introducing long-term care insurance in the future. A third, Ireland, has recently received the report of an independent review recommending the introduction of a form of public long-term care insurance (Mercer, 2003), and the government has set up a working group to consider various options.

Three other countries in the second group – Australia, New Zealand, and the United Kingdom – have in recent years modified their means-testing formula but have done so in different ways. Australia made additional types of public support subject to income and asset testing, while the other two countries have reduced the impact of means testing.

This section considers first the new public long-term care systems recently introduced in four countries – Austria, Germany, Japan, and Luxembourg – and the potential lessons from those reforms. It then looks at the different way in which the three countries that pay for long-term care from general taxation – Sweden, Australia, and the United Kingdom – have attempted to balance greater equity and quality in the system with sustainable financing within a tax ceiling.

### **New Forms of Public Programs for Long-term Care: Austria, Germany, Japan, and Luxembourg**

Since 1990, these four countries have each introduced a universal public scheme to cover a substantial share of the costs of long-term care. The methods adopted differ among the four countries but in each case policymakers decided that the costs of long-term care should be brought within the scope of each country’s system of social protection.

*Austria.* A tax-funded system of long-term care allowances was introduced in 1993. These allowances are payable in cash only, with the amounts determined by an assessment of recipients on a seven-point scale by type of care

**Table 6: Policy Concerns about the Quality of Nursing Home Care**

Group of issues mentioned	Countries
Recruiting and retaining an adequately educated and skilled workforce; improved qualification of staff	All twelve countries that replied to this question
Put in place or further develop quality assessment and monitoring system	Austria, Korea, US
Co-ordination of care services	Canada, Hungary, Germany
Building quality and amenity	Hungary, Japan
Other supply constraints: downward pressure on fees/inadequate fees paid to providers; lack of enough time for staff	New Zealand, UK, Korea (shortage of government subsidies)
Access to broader range of services, more differentiation	Norway, Austria (number of short-stay units)
Other mentioning of "top concerns" (country specific)	Use of physical restraints (Japan); Number of liability claims; lack of liability insurance for long-term care (US)

Notes: Data are based on replies from national administrations to the following question: "What are the top three concerns in your country in terms of quality of institutional care?"

Source: Questionnaire of the *OECD Long-term care study*

**Table 7: Policy Concerns about the Quality of Home Care Services**

Group of issues mentioned	Countries
Recruiting and retaining an adequately educated and skilled workforce; improved qualification of staff	Majority of countries that replied to this question
Improve skills of care managers	Canada, Japan
Put in place or further develop quality assessment and monitoring system; improved standards framework	Australia, Austria, Korea
Co-ordination of care services; continuum of care	Australia, New Zealand
Lack of information about services	Japan, UK
Prevention of inappropriate residential care admission	Australia
Supply constraints; limited financing	Korea, USA
Broader range of services; too little differentiation	Canada, Norway, UK
Adequate care supply for dementia cases	Germany, Japan

Notes: Data are based on replies from national administrations to the following question: "What are the top three concerns in your country in terms of quality of home care?"

Source: Questionnaire of the *OECD Long-term care study*

and number of hours of care needed. The allowance replaced – and made universal – a assessment criteria and benefits. The inequities generated by these different allowances, which had been introduced at different times to meet different needs, were a strong part of the case for reform as advocacy groups argued that similar needs should receive similar treatment. Policymakers also began to give strong support to enabling older people to be cared for at home, either by informal carers or by home-based care services.

The new allowances comprise one federal and nine provincial allowances, which together cover the whole population and are based on the same system of assessment and benefits. While the new allowances were to be funded from general taxation as part of the same reform package, the level of contributions to health insurance was increased by 0.8 percent for self-employed people and farmers and by 0.5 percent for retired people. This was done to reduce the large subsidy to the health insurance scheme from general taxation that had arisen as the costs of health care for older people had grown.

*Germany.* A public scheme of long-term care insurance was introduced in Germany in 1995-96. This comprises a mandatory public scheme, which currently covers just over 70 million people, and a private insurance scheme, which currently covers around 8.5 million people.<sup>29</sup> The public scheme is administered by health insurance funds, while the private scheme is administered by private insurers according to federal regulations. The private scheme must provide at least the same benefits as the public scheme. Contributions to the public scheme, from retired as well as working-age people, are set at 1.7 percent of gross income up to a specified maximum, with employers usually paying 50 percent while the individual pays the other 50 percent. Contributions to private long-term care insurance are age-related and subject to federal regulation. Where the recipient is receiving care in an institution, the benefit is

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<sup>29</sup> These are mainly higher-income groups and civil servants.

pre-existing number of allowances for different groups in the population, each with different received as payment for the service part of the costs of nursing home care (excluding accommodation) up to a specified maximum for each of the three care levels.

Two major goals of the reforms were, first, to reduce the burden on local social assistance budgets by reducing the number of people applying for social assistance to cover long-term care costs and, second, to maintain as many elderly people as possible in their own home.<sup>30</sup> The first objective has been met. In 2001, fewer than 5 percent of beneficiaries in their own homes and fewer than 25 percent in institutional care were receiving additional help from social assistance (Federal Ministry of Health and Social Security, 2003). There has also been a significant growth in spending on home-care services.

However, the current design of the program may not be financially sustainable, and this problem will need to be addressed in the future as the population continues to age. First, there is a growing gap between the cost of services in the long-term care market and payments per care level, which have been kept fixed since the introduction of the system and not been adjusted for price increases. Second, since 1998, the annual increases in revenues under the fixed contribution rate have been substantially lower than the growth of expenditure in all but one year, mostly due to the rising costs of institutional care. The long-term care insurance scheme had a deficit of 2 percent in 2002 and of 4 percent in 2003, and this deficit continued to grow during 2004. Following a ruling of the Federal Constitutional Court that called for different contribution rates for those employees with children and those without children, the individual contribution rates for the latter were raised in 2005 from 0.85 percent to 1.15 percent.

A government commission on the financial

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<sup>30</sup> For a full account of the background to the reforms, see OECD (1996a), Chapter 18. See also Evans, Cuellar, and Wiener (2000).

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sustainability of the social insurance systems recommended that the federal government should provide further incentives and support for care at home and should increase the contributions paid by pensioners (Federal Ministry of Health and

**Table 8: Privacy in Nursing Homes**

Country	Year	Average number of persons per room	Percentage of all residents living in room that is				
			Single	Double	3-bed	4-bed	5-bed or more
Australia	1997	1.60	24	29	9	29	9
	1999	1.56					
	2000	1.50	61	17	4	14	4
	2003	1.44					
Germany(1)	1999	1.40	45	49	4	1	
	2001	1.40	47	49	3	1	
Japan	2002	2.80	10	13	4	70	3
Korea	2004	2.90					
Netherlands	2000	2.00	22	35	4	33	6
Norway	2000	1.15	75	24	1		
	2002	1.08	80	20	0		
Sweden	2000		98				
UK	1996	1.40	46	44	6	1	2
	2003	n.a.	84	16			

(1) Number of beds per room

Source: Gray (2001) *Two year review of reform (Australia)*; Federal Statistical Office (1999; 2001) (Germany); The Ministry of Health, Labour and Welfare, Japan (2003) *Survey on Long-Term Care Service Institutions/Undertakings, 2002*; Netherlands (2000) *Branchnerapport Care*; Netten et al. (1998) *1996 Survey of Care Homes for Elderly People*; Laing and Buisson *Market survey, 2003 (UK)*; National Board of Health and Welfare (2004) *Care and services for elderly persons (in Swedish)*, and previous editions..

Note: UK, 2003 refers to private-for-profit institutions only, which, however, account for the majority of nursing home places

Social Security, 2004). Reports by other think tanks have recommended making fundamental reforms of the way in which the current system is financed (see German Council of Economic Experts, 2004). These proposals range from extending mandatory social insurance to the whole population to introducing a funded system

with a capital stock as a buffer in the context of the aging population.

*Luxembourg.* Luxembourg introduced a new arm to its social insurance system to cover long-term care in 1999. Forty-five percent of this insurance is funded from general taxation and

requires a 1 percent individual contribution based on salary or pension (which amounted to around 35 percent of funding in 2001). The remainder is funded from a special tax on electricity bills. The new insurance scheme provides benefits both in cash and in kind to cover the cost of care at home or in an institution, with benefits being calculated on a sliding scale based on the extent of need for help with the activities of daily living (Inspection Générale, 2003).

From 1999 to 2003, Luxembourg's long-term care insurance had an annual budget surplus due to the combination of fixed payments per care level and only moderate growth in the overall number of recipients. Moreover, there has been a significant shift in the balance of care between 2001 and 2004, with a larger share of care recipients now being cared for at home rather than in an institution. This was one of the goals behind the introduction of the new long-term care system. Projections on the longer-term financial sustainability of the new system are not yet available.

*Japan.* Japan introduced public long-term care insurance in 2000, funded 50 percent from general taxation (shared between central and sub-national governments), 32 percent from contributions from employees and 18 percent from contributions from pensioners. There is no single rate of contribution. Instead, the municipalities, which run the long-term care insurance funds, levy whatever contributions are necessary to cover their costs. These contributions depend on income up to a specified maximum, and social assistance funds subsidize the contributions of those with the lowest incomes. Long-term care insurance is currently restricted to people aged 40 and older. As a consequence, younger age groups with relatively moderate care needs do not contribute to the financial sustainability of the system.

Assessment of need is done by a case conference of health and social professionals according to a six-point scale based on the amount of help required with personal care and household tasks. On-site visits and the completion of the assessment is usually delegated to a service

provider or municipal official. All benefits are paid according to a national scale and are received as an equivalent amount of services. The user pays 10 percent of the cost of services. The new system collects contributions from, or pays benefits to, almost half the population. Given its large scale, the introduction of the scheme was assessed to have gone smoothly. It has also been very well received by the public. As one of the main goals of the scheme, the range of services to choose from was increased, mostly by increasing home-care services. Between April 2000 and October 2002, the number of home-care recipients almost doubled from 970,000 to 1,910,000 (97 percent) while institutional-care recipients increased by 37 percent from 520,000 to 710,000.<sup>31</sup>

The new insurance system, together with other service-related long-term care reforms, also had the goal of reducing inappropriate hospitalization of older people. Previously, large numbers of older people received long-term care in hospital. The proportion of older people residing in institutions in Japan was reduced between 1990 and 2000, partly due to reduced institutionalization in hospital in the period before the new system came into force as new long-term care services were gradually put in place. The new insurance system helps to pay for the nursing home and home-care costs of those who would otherwise have been in hospital and subsidized by health insurance in previous years.<sup>32</sup>

There is concern that the aging population in Japan will put increasing pressure on the current system. Recent projections suggest that average contributions per capita might have to grow by as much as 80 percent within the next 10 years to meet likely demand. In order to secure the financial sustainability of the new long-term care scheme in the long run, the government is currently considering trying to contain the costs

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<sup>31</sup> These data come from Japanese replies to OECD questionnaire on long-term care.

<sup>32</sup> For a full treatment of the Japanese system prior to the introduction of the new insurance system, see OECD (1996, Chap. 10). On the impact of the reforms on that system, see Matsuda (2002).

of long-term care by implementing more prevention strategies (Ministry of Health, Labor, and Welfare, 2004).

*Lessons from the Reform Process.* While the details of the reforms introduced in these four countries differ significantly and it is still too early to assess their long-term impact, they have some common features that are noteworthy. First, all of them have been funded by additional contributions.<sup>33</sup> They are not a “free good” but so far the public has been willing to support them paying the extra contributions.

Second, none of the schemes puts all of the financial burden onto the working population and employers.<sup>34</sup> All of the schemes require contributions from pensioners as well. In addition, in Austria, Japan, and Luxembourg, a substantial share of the cost is spread across all age groups via general or earmarked taxation. Requiring contributions from all age groups, including from the older population, is important if such schemes are to be sustained in an aging society.

Third, all of the schemes were implemented by existing health insurance or social services agencies. These were agencies administering the existing, rather fragmented dependency allowances in Austria, the health insurance schemes in Germany, and the municipalities in Japan. All had experience in assessing and delivering benefits to the public, and the use of these existing and well-known (to the public) mechanisms appears to have been instrumental in getting these new and extensive schemes up and running.

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<sup>33</sup> Although these were indirect in Austria, higher health insurance contributions to cover the acute health care costs of the elderly were a vital part of the package, enabling the launch of a tax-funded scheme.

<sup>34</sup> There are limits to the extent to which contributions can be raised from employees and employers, especially in countries where these contributions are already high and make up a big proportion of labor costs. If total labor costs are too high, this has implications for the level of employment, with resulting erosion of the contribution base. The same caveat applies to some forms of general taxation.

Finally, it should be noted that introducing a comprehensive public scheme does not have to be at the expense of reducing the coverage of private long-term care insurance. In Germany, the market for *voluntary complementary* long-term care insurance to meet additional costs not covered by the public scheme has grown alongside the establishment of the public long-term care system. There are now some half a million such policies. The public scheme has made such insurance affordable by covering the first tranche of the costs of long-term care.

#### Reforms to Long-term Care within the Tax Envelope: Sweden, Australia, New Zealand, and the United Kingdom

Countries that already fund both health and social services largely from general taxation will probably have no wish to adopt a social insurance system for long-term care. This section examines reforms in four countries that fund long-term care from general taxation.

*Targeting within the Nordic model: Sweden.* Sweden has faced the problem of trying to fund long-term care within a very high-cost welfare system in which additional expenditures were ruled out. Thus, reform required getting better outcomes from existing expenditure while not giving up the basic principles of the Swedish system. The approach that the government adopted has been to target services, and therefore public expenditure, to the most sick and disabled and requiring those with lesser disabilities to either buy private services or receive informal care from their families.

The key reform that initiated a period of considerable change in Swedish long-term care was the Ädel reform of 1992. This involved devolving responsibility for all long-term care and related services (accompanied by a transfer of funds) to the municipalities. This responsibility had previously been divided between the municipalities and the counties. The counties retained responsibility for acute care in hospitals, and, as part of their new responsibilities, the municipalities became financially responsible for older people who were unnecessarily retained in hospital beyond

the clinically necessary time (so-called “bed blockers”) as in principle they should arrange a suitable package of care to allow these people to be discharged.

One of the initial aims of the reforms – to reduce “bed blockers” – was successfully achieved. In 1990, it was estimated that as many as 15 percent of hospital beds were occupied by “bed blockers,” but this had been reduced to around 6 percent by 1999. During these years, the counties also drastically reduced bed capacity by 30 percent in short-term care and 55 percent in geriatric care between 1992 and 1998.<sup>35</sup>

One outcome of this considerable change in hospital use has been a steady and significant transfer of responsibility for long-term care to the municipalities. As this coincided at the beginning with a steep recession in the Swedish economy, municipalities were generally unable to raise new tax expenditure to meet the costs of this extended responsibility. In addition, between 1990 and 1999, the central government introduced various controls to cap local government taxation. The net result has been a considerable increase in targeting and a qualitative change in the nature of the services supplied.

As a result, one of the aims of the reforms, – to create more “social” nursing homes – has not been met in the face of the overriding need to “re-medicalize” nursing homes to cater for the higher nursing and medical needs of residents (Johansson, 2000, p. 13).

The impact on home care has been even more marked. Between 1990 and 1995, the proportion of the older population supplied with home care shrank from between 13-14 percent to around 9 percent,<sup>36</sup> a level that has been sustained since 1995. However, the volume of help supplied to this smaller group was higher. For example, in 1988, 16 percent of home-help recipients

received care during the nights and weekends, but by 1997, this had increased to 28 percent.<sup>37</sup> Charges to recipients were increased, but these were then capped by the central government in 2002, together with charges for nursing homes.

However, recent projections of the future cost of care of older people suggest that the pattern of care that has emerged following the Ådel reforms may be more sustainable over the longer term than was previously thought (Lagergren, 2002). Taking into account recent trends in improved health among older people results in a projection of a 20 to 25 percent increase in spending in real terms between 2000 and 2030, which is significantly lower than older projections that used a simple demographic multiplier. Current policies rest on this latest projection. The main issue for the future is not how to curb the growth in cost of services but rather is how to maintain – or increase – the level of employment among the working-age group to secure the tax base to fund services and benefits.

*Grappling with income and asset testing for long-term care: Australia, New Zealand, and the United Kingdom.* A major reform of long-term care was implemented in Australia in 1997. As the financing of institutional long-term care is primarily a federal (Commonwealth) government responsibility, the reform process was highly centralized, with the federal government consulting with community representatives and then implementing its proposals.

A major issue for the government was the high projected growth rate of the over-80 population, leading to concerns about the sustainability of the pre-1997 system, which was primarily government-funded with small contributions from users. There was also some concern that the separate scales of subsidy for nursing homes and for hostels (residential homes with some care provided) led to inequities in treatment. Hostels in many cases provided significant amounts of care, especially for older people suffering from dementia, but had a subsidy cap that did not recognize this. This might have

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<sup>35</sup> The average length of stay in hospitals also fell, very dramatically in the case of stroke victims from 56 days in 1989 to 13 days in 1999.

<sup>36</sup> These data come from the responses to the OECD questionnaire (see Table 2.3 in Chapter 2).

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<sup>37</sup> See Johansson (2000).

meant that these people would have to be relocated to a different facility even though the hostel would be willing to increase the level of care that they were providing.

To address these concerns, the reform unified nursing homes and hostels under one assessment and subsidy system and introduced income-tested fees to reduce the government subsidy. From 1997, all facilities were unified into one system that offers the full continuum of care. The system was subsidized through a single funding scale, the Resident Classification Scale, which was designed to cover the full spectrum of care needs in any location and to recognize the specific costs of caring for those with dementia. The reforms also unified the previously different systems for paying for care and accommodation in institutions. Under the reforms, users now had three possible components of cost to meet – a uniform basic contribution that was designed to be affordable to those receiving the public old-age pension, income-tested fees for care, and an asset-tested accommodation payment.<sup>38</sup> Federal subsidies now met any costs not met by users under these rules.

The outcome of the reforms was evaluated two years later. The evaluation found that the reforms had made it possible to provide a continuum of care, especially in hostels, and to focus on the needs of those with dementia (Gray, 2001). They had also increased the average level of user payments through increased income- and asset-testing, thereby generating enough finance to support the drive to raise standards in institutional care homes.

The UK government was also concerned in the late 1990s about the sustainability of financing long-term care in the long run. However, it did not take the view that its current subsidy of institutional care was over-generous, unlike in the Australian case where institutional long-term care subsidies had been available to most of the population. On the contrary, there was considerable concern on the part of advocacy

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<sup>38</sup> In Australia, the assets test excludes a significant part of the value of the family home, applying to long-term care the same rule as for pensions.

groups and the older public that service users were having to spend down their savings to a level that met the social assistance means-test level before they could receive any financial help with their nursing and residential home costs. Charges for home care were set by local governments according to different local formulas, which led to concerns about inequities across the country. In 1997, the recently elected Labour government set up a Royal Commission to consider options and recommend a sustainable system of financing for the future.

The Commission argued in its 1999 report that long-term care is a risk that is best covered by some kind of risk-pooling. Having considered and rejected other options for risk-pooling – such as private long-term care insurance and a social insurance scheme – the commission recommended that nursing and personal-care costs, both for institutional and home-based services, should be financed from general taxation in the same way as the National Health Service is financed.

The UK government responded to these recommendations as part of a wider program of investment and reform in health services – the NHS Plan. The government took a different view of priorities in health and social care for older people than that of the commission. It accepted several proposals for ameliorating the means-testing mechanism and to correct the anomaly that nursing care in nursing homes was currently means-tested rather than provided free of charge as in the health service. However, the government argued that to make all personal care free of charge would involve committing large sums of money with no increase in the amount of services available to older people.<sup>39</sup> So in 2001 and 2002, the government introduced reforms that reduced the impact of means testing for institutional care without removing it altogether. It also issued new guidance to local

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<sup>39</sup> In Scotland, however, following devolution of responsibility for health and social care to the Scottish Parliament, the commission's central proposal to provide personal care free of charge has been accepted and implemented.

governments to encourage a more consistent approach to charging for home care.

The New Zealand government that was elected in 2000 pledged to introduce a number of reforms to health and long-term care that were designed to make the system more effective and less costly to the users, as the quality and cost of care had been a growing public issue throughout the 1990s. As noted in Chapter 2, separate streams of funding for health and long-term care were brought together under the management of District Health Boards (DHBs) that are funded by the central government from taxation and that have assumed responsibility for all of these services (acute health in 2000 and long-term care in 2003).

Most institutional long-term care in New Zealand is provided in licensed private care homes, and around two-thirds of the residents are eligible for state subsidies through the Residential Care Subsidy scheme. However, some long-term care is still provided in public hospitals, which were the major supplier of this care in the past. The more generous terms available to users of the shrinking number of public sector hospital beds were a major driver of public criticism of means testing.

Access to Residential Care Subsidies is income and asset-tested, these tests being administered on behalf of DHBs by the Ministry of Social Development. The subsidy formula is designed to keep private cost-sharing below a specified maximum payment per week. In order to qualify for the subsidy, the person must have assets below a certain level, leading some users to “spend down” their assets, including housing, before qualifying for help. The impact on housing assets was a major public concern.

To meet their election commitment, the New Zealand government has announced that asset tests for institutional care will be phased out in stages from 2005, leaving a system of income tests that will on balance be more generous to the user than the current system. While making a commitment to increasing public costs for long-term care in future years, it is noteworthy that New Zealand has taken other measures to reduce the public finance costs of aging, most

notably by raising the age at which people qualify for the state pension from 60 to 65.

### **Conclusions about the Future Financial Sustainability of Long-term Care**

When confronted with the rising demand for long-term care, some OECD countries have been prepared to raise additional taxes or social insurance contributions specifically to finance a new benefit for long-term care. They have justified this on two main grounds: (i) it represents the most efficient way of insuring against this risk; and (ii) it yields immediate benefits to the public in relieving them of high personal costs or the need to apply for social assistance when their savings have been depleted.

Fortunately, the governments who have implemented these benefits have been able to use high-quality information to predict with some accuracy the expected scope and cost of the new benefit, which has helped them to avoid any immediate financial problems. While this has solved short-term problems by generating additional finance, these countries now have a significant new commitment to maintain in economic bad times as well as good. How feasible this is may hinge on how far the health of the older population improves in the future, thus containing the size and needs of the target population. It is far from certain that the long-term financial sustainability of their systems is assured.

The governments of those countries with universal long-term care coverage are concerned about the financial sustainability of their systems in the future as their populations age. In social insurance countries, the governments are currently discussing a number of options for further reform such as improving prevention and rehabilitation strategies and broadening the contribution base, for example, by seeking substantial additional contributions from pensioners.

Those countries trying to live within a tax envelope have faced difficult choices such as reducing the scope of services while targeting

services to the sickest and most disabled people (Sweden). Other countries with tax-funded systems have unified all of their systems of subsidies and care assessments (Australia). Means testing has been tightened in Sweden (where in the past benefits had been offered to most of the population) and increased for residential care subsidies in Australia but has been relaxed in New Zealand and the UK.

High private cost-sharing is a common cost-containment measure for public long-term care programs. Even “universal” systems may exclude important costs such as accommodation in nursing homes or services of low-level support. It is currently too early to judge if universal systems with cost-sharing are any more or less sustainable than systems based on means-tested benefits.

Another area where more research will be needed in the future is the role that preventive measures targeted to the elderly could play in containing spending on long-term care. This is all the more complex because these measures typically involve both health and long-term care, which are often funded from different sources.

Private long-term care insurance as primary cover against disability in old age has played a very limited role in most OECD countries (see Columbo and Tapay, 2005). However, private insurance might play a stronger role in the future in providing voluntary complementary long-term care insurance to meet additional costs not covered by public programs. This type of complementary insurance becomes more affordable when the public system covers the first tranche of the costs of long-term care.

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# Long-term Care in Germany

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## Introduction

After more than 20 years of debate, the Long-term Care Insurance Act of 1994 introduced mandatory long-term care insurance (LTCI) for practically the whole population of Germany (see Haug and Rothgang, 1994). Interestingly, the introduction of this new welfare state component happened under a middle-right government during an ongoing period of austerity.<sup>40</sup> There were many reasons for this (see Campbell, 2002). First, the “aging of society” resulting from an ongoing declining rate of mortality accompanied by constant fertility levels below the replacement rate caused the number of dependent people in Germany to increase. Even when the Act was passed, it was clear that the number of dependent people would rise over the following couple of decades. Second, there was growing concern about who would care for these dependent elderly. The family as the traditional backbone of care was seen as a declining resource, while the infrastructure for formal care, both home care and nursing home care, was underdeveloped relative to other European countries (Alber and Schölkopf, 1999 and Schölkopf, 1999). Third, due to rising fees for nursing homes, almost 80 percent of all residents of these homes were dependent on social assistance, a situation that was regarded, particularly by conservative social politicians, as a scandal. According to the prevailing conception of the welfare state, living a “normal life” (in other words, a life with a long record of gainful employment or as dependent spouse of such a person) should guarantee that no means-tested social assistance would be required in old age. This principle had clearly been violated, and the fact that so many nursing home residents depended on social assistance was the standard argument in favor of introducing an LTCI from a social policy point of view. The introduction of a LTCI, however, cannot be explained without adding a fourth

factor.

Particularly after the reunification of Germany, which put a severe burden on the economy and the public purse, municipalities were increasingly unable to bear the costs of providing social assistance to the dependent elderly. Therefore, the introduction of a LTCI was also a way to lift this burden from municipalities by relieving them of their role as financing agencies for social assistance.

Nevertheless, the introduction of a LTCI must not be seen purely as an expansion of the German welfare state arrangement. On the one hand, it was accompanied by cuts in other welfare state programs, and the relevant federal minister, Norbert Blum, stated that these retrenchments in some areas were made to make it possible to expand others (FAZ from 22-4-1992). Thus, the introduction of long-term care insurance was part of a program to restructure the welfare state by adopting programs to face “new risks” (such as long-term care and poverty due to single parenthood) at expense of programs that dealt with traditional social risks. In a way, this was an attempt by “old” social politicians like Blum but also by his social democratic equivalent, Rudolf Dressler to save the German system as a conservative welfare state in the sense that Esping-Andersen (1990) has described. Hence the introduction of a classical social insurance system based on the pay-as-you-go principle.

On the other hand, the newly introduced LTCI contains new elements that can be seen as a natural extension of the ongoing restructuring of the welfare state. For example, benefits are capped, the contribution rate is legally fixed, and claims for benefits are assessed by an agency run by the LTCI rather than by providers of care (as in health insurance) in order to prevent moral hazard. With respect to these new elements, which together mark the shift from a needs-driven to a budget-driven system (Rothgang, 1994), the new system contributed to the

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<sup>40</sup> The latter is also true for the Japanese LTCI. See Campbell and Ikegami, 2003 for an account of this.

reshaping of the welfare state in the age of permanent austerity (Pierson, 2001).

The LTCI that resulted from these considerations has been operating for more than 10 years now. This paper discusses the peculiarities of this system and its successes, failures, problems, and reform options.<sup>41</sup> The first section outlines the institutional framework of the LTCI. In the two subsequent sections, an account is given of the services provided by the LTCI and the fiscal side of the system respectively. The fourth section assesses the system's problems and related reform options, and the fifth section does the same specifically for the health sector's financing system. The conclusion discusses the lessons that can (or cannot) be learned from the German experience.

### **Long-term Care in Germany: The Institutional Setting**

In legal terms, the "need for long-term care" (or "dependency") refers to those people who are – as a consequence of illness or disability – unable to perform the activities of daily living (ADLs) independently for an expected period of at least half a year.

Until the introduction of Long-term Care Insurance (LTCI) in 1994, there was no comprehensive public system for financing long-term care in Germany. Dependent people or their families had to pay for care services – when they used them at all – out of their own pockets, with only means-tested social assistance as the last resort for those who had exhausted their assets and could not otherwise afford the necessary formal care. In effect, approximately 80 percent of the people in nursing homes relied on social assistance.<sup>42</sup> The LTCI Act of 1994 established public long-term care insurance and mandatory private long-term care insurance that together covers almost the whole population. Members of the public health insurance system become members of the public LTCI scheme, and those who have private health

insurance are obliged to buy private (mandatory) LTCI guaranteeing at least as much coverage as the public scheme does. Consequently, the same definition of dependency holds for both insurance systems, though different agencies are responsible for making individual assessments. As a result about 89 percent of the population is now covered by the public LTCI and 9 percent by the private LTCI. There are specific systems for 2 percent of the population, including police and firemen.<sup>43</sup> Since all insurance benefits are capped, private co-payments remain important, and means-tested social assistance still plays a vital role, particularly in nursing home care where about 30 percent of all residents still receive social assistance. At the state level, the "Laender" (in other words, the 16 provinces with different legislation) are responsible for subsidizing the building and modernization of nursing homes, thus reducing private co-payments and social assistance expenditure.

Public LTCI follows the *pay-as-you-go principle*, while private mandatory LTCI is partially funded with the addition of individual saving accounts for the young that will yield income when the members grow older. In principle, this mechanism should guarantee a constant premium for the whole of the contributor's life.

Public LTCI is financed almost exclusively by *contributions*, which are income-related but not risk-related. In the case of those who are employed, employers and employees pay 50 percent each of the worker's premium. The employers' part is tax-free. In order to compensate employers, the federal government abolished one national bank holiday. Originally, pensioners also had to pay half of the contribution, while the other half was financed from pension funds. Since 2004, pension funds no longer contribute, leaving the whole premium to be paid by the pensioners. In the case of the unemployed, their contributions are completely financed by unemployment insurance. Contribution rates are calculated as 1.7 percent of gross earnings up to an income ceiling of 3,525 Euro per month (2005 figure). Income from other sources such as assets or income

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<sup>41</sup> See also Rothgang, 2002a for an account in the Japanese language.

<sup>42</sup> See Rothgang, 1997: 215ff. See also Pabst and Rothgang, 2000 for the situation before LTCI was introduced.

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<sup>43</sup> For civil servants (*Beamte*), special additional systems (*Beihilfe*) remain in place.

from rent and leases is not considered in calculating contributions. The contribution rate can only be changed only by an act of Parliament.

From 2004 onwards, insured people aged 23 or older who have never been parents have to pay an *additional contribution* rate of 0.25 percent. This extra contribution was introduced to fulfill a verdict of Germany's Federal Constitutional Court dating from 2001 ruling that families were disadvantaged by having to pay contributions as anyone else for themselves while also having to raise future contributors to the system (their children) at their own cost. In economic terms, families thus produce a positive externality that benefits for all insured people, and the Court's argument was that this benefit had to be internalized in the interests of both efficiency and justice (see Rothgang, 2001). While the Court aimed to reduce the burden on families, the legislature instead raised the contribution rates of those without children, ignoring the Court's justification that clearly indicates that the number of children is also relevant to determining just contributions. Although the resulting regulation was criticized by all experts, it was nevertheless implemented (Schmähl and Rothgang, 2004).

Public LTCI is administered by different *LTCI funds*. Since the benefits, as well as the contribution rates, are common and all expenses are financed by the sum of all contributions – irrespective of which fund is responsible – there is no competition between these funds.

In contrast with the Japanese Long-term Care Insurance, in Germany, *entitlement* is independent of the age of the dependent person. However, almost 80 percent of all beneficiaries are 65 years old or older and more than 50 percent are at least 80 years old (own calculations based on information from the Department of Health for 2004). The entitlement to claim benefits is based on whether the individual needs help with carrying out at least two basic and additional instrumental activities of daily living (ADLs and IADLs for an expected period of at least six months. Three *levels of dependency* are distinguished depending on how often assistance is needed and

how long it takes a non-professional carer to help the dependent person (see Table 1).<sup>44</sup>

The LTCI benefits are set by law. Beneficiaries (and their relatives) may choose between different benefits and services. It is important to note that this *choice* is up to the beneficiaries and not to care managers, state agencies, or long-term care insurance funds. The LTCI benefits are for home care, day and night care, and nursing home care. People in *home care* can choose between in-kind benefits for community care and cash benefits. Cash benefits are given directly to the dependent person, who can choose to pass it on to a family carer. However, there is no obligation for the dependent person to do so, and the use of cash benefits is at the beneficiary's discretion. Community care is provided by both non-profit and for-profit companies. Up to certain ceilings (see Table 2), their bills are covered by LTCI funds. Cash and in-kind benefits may be combined. For example, if a family carer is on vacation, the LTCI will cover the expense of a professional carer for a period of up to four weeks – up to a ceiling of 1,688 Euro. This is a benefit in its own right but is weighted against other claims for home care. There is also a small grant for special aides, and the insurance funds offer courses for non-professional carers.

In *nursing home care*, the dependent person is responsible for paying the costs of housing and catering (so-called “hotel costs”). Hotel costs do not include the annuities resulting from building or modernizing nursing homes. These “investment costs” are partly financed by the provinces and partly by the nursing home residents themselves. Only care expenses are co-financed by LTCI funds up to a certain ceiling (see Table 2). LTCI funds pay the

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<sup>44</sup> Of course, there are also less dependent people who do not qualify for LTCI benefits. According to a representative survey conducted in 2002, there were 1.4 million dependent people in private households who would qualify for LTCI benefits, but there were also about 3 million older people who needed help, mainly with IADLs, who would not qualify for LTCI benefits (Schneekloth and Leven, 2003, p. 7). Thus, in private households, there are about an additional 2.1 people in need of some help for every recipient of LTCI benefits.

**Table 1: Definition of Dependency**

	Level I:	Level II	Level III
Need of care with basic ADLs	At least once a day with at least two bADL	At least thrice a day at different times of the day	Help must be available around the clock
Need of care with instrumental ADLs	More than once a week	More than once a week	More than once a week
Required time for help in total	At least 1.5 hours a day, with a least .75 hours for bADL	At least 3 hours a day with at least 2 hours for bADLs	At least 5 hours a day with at least 4 hours for bADLs

Source: § 15 SGB XI.

**Table 2: Amount of LTCI Benefits (Major Types of Benefits)**

in Euro / per month	Home care		Day and night care	Nursing home care
Level	Cash benefits	In-kind benefits	In-kind benefits	In kind benefits
I – moderate	205	384	384	1,023
II – severe	410	921	921	1,279
III – severest	665	1,432	1,432	1,432
Special cases		1,918		1,688

Source: §§36-45 SGB XI.

**Table 3: Average Monthly Rates for Nursing Homes, LTCI Benefits, Co-payments in 2002**

in €	(1)	(2)	(3) = (1) + (2)	(4)	(5) = (1) - (4)	(6) = (3) - (4)
Level of care	care costs	Accommodati on and food	daily rate (investment excluded)	LTCI benefits	co-payments, care costs only	Co-payment, care and hotel costs
Level I	1.172	738	1.910	1023	149	887
Level II	1.558	738	2.296	1279	279	1.017
Level III	1.979	738	2.717	1432	547	1.285

Source: AOK

pension contributions of informal carers,<sup>45</sup> who are also covered by accident insurance without having to pay contributions. In general, all benefits are capped or given as lump sums. Table 2 contains the respective amounts of money for the most important types of benefits as laid down in the Sozialgesetzbuch, 11. Buch (SGB XI). As the table shows, in-kind benefits for home care are about twice as high as cash benefits, while day and night care is in line with in-kind benefits. In grades I and II, benefits for nursing home care are higher than for home care. Only in grade III are benefits for all types of formal care the same. This policy was aimed at preventing a shift towards nursing home care as a result of the introduction of LTCI.

LTCI funds provide co-payments that, in general, are not sufficient to cover the costs of formal care at home (see Rothgang, 2000) or in a nursing home. As Table 3 reveals, LTCI benefits are even insufficient to cover average care costs. Since residents are responsible for paying for hotel costs, co-payments are quite substantial, particularly if an average monthly amount of about 300 € for investment costs is added.

Moreover, there are no regulations concerning *how benefits can be adjusted* by the federal government. Until the time of writing, benefits have never been adjusted, not even for inflation, while prices for nursing home care, to give one example, have gone up by 10 to 15 percent. Consequently, the purchasing power of LTCI benefits is declining.

The LTCI Act aimed to introduce *competition* between providers of long-term care. To this purpose, all of the privileges of non-profit providers have been abolished, and the LTCI funds are obliged to contract with any provider – irrespective of need. Hence, barriers to entering the market have been torn down. In particular, planning systems for service provision at the

provincial level have been abolished or are in the process of being abolished.<sup>46</sup> In theory these needs-planning systems were meant to prevent under-supply by subsidizing, for example, the building of nursing homes. In practice, however, this often meant that government agencies would not allow new providers to enter the market because there was already “sufficient” supply to meet needs.

The LTCI funds and municipalities are expected to create *information centers* to increase the transparency of the formal care market and to correct any inaccurate information about LTCI activities and benefits. LTCI funds also have to provide comparative price lists to LTCI beneficiaries, which have recently had to be transformed into a list of prices and services. Since the attempts to empower beneficiaries have not been sufficient, additional legislation (*pflege-Qualitätssicherungsgesetz*) was passed in July 2001 that aimed to guarantee minimum quality levels. Moreover, LTCI funds and providers have to sign contracts that regulate quality standards. Unfortunately, these standards relate to structure and process rather than to the outcomes of care. While the system of regulation is tight in the area of formal care, there is hardly any quality control for the care provided by families.

The *prices* of formal care are agreed in a process of collective bargaining between providers and financiers, in other words, LTCI funds and social assistance bodies. If agreements are not reached, a so-called arbitration board (*Schiedsstelle*), whose members have been nominated from both sides, decides.

Provinces have the responsibility for financing *investments* in the provision of long-term care services. Regulations vary greatly among the 16 provinces. Some states directly invest in, for example, nursing homes, while others only

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<sup>45</sup> The amount of contributions differs according to the extent of the dependency of the person cared for and the time spent caring. Contributions to pension funds require a minimum of 14 hours of care work a week. The minimum contribution paid is 26.7 percent of a full-time employee’s average salary, while the maximum is 80 percent of this amount.

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<sup>46</sup> Only gradually did all Länder governments realize that they must no longer prevent providers from entering the market or subsidize particular providers to give them an advantage against newcomers. This realization has mainly been due to recent rulings by their respective courts.

provide subsidies for dependent older people living in nursing homes who rely or would otherwise rely on social assistance (*pfl egewohn g e l d*). In order to help East Germany to “catch up” with the former West Germany, however, a special program was set up that invested about 500 million Euro a year in the former East Germany between 1996 and 2003. The central government covered 80 percent of this amount as long as the respective region provided the remaining 20 percent share.

With respect to *regulation*, collective bargaining between providers of services and funds is the predominant governance structure within a neo-corporatistic framework (*gemeinsame Selbstverwaltung*). Providers and payers agree on guidelines of good care and requirements for good quality that must be met if providers are to be allowed to enter the care market. At the provincial level (*Landespflegeausschüsse*) and the federal level (*Bundespflegeausschuß*), coordinating bodies have been established that include representatives of all of the relevant actors. However, these bodies are more of a forum for discussion and communication than for decision-making. In some regions, such coordinating bodies have also been established at local levels (see Eifert and Rothgang, 1997 for details). Generally, LTCI funds are the most important actors in the field. They are responsible for contracts with care providers (including admission to the market and prices), pay (for in-kind care), and cash benefits. The Medical Services of the Health Insurance system (*Medizinischer Dienst der Krankenversicherung* or MDK) perform the assessment to determine whether an individual is entitled to benefits. For private LTCI, Medicproof, a private company, carries out this task.

### **The Provision of Care**

Long-term care is often provided informally by families and friends – mainly spouses, daughters, and step-daughters – as well as formally by public and private (profit and non-profit) care providers. Formal care is provided in private households (in other words, home care); day and night care centers, and nursing homes for older people. Long-term care is also provided in nursing homes for the disabled, although in Germany these institutions mainly

aim to integrate younger disabled people into working life.

The beneficiary’s opportunity to choose between different care arrangements and respective benefits is one of the innovations of the LTCI Act. Therefore, it is interesting to take a close look at the development of these arrangements. In the next subsection, I review some patterns in the development of care arrangements over the last decade, and in the following subsection, I discuss expected future developments.

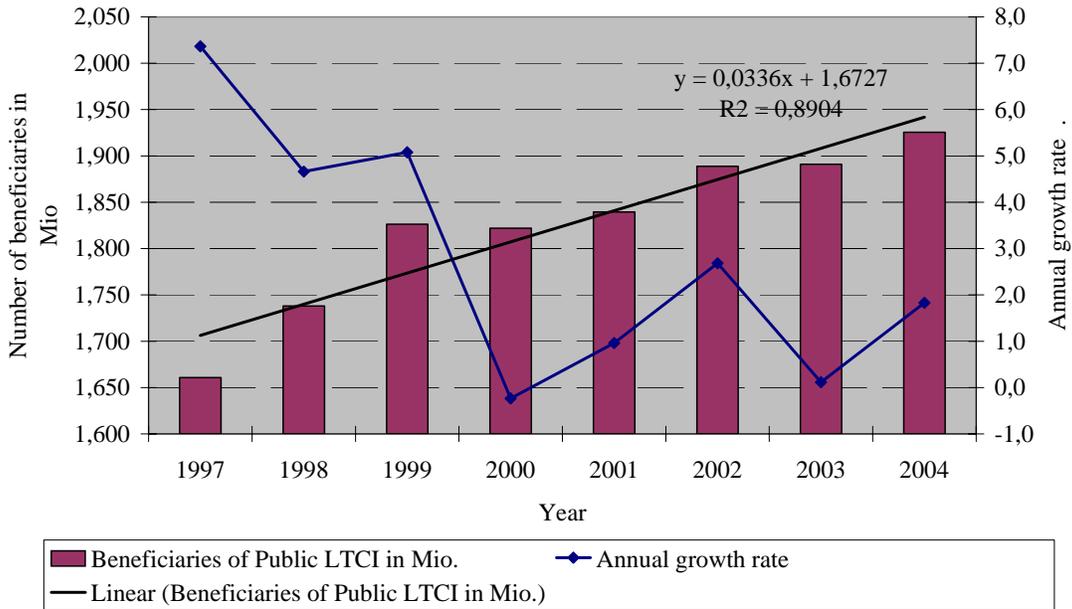
### The Current Situation

Long-term care insurance was phased in gradually. The first contributions were due in January 1995, but benefits for home care did not start being dispensed until April. Nursing home care benefits only came into being in July 1996. Between 1997, the first year when the system was fully operating, and 2004, the *number of beneficiaries* increased by about a quarter of a million, which equals about 34,000 per year on average. The highest growth rates however, occurred in the early years of the system when the population still had to get used to having a right to benefits. In the last five years, an annual growth rate of 2 percent was exceeded just once (Figure 1). Thus, there has been no “explosion” of the number of beneficiaries but rather slight but steady growth. However, the gradual shift in care arrangements is even more interesting (Figures 2 and 3).

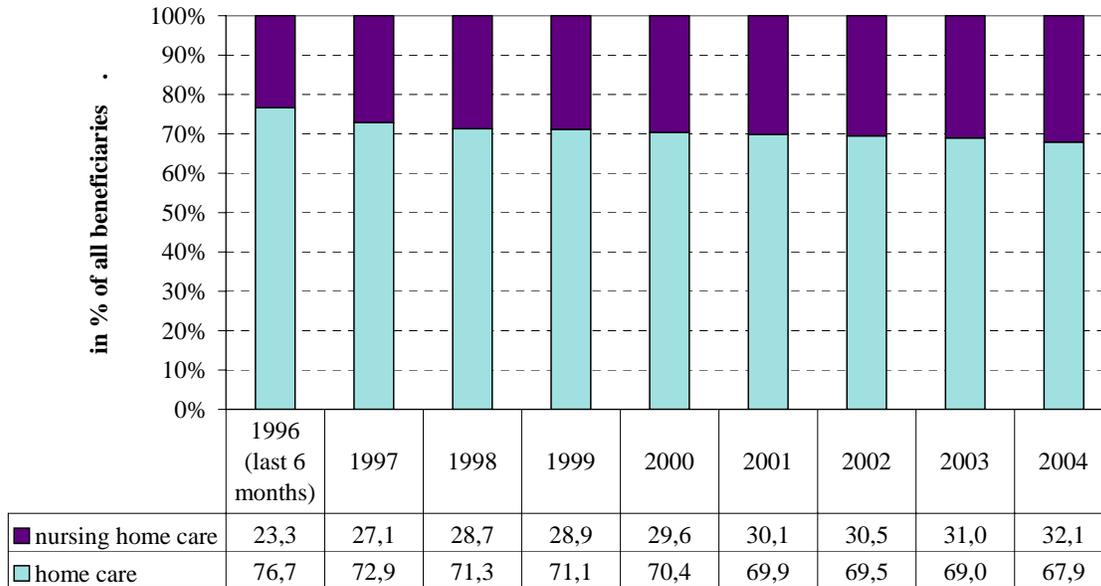
From 1997 to 2004, the share of dependent people in public LTCI has increased from 27 to 32 percent (Figure 2). At the same time, the share of those dependents who are informally cared for at home decreased from 78 to 72 percent (Figure 3). So, while about half of all dependent people are still cared for without the involvement of any professional carer, this figure has fallen from 56.7 to 48.9. This drop of 7.8 percentage points clearly indicates the *growing involvement of formal care services* in care-giving.

With respect to the *levels of dependency*, Figure 4 reveals that the share of dependent people who fall under level I is growing, whereas the share in both level II and level III has declined. Since the share of the very old (those aged 75 and over) among the beneficiaries has not decreased

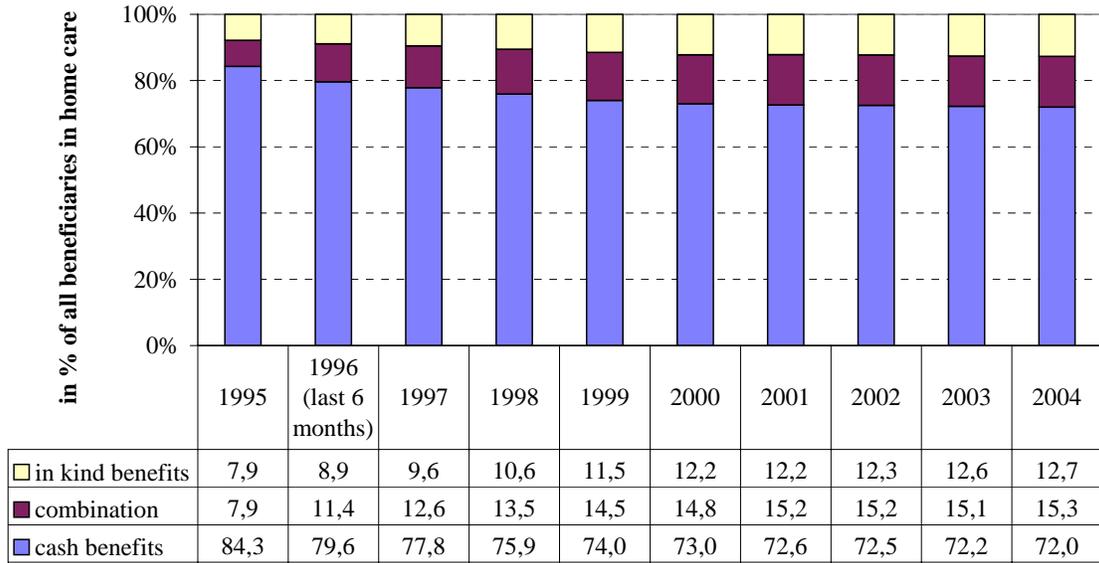
**Figure 1: Number of public LTCI beneficiaries**



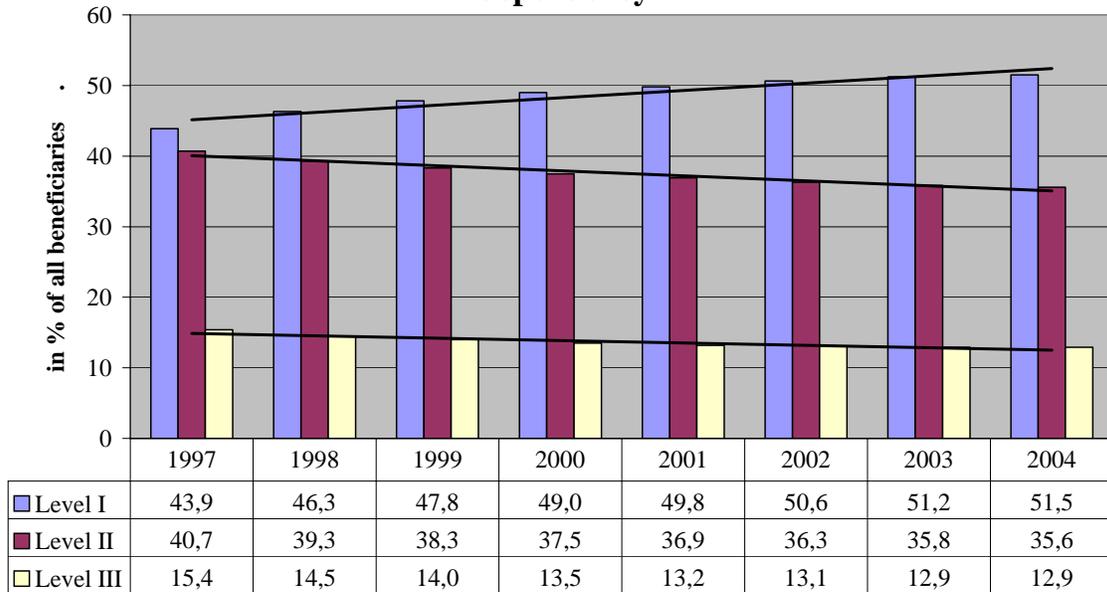
**Figure 2: Share of Dependent Persons in Home Care and Nursing Home Care**



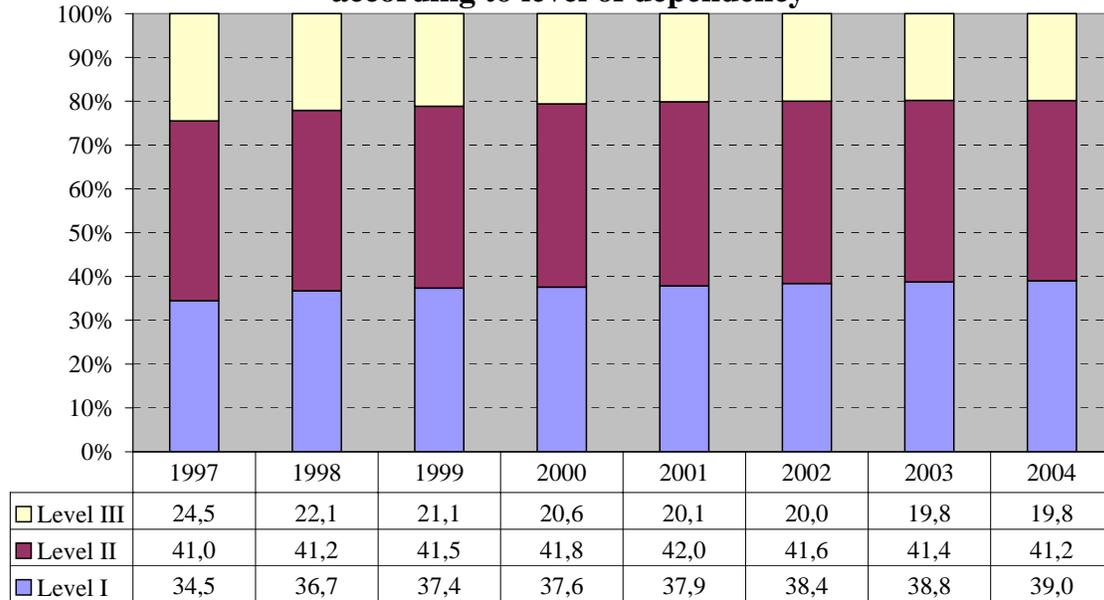
**Figure 3: Beneficiaries in Home Care**



**Figure 4: LTCI beneficiaries according to level of dependency**



**Figure 5: LTCI beneficiaries in nursing home care according to level of dependency**



but rather has slightly increased, this could be the effect of tighter assessments by the MDK.

Even more puzzling is the growing share of level I dependent people among beneficiaries in nursing home care (Figure 5). The LTCI Act states a preference for home care over nursing home care. Correspondingly, benefits for nursing home care must only be granted if home care is “impossible,” which was thought to be the case for dependent people in level III and partly in level II but only rarely in level I. Thus, it was expected that there would only be a small and decreasing share of moderately dependent people in nursing homes.

As Figure 5 shows, however, the share of dependent people in level I has been increasing constantly, from 34.5 percent in 1997 to 39.0 percent in 2004. This can partly be explained by the benefit structure. For those in level I, benefits for nursing home care are much higher than for home care (Table 2), while co-payments on the other hand are smaller than for those in levels II or III (Table 3). Thus, there are incentives for beneficiaries to choose nursing home care, particularly for those in level I who may not always need that degree of care.

Table 4 gives an overview of the *relation of*

*family carers to the dependent people they care for*. Not surprisingly, about three-quarters of all main carers are female. However, over the last decade, this share has decreased by 10 percentage points. As the table shows, care by spouses or partners has decreased over the last decade from 37 percent in 1991 to 28 percent in 2002, while the share of other groups among main carers on the other hand is fairly stable. Today, 42 percent of carers are the children or daughters-in law of the dependent elder, which highlights the importance of inter-generational care and also the vulnerability of the care system to the fact that the ratio of children to the dependent elderly is declining.

With respect to formal care, the LTCI Act triggered an *expansion of capacity*. In both nursing home care and home care, the number of providers doubled between 1992 and 1997. However, the official figures should not be over-interpreted. As residential homes for the elderly were re-founded as nursing homes and as former informal help systems (such as those organized by churches) transformed themselves into formal care providers, there are no valid time-series data showing the exact expansion of capacity before and after the LTCI Act. Table 5, therefore, concentrates on the development from 1999 onwards for which reliable data exist.

**Table 4: Main Carer of Dependent People in Private Households**

Share in %	1991	1998	2002
<b>Sex</b>			
Male	17	20	27
Female	83	80	73
<b>Relation of Carer to Dependent Person</b>			
Husband or (Male) Partner	24	20	28
Wife or (Female) Partner	13	12	
Mother	14	11	12
Father	0	2	2
Daughter	26	23	26
Son	3	5	10
Daughter-in-law	9	10	6
Son-in-law	1	0	
Other Relative	6	10	9
Neighbor / Friends	4	7	8
<b>Residence of Main Carer</b>			
Co-resident	78	73	62
Separate Household	22	27	38

Sources: Schneekloth and Potthoff, 1993, 126; Schneekloth and Müller, 2000, 52; and Schneekloth and Leven, 2003: 19.

**Table 5: The Capacity of the Formal Care Sector**

	Home Care			Nursing Home Care	
	Number of Providers	Employees	Full-time Employees	Number of Providers	Number of Beds
1999	10,820	183,782	56,914	8,859	645,456
2001	10,594	189,567	57,524	9,165	674,292
2003	10,619	200,897	57,510	9,743	713,195
1999-2001	-2.1	3.1	1.1	3.5	4.5
2001-2003	0.2	6.0	0.0	6.3	5.8
1999-2003	-1.9	9.3	1.0	10.0	10.5

Source: Federal Bureau of Statistics

**Table 6: Projections of the Number of Dependent People**

Assumption about Age-specific Dependency Rates	Growth in Number of Dependent People until 2040	Source
Constant	50-75%	Hof, 2001
Constant	60%	Dietz, 2002
Constant	60%	Rothgang, 2002b
Constant	80%	Ruerup –Commission, 2003
Declining	45%	Rothgang, 2002b

While the number of providers and the overall capacity of nursing home care (measured by the number of beds) are still growing, the picture is more complex for home care. The number of providers decreased slightly between 1999 and 2003, while the number of employees grew. Obviously, this must reflect a process of concentration and also changes in staff structure leading to a growth in the number of part-time employees. Overall, from 1999, (in other words, well after the end of the initial boom to 2003), capacity in home care stopped growing.

#### Future Developments

In the future, the *number of dependent people* can be expected to grow and care arrangements can be expected to change. According to OECD figures, the number of people aged 65 or older and 80 or older will grow by 80 percent and 130 percent respectively by 2040. Since these are the age groups with the highest dependency rates, the number of dependent people will also increase. Projections based on constant age-specific and sex-specific dependency rates show growth rates of between 50 and 80 percent. Assuming a decline in age-specific dependency rates (as assumed, for example, by Jacobzone et al, 1998) results in much lower but still considerable growth rates (Table 6).

As demonstrated above, over the last decade formal care has partly begun to substitute for family care. A further *shift to formal care* can be expected to occur in the future due to at least four factors. First, for demographic reasons alone, the number of potential caregivers will be declining. The share of widowed dependent elderly will decline as the war generation is gradually replaced by post-war generations so there will be fewer dependent elderly who need to be cared for. However, the ratio of children per dependent person is also declining. Second, female labor market participation is likely to increase, which will increase the opportunity costs of care-giving for women. This is reinforced by the fact that future female cohorts will be better educated and may earn higher wages than their mothers and grandmothers. Third, the share of single households among the elderly is expected to grow (Alders and Manting, 2003; Hullen, 2003; and Mai, 2003). Finally, as surveys reveal, the moral obligation to care for dependent parents is gradually

vanishing. This has been partly reinforced by the introduction of the LTCI, which regards long-term care as the responsibility of society as a whole, thus making clear that it is no longer a purely family obligation.

Projections therefore assume a shift towards formal care, which, however, could either lead to more nursing home care or to a strengthening of formal home care.

#### **Fiscal Developments**

While the last section dealt with the provision of care, this section treats the other side of the coin, that of financing. After giving an account of the past and present situations, we present the results of some projections, thus laying ground for the discussion of reform debates and proposals in the following section.

#### The Current Situation

While beneficiaries tend to choose cash benefits, public LTCI funds spend more on nursing home care because this type of care has higher per capita benefits. Over time, the proportion of LTCI spent on nursing home care is even increasing (Figure 6). This demonstrates once again the past and potential future fiscal effects of a shift in long-term care towards nursing home care.

What is most important for the sustainability of the long-term care insurance system, however, is the *balance sheet*. As Figure 7 demonstrates, this balance has been deteriorating constantly from high surpluses in the mid-1990s to considerable deficits in recent years. Current deficits can be met by money in the reserve fund, which was accumulated in the first three months of public LTCI, when only contributions were paid but no benefits were granted and which was further filled by the considerable surpluses of 1996 and 1997.<sup>47</sup> The deficits of 2003 and 2004 however, started to drain this reserve fund, which will only last until 2007/08 according to government projections.

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<sup>47</sup> In 1995, a loan of 560 million € was given to the central government, which paid it back without interest in 2002.

Figure 6: Structure of expenditure on benefits

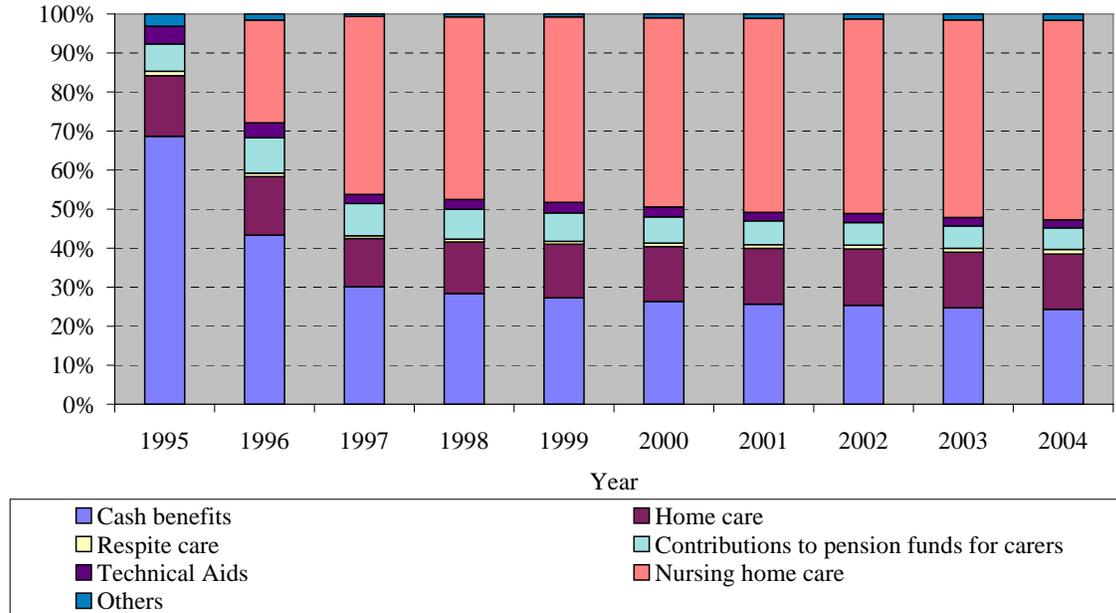


Figure 7: Balance sheet of public LTCI

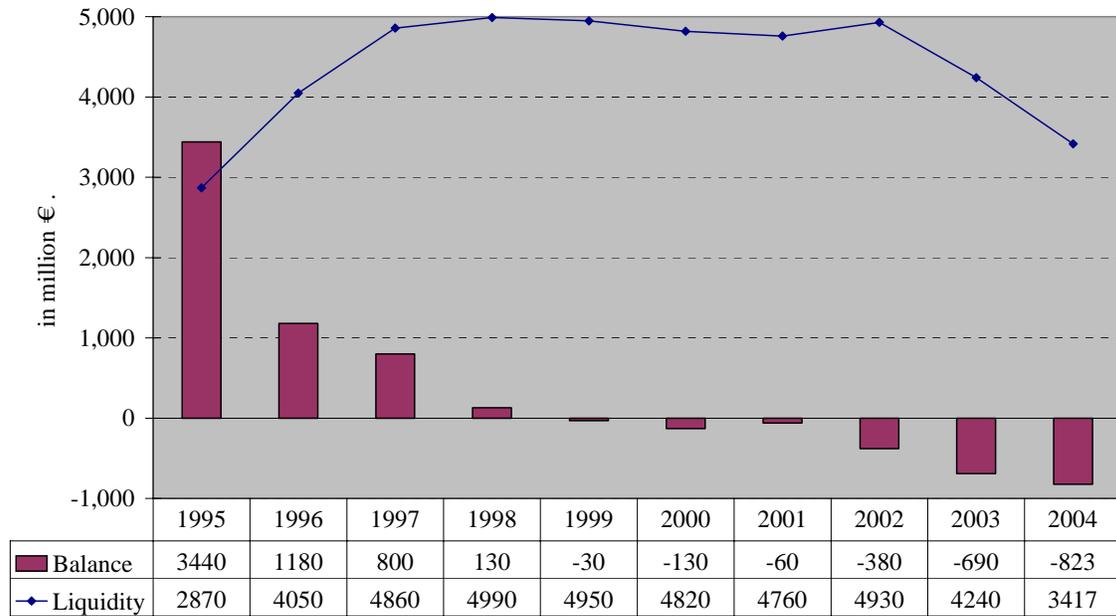
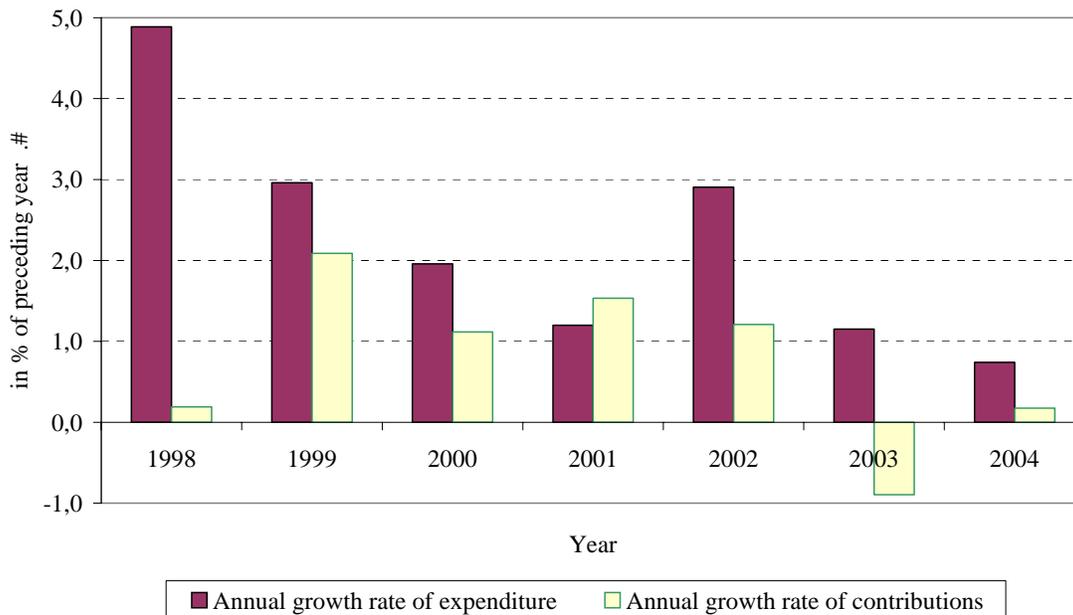


Figure 8: Growth Rates of Contributions and Expenditure



In order to explain this development, it is necessary to look at annual growth rates for contributions and expenditure, which are given in Figure 8. In every year except 2001, the expenditure growth rate was higher than the contribution growth rate. Not that the growth rates for *expenditures* were extraordinarily high. Since 2000, the growth rate has exceeded 2 percent only once, and from 1997 to 2003, the geometric mean was a mere 2.2 percent.

The actual deficit has instead been caused by disappointing growth rates for (nominal) *contributions*. From 1997 to 2003, the average annual growth rate of nominal contributions was 0.8 percent (geometric mean). In 2003, contributions actually declined and in 2004, they remain practically unchanged. Thus, growth rates of contributions have been much lower than had been projected by government agencies and researchers alike.

Both of these developments – the moderate growth rates for expenditure and the disappointing growth rates for contributions – need to be explained. The *moderate growth of expenditures* has been due to two major factors. First, the insurance system is based on a tight definition of dependency (see Rothgang and

Comas-Herrera, 2003), and entitlement for LTCI benefits is based on a rigorous assessment by the Medical Service of funds to preventing any *ex ante* moral hazard, which might have been expected if service providers were to make these assessments. A recent revision of the assessment guidelines that aimed to reduce regional variations in assessment results actually reduced the number of claims that were approved. Second, all benefits are capped and have not been adjusted since 1995, not even for inflation. So, while the assessments have prevented any explosion of the number of beneficiaries, the benefit caps have controlled expenditure per beneficiary. Of course there is a price to be paid for cost containment of this kind. First, the tight definition of dependency has meant that people with dementia are entitled to LTCI benefits only insofar as they need help with the activities of daily living as the assessment does not evaluate or take into account the general need for supervision. Second, due to the benefit caps, there is still a large amount of out-of-pocket payments, which is unusual for the traditional German social insurance system, and still considerable amounts of social assistance being claimed, which should have been reduced by the introduction of the LTCI. Moreover, the fact that the benefits have never been adjusted in a

decade has caused the purchasing power of LTCI benefits to decline, which will eventually lead to a de-legitimization of this branch of social insurance. This is why it is simply not feasible to continue to control costs by capping benefits but never adjusting their value.

The *slow growth of contributions* is partly an effect of certain social policies. Certain changes in social law have reduced contributions either explicitly or implicitly. For example, in 2000 the federal government reduced contributions for the unemployed, which have to be financed by the unemployment insurance, because, at that time, it was beset with fiscal problems. Similarly, the introduction of so-called mini-jobs and midi-jobs, that is jobs earnings up to 400 € and 800 € a month respectively, reduced the amount of contributory income to the LTCI funds as these workers are exempt from making regular contributions. This effect is likely to become yet more noticeable as normal jobs are increasingly transformed into mini-jobs. Something similar is happening to the old-age security system. Since the public pension system is disintegrating, the government has introduced new opportunities for sacrificed compensation to give private providers an incentive to enter the market, which also has reduced the amount of contributory income. A general feature of social policy over the last

decades has been that the problems in one branch of the insurance system have often been resolved at the expense of others. As for the existing reserve fund, the LTCI has been used as a melting cow for other branches of social security. In addition, LTCI contributions have suffered from the general trends that have affected all branches of social security, namely the reduction in the number of jobs that are subject to social insurance contributions, cyclical and structural unemployment, and low (if any) rises in wages and pensions.

Thus, it is an irony of history that LTCI financing is in trouble despite successful cost-containment because of inadequate contributions partly caused by social policy regulations aimed at solving problems in other branches of social security. Even if contributions were to rise faster in the future, that would not be sufficient to balance the LTCI budget because the ongoing decline in the purchasing power of LTCI benefits will eventually undermine the legitimacy of the insurance system.

As mentioned before, the capped benefits are insufficient to cover even the assessed needs of the current number of dependent people in Germany. Consequently, both *private financing and social assistance* still play an important role in financing long-term care (Table 6).

**Table 6: Sources of Funding for Long-term Care**

Source of Funding	In million Euro	As % of Public / Private Spending	As % of All Spending
Public Funding	24,230	100	75
Public LTCI*	17,360	79	60
Private Mandatory LTCI*	0,520	2	2
Social Assistance	2,900	13	10
Investment Financing*	1,070	5	4
Public Accident Insurance	0,080	0	0
Out-of-pocket Private Funding** on:	7,220	100	25
Nursing Home Care	5,050	70	17
Home Care	2,170	30	7
<b>Total</b>	<b>29,160</b>		<b>100</b>

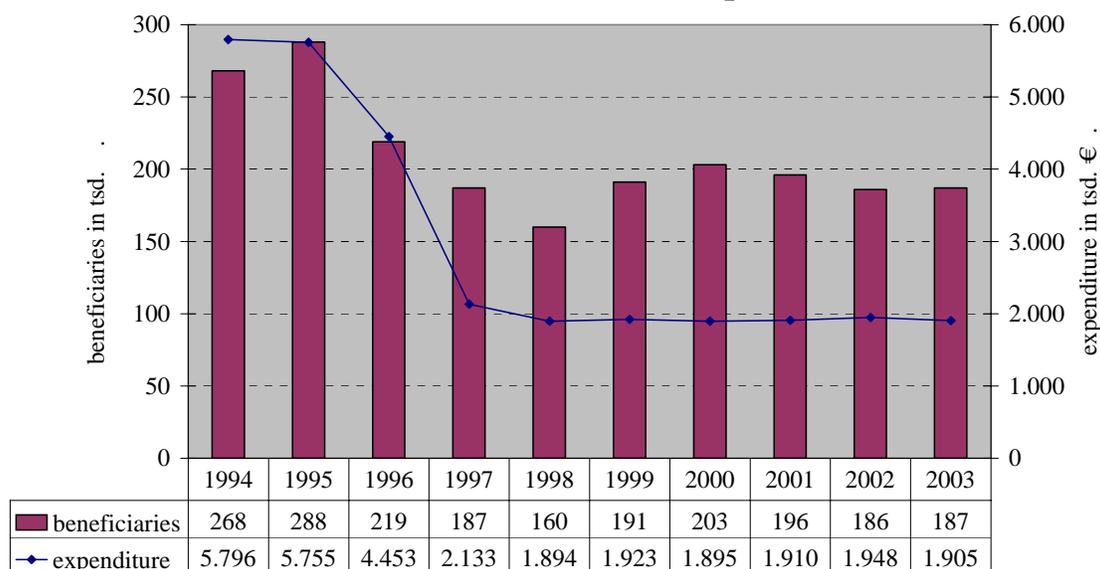
Notes: \* Cash allowances are included \*\* Estimated.

According to the figures in Table 6, about one-quarter of all funding is out-of pocket, and another 10 percent comes from means-tested assistance. About 80 percent of public funding and 60 percent of all funding comes from LTCI,

which means that this system is still very important in the financing of long-term care.

*Social assistance* expenditure on nursing home care nowadays is less than one-third of what it

**Figure 9: Social assistance for nursing home care:  
Number of beneficiaries and expenditure**



was in 1995. The number of beneficiaries has also dropped considerably but still is about two-thirds of the 1995 figure (Figure 9). The introduction of LTCI has not been as successful in terms of the number of beneficiaries as it has been in terms of reducing the fiscal burden on municipalities.

### Future Developments

Projections can be made concerning the expenditure of public LTCI funds and the contribution rate. Due to demographic changes, both the number of beneficiaries and the funds' expenditure levels can be expected to increase by about 1.2 to 1.5 percent per year. Due to changes in care arrangements, an additional rise

in expenditure of up to 0.5 percent per year can also be expected. If we assume that benefits are likely to be increased by about 2 percent per year, this adds up to a 4 percent growth rate per year in expenditure, which simply cannot be financed if the contribution rate stays the same.

Table 7 contains the results of some projections on the contribution rate that all assume rising real wages but differ with respect to what drives the adjustment. As long as benefits are adjusted only for inflation, the current contribution rate will suffice albeit with deteriorating purchasing power. However, as soon as we assume that an adjustment will be made (partly) according to wages, the contribution rates are projected to rise.

**Table 7: Projected Contribution Rate in 2040**

Projections	Adjustment according to	Source
1.6 – 2.1	Inflation	Rothgang, 2002a
3.6 – 3.9	Average wages and salaries	Rothgang, 2002a
3.0	(Average wages + inflation) / 2	Ruerup –Commission, 2003

### Reforming Market Regulation and the Benefits Structure

Part of the reform debate relates to market

regulation and to the benefit structure. While some debates have already led to changes in the institutional structure, most center on future reforms.

### Market Regulation

With respect to market regulation, two issues have dominated the debate – the relationship between competition and planning on the one hand and the mechanisms by which remuneration for nursing homes is determined on the other.

*Competition and Planning.* While *competition* between health insurance funds was introduced in the early 1990s, there is no competition among LTCI funds. All funds offer identical benefits and require an identical contribution rate and have identical contracts with providers. Moreover, an equalization scheme guarantees that all expenses are covered by all contributions. Hence, in effect, all funds are just branches of one LTCI. Competition is among (contracted) providers for contracts with dependent people and their families, who choose not only among different providers of services but also between two different care arrangements, in other words, between buying formal care or relying on the help of family or friends. The choice between cash benefits and in-kind benefits enhances this make-or-buy decision for each household. As the increased use of formal services implies a reduction in the receipt of cash benefits, there is an implicit co-payment for all service use that prevents over-use and produces some price elasticity of demand.

The intensity of competition in these circumstances heavily depends on how much access providers have to the market. The LTCI Act tried to intensify competition by stripping public and private non-profit providers of all of the privileges that they had traditionally had. Moreover, the LTCI Act entitles every provider that fulfils certain formal criteria to a contract with the LTCI funds – irrespective of need. Since benefits are capped and providers do not assess beneficiaries' entitlement to benefits, the federal government did not regard oversupply as a problem for the system.

At the provincial level, however, this was seen differently. Laender governments restricted their subsidies to those nursing homes that they regarded as "necessary." Without public subsidies, the daily rates were higher, putting the nursing homes that did not receive subsidies at a

disadvantage. Even worse, social assistance was denied if dependent person were to go to a nursing home that did not receive public subsidies. Thus, the market was effectively closed to newcomers. However, following a ruling from the Federal Court of Social Law in 2001, regulations of this kind were abolished or are about to be abolished. Today therefore, provinces have reduced their planning activities and are allowing more competition.

*Remuneration of Nursing Home Care.* Daily rates for nursing homes are set as a result of a bargaining process between LTCI funds and social assistance agencies on the one side and the providers on the other side. Rates are differentiated according to three classes that by and large follow the three levels of care. Recently, this *system of pricing* has been challenged on three counts.

First, the legitimacy of the *bargaining system* has been questioned. Funds negotiate with providers over rates for care although they only finance benefits that fall well below those rates. Furthermore, they are also responsible for negotiating rates for accommodation and food, which they never finance and are thus not affected by the results of negotiations. This also applies to municipalities, which negotiate on behalf of residents of nursing homes who never receive any social assistance. Funding agencies thus negotiate only as advocates for their clients without being (fully) affected by the results of the negotiations. Therefore, many experts are now advocating in favor of introducing market pricing in those regions with sufficient supply of providers. As residents of nursing homes are captive consumers, it would be vital to implement regulations to protect them from abrupt rises in rates. Similar regulation already exists for rented flats. Furthermore, a maximum rate would have to be fixed for recipients of social assistance, for example, based on the average rate. For those users not eligible for social assistance, the co-payment resulting from capped benefits would act as an incentive against *ex post* moral hazard.

Second, the *unit for pricing* has been challenged. Since only three classes exist, there is a lot of heterogeneity within each class. Thus, nursing homes must charge the same rate for people needing very different amounts of care. Even if

the number of classes were to be increased to five as in Japan, the problem would still exist. A more fundamental change would be to introduce the same units as in formal home care, which is about two dozen service packages (*leistungskomplexe*) such as bathing and morning toilet. This would also help to blur the distinction between home care and nursing home care. Alternatively, classification systems such as those used by the Resource Utilization Group System could be implemented, which distinguishes among 44 classes of dependency.

Third, the *base for price negotiations* itself is being questioned. Although prospective budgeting is used, in practice the costs incurred by each nursing home in the past still influence what daily rate it can achieve in the negotiations. Therefore, nursing homes have no incentive to strive to make efficiency gains. If the remuneration on the other hand were based on the average costs incurred by nursing homes in a given region, then this would give all of those homes an incentive to increase efficiency.

Although the pricing system has been questioned, for example, in a recent report from the province of Northrhine-Westfalia (Landtag NRW, 2005), reforms are unlikely to be adopted in the near future as other questions are more pressing.

### **The Structure of Benefits**

There are two major issues currently being discussed with respect to the structure of benefits – the introduction of additional benefits for dependent people with dementia and the equalization of benefits for formal home care and those for nursing home care. The so-called Ruerup Commission (the commission for achieving financial sustainability for the social security system) made suggestions about both of these issues, which were picked up in a reform bill that was prepared in the winter of 2003/04. However, the reform proposal was shot down as a whole by the German chancellor, Gerhard Schroeder, who felt that his pension and labor market reforms had caused enough trouble for his government at that time. Therefore, he decided to postpone any LTCI reform that would require the population to make more sacrifices. So it was not the content of the reform but rather its timing that put an end to this reform

initiative.

*Benefits for People with Dementia.* By now, all political parties and all experts agree that *people with dementia* are discriminated against. Dependency is defined only with respect to ADLs without taking into account the particular needs of people with dementia. Consequently, many people with dementia do not qualify for LTCI benefits or receive benefits for moderate dependency (level I) even though they need care and supervision around the clock. From 2002 onwards, additional benefits for dependent people with dementia in home care were introduced as a first step towards solving this problem. These benefits are earmarked for day and night care, respite care, or related services. However, the maximum annual amount to be spent on those additional services was set at a mere 460€ This low ceiling may be the most important reason why in 2003 only 30,000 people applied for this specific benefit out of an estimated 400,000 people who were likely to be entitled to it (BMGS, 2004). So while the government originally expected to spend an additional 250 million € on this benefit, in 2003 it spent only 13.4 million €

The most straightforward way to resolve the problem would be to change the (legal) concept of dependency and establish a definition that is not based on ADLs and physical needs alone. As the fiscal consequences of such a bold move are difficult to calculate, this has not been seriously discussed among politicians. Politicians of all parties rather favor a more modest solution that is likely to be included into the next reform bill – granting all people who suffer from dementia an additional need of care of 30 minutes a day in their LTCI assessment. While this will put some people into a higher category of dependency, it will allow others to qualify for LTC benefits for the first time. The government estimates that this will cost an extra 500-750 million € which is the amount of money that could be spent additionally on dementia.

*Equalizing Benefits for Formal Home Care and Nursing Home Care.* Another element of the failed reform of the winter of 2003/2004 was the attempt to *equalize benefits* in formal home care and nursing home care. This proposal is also likely to be implemented one way or the other in

the reform that will inevitably be decided upon after the general election this autumn (2005). The starting point of the proposal is a reversal of a perverse incentive in the current benefit structure. In levels II and III, benefits for nursing homes are much higher than benefits for formal home care, thus creating an incentive in favor of nursing home care, particularly in level I where – generally speaking – nursing home care is least necessary. This incentive would be abolished if benefits were the same for formal home care and nursing home care. There would be another advantage of such an equalization. Today, each care arrangement must be categorized either as nursing home care or as home care. Alternative care arrangements such as small groups of dependent people living together in a flat suffer from the legal restrictions caused by this dichotomy. Equal benefits for all types of formal care would help to minimize this kind of restriction.

The fiscal effects of this equalization, however, would depend on how the benefits were equalized. If this were achieved simply by cutting benefits for residential care, this can be expected to lead to a decline in LTCI expenditures but also an increase in the number of recipients of social assistance. Also, making moderate cuts in benefits for nursing home care while at the same time increasing benefits for professional home care would have unclear fiscal consequences due to the possible substitution of cash allowance by (higher) care service benefits.

### **The System of Financing**

The financing of the health sector is another major issue on the reform agenda. The current deficit of LTCI funds is the starting point for most reform debates, which therefore tend to revolve around fiscal issues. Allowing benefits to be adjusted is one issue that is rarely missed out of any proposal. In order to fund such adjustments, two different kinds of proposal have been made – radical reforms and reforms within the current system. We consider each of these in turn in this section and then discuss whether any of these proposals are likely to be implemented and whether they would solve the problems at hand.

### Adjustment of Benefits

There is a general consensus that LTCI benefits must be adjusted if the system is to survive. This could be done more or less regularly at the discretion of politicians or by the introduction of an adjustment mechanism, which would guarantee an automatic adjustment according to some pre-agreed formula. Given what is known about other branches of social security, only an adjustment mechanism will yield a regular adjustment. Since future economic development is always hard to project, adopting any system with a fixed adjustment rate of X percent per year is doomed to fail as the rate is likely to be considered either too high or too low depending on the prevailing economic situation. Therefore, any formula should relate to such macroeconomic indicators as inflation or the rise in average (nominal and gross) wages. Assuming that wage increases in the care sector are similar to those in the rest of the economy and assuming further that in the long run wages are the major determinate of the price of labor-intensive care services, adjusting benefits according to the rise in average wages seems to be the perfect indicator if their purchasing power is to be maintained.

### Radical Reform

The two main radical reforms that have been suggested as a way to finance LTCI are to integrate LTCI and health insurance or to abolish LTCI in favor of either a tax-funded system or a (mandatory) funded private insurance scheme.

*Integrating LTCI and Health Insurance.* The suggestion to abolish the separate LTCI and integrate long-term care into health insurance is as old as the insurance system itself. Recently it has been discussed (favorably) by the Enquete Commission (2002) and (less favorably) by the Ruerup Commission (2003). Advocates emphasize the fact that elderly people suffering from several different conditions would be better able to receive integrated care under this arrangement. Today, LTCI funds have no incentive to pay for rehabilitative measures that could reduce dependency because the expenses of long-term care are financed by all of the funds together. On the other hand, integrating LTCI and health insurance has dangers and disadvantages as well. Given the relative weight

of both areas, most likely long-term care issues would be dominated by health issues. Even today, the long-term care divisions within the LTCI funds are rather weak and after any integration, this domination would be likely to increase. The same applies on the service side. As highlighted by Ikegami and Campbell (2002: 721f.), in an integrated system, medical doctors tend to predominate over nurses, with the result that terminal care is over-medicalized and rehabilitation is under-medicalized.

The introduction of competition among LTCI funds would be a more moderate solution to the lack of incentives for funds to care for dependent people. As a consequence, the contribution rate could no longer be legally fixed, and each fund would be able to set its own rate. As is well known from the experience of the health insurance system, introducing competition also requires the introduction of a risk-equalization scheme.

However, neither option is likely to be implemented in the next reform, because such schemes are inevitably complicated and as such tend not to be vote-winners. Moreover, the administration seems to be overloaded with complicated reforms in the health care area already.

*Replacing LTCI with a Tax-financed System.* During the discussions leading up to the LTCI Act, policymakers also discussed a means-tested tax-financed system but ultimately dismissed this alternative. Recently, one member of the Ruerup Commission started the discussion again, but the proposal was dismissed within the Commission. As all major parties favor an insurance system, the replacement of LTCI by a tax-financed system seems extremely unlikely.

*Switching to a Funded (Private) System.* Switching to a funded private system has mainly been suggested by those economists who generally favor funded systems. Basically, they have suggested two variants of this idea. First, the Kronberger Kreis (Donges et al, 2005), a group of conservative economists, has suggested completely switching the whole population at once. Alternatively, the Council of Economic Advisers (2005) advocates a cohort model in which only those born after 1950 switch to a private funded system while older people remain in the traditional social insurance system. As the

older generation cannot bear the financial burden of their own insurance by themselves, they have to be subsidized by the younger generations. Any kind of switch towards a funded system would transfer the future burden into the present and would necessitate enormous increases in contributions since benefits for the elderly would have to be financed at the same time as capital stock would have to be build up (a double burden). Moreover, this move would not solve the system's current fiscal problems but in fact would increase its actual problems. Therefore, only the small Liberal Party advocates such a policy, which means that a switch of this kind seems very unlikely in the near future.

*Introducing a Mandatory Supplementary Funded System.* To avoid the double burden, some have advocated a hybrid system that combines public LTCI with a mandatory supplementary funded system. Basically, the existing LTCI would remain untouched – with nominally fixed benefits, which could be financed at the present contribution rate. To compensate for the declining purchasing power of these benefits, each person would be obliged to buy private supplementary insurance. The benefits of this insurance would be set at whatever level would be necessary to fill the gap caused by missing adjustment in public LTCI.<sup>48</sup> The monthly premium would be 8.5 € per person. It would neither income- nor risk-related. Each year the premium would rise by 1 €

This model would avoid dramatic rises in premiums and has no legal pitfalls as everyone

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<sup>48</sup> The proposal assumes a proper adjustment of LTCI benefits of 2 percent per annum, and the mandatory supplementary insurance to fill the gap between this proper benefit and the nominally fixed LTCI benefits. Benefits for the supplementary system can therefore be calculated as:

$$B_{sup} = (1,02^t - 1) * B_{pub},$$

with  $B_{sup}$  denoting the benefits of the supplementary system,  $B_{pub}$  the (nominally fixed) benefits of the public system, and  $t$  the number of years after the introduction of the supplementary system.

After 35 years, the benefits for the supplementary insurance would be as high as those of the public LTC.

remains in the existing system. In the long run, however, it would put a considerable burden on households, particularly on low-income households, which would suffer from the abolition of income-related premiums. Furthermore, administrative costs would be fairly high as another system would have to be built up for comparatively very low benefits and premiums. Finally, the co-operation of both insurance systems would have to be secured, which might prove difficult, because supplementary insurance benefits would be low immediately after the introduction of this scheme but would grow continuously until they were higher than the benefits from public insurance.

Despite these problems and disadvantages, this model is highly favored by the Christian Democratic party, which is most likely to form the incoming government.

#### Reform within the System

Other than these radical reforms, there are several options for making reforms within the system, that is reforms that neither abolish public LTCI nor supplement it with an additional system, but rather concentrate on changing the parameters of the existing financing system.

*Tax-financed Subsidies or Contributions to the Insurance System.* Both pension insurance and health insurance receive tax-financed subsidies or contributions that are fed into the system. Obviously, this raises the question of whether something similar is possible for LTCI. However, making tax-financed subsidies to insurance systems needs to be justified. Particularly in pension insurance, the justification centers around the idea that the insurance scheme also provided benefits that are out of its control and rather are governed by, for example, the area of family policy. With respect to LTCI, it could be argued that insuring children without contributions is one kind of family policy that should be tax-financed. Accordingly, tax-financed subsidies to LTCI or tax-financed contributions for children could be justified. Since children produce about 5 percent of all public LTCI expenditures, it might be reasonable to expect the public purse to contribute the same amount. Of course, this could only be one small part of any fiscal reform.

*Additional Contributions for Pensioners.* Current pensioners gained windfall profits when LTCI was introduced as a pay-as-you-go system. This fact can be used as a rationale for introducing an additional contribution for pensioners as has been suggested by the Ruerup Commission. Such an additional contribution would in effect counteract this initial “present” from the elderly. As windfall profits get smaller as the younger cohorts also get smaller, the justification for a pure additional contribution will vanish over time. To compensate for this, the introduction of an additional contribution for pensioners could be combined with a new compulsory requirement on younger generations to contribute to a private funded pillar of the old-age security system. This would enable them to pay the additional contribution once they become pensioners themselves. In effect, an extra element of funding would be introduced without the need to introduce a supplementary LTCI.

As normative justification is possible and the potential fiscal effects are substantial, this could be an important element in any financing reform. Unfortunately, pensioners have recently been subjected to cuts in their pensions. Therefore, any additional LTCI contributions from pensioners must be discussed against the background of social policy in general and old-age security policies in particular.

*Raising the Contribution Rate.* The easiest way to raise additional funds, however, is simply to raise the contribution rate. This can be done without much administrative effort and will yield additional revenue at once. Even when the system was first introduced, policymakers anticipated that they would increase the contribution rate. A moderate rise could not harm the country’s economic performance and would hardly affect the labor market, particularly if it were combined with a freeze on the employers’ contribution.

If any rise is moderate, any fiscal effects would be limited as well. Nevertheless, a moderate rise in the contribution rate could be introduced as part of a sensible package deal. For ideological reasons, however, this is unlikely to happen. As all major parties agree that social security contribution rates must be reduced, the current rate of 1.7 has become a kind of a dogma.

*Buergerversicherung.* The Social Democratic Party (at least its left wing) and the Green Party both favor transforming the existing long-term care (and health) insurance into a citizens' insurance (*buergerversicherung*). As the current government is expected to lose the next general election in the autumn (of 2005), this concept as a whole has little chance of being implemented. Since it is the counterpart of right-wing concepts of a funded system or insurance based on flat premiums, it is worth exploring.

The concept is based on two elements. First, all citizens should be part of one insurance system. When implemented, this principle would mark the end of a separate mandatory private LTCI. Second, contributions should be based on all sources of income, not just on income from gainful employment (and derived benefits as benefits for the unemployed and pensions). Both elements combined would increase horizontal justice as all types of income would become contributory, and it would also increase vertical justice as high-income groups would participate in redistribution without being able to opt out. The combined insurance would also attract additional revenue equivalent to an increase in the contribution rate of up to 0.2 to 0.5 percentage points. There are, however, administrative and legal problems connected with both elements and only the former element is favored by the Council for Economic Advisers and other more conservative groups. Thus, there is a chance that the whole population would be forced to enter the public system if this were combined with a radical reform of public LTCI.

### Discussion

Due to demographic changes, the number of dependent elderly will continue to increase over the next decades. Although it might be possible to influence the speed of this increase by prevention and rehabilitation and although the fiscal effects of reduced dependency rates are considerable, there are no policies for long-term care on the political agenda.

Generally speaking there are three remaining options to deal with demographic changes. First, the eligibility criteria could be tightened in order to moderate the expected increase in the number of beneficiaries. Second, individual benefits and/or remuneration for providers could

be cut. Third, sources for additional revenue might be discovered and exploited.

In Germany even today, *eligibility criteria* are tighter than in Japan (Campbell, 2002) or in other countries (Rothgang and Comas Herreras, 2003). Moreover, the number of beneficiaries is growing at a moderate pace, and on average the assessed level of care is declining. A recent report concludes that the declining level of assessed need is due to tighter eligibility assessments as there is no evidence that the real level of need is decreasing (Landtag NRW 2005: 457, own translation). Therefore, there is little room to make even tougher assessments in the future.

*Cutting benefits* has been the predominant policy of the last decade. Since benefits are nominally fixed, this policy could be executed smoothly simply by not allowing the benefit caps to be adjusted. Although there has hardly been any protest against this practice in the past, it seems impossible to continue this policy forever. Too many commissions and reports have brought up this issue, and by now the deteriorating real purchasing power of LTCI benefits is being discussed in the media. *Cuts in remuneration* would not reduce LTCI expenditure as this cannot be done as long as benefits are fixed. Reduced remuneration would increase the purchasing power of benefits and thus ease the pressure to allow them to be adjusted. On the other hand, cuts in remuneration could make formal care benefits more attractive to beneficiaries and thus reduce the extent to which they choose (cheaper) cash allowances. So this would in fact increase LTCI expenditure.

In a nutshell, cuts are no way to deal with fiscal problems as this strategy has been used exhaustively during the last decade. In recognition of this, recent debates about reform have concentrated on the final option – identifying *new sources of revenue*.

*Radical reforms* are unlikely to be adopted as the political costs would be enormous, and the system is too small (and unimportant) to make it worthwhile to start a public relations campaign on this. This is why *solutions within the system* are more likely or rather solutions that combine new elements with the existing system.

The obvious way to deal with the fiscal crises, in

other words, to increase the contribution rate, cannot be done for ideological reasons. The *buergerversicherung* idea is associated with the present government, which has very little chance of being re-elected. Thus, a *supplementary privately funded system* seems to be the most feasible option as it is ideologically sound (funded private insurance) without causing too much opposition as the initial additional financial burden would be too small to engender much conflict.

### **Lessons from Germany**

In order to learn any general lessons from Germany, it is necessary to reassess the successes of the German LTCI on the one hand and its failures and problems on the other hand.

#### Successes and Failures

At least five *major successes* have to be mentioned. First, due to the introduction of a public LTCI that followed the pay-as-you go principle, immediate benefits were available to those who were eligible. Second, family care was strengthened, particularly through the introduction of cash benefits and contributions to pension insurance for family carers. Third, the fiscal burden on municipalities was lifted as social assistance spending for dependent people declined by two-thirds. The number of recipients of social assistance was reduced by one-third, which is less than was promised but is still a success. Fourth, the LTCI Act triggered an expansion of capacity in the formal sector and improvements in the quality of care. Finally, attempts to control costs were quite successful.

On the other hand, the system suffers from several *failures and problems*. First, there are the structural problems of service provision. The quality of care is still not satisfactory, alternative care facilities (such as assisted living) are developing only very slowly, there is too little rehabilitation for dependent elderly, there are still breaks in the chain of care between institutions (hospitals, nursing homes, and rehabilitation facilities), and there is no trajectory management and no case

management. Second, there are those problems that could easily be solved if more funding was available. For example, the narrow concept of dependency leads to the neglect of communication needs in general and the particular needs of people with dementia. Tight budgets cause understaffing in nursing homes, and the nominally fixed benefits of the LTCI have caused their purchasing power to decline. Finally, the collapse of revenue in particular has caused the public LTCI to incur increasing deficits, which are at the heart of all current reform debates.

#### Generalizations

Based on this account at least three lessons can be learnt from the German experience. First, cash allowances can help to stabilize family care and thus expenditure on long-term care. More than half of all dependent people are cared for without the involvement of any professional carer. Although the data clearly reveal a trend towards formal care, there can hardly be any doubt that cash allowances moderated this trend. Moreover, future care arrangements will inevitably be a combination of formal *and* informal care. The opportunity to combine cash and in-kind benefits has opened the way to such arrangements.

Second, it is possible to control costs. The German system has been quite successful at this, mainly by capping benefits and by having an institution that is independent from providers assessing the eligibility of potential beneficiaries. However, this strategy of effecting real cuts through nominally fixed benefits cannot be applied forever as it causes the purchasing power of the benefits to decline, which will sooner or later de-legitimize the whole system.

Finally, even successful cost control is not sufficient to stabilize the system unless a steady growth in revenue can be guaranteed. It must be regarded as an irony of history that the German system is financially unbalanced despite its success in cost-containment simply because of the collapse of revenue.

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# Sustaining Long-term Care Insurance in Japan and Beyond

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## Introduction

Long-term care (LTC) for frail elderly people has been viewed as the last frontier for the welfare state. It used to be seen as a family responsibility that required state intervention only in exceptional dire cases. The growing number of frail old people along with a weakening of family care capacity has put pressure on governments to do more. The initial responses were piecemeal, extending existing health-care or social-welfare programs to cover more and frail older people. Inevitably there were strains.

Some countries have gone a step further and installed what could be called “comprehensive long-term care systems.” Without being too strict about definitions, comprehensive means a program that goes well beyond a safety-net. It need not cover all needed services, and perhaps people with ample financial or family resources might be excluded, but a comprehensive long-term care system would play a primary rather than subsidiary role in providing assistance to the population of frail older people (though of course not an *exclusive* role since in all nations the majority of care comes from families).

In creating comprehensive systems, nations naturally built on their institutional heritages. The first countries to move in this direction were in Scandinavia, notably Sweden. It already had extensive social welfare programs established at the municipal level. Three factors – a heightened sense of the needs of frail older people and their caregivers, a desire to employ more women, and a general sense of prosperity – led municipalities (aided by a national government subsidy) to expand long-term care programs incrementally but quite substantially.

A tax-based, direct services program is one way to do comprehensive long-term care. It requires a substantial social services infrastructure to start with, and is most likely in countries in which health care is also covered from tax revenues. In such systems, local caseworkers

determine eligibility, often on particularistic grounds, and decide on which services will be provided by whom – usually the local government itself or a monopoly contracted-out provider. The other main possibility is social insurance, which has been more attractive to countries that have also taken a social insurance approach to health care. Here, financing comes from contributions accumulated into a fund and consumers become entitled to a certain level of cash or in-kind benefits strictly on the basis of the degree of disability.

Two important examples of comprehensive LTC systems are Germany and Japan. From its start, the German program has been a pure social insurance system. Japan started off in a different direction but then adopted a mixed program that mainly operates as a social insurance type of system.<sup>49</sup>

## Origins of the Japanese and German Systems

The German and the Japanese long-term care insurance (LTCI) programs are similar enough and different enough to make for interesting comparisons. To look briefly at similarities, it is striking that the long-term care issue reached the policy agenda in both countries in the same year, and indeed by the same route.<sup>50</sup> Facing the 1990 general election in Japan, Hashimoto Ryutarou, the LDP top leader most identified with health and welfare policy, committed his governing party to a new policy for frail older people. Facing the 1990 federal elections in Germany, Norbert Blüm, the CDU top leader most identified with health and welfare policy, committed his governing party to a new expansive policy for frail older people.

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<sup>49</sup> Note that various combinations are possible. Austria pays social insurance type cash benefits financed from taxes. The Netherlands relies on social insurance financing, but most of its benefit delivery has been carried out by municipal governments in Scandinavian fashion.

<sup>50</sup> This comparison of the two systems is drawn from Campbell, 2002.

Similar factors were in the background for both countries. First, population aging was proceeding at a rapid rate, and was already quite high compared to other nations, at the same time that traditional family care was looking more and more inadequate. Second, the strains of providing institutional care for frail older people were affecting the finances of existing systems. In Germany, increased numbers of people in nursing homes, largely supported by public assistance, pressured municipal government budgets. In Japan, frail old people were more likely to go into hospitals, and their costs pressured health insurance financing.

Hashimoto and Blüm's statements put LTC on the policy agendas of their governments. In Japan, which up until then had adopted the "Scandinavian model" albeit at far lower levels, social services including nursing homes and home and community-based services (HCBS) were being delivered by municipal governments with heavy national subsidies. When the LDP announced its "Gold Plan" or "Ten-Year Strategy for Health and Welfare Services for the Elderly," it backed it up with sharply increased expenditures in the 1990 budget.

Germany had the world's longest social insurance tradition and little infrastructure for direct, tax-based provision of social services. Although the desirability of a Scandinavian approach was suggested by a few academics, it was not seriously considered (nor did the idea put forward by free-market conservatives of private long-term care insurance get far). Instead, German political party leaders, governmental ministries, and powerful interest groups (notably big business and labor) entered a long and difficult negotiation over starting a new social insurance program.

This struggle occurred just as reunification was getting underway, which required huge government subsidies to the East and future economic uncertainties. It is no wonder that opposition to a new spending program that would burden companies and employees was strong. One reason it could be overcome, and an LTCI law finally passed in 1994, was public opinion – German citizens were worried about the personal and social burdens of caring for the frail elderly. There was no other plausible solution.

Japan too was in economic travail in this period, just after the bursting of the economic "bubble" in 1989-90. Asset prices were plunging, growth was anemic, and official committees were worried about the future fiscal obligations of the welfare state. The "Gold Plan" was really little more than an election promise, and after the big old-age services budget for 1990 (announced just before a general election), the government could well have tapered off spending growth thereafter. However, to the surprise of observers who thought Japanese truly believed in family care, public demand for the expanded services was enormous – a "New Gold Plan" with higher 10-year targets was announced in 1994.

While Germany had simply added a "fifth pillar" to its extensive system of social insurance, Japan seemed headed down the road to a full-scale Scandinavian-style welfare program (albeit just for frail older people). However, Ministry of Health and Welfare (MHW) leaders soon came to see that this course would require both higher taxes and a large and capable local bureaucracy, and decided instead to pursue something more like a German-style system. *Kaigo Hoken*, Japanese LTCI, was passed in 1997 and came into effect in 2000.

### Differences

Although Japanese experts often visited Germany and other countries in drawing up their plans, *Kaigo Hoken* should be seen as mostly homegrown rather than an imitation.<sup>51</sup> The two programs are different in at least four important ways:

- 1 Spending growth is firmly controlled in German LTCI and is not formally constrained in Japanese LTCI.
- 2 Japanese LTCI is much more generous than German LTCI, both in the number of people covered, and in benefits.
- 3 German LTCI covers all ages, while Japanese LTCI essentially is only for old people.
- 4 German LTCI provides a cash allowance to subsidize family or other informal care,

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<sup>51</sup> Note that a plan close to the final version had been developed by 1993 in Japan; German LTCI was passed in 1994 and started in 1995, so there was no program to imitate.

while Japanese LTCI only provides formal services.

It is interesting to look at why these differences appeared.<sup>52</sup>

### Fiscal Controls

German LTCI was subject to very stringent spending controls. The law specified that all expenditures had to be covered by social insurance contributions, with no subsidies from taxes. The contribution rate was also specified, meaning a new law would be required to raise it. Increases in total spending would therefore be limited to the “natural” growth in revenues of more contributors and higher wages (in the event, neither really materialized).

No mechanism was specified for holding down expenditures. Benefit levels were frozen by law. The purpose was to prevent increases, even for inflation, but that also barred decreases to cope with revenue shortfalls. Eligibility and the level of need were supposed to be based on an objective test of Activities of Daily Living (ADL), so that supposedly there would be no control over entitled benefits. However, these tests are physical and mental examinations carried out by the “Service Corps” of physicians employed by the insurance funds. The doctors presumably could be asked to tighten their standards, without any public notice, thereby restricting the number of enrollees or their level of benefits.

Japan had no such clear-cut ceiling on revenues. Contribution rates could be raised, by municipalities for the premium on people aged 65 plus, and by the national government on workers aged 40 to 64. Half of the revenue comes from taxes, and that amount would be raised automatically to match contributions. As for controlling spending, the test for eligibility and level of benefits was based on a long questionnaire graded by a computer, with the result then reviewed by a committee that was independent of any government control.

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<sup>52</sup> My account of Germany is sketchy and does not provide a comprehensive picture; my aim is to provide a contrast with the Japanese system. For details on Germany, see the paper by Heinz Rothgang.

This difference in formal constraints is an important explanation for why the Japanese program expanded at about 11 percent per year (by one calculation) and the German program at just 2 percent, as we will see presently. For now, we should ask, why this extreme difference?

The answer is not simply institutional legacy. Indeed, German social insurance programs have generally included adjustments for inflation. But their increasing costs were a key argument for fiscal conservatives who wanted to defeat the new program. In order to get it approved at all, proponents had to guarantee fiscal conservatives that spending would not explode by imposing stringent caps.

The German debate over LTCI focused mainly on money, with rather little attention to details above caregiving. The debate in Japan was the opposite. Criticism of the LTCI idea was coming mostly from people attached to the Scandinavian model who were concerned that service levels would be constrained. There was remarkably little attention to future cost estimates, and indeed very little opposition from fiscal conservatives. We can assume that the Ministry of Health and Welfare (MHW) had a preference for not having its hands tied by financial strictures, and lacking any challenge, its preference prevailed.

Still, the lack of opposition seems puzzling. After all, this was a large new program whose costs would have to be borne by employees and companies through contributions and taxes. One factor was that the MHW’s argument that LTCI was needed to reduce pressure on health insurance spending – which was a lively concern among employers and workers – seems to have been rather convincing even though specious. Another, perhaps, was that businessmen were too distracted by all the bad news of the post-bubble economy to pay much attention. I don’t find either explanation very satisfying, but for whatever reason, business opposition was far from vocal.<sup>53</sup>

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<sup>53</sup> Incidentally, the Ministry of Finance, which normally would oppose a new spending program, was actually supportive because LTCI was a good pretext for its long-cherished goal of increasing the consumption tax from 3 to 5 percent.

Size

Japanese LTCI is a much bigger program than German LTCI. First, the threshold for eligibility is much lower - Japan has six levels of benefits, as opposed to three in Germany, and the ADL criteria for the lower two would not qualify for any coverage at all in Germany. As a result, some 10 percent of the over-65 population in Germany is covered, while the figure is edging toward 15 percent in Japan.<sup>54</sup> Secondly, benefit levels are much higher in Japan. For example, someone at the lowest level of eligibility in Germany would receive about US\$375 a month in services if living at home, or US\$1,000 toward nursing home costs; a Japanese at a similar level of disability could get US\$1,300 in services at home or US\$1,680 for a nursing home.<sup>55</sup>

Why this difference? The explanation for the difference in fiscal controls – the strong role of fiscal conservatives in the German but not the Japanese debate, also applies here. Proponents in Germany had to fight hard to keep enough benefits to have any claim of dealing with the problem - in effect, they decided to cover no more than half of need. In Japan size was not a contentious issue.

Having said that, the size of Japanese LTCI is quite striking. Both the low threshold and the high benefits are considerably more generous than the levels not only in Germany but in the rest of the non-Scandinavian world as well.<sup>56</sup> That is quite surprising for a country long known as a “welfare laggard”, and demands more explanation.

In particular, there is no reason to assume that MHW officials would have a strong motive to establish the biggest and most expensive

program possible. A smaller one would be far easier to manage. However, in effect their hands were tied by a policy legacy, albeit a recent one.

That is, programs and services for frail older people had expanded very rapidly under the Gold Plan, growing at a rate of over 10 percent a year for the entire decade of the 1990s even amid continuing budget stringency. Recall that these programs were in the hands of municipalities, which since 1990 had been required to draw up plans for health and welfare services for the elderly based on need surveys. The municipalities faced rising public demand on the one hand and had increasing national subsidies on the other. A problem was that their organizations and personnel were equipped for small-scale, means-tested programs and were not up to managing an expansion to “ordinary” or middle-class clients. Determinations of eligibility, the amount and kind of services needed, and the fees to be collected were often willy-nilly, and by default not very strict.

As a result, by 1995 when LTCI was being debated, 1997 when it was enacted, and certainly 2000 when it started up, many more people were receiving services than earlier in the decade, and quite a few of them were getting services when they were not really very frail, getting more services than they really needed, and/or getting all their services free. Still more consequential, since the 1970s, great numbers of older people had been getting LTC in hospitals, covered by health insurance, where admission standards were quite lax and the out-of-pocket costs were minimal.<sup>57</sup>

Given this environment, a higher eligibility threshold would have cut off many current recipients, and anything less than full coverage of needs would have meant a substantial cut in the quantity of services for others. That was seen as politically impossible. As it was, throughout the 1990s, the LTCI proposal was drawing fire mainly from the left, attacking the impact on low-income people of the 10 percent co-pay (as well as the new premium) and the restrictions on quantity of services inherent in

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<sup>54</sup> This figure is approximate and includes people who have been judged eligible but are not yet receiving benefits, and people still getting LTC in hospitals covered by health insurance.

<sup>55</sup> Figures as of 2000 converted at purchasing power parity rates; Japan is for level two.

<sup>56</sup> This is an assertion based only on impressionistic evidence since data on benefits are scarce and comparisons across different systems are difficult. In any case, Japanese generosity is certainly “surprising”

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<sup>57</sup> Actually, many old-age hospitals charged various extra fees to be able to provide decent care, but in principle and often in reality, the charges were very low.

the eligibility process.

It is interesting to speculate what would have happened if LTCI had been proposed in 1990 rather than the Gold Plan. Since at that time the level of services was quite low, and largely restricted to people who had neither much money nor family care available, a social insurance program of the size Germany started five years later would probably have seemed very generous. But it would have taken an awful lot of planning and negotiation. At the time, with an election impending, the need was for a concrete plan backed up by immediate action, and there really was no alternative other than expanding existing programs and quickly adding on any new ideas that MHW specialists had been thinking about.<sup>58</sup>

### Scope

In one respect, German LTCI was more encompassing than Japanese LTCI. The possibility of covering only older people rather than disabled people of all ages was not entertained in Germany. Given that the financing had to be completely covered by contributions, it would be necessary for the entire workforce to contribute. If younger people were contributing, they should be covered. That is normal social insurance thinking.

Some in Japan had the same idea, but they were opposed by politicians who were concerned about imposing a new premium. Limiting the premium to people aged 65 and over was not feasible either fiscally or politically (that old people would bear any burden at all was an important first for Japanese social programs), so a compromise was reached rather amicably. Premiums would be charged from age 40. The main justification was that middle-aged people would be worried about caregiving for their parents and could see their own aging not far off, but as an added inducement, “age-related impairments” due to stroke early-onset Alzheimers and so forth would be covered.

In a broader sense, having LTCI aimed almost

exclusively at old people is not at all surprising. The “aging society crisis” had been at the top of the public agenda for years, with the problem of caring for frail older people seen as a critical factor. Caring for younger disabled people was seen as a problem only by disabled people and their representatives themselves. And to make their inclusion even less likely, several disability interest groups, for various reasons, were opposed to coverage by LTCI.

### Cash Subsidy for Family Care

In all nations, most care for frail older people is provided by family members, most often a spouse, daughter, or daughter-in-law. Many see family “informal” care as natural and as preferable to “formal” care by outsiders from the point of view of the older person, although of course the burdens on caregivers are often considerable. A logical approach for public policy is to encourage family members (or other informal providers such as neighbors) by paying a cash allowance that the frail older person can use as he or she wishes.

Germany followed this route: the eligible person can choose between institutional care, formal community-based services, a cash payment, or a combination of the latter two. For all three levels of need, the cash payment was substantially less than the payment for institutional care or formal community-based services, although there is an additional fringe benefit that LTCI will pay pension premiums for a family caregiver. The majority of clients of home and community-based services (HCBS) take the money, though the proportion of those selecting only services or a combination has been rising a little.

The reasons for this approach appear straightforward. The immediate precursor was the introduction of cash benefits in the medical insurance system, for recovery at home after hospitalization, instituted in 1988. More broadly, cash payments are seen as normal (and direct services not) in Germany’s social insurance based approach. Moreover, the basic policy problem (along with the increasing number of old people) was perceived as a decline in the capacity of the traditional family to take care of frail older people. Germans saw the cash benefit as a way to prevent or at least postpone this

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<sup>58</sup> See Campbell, 1992 (Chapter 7), for a detailed account of Gold Plan decision-making.

decline by shoring up the family's willingness to provide care. Although a few specialists criticized the cash allowance on grounds that quality of caregiving could not be assured and it really would not change existing patterns very much, there was little real debate over this provision and it was included almost as a matter of course.

In Japan, the question of whether or not to offer a cash allowance for family caregiving was discussed through the entire decade of the 1990s. The law as enacted did not include a cash allowance, although debate on this point continued in and out of the Diet right up to implementation and there was a last-minute small compromise.

On the face of it, it seems quite surprising that Japan would reject family caregiving and come down so strongly for formal services. The German example would itself seem to boost the cash allowance idea, particularly in that this approach was demonstrably cheaper on a per-case basis. Popular opinion favored support for family caregiving, at least as an option.<sup>59</sup> And in terms of history and ideology, Japan had relied more on the family for social support than had Western countries, and quite a lot of popular rhetoric ("Japanese-style welfare society" and so forth) had enshrined this custom as a principle and a virtue.

There were three reasons why Japan opted against a cash subsidy for family care. First, finances: although offering a cash allowance at lower cost than the services option would seem to save money, in the short run at least it would cost more. If cash were available everyone would apply all at once, while a desire for services would develop more slowly. To have the new program start at nearly full cost was not

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<sup>59</sup> By 58 percent to 28 percent in an August 1995 government survey and by 72 percent to 24 percent in a Mainichi survey the following month. In an NHK survey in November with more options, 7 percent said they preferred cash only, 25 percent services only, and 63 percent both. In an Asahi Newspaper survey the following February, however, 48 percent approved and 42 percent opposed substituting cash for services. (Results summarized in Kouseishou Koureisha Kaigo Taisaku Honbu Jimukyoku, 1996, pp. 520–523.

a problem for Germany because all the financing was from a new social insurance contribution which also started at the full rate. In Japan, half the money was budgeted from tax revenues, at all three levels of government, and such an abrupt surge of expenditures would be hard to handle.

The second reason was the argument that home-care based services were poorly developed in Japan; if the supply of home helpers, day care and so forth were to be available for Japanese households, enough demand to induce a critical mass of services would be needed.

The third reason has to do with ideology or even culture. The fight against a cash allowance was led by a group of women who were involved throughout the planning stages of LTCI, who took a strongly feminist position is nicely summarized in a comment at a 1995 committee meeting:<sup>60</sup>

"In some cases, by receiving cash, the pattern of family caregiving would become fixed (*koteika*), and in particular there is the danger that women will be tied down (*shibaritsukareru*) to family caregiving. A cash benefit is allowed in German LTCI, but the family situation is different in Japan and Germany."

The difference in the family situation is that traditionally older people in Japan lived in the same household as their oldest son and the son's wife was responsible for their care. In reality, in the 1990s, only about half of people over 65 lived with a child, and many of these lived with a daughter, but there certainly were enough women who were virtually trapped into burdensome caregiving roles to reinforce the image of a perpetual "caregiving hell" (*kaigo jigoku*).

It is not common for feminist views to be influential in Japanese policymaking, but this argument at least had the effect of deflating any social conservative claim that support for traditional Japanese family practices could solve the problem of caring for the frail elderly - a

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<sup>60</sup>It was the December 4 meeting of the Long-Term-Care Benefits Subcommittee of the Advisory Council on Health and Welfare of the Elderly. From *ibid.*, p. 129.

view that was quite prevalent in Germany. Together with the two less emotional reasons mentioned above, the appeal to liberate Japanese women was enough to keep the Japanese LTCI system restricted to formal services, with no subsidy for family care.

### **Reforms for Sustainability**

LTCI got underway in Germany in 1995 and in Japan in 2000. Now that they have been in operation for, respectively ten and five years, it is possible to get some sense of the problems the two systems have encountered and the solutions proposed. Actually, the German program has yet to be modified, although a review in 2002-03 by the Ruerup Commission produced some recommendations for reform that then came to be short-circuited at the political level.<sup>61</sup> The Japanese program has been changed. In its five years of operation, it went through a fiscal review in 2003 and an overall review in 2005.

Unquestionably, the most important observation to make is that both programs have been popular with the public and are now accepted as normal and important components of national social policy. The Ruerup Commission mentioned that there had been suggestions to convert to tax-based rather than social insurance financing, or to private LTCI, or to merge the program with health insurance, but it rejected them in favor of incremental reform proposals. In Japan, there have been virtually no serious proposals for radical changes.

Given the assumption that LTCI should continue in both countries without radical change, “sustainability” becomes the key concern. The programs must maintain their public support (often called “legitimacy”) on the one hand, and

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<sup>61</sup> This was the Commission for the Financial Sustainability of Social Security Systems, or Ruerup Commission, which discussed LTCI after major reform proposals for the pensions and health care system. An English translation of its report was published in PDF format by the Federal Ministry of Health and Social Security in 2003. In Japan, the only radical proposal was to broaden LTCI to include younger people (as contributors and potential beneficiaries), which did not succeed but in any case was an expansion and endorsement of the program rather than a critique.

on the other must not become so expensive that fiscal conservatives (big business, the Treasury, and parties and politicians of the right) will mobilize against it.

Usually when we say “sustainability,” we are thinking mostly about imposing constraints. In the normal course of events, cost control is difficult for LTCI. First, population aging alone - more old people and more “old-old” people - will require increased spending. As Heinz Rothgang observed, the impact of population aging might be mitigated by “compression of morbidity” (a decline in the incidence of disability in successive cohorts of older people), but surely not enough to offset increased numbers completely. Second, additional cost pressure comes from wage inflation since LTC is inevitably quite labor-intensive.

### Sustainability and Legitimacy in Germany

However, the “legitimacy” side of sustainability was emphasized by the Ruerup Commission. This was because, as emphasized earlier, cost control was such a dominant theme when LTCI was initiated - a severe cap had been imposed on total spending, which in fact was effective. As Heinz Rothgang shows, expenditures have grown only an average of 2.2 percent a year since the startup period (indeed, under 1 percent in 2004), mainly because the number of beneficiaries grew by 2.0 percent a year.

Such a slow rate of increase at a time when the number of recipients was growing meant great pressure on spending per recipient. Their benefit entitlement could not be cut in nominal terms (since fixed by law), but in effect, real benefits were reduced by inflation. For those getting a cash allowance, that meant lower purchasing power; for those in HCBS, since the fees paid to providers had to be raised a bit due to wage inflation, the hours - quantity of service - were reduced.

Heinz Rothgang further points out that among beneficiaries, the proportion of those in the heaviest care category went down and those in the lightest category went up. Clearly, this was not because individuals had improved; it is because each year’s new cohort gets lower scores. This could be “compression of morbidity” but more likely it is because the

“service corps” physicians toughened their criteria - whether due to some spoken or unspoken instruction from their employers, the insurance funds, is hard to say.

It is interesting that neither of these trends, which represent real reductions in average benefits, became known to the public or at least provoked any political protests. Presumably this was because the evidence was rather subtle if not murky and because no interest groups were watching very closely. The fact that did generate a lot of publicity was about how the program was running in the red, and many people probably jumped to the conclusion that spending was out of control. Certainly some conservative observers in the United States – people who always think entitlement spending is out of control – were happy to make that claim. In reality, of course, it was severe shortfalls on the revenue side that had caused the red-ink “crisis” such as it was (actually just an annual shortfall which could easily be covered by reserves for several years).

The Ruerup Commission, which was paying closer attention, saw the problem of restricted expenditures as most worrying for the long term, foreseeing that a system that was covering a smaller and smaller portion of the real costs of care would lose legitimacy and eventually become irrelevant. The Commission’s reform proposal therefore centered on *easing* rather than tightening the cost controls in the initial legislation. In effect, it called for older people themselves to be charged a higher premium that would allow benefits to be indexed to inflation, and it suggested other provisions to take care of a surge of beneficiaries in the future.<sup>62</sup>

#### Sustainability and Cost Control in Japan

This sort of concern about sustainability in the sense of legitimacy is probably rare. Nearly always it is cost control that is evoked, or, more specifically, controlling government spending on long-term care. This was certainly the dominant

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<sup>62</sup> The additional charge would eventually amount to about 20 Euros a month. This plan, described on pp. 15-16 of the English report, is actually much more complicated but is not worth describing at length since it was not adopted.

though not sole theme in the Japanese reforms.

It has been argued that expenditures grew much faster than expected in the first five years of LTCI. Actually, this is difficult to measure. At the time the LTCI system was enacted and even at the time it started, Welfare Ministry officials were remarkably cagy about how much the system would cost. It is possible to find forecasts but it is hard to say how authoritative they were; it is also hard to know what the right starting point should be: estimated or actual first-year expenditures.

In any case, expenditures did grow fairly rapidly. The official calculation in the third-year fiscal review raised contribution rates to cover increased expenditures by an amount that assumed growth of about 7 percent a year. Many statements by MHLW officials at the time the fifth-year review was getting under way indicated that they were concerned about expenditure growth. They proposed reforms that would demonstrate their intention to constrain spending, in order to deflect criticism. They probably hoped there would also be some real effects.

#### Limiting Eligibility

If the Ruerup Commission was trying to correct for excesses in the original design of German LTCI - fiscal rigidity - Japanese reformers took aim at what in retrospect must have looked like excessive generosity. That is, as emphasized earlier, political imperatives had led to a very low threshold of eligibility in Japan, so that something like 15 percent of the over-65 population qualified compared with about 10 percent in Germany. Moreover, lighter-care beneficiaries were entitled to quite a high level of services if they wished them.

The trend that was seen as most alarming was that the number of beneficiaries was growing rather rapidly even after the initial start-up period. Eligible recipients increased by 76 percent in the four years from the program’s start to 2004 with no tapering off as yet. The growth was quite uneven across levels: the two lowest groups, those who for the most part would not have been eligible at all in Germany, more than doubled in this four-year period, while the heavier-need groups went up by 50

percent.

Note that this trend is similar, though more extreme, than the German trend. There, the increased proportion of lower-rated clients was interpreted as demonstrating tougher criteria on the part of the service corps physicians. The fact that this occurred when the total number of recipients was not growing very quickly lends weight to this interpretation. In Japan, however, the total number was going up quickly. Moreover, the certification process in Japan really does not allow a change in criteria – the computer exam is too out-in-the-open, and the review of its recommendation by an expert committee cannot be controlled by the insurers.

The most plausible explanation for the difference from Germany is that lighter-need people (or their families) did not have as much desire for services and so were not as quick to sign up as the heavier cases. They applied when they became more acquainted with the program. This would not have occurred in Germany because, again, cash was available and of course was desired by all.

This Japanese trend can therefore be seen as a normal pattern, although some MHLW comments about it had something of a moralistic edge. But whatever the cause, it was worrisome. More and more resources were going into services for people who needed them less. In Sweden, growth in its extraordinarily generous LTC policy was constrained substantially when the economy slowed, by means of targeting services on the most needy. It is estimated that about 25 percent of the over-65 population was getting services, and that figure was reduced to just 16 percent by 2004.

In Sweden, the process of concentrating resources on the heavier cases at the expense of those who were not as needful was carried out over time via individual decisions by caseworkers who worked for municipal governments. It was very hard to see. As was true of the milder form of targeting that happened in Germany, there was little in the way of political protest.

Japanese policymakers no doubt thought wistfully about simply making the eligibility criteria tougher, or reducing benefits for the

lower-need categories, but this would have had to be done out in the open, and in effect was politically impossible. Instead, they purported to come up with a way to serve this group *better* - and only incidentally, at lower cost.

The notion they came up with was *kaigo yobou*, which translates literally as “care prevention” and has sometimes been called “preventive rehabilitation.” The logic, as set forth in a public relations barrage that got started about two years ago, is as follows.

The goal of the LTCI program, in law and in practice, is supposed to be “independence” (*jiritsu*). By providing professional services, it is supposed to liberate frail older people from their own physical limitations and from dependence on family members. However, the argument goes that, when people are not very frail, the same services can lead to a *loss* of independence. Two examples were frequently mentioned. If an older person can perform chores around the house only with difficulty, he or she qualifies for a home helper under LTCI, but if the home helper does all the work the old person will lose the ability to do chores or any other sort of physical activity. Or, giving old people who can barely walk a wheelchair could mean they would never try to walk again. They become *more* dependent.

The response to this situation, then, would be to substitute independence-creating services for dependency-creating services. Instead of getting a home helper, people would be encouraged to undergo “muscle training” at a local center (essentially an exercise program, though many detailed articles have been written to show how it should be done). Nutrition counselling and other services would also be offered. If a home helper is allowed, then he or she should assist the client to do more and more rather than doing things for him or her.

This idea was not just a policy recommendation. It was embodied in a substantial organizational reform. During the certification process itself, people who are scored in the bottom two of the six eligible categories would be evaluated to see if “care prevention” would be better for them than the regular caregiving services. The methodology for making this judgment is not yet clear (although it has been specified that it will

not apply to people with dementia), but in any case the people who are excepted will be treated as before, which is to say, they could pick whatever services and providers they want up to their limit. In most cases, they would be assisted by a “care manager,” but the client always has the right to choose (and to change) care managers if desired.<sup>63</sup>

For those identified for “prevention,” however, a brand-new system was to be set up. Instead of being able to pick their own care manager, a committee under municipal government auspices would take charge of their case and specify what services they would be offered. Most would be provided by the local government directly or under contract, in a new “neighborhood comprehensive center.”

This reform did generate some opposition from advocates for both clients and providers. Critics said that it would violate the principle of consumer choice in LTCI - clearly correct - and that many clients really do need the regular services. However, whatever the merits of these arguments, the protests were too little too late. A conference meant to mobilize resistance was held after the reform bill including this plan was just passing the Lower House and on its way to enactment. Similar questions had been raised during legislative proceedings but not to much effect.

Whether this reform is good or bad is beside the point. Indeed, one could agree with all the opponents’ arguments and still argue that Japan should have used more restrictive criteria, perhaps to come out at around 10 percent of the Japanese over-65 population like Germany, in the first place. This view depends on one’s sense of how public money should be spent and of what spending levels will be required for long-term political sustainability.

This approach, in my view, may demonstrate that substantial cost savings without blatantly cutting off beneficiaries or slashing benefit levels. How much money will be saved is hard to say until one sees what percentage of the

bottom two categories will be shunted off into this new category (well more than half, it is thought), how stringently the new rules will be imposed, how much the preventive services will cost, and – perhaps most significantly – how many recipients will say they simply are not interested in exercising or any other part of it, and simply walk away.

This reform has only just passed and it is not at all clear how quickly and in what ways it will be implemented or whether the recent opposition will have some effect in modifying the Ministry’s plans.

#### Cutting Fees

The “preventive rehabilitation” strategy for cost control via eligibility limitation is, so far as I know, unique to Japan. Its other strategies have been more commonplace but are worth a brief description.

The main institutional forerunner for LTCI in Japan was health insurance. The MHLW had been struggling to constrain medical spending for decades, and had developed an unusual but effective mechanism: selective reductions in the prescribed fees for all medical goods and services. Every two years, the government negotiates with the Japan Medical Association to revise the fee schedule, item by item. Some are raised, but most are reduced, particularly those that seem to be excessive based on surveys or simply on the evidence that usage was increasing.<sup>64</sup> It was therefore natural for Ministry officials to keep tabs on how its LTCI fee schedule was working out and to fine-tune the “relative values” of the various services. This was in the scheduled fiscal review in the third year of the program, 2003.

The biggest change was to reduce the fees for institutional care in nursing homes by an average of about 3 percent. When the original fees were set, the authorities had been mindful of the financial viability of nursing homes, which were mostly run by small-scale, not-for-profit organizations. Under the previous system, they had been paid on a set formula amounted to the

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<sup>63</sup> These and many other features of LTCI in Japan are not covered in this paper, but see Campbell and Ikegami, 2003.

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<sup>64</sup> The process is quite complicated, and is detailed in Campbell and Ikegami, 1997.

managers simply getting a check from the municipal government (including national and prefectural subsidies) every month. Under LTCI, their revenues would come with individual residents, the amount depending on their certified level of care; moreover, the residents would be picking the nursing home themselves rather than just being assigned to one by the municipality. Another new factor was the emphasis on home and community-based services, which would seem to be competition.

From a nursing home manager's point of view, this transition looked something like being pushed into an uncertain and dangerous market environment. Many responded by trying to cut their fixed costs, mainly by moving away from permanent full-time staff to rely more on temporary and part-time employees.<sup>65</sup> Their efforts succeeded to the extent that, under the new system, many nursing homes started running surpluses - because demand for nursing home beds actually increased, their new environment was not so uncertain and dangerous after all.

At least one MHLW official I interviewed regretted that nursing homes had reacted so defensively rather than taking the new system as an opportunity for innovation, but given the cost concerns that were already coming to the fore in 2003, it was natural to reduce their fees. It is noteworthy, however, that, rather than cutting across-the-board, the MHLW reduced fees for lower-need and actually gave small increases for the heavier residents. This was partly based on real costs and partly on the policy goal of incentivising the homes to favor heavier-care applicants. Fees for home helpers and some other HCB services were adjusted for similar reasons, although the average fees were not reduced.

#### Discouraging Institutionalization

A cherished assumption among specialists and policymakers in the long-term care field is that frail older people should remain at home or in the community, rather than going into an

institution. This is held to be better from the point of view of the client's preferences and quality of life and is also supposed to be cheaper for all but the heaviest cases. The main reason why this goal remains more a wish than an effective policy in countries like the United States has been the fear that HCBS cannot easily be targeted on those who otherwise would go into a nursing home, so increased spending would not be offset by savings on institutional care.

Once a nation commits to a comprehensive approach to LTC, this obsession about costs is less pressing, and there have been many successful examples in Europe of improved HCBS leading to reductions in institutionalization (though not in total spending). The question is then not whether to provide extensive HCBS, but rather, how to balance out-of-pocket costs and other incentives between home and institutional care to obtain an appropriate mix.

In Germany, one of the proposals from the Ruerup Commission was to discourage institutional care by equalizing benefits at each need level between HBCS and nursing homes. Originally, institutions received much more to reflect their actual costs. No doubt that was seen as crucial because reducing the burden of institutional care on municipal public assistance budgets was an important reason for instituting LTCI in the first place. This problem has hardly gone away - many nursing home residents still have some of their costs covered by public assistance - and the suggestion of such a radical rebalancing indicates how important the Commission viewed the goal of deinstitutionalization.

Japan was not so radical. Another of the significant reforms in the fifth-year review of LTCI was to shift the "hotel" costs in institutions into the out-of-pocket category, residents will now pay the equivalent of their room rent as well as their meal charges. The rationale was "fairness" since the room "charge" was being "paid" when families kept the older person at home (most often in the sense of forgone other uses for the room, in a cramped Japanese house, rather than a cash outlay). Concerns were raised about how low-income people would be able to

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<sup>65</sup> In Japan these terms connote employees with less pay and job security, although many stay for extended periods and essentially work full time.

bear the additional expenditure.

### Broadening the Scope

These Japanese strategies have all been aimed at cost-containment. To the extent the problem is defined in terms of the balance sheet of the program, rather than growth in expenditures, solutions may be sought on the revenue. An obvious example from the United States is the way Social Security fiscal imbalances over the years were handled by enlarging the scope of the program - it had started as employees only, but the self-employed, farmers, employees of state and local governments, and other occupational categories were successively added in order to broaden the base of contributors.

In a pension program, this is only a temporary fix, since eventually all these people would become entitled to benefits, but the situation is different in LTCI. As mentioned earlier, when Japan's LTCI program started, it had been crucial to have people aged 40 and over contributing or else it could not have been social insurance (total contributions from the 40 to 64 age group are double those of the over 65 age group and make up one-third of revenues). To justify those contributions, people aged 40 and over who had an "aging-type" disability could get benefits, but they made up only a small portion of beneficiaries (4 percent) and expenditures.

One of the Japanese government's top priorities in the fifth-year review was to expand the program's coverage down to age 20 for both benefits and contribution, as had been the case in Germany from the start. The main goal was clearly to improve the balance sheet, since even though all disabilities rather than the narrow

"aging-type" would be included, revenues would greatly exceed expenditures for the younger age group. Another goal was rationalization of care for the younger disabled - a new system called *Shienpi* had been started in 2004 and, due to incorrect assumptions and poor design, it was already causing major headaches. In particular, it lacked effective eligibility and benefit determination processes.

The MHLW did its best to sell this proposal, but it failed and was dropped from the fifth-year review legislation. Opposition had come from politicians in the ruling party, who were worried about imposing a new social insurance contribution on younger people (many of whom were not paying their pension premiums as it was), and from most of the interest groups in the disability field. They raised a variety of issues, but one factor was their perception that LTCI would be stricter than *Shienpi*.

### **Conclusion**

A comprehensive approach to long-term care, in particular a model based on social insurance, is a reasonable and viable policy option for rich countries. It is reasonable in that it deals with a major aspect of the ever-growing problem of population aging in a fair way - that is my own opinion but it is shared by the citizens of the countries that have taken this path. It is viable in that, unlike some of the social programs that frighten policymakers so much, it is unlikely to go "out of control." The German experience indicates that controlling expenditures is not impossible or necessarily even particularly difficult compared with other public programs. The Japanese experience indicates that incremental but substantial mid-course corrections are possible.

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## Summary of the Discussion

Kotaro Tanaka  
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The second session opened with a brief presentation by Manfred Huber on the comparative study of long-term care (LTC) in 19 OECD countries. Then Heinz Rothgang reported on the 10 years during which the long-term care insurance (LTCI) system has operated in Germany. After Heinz Rothgang had answered some questions and comments specific to his presentation, John Campbell reported on the LTCI in Japan from a comparative aspect.

After the coffee break, the chair opened the discussion by referring to the discussion points in the handout prepared by Kotaro Tanaka. On the first topic (controlling increases in expenditures caused by an aging population), Naoki Ikegami opposed the notion of concentrating public resources on the more severely dependent and having little family support because the family would then receive no services until it was no longer able to care for its own members. He also doubted whether the new preventive services that will be provided by the Japanese LTCI will be effective in controlling expenditures because of the difficulty of monitoring whether the home-help service had been provided with the active participation of the client, as had been prescribed by the regularions, instead of as a passive recipient.

This led to a discussion on the effectiveness of preventive services in general. Wendy Edgar described New Zealand's positive aging campaign to change diet and exercise habits. However, several participants expressed doubts about whether people could be induced to change their behavior on a population basis. Nevertheless, Manfred Huber pointed out that, if dementia could be prevented, this would lead to a considerable change in the burden for dementia patients and their families.

The discussion then turned to the integration of health care and LTC. Naoki Ikegami argued that there should be better integration between services provided by health insurance and by

LTCI. A comprehensive disease management program that provides for both health and social care management may yield better health outcomes than having two separate programs. On this point, John Campbell stressed the need for much greater coordination between the two sectors without making the system too complicated. However, in New Zealand, integrating the two sectors has led to an increase in the number of people identified as needing these services, which has thus increased the pressure on the health system overall. Alan Maynard stressed the importance of designing appropriate incentive structures: for example, making local governments pay hospitalization charges for any patients who could be discharged to the community appeared to be the only effective measure to decrease bed-blocking. Manfred Huber pointed out that, in Sweden, giving more authority to community nurses in LTC service provision had more impact than the transfer of financial responsibility from the counties to the municipalities in the Adel Reform.

On the basic differences between health services and LTC, the discussion centered on two issues: episodic versus continuous function and reversible versus uni-directional function. LTC appears to be continuous and uni-directional (towards decline) when compared with health services. William Hsiao stressed that, since LTC is a broader concept than basic health care, designing benefit packages is likely to be more difficult for LTC than health care. If formal services are available, then patients are likely to choose these services over being cared for by family members. Joseph White argued that income protection is less important in LTC because those receiving services do not expect to come out alive. Heinz Rothgang provided data based on a longitudinal analysis of changes in the dependency level in Germany showing that, although some people in Level 2 do improve to Level 1, most tend to decline or die with time.

On the issue of how to fund LTC, William Hsiao

### *Summary of the Discussion*

recommended a three-tier mixed model. Concerning cash benefits, participants discussed the implications for the employment of informal caregivers. Soonman Kwon thought that recipients could be trusted to make rational choices in the use of informal care, and so argued that cash benefits should be introduced. Some were opposed to this because there is no guarantee that the cash would be used for caregivers. Regarding measures to monitor the quality of informal care, Heinz Rothgang explained that in Germany, assessments are made by professionals every six months. One alternative to providing cash or service benefits is the new “personal budget” in Germany, which allows recipients to choose among a wide circle of caregivers that includes non-licensed workers and volunteers.

How to prevent institutionalization was discussed next. Nursing home care appeared to be needed increasingly only for relatively short

periods of time for those with physical disabilities, but patients with dementia continue to need long periods of care. It was recognized that hotel (bed and board) costs are generally excluded from LTC benefits in most countries, and so are covered by public assistance for those who cannot pay. However, this was not the case in Japan until the recent revision in the legislation. Naoki Ikegami pointed out that the definition of “institution” differs greatly from country to country, which should be taken into consideration in comparative studies. The distinction between hotel services and care services should also be made clearer.

At the end of the discussion, John Campbell commented that since relying on family care will become increasingly difficult, while relying entirely on formal care will be too expensive, policymakers must design an appropriate mix of arrangements within publicly funded LTC systems.

## Chapter 3: Increasing Public Expenditures on Health Care

### Increasing Investment in the UK-NHS: Some Policy Challenges

Alan Maynard  
University of York

I was asked to consider the challenges created by increasing expenditure in a centralized health care system, the UK's –National Health Service (NHS).<sup>66</sup> After describing the political rationale of this policy, I will review the demand-side and supply-side challenges that it has posed. I will focus not only on the positive achievements of this policy but also on the problem that rapid growth in spending creates opportunities for rent-taking by providers and how this has limited the positive impact of increased funding on outcomes and performance and on the achievement of political goals.

#### Background

The Labour Government came to power in 1997 with no clear health care policies except the intention to remove the “failed” vestiges of Margaret Thatcher's internal market (in particular to abolish Hospital Trusts and GP fund-holding). For the first two years of the Blair administration, government funding was parsimonious and in line with the policies of the preceding government. Then in 2000, the Blair government radically altered its policies as part of a program of public sector reform that greatly increased investment. Initially, this policy focused on “acting smarter in the provision of health care.” More recently, the increased investment has been accompanied by the re-adoption of such Thatcherite “market” policies as Foundation Trust Hospitals and GP budgeting (now called “practice-level budgeting”) in primary care and by a much greater emphasis on the use of competing private suppliers to provide care for NHS patients.

In 2000, the Prime Minister announced an extended investment program that was to

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<sup>66</sup> In fact, this paper addresses the performance of the NHS in England. The NHS in Scotland, Wales, and Northern Ireland differs in structure and policy following devolution but remains publicly funded by the UK government.

increase NHS expenditure to equal the “average” expenditure by the European Community countries. This was a changing and ambiguous target, especially following the enlargement of the EU to include 10 relatively poor states. The UK government pledged to increase real NHS expenditure by 7 to 8 percent every year until 2008. Subsequently the Wanless Report (Wanless, 2002), which sought to forecast future health investment needs for the NHS, rationalized and supported this policy.

After over 50 years of parsimonious funding, which some health economists argued had constituted systematic under-investment in the NHS, there was suddenly a large and sustained injection of increased funding, and this created some significant challenges. Because of shortages of labor (especially of doctors and nurses), time lags in acquiring and implementing increased bed and diagnostic capacity, and significant monopoly power in the health care market in the form of strong and skilful medical trade unions and a powerful pharmaceutical industry, there was a major risk that part of the increased investment would not only reduce waiting times and improve quality of care but would also be partly absorbed as rents or as higher prices for inputs.

#### Demand-side Controls

Taxation is the predominant source of funding for the NHS – a combination of national (social) insurance payments and general taxation, with user charges financing 5 percent of expenditure. The Blair government's expenditure increases have been funded by a 1 percent increase in the national (social) insurance contribution (in other words, by a proportional tax) rather than by progressive income taxation. Consequently, the redistributive effect of the funding has been reduced now that the system is more dependent on proportional taxation.

Co-payments are charged for pharmaceuticals and for the small slice of the dentistry sector that

the government still covers. Coverage of community care, in particular the provision of nursing home care, remains means-tested with public funding channeled through local government. Local councils fund patients in privately owned and operated nursing homes. The problem of “bed blocking” (when elderly patients in need of social care occupy expensive hospital beds even after their medical needs have been met), has been solved following the Swedish model, by fining those local governments that fail to move such patients out of NHS facilities and into residential care. The introduction of this policy, under which local governments have to pay the NHS the cost per patient bed day, was accompanied by additional funding for nursing home care and has significantly reduced bed blocking and the demand for NHS facilities by elderly patients needing social care.

### **Supply-side Issues**

When Blair increased spending on the NHS, he also required that it “act smarter,” in other words, that it increase the efficiency with which it uses resources. Initially, efforts to increase efficiency focused on central institutions. For example, in 1999, the National Institute of Clinical Excellence<sup>67</sup> (NICE) was created to appraise new and old technologies in terms of their clinical and cost effectiveness and to facilitate the production of evidence-based clinical guidelines (where economic elements are only now being injected).

In another attempt to improve quality, the government issued a series of National Service Frameworks (NSFs), setting out targets for reducing waiting times and enhancing the quality of provision in areas such as cancer, heart disease, diabetes, renal medicine, the care of the elderly, and children’s care.<sup>68</sup> The NSF targets are complemented by a primary group of targets against which the performance of providers and purchasers is graded annually according to a star rating system. There are currently eight primary targets for hospitals and

over two dozen items in what is called “the balanced scorecard” where the organization’s performance relative to its peers determines its grading. These measures of “success” focus on process, in particular reductions in waiting times for certain elective procedures (such as hip replacements), cleanliness of facilities, and the prompt delivery of interventions such as thrombolytics after myocardial infarctions. Success merits some financial rewards (for example, £1 million if a hospital achieves three stars) and the dismissal of management staff in “failed” hospitals with zero stars.

The Commission for Health Improvement (CHI) was created to “police” the working of the NHS in relation to its performance targets, the NSFs, and the use of NICE guidelines. It is now called the Health Care Commission (HCC) and is responsible for grading the performance of purchasers (Primary Care Trusts or PCTs) and primary and secondary providers.<sup>69</sup> Currently, the performance of the NHS is being reformed by this regulatory agency. (Health Care Commission, 2005)

### **Supply-side Achievements**

The large investment in resources and the centralized system of target setting and monitoring has achieved some significant changes in patients’ waiting time for care, particularly for elective care (see Table 1). At the time when the policies were initiated, many patients were having to wait over 12 months for elective procedures. Now, no one in England has to wait for longer than nine months, and by the end of 2005, no one will wait longer than six months. However, this average statistic disguises certain issues. In particular, those who have had a lengthy wait and who have often been categorized as non-urgent by their clinicians have been “tail-gunned” – in other words, policy and management have focused on reducing the tail of the distribution. This has been successful in reducing the mean waiting time for elective surgery by 30 percent and reducing the median waiting time by 21 percent.

<sup>67</sup> This was recently expanded into the National Institute for Health and Clinical Excellence to cover health improvement and illness prevention but is still referred to as NICE ([www.nice.nhs.org.uk](http://www.nice.nhs.org.uk)).

<sup>68</sup> The NSFs can be found at [www.doh.gov.uk](http://www.doh.gov.uk).

<sup>69</sup> [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)

**Table 1 : Waiting and Access Targets**

	<b>Delivery Date</b>
<b>Hospital services (elective care)</b>	
Maximum wait for inpatient treatment: 6 months	End 2005
Maximum wait for inpatient and <b>day case</b> treatment: 3 months	2008
Maximum wait for outpatient appointment: 3 months/13 weeks	End 2005
Maximum time from GP appointment to treatment: 18 weeks	2008
<b>Emergency care</b>	
Maximum wait in A&E: 4 hours	End 2004
75% of emergency ambulance calls to be responded to within 8 minutes	2001
<b>Primary care</b>	
Guaranteed access to primary care professional within 24 hours	2004
Guaranteed access to primary care doctor within 48 hours	2004

This means that the mean waiting time for inpatients in 1997 – of over four months – was reduced to under three months by 2004, and the median waiting time fell from three months to two and a half months (The King's Fund, 2005). As the government adopts increasingly ambitious targets (for example, no one having to wait more than six months by December 2005 or more than 12 weeks by 2008), the absolute number of patients who have to be treated becomes ever greater.

Not only has there been some success in the timely treatment of elective patients, there have also been improvements in the treatment of emergencies. For instance those patients labeled as “urgents” by general practitioners (such as cancer sufferers) now have to be seen within 14 days, and no patient should have to wait in accident and emergency for more than four hours. These modest goals are increasingly being achieved because Chief Executives and their teams know that their jobs are on the line if they fail to meet these centrally determined targets.

There has been considerable investment in physical facilities and equipment for treating patients, with the consequence that they are continually improving after decades of relative neglect. This aspect of the “modernization” of the NHS is not detectable in the activity-

oriented performance measures.

Significant resources have also been invested in services for conditions such as heart disease, cancer, and mental health. The performance of the NHS in this respect has improved, with patients being seen and treated more rapidly. Whether these improvements have yielded improvements in health is less clear. Fewer Britons are dying of cancer and heart disease, but these trends were evident before the government's increased investment. There is no evidence (yet) that levels of obesity are declining or that healthy eating, and exercise are increasing. Smoking levels are declining slowly. The impact of the National Service Frameworks on, for instance, five year survival rates will take time to emerge and will also require better data collection.

**Challenge: Rent Seeking**

The relaxation of the tight NHS budget constraint has inevitably induced providers to seek “rents”, in other words, to enhance their rewards without improving their activities or their outcomes. This situation has manifested itself in several ways.

The National Institute for Clinical Excellence was originally conceived as a mechanism to *ration* resources (Maynard and Bloor 1997). However, it has developed in a way that is

actually contributing to inflation, particularly in pharmaceutical expenditures. NICE is “approving” for use in the NHS (and sometimes for only particular sub-groups of patients) new and expensive drugs that have only marginal clinical benefits. This situation arises because NICE approval requires only a minimal threshold of approximately £30,000 per quality adjusted life year (or QALY). Certain cancer drugs are prime examples of this practice, although recently NICE has begun to show more rigor in its rationing by suggesting in one of its guidelines that the Alzheimers drug Aricept should not be reimbursed in the NHS, and as a consequence it cannot be prescribed for NHS patients in future. There is currently much discussion in both academia and government that either the NICE acceptance threshold should fall to £12,000 to 15,000 per QALY or that the organization should be given a budget sufficient to cover the costs of the entire NHS adopting its guidelines, which would oblige it to ration more effectively (Maynard, Bloor, and Freemantle, 2004). Until the implementation of some such constraint, NICE will continue to be, in effect, the “marketing arm” of the pharmaceutical industry, injecting expenditure inflation into the NHS by obliging it to adopt drugs of marginal clinical effectiveness.

Another provider group that has been very successful in acquiring rent has been the medical profession. The government negotiated a new contract for hospital specialists or consultants, which has given members of the profession significant pay increases (20 percent and more) with no return to the NHS in terms of either increased activity or improved quality. The contract has cost the NHS several billion pounds, but there has been no observable reduction either in the variation in clinical activity between specialists in particular specialties or in the temporal trend for surgeons in particular to reduce activity (Maynard and Bloor, 2003b).

Clinicians’ large and unaccountable variations in activity have been well chronicled in the USA by the Wennberg group at Dartmouth Medical (Wennberg et al, 1989; Wennberg, Freeman, and Culp, 1987; Wennberg and Gittelsohn, 1973;

Wennberg, 2002; and Wennberg, 2004).<sup>70</sup> The universal nature of these variations and their continuation over decades is as remarkable as it is wasteful (Fisher, 2003). These variations are evident in routine administrative NHS data, which are also unmanaged (Bloor and Maynard, 2002). To vary is human, but the variations in the USA and in the UK’s NHS are *prime facia* evidence of considerable inefficiency and are usually ignored in health care reform efforts (Maynard, ed, 2005). Furthermore, they substantiate the hypothesis that increased activity could be produced from existing consultants if the mean of the distribution could be increased and/or if the shape of the contribution could be altered. To this end, in 2004 the government supplemented the consultant contract with fee for service “pilots” in the hope that mixed remuneration systems would increase the activity levels of specialist doctors in NHS hospitals. While this may be beneficial in terms of increasing activity, the preceding contractual settlement was, in effect, rent. Consultants were given significant pay rises (many are now being paid in excess of £100,000 per annum) with no corresponding improvement in the delivery or quality of patient care.

Unlike the consultant contract reforms, the new contract for general practitioners included incentives in the form of generous fees for the delivery of 10 categories of patient care. The quality framework (QOF) assigns points to particular tasks, and points are awarded to practices based on the extent to which it meets its target. In this way, doctors within each practice are encouraged to police each other. The QOF was accompanied by the chance to opt out of the contractual obligation of GPs to provide round the clock care for patients, whether directly or via cooperatives of local GPs. For a £6,000 reduction in salary, GPs could be released from this part of their contract, and most GPs have done so. However, many still offer this out-of-hours service through primary care trusts (PCTs) and receive pay rates for doing so that are considerably higher than they used to be paid for this service. Recent surveys of GPs’ salaries have revealed that they receive

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<sup>70</sup> [www.dms.dartmouth.edu](http://www.dms.dartmouth.edu)

of £100,000 per year. The opportunity cost of the QOF is unclear. What has been given up to make it possible to pay these generous fees for service (Maynard and Bloor, 2003a)?

The combined effects of these three factors – NICE approving expensive drugs with marginal clinical benefits, the inflation of doctors' salaries with no increases in activity or quality, and increased capital costs due to the full employment economy and public sector reform, – highlight an important question in financing reform. How can you avoid the acquisition of rents by provider groups when funding is rapidly increased with little prior warning and planning?

There is a further challenge involving rent seeking in the health labor market. The *Agenda for Change* is a national policy document that classifies the hundreds of skill categories and wage systems in the NHS into a simple national banding system. The aim of the new policy is to ensure that all non-physician workers are neither unduly downgraded and de-motivated nor able to create further wage inflation without productivity gains.

The government has also adopted policies that are meant to improve the quality of care provided in the NHS but are likely to be highly inflationary. For example, the European Working Time Directive requires all NHS institutions to limit the hours of junior hospital staff to 56 hours per week, with a further fall by 2009 to 48 hours. The UK government reinforced this policy by offering junior staff very high overtime payments if their employers made them work over this limit, making the opportunity costs of non-compliance very high for employers. As a result, compliance with the Directive is being achieved at high cost with short-term pay increases and the necessity to reduce hours and hire additional staff to replace lost manpower. Two more examples of new policies with inflationary potential are emphasizing classroom teaching rather than on-the-job experience in the training of junior staff and making all hospital services consultant-led or specialist-led. Both of these policies require the recruitment of new staff to maintain patient services. The impact of these changes on quality has yet to be evaluated.

As a result of these alterations in pay and organization, purchasers and providers have had to increase their activity to achieve waiting time targets by increasing capacity proportionately rather than by complementing such investment with increases in productivity and “sweating” assets. Consequently, there has been little funding left over to pay for the quality changes required by the NICE guidelines and the imperatives of the National Service Frameworks. At worst, they have to struggle not to go into the red as deficits are not tolerated by central managers in the NHS. Figures for the 2005-6 fiscal year in Scotland indicate that, of the new money available at the local level (£524 million), 92 percent was already committed before the start of the year to meet promised pay increases and other obligations mostly related to pay, pharmaceuticals, and working conditions (Walker, 2005).

A paradoxical aspect of the sharp increase in funding created by the Blair reforms is that the organizations that are delivering care are in increasing financial difficulties. Quite rightly, the government has raised the expectations of the public that waiting times for elective procedures will be reduced and that quality will be improved in elective, chronic, and emergency care. However, the changes being made to achieve these targets, while creating some significant improvements, are creating some avoidable waste and arousing frustration in both politicians and the public who expected more rapid change.

### **Challenge: Increasing Capacity**

The Blair government has operated on the principle that increasing the funding of the NHS will produce the necessary additional capital and labor to reduce waiting times, increase physician activity, and improve the quality of patient care. However, an immediate problem with this strategy is that it can take a decade or more to plan, build, and open new hospitals and that training doctors can take 10 to 15 years before they can be licensed as specialists and independent practitioners. With this in mind, the government has adopted a range of policies aimed at resolving these difficulties.

The preceding Conservative Government had developed the Private Finance Initiative (PFI) as a way to reduce public sector capital expenditure by replacing it with private funds, with the aim of increasing efficiency in the building and operation of hospitals and other health care facilities. The Blair government has not only retained the PFI policy but has significantly expanded it as a way to further its public sector reforms and to contain public sector expenditure. This policy has been controversial and is difficult to evaluate, as many aspects of PFI contracts are “commercial in confidence”, in other words, secret, so that rivals cannot detect providers’ cost and quality structure. Also, the transaction costs of PFI projects have been high, as each function of the facility being built is subject to a separate contract. Recently the decision of the Office of National Statistics to count PFI expenditure as part of the government’s expenditure may mean that there is less reliance on this funding source in the future.

The capital program, both public and private, aims very gradually to increase the size and quality of the stock of hospitals and of diagnostic and other equipment. However, high consumable costs associated with upgrading equipment and procedures can increase expenditures significantly (for example, switching from open to laparoscopic surgery). Whether these improvements have been implemented efficiently is difficult to determine. Given the way in which capital markets appraise risk, the private sector inevitably borrows at a higher cost than the public sector, and the resulting increase in costs has to be offset by efficiency savings in the creation and operation of more and better facilities. As PFI contracts exclude clinical inputs, savings have to be made on the non-clinical aspects of care. At present, it appears that private contractors are receiving “healthy” rates of return on their PFI contracts as revealed by the UK’s new Freedom of Information legislation.<sup>71</sup>

The development of labor market policies has been more problematic. The policy governing

the recruitment of doctors has focused first on increasing the intake at medical schools and second on immigration. New medical schools have been created and old ones expanded, and intake has increased by 30 percent, but it will take at least a decade for the number of doctors to increase accordingly. Consequently, the NHS has been actively recruiting doctors from overseas. This is a contentious policy as many of these immigrant doctors come from relatively poor nations, and the flow can be regarded as “reverse foreign aid.” For example, countries such as India “traditionally” over-produce and export doctors to the UK. In fact, at the moment, the NHS cannot provide its services without the over 25 percent of UK doctors who are foreign-trained. With 10 countries joining the European Union (EU) last year and free movement of doctors and nurses throughout the EU guaranteed, more immigration is likely, subject to language restrictions and EU registration criteria.

Yet, even after the recent increased flow of doctors and nurses from Spain and nurses from Finland and the Philippines, recruitment problems remain. The government has therefore attempted to alter the skill mix of staff who provide services to patients. Nurses and pharmacists are being given prescribing powers for the full formulary, and nurses are being trained in anesthesia, surgery, and endoscopy. While there is some evidence that nurses are proficient in such skills, it takes a long time to train them properly, and if this training time were reduced, the diagnostic and therapeutic quality of such practitioners might not be good enough. Furthermore, although nurses may be clinically effective, the limited research literature does not reveal whether such skill substitution is cost-effective (Lankshear et al, 2005; Lankshear, Sheldon, and Maynard, 2005; Laurant et al, 2005; and Sibbald, Shen, and McBride, 2004).

For nurses and especially for doctors, the increase in their pay may reduce emigration and retain more staff in the medical professions. To date, there has been no systematic analysis of these issues or any appraisal of the changes in gender and skill mix.

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<sup>71</sup>[www.dh.gov.uk/PublicationsandStatistics/FreedomofInformation/ReadingRoom/fs/en](http://www.dh.gov.uk/PublicationsandStatistics/FreedomofInformation/ReadingRoom/fs/en)

## **Quality**

The annual hospital league tables show that performance is now an integral part of the NHS's star system for grading hospitals. Also, the Royal College of Physicians voluntarily determines and appraises "ambulance-call-to-needle" and "door-to-needle" times for thrombolytics in cardiac care, at both the institutional and the individual clinician level. Not all NSF targets for the different care categories are mandatory performance standards, but there is pressure from the Department of Health for some elements of the framework (such as thrombolytics and stroke care) and, more generally, for Trusts to be required to comply with these targets. Waiting time targets for diagnostic and therapeutic interventions in cancer care are already mandatory, but the government should be careful about extending this to cover all NICE guidelines. For example, certain NICE treatment guidelines for cancer have been implemented unevenly (Sheldon et al, 2004).

Some NSFs (for example those related to renal care and diabetes) are relatively new, have not yet progressed significantly, and will add to funding pressures. The slow implementation of the mental health NSF reflects the low social and political profile of this sector, a factor increasingly recognized as unacceptable and counter-productive. A prime example is that many patients in acute care suffer from dementia, making the absence of psychiatric liaison care a cause of "bed blocking." Also, research demonstrates that outcomes are improved both for younger patients in acute care (for example, after breast cancer surgery) and older patients if their social and psychiatric needs are met.

While the creation of NICE was essential and its role is pivotal in rationing resources and targeting interventions in the most cost-effective way, its influence has been mixed during the first six years of its existence. First, its impact has been marginal and cumulative as it has only appraised a few therapies as yet. Second, the political processes that have determined its selection of interventions for appraisal have tended towards new technologies at the expense

of considering those old marginal therapies, which could be eradicated from clinical practice. Finally, the threshold at which NICE approves technologies for use in the NHS remains too generous at £30,000 per QALY, with the consequence that marginal and expensive therapies have been approved by NICE that produce only limited patient health gains (for example, some pharmaceutical interventions for cancer patients).

A noticeable limitation of the Blair reforms has been their neglect of both variations in activity and outcome measurement. A private sector firm, Dr Foster<sup>72</sup> has published annual mortality rates for hospitals in England, based on the work of Jarman and colleagues (Jarman et al, 1999) using NHS data. The data come from an annual administrative series, the Hospital Episode Statistics (HES), and record a considerable amount of process detail for every NHS patient (including the patient's post code, the referring GP's practice, the type of procedure(s), the length of stay, the name of the specialist, readmission rates, and mortality rates). This vast data set has been collected since 1987 but has rarely been used in research, let alone in routine management. Simple analysis of these data shows considerable variation in the activity rates both in crude numbers of finished consultant episodes (FCEs) and tariff-adjusted FCEs (Bloor and Maynard, 2002).

Certain policy issues are highlighted by this variation. For instance, would supplementing the salaries of hospital consultants with fee-for-service payments shift the mean of this distribution and produce more activity from existing doctors? If so, would it be necessary to bring in overseas practitioners and affect so significantly an increase in the intake of medical schools? The choice of the UK Government has been to underplay this issue. Instead of focusing on variations and seeking to produce more activity from existing doctors, it has chosen instead to import and train more doctors. Although such activity analysis can be useful and a certain amount of variation is both inevitable and human, the government's focus on waiting times has caused it to neglect all

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<sup>72</sup> [www.drfooster.co.uk](http://www.drfooster.co.uk)

outcome measures other than mortality and recurrence rates. It is remarkable that the international health-related quality of life (HRQoL) measurement is absent from health systems. An experiment by the Rand Insurance led to the creation of Short Form 36, an HRQoL completed by patients themselves assessing their physical, social and psychological functioning.<sup>73</sup> European work in the 1990s led to the creation of a generic HRQoL that can be converted into a simple numerical score (unlike SF36).<sup>74</sup> These two generic HRQoLs have been used in thousands of clinical trials across the world and have been translated into dozens of languages. However, no health care system uses these measures to compare the condition of patients before and after treatment by determining whether the HRQoL of patients has improved.

Following problems with a gynecological surgeon's practice and outcomes, a UK insurer (the British United Provident Association, more commonly known as BUPA) has been using SF36 for some of its patients. It is thus able to offer better consumer protection and to give feedback to the surgeons that it employs how well they have performed relative to their peers in terms of improving their patients' physical, social, and psychological functioning. BUPA manage these data using the "six sigma"<sup>75</sup> safety engineering techniques; in other words, they focus on the tails of the distribution to learn how the best surgeons succeed and how such knowledge can be used to improve the performance of practitioners in the "poor" tail of the distribution. They apply SF36 before and six months after the procedure at an estimated cost of £3 per patient, which is considerably less than the cost of a full blood test.

BUPA surgeons, being NHS employees working privately, are transferring this type of measurement into the public sector. To date, this is being used by clinicians but not by non-clinical management. There is the prospect that PCT contractors will be chosen not merely on the basis of price and volume but also on the basis of their HRQoL measurement and practice

standards. This is likely to be introduced initially as a pilot scheme in the NHS. Hopefully, it will be carefully evaluated to ensure both the validity and sensitivity of the instruments before being extended to the entire NHS.

The fact that quality issues have not been integrated into policy and practice in the UK's NHS or in all other national health care systems is puzzling. Reformers worldwide are eager to improve quality. However, they have an unfortunate tendency to blur the distinction between process quality and outcome quality, which makes it difficult to measure the success of reforms. While economists may assume that the goal of investments in health care is to improve population health, it is clear that there is much evidence of failure and little evidence of a public desire to measure success (for example, enhancements in the length or the introduction of HRQoL). This is because politicians and the public tend to focus on process, activity levels, and access, which when changed may or may not improve patient health. The sharp recent increase in investment in the UK's NHS has given this issue more prominence and may eventually lead the government to introduce HRQoL evaluation and contracting in the health care system. Currently, the government plans to evaluate all new Diagnostic and Treatment Centers (DTCs) using HRQoL.

### **The Economics of Frustration**

The failure of the increased funding to realize more swift and significant changes in waiting times and other process measures of success led to disillusionment in the government. When it became clear that the public sector in general and the NHS in particular was not using its increased funding in a flexible and efficient manner to facilitate rapid improvements, the government launched a radical program of change.

In 2003, it reintroduced Hospital Trusts, which had been introduced under Margaret Thatcher's government<sup>76</sup> and which Blair had abolished in 1997. In their new incarnation, these are called

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<sup>73</sup> [www.sf36.org](http://www.sf36.org)

<sup>74</sup> [www.euorqol.org](http://www.euorqol.org)

<sup>75</sup> [www.sixsigma.com](http://www.sixsigma.com)

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<sup>76</sup> See Bloor, Maynard, and Street, 2000.

Foundation Trusts and are regulated intensively by Monitor, the Independent Regulator of Foundations Trusts.<sup>77</sup> In addition, since April 2005, the government has been incrementally introducing a system of price regulation with national tariffs (an English version of Diagnostic Related Group pricing), with all elective care being reimbursed at the set tariff rates. Those hospitals that are deemed to be sufficiently secure in their finances have been awarded Foundation status, one advantage of which is that all their activity is reimbursed at tariff rates. Thus, those providers with low costs and unused capacity are finding it relatively remunerative to increase utilization and generate “surpluses.” In other words, if costs are less than tariffs, hospitals that increase activity generate more surplus, or profit.

Also in April 2005, the government reintroduced GP fund-holding, another Thatcher innovation that the Blair government had abolished in 1997. This is now called “practice-level budgeting.” There is some evidence that the Thatcher system of GP fund-holding reduced hospital admissions by a small but significant percentage (Dusheiko et al, 2003). Given that the introduction in 2004 of the GP contract with its out-of-hours clause may have increased hospital referrals, it is hoped that practice-level budgeting may provide practices with incentives to retain patients wherever possible at the level of primary and community care, thus reducing out-of-hours hospital admissions. However, this will require radical improvements in the initial structures being adopted. Hopefully, practice-level budgeting will be evaluated more thoroughly than was GP fund-holding, which gave finite budgets and activity contracts to GPs and their practices.

In addition to this reversal of earlier policy, the Labour government is forceful in its advocacy of the merits of competition. One way in which it has sought to create it is by adopting a five-year plan to invest in alternative private providers to create additional elective capacity to enable the system to meet waiting time targets and initiate a policy of consumer choice. Under this policy, GPs must offer patients who have to wait for

care a choice of five alternative providers – either in the NHS or in the private sector – with shorter waiting times. The government then pays the private providers for the care that they provide to NHS patients at national tariff rates plus 15 percent from PCT funds earmarked for the specific procedures. In doing this, and by guaranteeing NHS finance for 5 years, the government hopes to induce the private sector to develop sufficiently rapidly as to be able to own 15 percent of NHS provider capacity by 2008. Currently, NHS utilization is very high, with over 90 percent of the available bed stock in most hospitals in use. Demographic pressures and other factors (for example, the changes in GP out-of-hours activity in 2004) mean that emergency demand continues to grow, putting pressure on elective capacity. The government’s response has been to invest initially in NHS Diagnostic and Treatment Centers (DTCs) and then in private sector DTCs. These units tend to be small and focused on specialized elective procedures for which there are long waiting times, such as hip replacements and cataract removals.

One possible effect of this investment strategy is the separation of elective and emergency care, with uncertain effects on cost structures. In the early summer of 2005, the government announced the second tranche of its investment in diagnostic and treatment capacity to increase choice for patients by creating excess capacity. The tranche of £500million will be targeted to the private sector to achieve its increased capacity target.

The government is investing to increase capacity in primary and secondary care both within and outside the public sector and is seeking to increase patient choice in elective procedures so that patients will have the option of five providers to select from by 2006. The government sees the targeting of increased investment to private facilities as a catalyst to induce more flexibility and change in the public sector. If the NHS provider does not act “smarter,” then the private sector will erode its market. The NHS can either increase access and improve quality or lose business to the private sector. The government has stated that it is prepared to make radical changes in NHS

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<sup>77</sup> <http://www.regulator-nhsft.gov.uk>

management and capacity if it fails to improve. Whether it will be able to accept actual NHS closures only time will tell. Furthermore, this policy is likely to fail if public and private providers collude locally to agree market shares. As ever, capitalists are the enemies of capitalism and competition is difficult to create and sustain.

### **Overview**

The Labour Government of Prime Minister Blair is involved in a major social experiment, which has so far significantly increased access to health care and may be improving the population's health substantially. Nevertheless, it is wasting some resources because of rent seeking by powerful providers (Campbell, 1969). It is unfortunate that there has been little evaluation of this experiment and that it is only possible to draw tentative lessons from it at this stage. There are undoubtedly observable improvements in patient care as waiting times for elective procedures are being reduced significantly. The government has taken a bold decision to spend more public health resources on increasing the share of private providers who can meet the care needs of NHS patients. This has created a new interest among the private sector in the health care legislative process and may prompt NHS providers in primary and secondary care to accelerate their own improvements in both quality and volume of care. The choice of market forces and competition as the central instruments of public sector reform, while novel, is unproven and risky but fascinating and will require the development of market rules (for example, for bankruptcies, mergers, and anti-trust) and careful regulation. This has yet to be put in place.

There is considerable evidence both of rent seeking and acquisition and of continued long-term inefficiency in the delivery of patient care (Maynard, 2005). These inefficiencies include variations in medical practices, the delivery of inappropriate care, the failure to deliver

appropriate and cost effective care, and the continuing absence of measurement and management of patient-related health outcomes (Appleby and Devlin, 2004 and Kind and Williams, 2004). The resistance of the medical profession and major health care suppliers (such as the pharmaceutical industry) to change is based on commercial self-interest and political influence, and policymakers are going to have to tackle these obstacles with determination and vigor.

An important issue that is still being neglected in the health policy debate is whether such expensive and complex reforms as those in England are improving the health of the population in the most efficient manner possible. Rapid increases in investment inevitably create short-term supply shortages and rents for providers, but even if this were not so, it is likely that in some areas of health care investment (such as cancer care), "flat of the curve medicine" is being produced: that is, increased investment brings little health gain. It is possible that channeling the same amount of money into promoting healthy behavior by educating the young and the poor (particularly in improving their nutrition) would produce more population health improvements in the longer term, even in rich developed countries (Maynard and Sheldon, 2002). If such investments were contemplated, it would be necessary for policymakers to have far more information about the cost-effectiveness of the various means by which such a policy could be implemented.

Health care policymaking in the UK remains hasty and based on a limited evidence base. As the former President of The Royal College of Physicians argued when he criticized the Thatcher reforms, British policymakers "instead of making ready, taking aim, and firing, tend to make ready, fire, and then take aim." As with Thatcher, so with Blair.

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# Re-Casting Canadian Federalism: Health Care Financing in the New Century

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## Introduction

Health care in Canada was in a state of crisis during the 1990s. Federal funding for health care had dwindled throughout the decade. Relations between the federal government and the provincial and territorial governments had become increasingly antagonistic. The Canada Health Act – the federally imposed compact between the two levels of government established in 1984 – was unraveling. The provinces and territories were frustrated with the federal government's (in Ottawa) insistence that the public principles of Canadian health care be maintained even though it was providing less financial support than before and giving no assurances that it would ameliorate the fiscal situation any time soon. In other words, the provinces and territories were doubly pressured by the countervailing principles behind the Canada Health Act and pressing fiscal realities. Indeed, Canada's ailing national health care system mirrored broader challenges in sustaining Canadian federalism. Negative public opinion fuelled this discourse of crisis during the 1990s.

However, the situation changed between 2002 and 2004. The November 2002 report of the Commission on the Future of Health Care in Canada, commonly referred to as the Romanow Report after its commissioner, former provincial Premier of Saskatchewan, Roy Romanow, recommended that the federal government should inject an additional \$15 billion into the health sector.<sup>78</sup> It also recommended that the two levels of government introduce new

mechanisms to ensure transparency and accountability in how new health care dollars were to be allocated.

Despite some early skepticism among health policy watchers about the policy impact of the Romanow Report, the federal government quickly responded.<sup>79</sup> By the end of 2004, the federal government had committed to adding approximately \$30 billion of new funding to the health care budget over the next 10 years. Considering that total public health spending in 2001-2 amounted to \$74.6 billion, this federal pledge was not insignificant.<sup>80</sup> Furthermore, the federal, provincial, and territorial (FPT) governments agreed to develop new joint monitoring and accountability mechanisms to be phased in over several years. It is my view that the policy events of 2002 through to the fall of 2004 represent a new paradigm in Canadian health policy in which long-term federal funding commitments have come to co-exist with a principled emphasis on accountability both between the two different levels of government and between each government and its citizens. This paper endeavors to explain both why and how these agreements were struck and to appraise their impact on health policymaking and health care policy in the context of Canada's changing federalism.

The paper is organized in six parts. The first two sections provide overviews of intergovernmental relations and health care financing in Canada. Sections 3 to 5 examine the 2002 Romanow Commission Report, the 2003 Health Accord, and the 2004 Ten-year Plan; they focus on the changing political dynamics between the federal and the provincial and territorial governments. Section 6 looks inside the provinces, highlighting current reform initiatives in Ontario and Alberta, specifically in the areas primary health care reform and waiting

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<sup>78</sup> All dollar amounts in Canadian dollars.

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<sup>79</sup> Coyne, 2002 and from the medical profession's perspective, see Canadian Medical Association Journal, 2002, p. 1199.

<sup>80</sup> Romanow Commission, 2002, p. 312.

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times reduction.

The analytical portions of the paper are structured around four general themes. I describe them briefly here and will develop each theme more fully in the paper's conclusion.

Federal Funding Commitment

Although the actual health implications of the 2002 Romanow Report and the 2003 and 2004 funding agreements have yet to be observed, the short-term financial consequences of these recent intergovernmental deals are quite clear.

Federal cash transfers for health increased by almost 17 percent in the first fiscal year after the 2002 Romanow Report was made public (Table 1). Subsequent to the 2003 Health Accord, federal cash transfers increased again, this time by over 20 percent, and continued to outpace growth rates in provincial (in other words, public) health expenditures by a considerable margin. Federal cash transfers amounted to nearly one-third of total health expenditures in 2004-2005, a marked increase over expenditures in the mid-1990s when federal funds accounted for only 16 percent of total health spending.

**Table 1: Federal Health (and Social) Transfers to Provinces/Territories, 2000-2005**

	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
Federal Transfer *	16000	18800	19100	22325	27005
Rate of Growth	--	17.5%	1.6%	16.9%	21%
Public Health Expend	68958	74590	79539	86034	91054
Rate of Growth	--	8.2%	6.6%	8.2%	5.8%

Note: \* This figure includes social transfers in addition to all new "targeted" investments (the health reform fund, the Romanow gap, waiting times reduction, medical equipment) and excludes federal tax points and equalization transfers.

Re-Casting Federalism

The 2003 and 2004 pacts for health care renewal effectively re-cast Canadian federalism in practice. In contrast to more confrontational modes of intergovernmental interaction during the 1980s and 1990s, Canadian federalism moved towards what David Cameron and Richard Simeon refer to as "collaborative federalism." Under this new paradigm, jurisdictional authority in health matters is shared between the two levels of government and health policy goal-setting and, thus, the mechanisms for intergovernmental accountability are increasingly determined collaboratively by the provinces, territories, and the federal government in Ottawa.<sup>81</sup>

Unpacking "Investment"

New federal commitments to health care financing were not intended to expand the scope of existing services that are already covered by the Canadian Medicare system. Rather, new federal "investments" into the health care system have by and large been motivated by the need to

maintain existing health benefits as well as to increase productivity (including efficiency and accessibility) in health care provision. In this respect, these investments by Ottawa have been less transformative than initially anticipated, though the political optics of targeting investment at popular mandates – waiting times reduction, for instance – have produced important political payoffs to both levels of government.

Political Uncertainty

The 2003 and 2004 health care agreements were political deals, and, as such, their survivability is subject to the political uncertainties inherent in democratic politics. In Canada, the elected government of the day need not honor intergovernmental pacts made by former administrations. Therefore, political uncertainty and instability threaten the long-term financial commitments agreed upon by both levels of governments. Indeed, as I will argue in the concluding section of this paper, the present moment of collaboration in Canadian federalism is not the norm but rather an anomaly.

<sup>81</sup> David Cameron and Richard Simeon, 2002.

### **Canadian Federalism: A Framework of Analysis**

The two levels or orders of government in Canada comprise the federal government in Ottawa and 13 provincial and territorial governments (10 provinces and three territories). Jurisdictional authorities and the powers afforded to each order of government have historically been delineated in the Constitution. Section 91 of the Constitution Act outlines the powers of the federal government, while Section 92 covers the powers of the provincial governments. This constitutional or *de jure* clarity notwithstanding, the real dynamics of federal-provincial-territorial (FPT) relations in Canada have been and continue to be fluid and *politically contested*. The axiomatic assertion that each level of government entails jurisdictional “watertight compartments” simply does not reflect federalist realities in Canada. In practice, there is significant jurisdictional overlap between the two orders of government. In the area of health care, for instance, the provinces are responsible for the maintenance and management of health care provision, while the federal government has general taxing powers and is responsible for broadly defined “public health matters.” Herman Bakvis and Grace Skogstad note that the two orders of government are in fact “highly interdependent.” They go on to add that there “are very few areas of policy where Ottawa or the provinces, individually or collectively, can proceed without bumping into the jurisdiction of another government.”<sup>82</sup>

Given the realities of jurisdictional interdependence among the provinces (and territories) and Ottawa, intergovernmental relations in Canada are characterized by continual power struggles and assertions of political autonomy. Federalism is political; it is not simply a matter of public administrative wrangling. Lines of political contestation among governments are drawn along *vertical and horizontal axes*. The vertical axis captures the relationship between provinces (and territories) and Ottawa. In this case, the relationship between the two levels of government is shaped not only by

constitutionally derived powers and authority but also by the federal government’s use of policy instruments to compel (or coerce) the behavior of the provinces and territories. For example, historically the federal government has used its spending power on health to shape how the provinces and territories deliver health care to their citizens.

Federalism in Canada, however, is not just about top-down and bottom-up relations between the two orders of government. It is also about horizontal relations between the individual provinces and territories. Canadian federalism ensures political equality between each of the provinces and territories, irrespective of any demographic, economic, and political differences among them. Fiscally, Ottawa pays out close to \$10 billion per year in equalization payments to the provinces to ensure fiscal balance among the provinces. This in turn protects diversity among the sub-national jurisdictions, resulting sometimes in “asymmetrical federalism.”<sup>83</sup> Quebec, for example, maintains its own public drug plan and comprehensive child care program, while the other provinces and territories do not. Inter-provincial diversity and political autonomy are generally understood to be the strengths of Canadian federalism. Indeed, federalism works best in terms of policy innovation when provinces function as “laboratories” for policy change.

Politics along both the vertical and horizontal axes of federalist arrangements is not static. Where each government is situated on these axes determines the *various modes of interaction* between itself and other governments. The prevailing conventional wisdom regarding Canadian federalism notes two principal modes of interaction: *cooperation* and *competition*. Cooperative federalism is understood to be an arrangement in which governments cooperate in shared or interdependent policy areas, with the federal government playing a key leadership role. Competitive modes of interaction, on the other hand, are characterized by antagonistic intergovernmental relations in which the provinces show little deference to federal mandates. In this conception of federalism, the

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<sup>82</sup> Bakvis and Skogstad, 2002.

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<sup>83</sup> See Rocher and Smith, 2003.

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two levels of government typically invoke the language of autonomy and authority when competing over what are, at least constitutionally, distinct policy responsibilities.

Observers have noted a new mode of intergovernmental relations that has recently emerged: *collaborative federalism*. Collaborative here refers to a mode of interaction that is qualitatively more than just cooperation and co-existence between the two levels of government. Cameron and Simeon (2002) define collaborative federalism to be “the process by which national goals are achieved, not by the federal government acting alone or by the federal government shaping provincial behavior through the exercise of its spending power, but some or all of the eleven governments and the territories acting collectively.”<sup>84</sup> In this view of Canadian federalism, the policy process (agenda-setting, decision-making, implementation, output evaluation, and policy feedback) involves concerted and regular interaction between the orders of the government. The lines of policy leadership run both ways, from the top down, as in the conventional understanding of cooperative federalism, through equally as likely from the bottom up. Relationships among provinces, territories, and Ottawa are dynamic and change over time, even over the lifetime of a single policy debate.

These conceptual (and variable) dimensions of Canadian federalism – degrees of jurisdictional interdependence, both vertical and horizontal axes, and variable modes of interaction – provide the basis for a generic framework through which we can analyze intergovernmental relations in the context of health care renewal. Moreover, they provide for us a roadmap with which to capture the continually changing contours of Canadian federalism, both in terms of its politics and the processes of public policymaking. As the rest of this paper will show, the dynamics of health care financing in Canada have gradually moved away from cooperative and competitive modes of intergovernmental interaction towards a more collaborative (though still evolving) model of federalism.

### **Health Care Financing in Canada**

It is a complete misnomer to characterize health care delivery in Canada as a coherent “system.” In reality, health care consists of 13 different provincial and territorial systems. These systems are bounded, on the one hand, by overarching public health principles, which are enforced by the federal government. As such, some similarities do exist among the provinces and territories exist, including publicly financed and universal medical insurance (rather than individual payroll-based premiums), a mix of fee-for-service and global budget schemes used for provider compensation, and a common list of “essential” and, therefore, insured health care services. However, inter-provincial differences exist as well. Provincial and territorial governments design their own specific health systems to reflect their jurisdiction’s particular health care priorities. Therefore, the organization and delivery of health care in Canada is relatively decentralized, even though the federal government plays a significant role in financing health care from out of the federal coffers. Certainly, the 13 health care systems operating in Canada are far from identical.

Public health care in Canada originated as a provincial experiment in Saskatchewan, with the introduction of public hospital insurance in 1947 and then public medical insurance in 1962. The federal government in turn enacted the Hospital Insurance and Diagnostic Services Act in 1957, followed by the 1966 Medical Care Insurance Act. These federal laws stipulated that every province was to implement a public medicare program by 1971 and that the federal government would fund 50 percent of the provinces’ health spending through direct cash transfers. The laws also mandated that the provincial programs should: (i) provide comprehensive benefits coverage, (ii) be available to everyone, (iii) be portable (across provinces), and (iv) be publicly administered. Aside from these broad federally mandated conditions, the provinces were free to innovate in terms of policy. In other words, public health care in Canada – which Antonia Maioni suggests originated during an era “infused with a spirit of negotiation and compromise” – was the product

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<sup>84</sup> Cameron and Simeon, 2002, p. 54.

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of cooperative federalism.<sup>85</sup>

Federal commitments to this early inter-governmental bargain were relatively short-lived, however. Between 1968-9 and 1976-7, total federal cash transfers to the provinces consisted of no more than 37.7 percent of total provincial health care expenditures, far short of the promised 50:50 funding that had been promised earlier on.<sup>86</sup> From the federal government's point of view, the open-endedness of that early promise left it with few policy instruments to control escalating costs. As a result, in 1977, the federal government introduced the Established Programs Financing (EPF) federal transfer scheme. Through a mix of direct cash transfers and "tax point" financing (amounts that the provinces and territories are allowed to raise to fund health care through provincial taxation), the EPF scheme linked health and education transfers to GNP growth and put them on a per capita basis rather than on the actual costs to administer these social programs.<sup>87</sup> Re-distributive equalization payments were also introduced at this time to offset lower fiscal allocations to poorer provinces and territories. In the aggregate, however, provincial and territorial governments were fiscally shortchanged by the EPF scheme. As Table 2 demonstrates, total federal transfers (cash and tax points) to provinces decreased from 41.3 percent in 1977-8 to 32.1 percent in 1995-6. Moreover, direct cash transfers from the federal government decreased proportionately, bottoming out at 16.3 percent of total provincial health expenditures in 1995-6.

Provincial and territorial governments were further constrained fiscally and in terms of policy latitude when the federal government passed the Canada Health Act (CHA) in 1984. The CHA amalgamated the 1957 hospital insurance and the 1966 medical care insurance acts and codified into legislation the federal government's guardianship role over five core principles of health care provision in Canada. It re-affirmed Ottawa's insistence that health care must be comprehensive, universal, portable, and

publicly administered. The CHA added a fifth principle – "equal access under uniform terms and conditions." From the perspective of the federal government, the CHA prohibited provinces from collecting out-of-pocket user fees and from allowing extra-billing by for-profit providers. Ottawa defended its position by arguing that the CHA reflected Canadian norms and public opinion about how public health care should be provided. However, from the perspective of the provinces (and of medical care providers), the CHA put a straitjacket on provincial and territorial health policymakers, especially given the federal government's threats to withhold federal transfers in the event that any provincial or territorial government contravened the principles of the 1984 act. As a federally imposed pact, the 1984 CHA was in effect an instrument of "prohibitive federalism" in the sense that its primary motivation was to *forbid* certain policy initiatives by the provinces.

Federal funding for provincial health care continued to decrease into the 1990s. As Ottawa tightened its fiscal belt, it froze the size of cash transfers to the provinces in 1990. The cash freeze continued beyond 1993 after the Liberal Party replaced the Conservatives in forming the federal government. Motivated in large part by national fiscal deficits, Ottawa replaced the EPF program in 1995 with the Canada Health and Social Transfer (CHST) scheme. CHST funds were allocated to each of the provinces and territories as a block fund, combining previously separate transfers in social assistance, health, and post-secondary education. The cash component of federal transfers to the provinces decreased dramatically in three years from 16.3 percent of total provincial health care expenditures in 1995-6 to 9.8 percent in 1998-9. By 2001-2, federal transfers to the provinces, including cash and tax points, amounted to only 27.5 percent of total provincial health spending. Politically, the federal government portrayed the CHST arrangement as a way of renewing "flexible federalism." As one observer put it, however, "flexibility [wa]s seriously circumscribed by a reduced amount of money moving from the federal to provincial/territorial

<sup>85</sup> Maioni, 2002 in Bakvis and Skogstad (eds), 2002, pp. 90-91.

<sup>86</sup> Romanow Commission, 2002, p. 313.

<sup>87</sup> Maioni and Smith, 2003 in Rocher and Smith (eds), 2003.

**Table 2: Federal Funding for Provincial and Territorial Health Spending  
during the EPF Era**

Fiscal Year	Total Federal Transfer as % of Provincial – Territorial Health Spending	Federal Cash Transfer as % of Provincial – Territorial Health Spending
1977-78	41.3	24.9
1979-80	43.3	26.1
1981-82	39.8	23.2
1983-84	38.3	23.4
1985-86	38.9	23.4
1987-88	37.7	21.2
1989-90	35.2	18.7
1991-92	31.2	16.8
1993-94	31.2	17.0
1995-96	32.1	16.3

government.”<sup>88</sup> Not surprisingly, provinces did not buy Ottawa’s pitch.

Ottawa created the CHST scheme to relieve some of the fiscal pressures that it faced in maintaining its financing commitments for social policy. At the sub-national level, health policy authorities were forced to consider more innovative policies for delivering and managing health care. For the health system as a whole, however, the 1995 CHST reform deepened Canada’s fiscal crisis. Politically speaking, it also de-legitimated the federal government’s leadership role, which in the past had been afforded to Ottawa because of its spending power. As a result, provinces and territorial governments renewed their efforts to challenge the federal mandates to maintain broad uniformity (according to the 1984 CHA). Indeed, the 1995 CHST raised serious concerns about accountability in health care spending and provision and also about existing jurisdictional arrangements and commitments between the two levels of government. By the mid- to late 1990s, the cooperative federalism that had been established during the early postwar period gave way to a more competitive mode of interaction between Ottawa and the 13 provinces and territories.

### **The 2002 Romanow Report**

The sense of crisis surrounding Canadian health care that had percolated throughout the 1990s ultimately set the stage for policy reform and

renewal at the turn of the 21<sup>st</sup> century. Around 2000, a window of opportunity emerged for concerted action among the federal and provincial/territorial governments. Several factors converged at the time, giving political impetus to new initiatives in health care and health financing. Interestingly, cost containment and financial retrenchment were not on the reform agenda, whereas federal re-investment in health was.

### The Impetus for Renewal

First, the discussion surrounding the health care crisis was not confined to government policy elites but also involved the Canadian public, which had begun to demand change. Second, the discussion centered on several issues regarding political accountability that were central both to citizens’ frustrations and to political conflict between the federal and provincial/territorial governments. As in many federal systems, the two levels of government had escalated the politics of blame avoidance, and there seemed to be little hope for any resolution in the near future. This was understood to be unsustainable and unacceptable to Canadians over the longer term.<sup>89</sup> Third, while the federal government in Canada portended to safeguard the core principles of the Canada Health Act (in other words, public medicare), several provinces nonetheless threatened to defect from the national health care pact to experiment with private sector alternatives, administrative re-scaling, and extra-billing mechanisms. With less funding coming from Ottawa, provinces

<sup>88</sup> Jennissen, 1997 in Blake et al., eds., 1997, p. 225. See also Prince, 2000, Cohn, 1996 and Rice, 1995.

<sup>89</sup> Marchildon, 2005.

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increasingly felt that there was little to compel them to adhere to federal mandates on health care organization and delivery.

Finally, and perhaps most importantly, the federal government enjoyed a sizable fiscal surplus at the end of the 1990s. At the 2000 First Ministers Meeting (of the Prime Minister and the 13 provincial and territorial Premiers), the federal government agreed to raise the CHST base to \$15.5 billion over the subsequent five years (through to 2005-6), in large part to make up for federal funding gaps incurred throughout the 1990s. Furthermore, Ottawa agreed to inject an additional \$20 billion in federal transfers over the same period. Two billion dollars from the CHST was earmarked for early childhood development programs. In addition, the federal government created a separate \$1.5 billion fund for investments in medical equipment and health information technology, plus an \$800 million Primary Health Care Transition Fund. In exchange, provincial and territorial governments agreed, at least in principle, to begin developing a system for health performance reporting.<sup>90</sup> In sum, political urgency, exhausted federal relations, and fiscal surpluses in Ottawa gave impetus to concerted efforts from both orders of government for health care renewal and reform.

The Content of the Romanow Report

The Royal Commission on the Future of Health Care in Canada, headed by Roy Romanow, the former provincial Premier of Saskatchewan, was created with the encouragement of Romanow himself and by order of the federal government in the spring of 2001. The Commission's work lasted 18 months and involved several weeks of public hearings and expert workshops. It received approximately 11,000 letters and emails from citizens, in addition to over 13,000 completed on-line survey workbooks. Although several other health reform efforts were launched at around the same time – such as the Senate Report on health authored by Senator William Kirby and the Premier's Advisory Council on Health in Alberta – the Romanow Commission received the most attention from the general public and from health policymakers in Ottawa and the provinces. This was due in

large part to its broad consultative mandate. Romanow's work also gained a great deal of attention because it resonated with prevailing Canadian values and norms surrounding publicly financed health care. Regardless of its policy substance, the Romanow Report was particularly important in funneling the policy agenda for subsequent reform debates between the two levels of government.

The Romanow Report was unveiled in November of 2002. Although the report comprised 47 different funding and organizational recommendations, three broad themes emerged. First, the Romanow Report stressed the idea that reform was to “buy change.” New funding from the federal government was to be more than just a short-term cash infusion into the ailing system; instead, the additional funding was to be used to facilitate innovations in health policy and organizational change. Second, the report's funding recommendations targeted specific health care priorities, which would hold provincial and territorial governments, along with Ottawa, accountable for how the new funds were allocated. The report stressed the need to devise mechanisms for comparable reporting and performance measures, building on the agreements established at the 2000 First Ministers Meeting. Third, the Romanow Report sought to repair Canadian federalism, saying that in “the Commission's view, those charged with the governance of the health care system need to restore a level of mutual respect and trust that has been missing in recent years, especially in the relationship between the federal government and the provincial and territorial governments.”<sup>91</sup> Thus, the Romanow report looked to reinvigorate the spirit of cooperative federalism.

The Romanow Commission emphasized the need for long-term and stable funding from the federal government. The Commission recommended that the CHST block funding mechanism (established in 1995) be replaced by a dedicated Canada Health Transfer (CHT) scheme. According to the Commission's report, the federal government would have to allocate at least \$15.3 billion to the CHT by 2005-6 that

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<sup>90</sup> Tuohy, 2002.

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<sup>91</sup> Romanow Commission, 2002, p. 46.

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would be designated for the provinces and territories. Furthermore, the CHT base would be adjusted yearly to reflect real growth rates in health care expenditures. The Romanow Report also recommended that federal cash transfers for health should equal at least 25 percent – effectively a cash funding floor – of total health spending for insured services mandated by the Canada Health Act. Additional federal funds totaling \$8.5 billion were to be allocated over a two-year period starting in 2003-4 for the following short-term priorities:

- Rural and Remote Access Fund – \$1.5 billion
- Diagnostic Services Fund – \$1.5 billion
- Primary Health Care Transfer – \$2.5 billion
- Home Care Transfer – \$2 billion
- Catastrophic Drug Transfer – \$1 billion

By the report's calculations, this new federal funding for health care (over current forecasts) would equal \$15 billion by the end of fiscal year 2005-2006. To ensure that these funds would be allocated by the federal and provincial/territorial governments according to these targets, the report argued that a sixth principle – accountability – should be added to the Canada Health Act. The Commission thus recommended the creation of a Health Council of Canada, a forum for federal and provincial/territorial collaboration and sustained dialogue, specifically pertaining to evaluating health care performance and constructing national standards and benchmarks. The Health Council, as envisioned by the Commission, would report annually to the public on the performance of Canada's health care system.

#### Reactions to the Romanow Report

The Romanow Report, while expansive in breadth and detail, effectively focused the policy agenda on two inter-related core issues: increased federal funding and new mechanisms to ensure accountability. In doing so, the Romanow recommendations went beyond fiscal tinkering; they endeavored to re-affirm and then re-cast the federalist pact underpinning health care and health financing. Indeed, the immediate response by provinces, territories, and the federal government uniformly centered on *the prospects of new dollars and the strings attached to those dollars*.

The First Ministers were scheduled to meet in early 2003 to negotiate the terms of a new Health Accord. As alluded to above, the Romanow recommendations inadvertently set the agenda for the Ottawa meetings. For instance, Prime Minister Jean Chrétien, while lauding the Romanow Report, immediately warned that the federal government was not going to be able to fulfill all of the report's funding recommendations. On the day that the Romanow Report was unveiled, the Prime Minister remarked: "We could find some money, probably not as much as Mr. Romanow is recommending."<sup>92</sup> Chrétien also made it clear that the federal government was not about to sign and hand over 13 blank checks to the provincial and territorial governments.

The provinces similarly dug their heels in politically shortly after the Romanow Report was made public. Ontario's Premier, Ernie Eves, intimated that while, the provinces welcomed new funding, the share allocated to Ontario was still too small. Quebec stated that it intended to opt out of any agreement in which Ottawa intruded upon the province's management of health care services in any way. Alberta's Premier, Ralph Klein, similarly rejected the notion of any conditions or strings being attached to new funding from the federal government. Indeed, his was not a minority view. Most of the provinces opposed the creation of the Health Council of Canada on the grounds that it encroached upon provincial autonomy and would in effect create another layer of bureaucracy in what was already an overly managed health care system.<sup>93</sup>

All governmental stakeholders found problems with the recommendation that funding from the federal government should target certain health care priorities. Some suggested that the targets were *too vague* and that it would therefore be too difficult to develop comparable measures of performance. At the same time, others, primarily the provincial and territorial governments, contended that the targets were *too specific* and thus posed inflexible constraints on how federal funds could be allocated. Both interpretations of proposed funding targets – too

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<sup>92</sup> Cited in Fraser, 2002, p. A1.

<sup>93</sup> Mickleburgh, 2002, p. A4.

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vague or too specific – cut to the core of the Romanow Commission’s insistence that accountability be a condition for additional federal funding. Indeed, it was unclear as to whom the provincial governments were to be accountable. Tensions between funding and accountability animated the dialogue among provincial and federal health policymakers right up to the February summit.

### **The 2003 Health Care Accord**

Federal and provincial health ministers met in December of 2002 to lay out an agenda for the February meeting. It was clear that there was little consensus among the provinces at that time about how to proceed with health care renewal. For example, while most of the provincial and territorial governments agreed that new federal funding should be given without conditions, Saskatchewan balked at such a hard-line position. When the Premiers met in late January in Toronto, they hoped to craft a more unified position. Their efforts, however, were derailed from the get-go. Before their meetings, the federal government leaked information to the media regarding its fiscal position for the upcoming February summit. Although Ottawa did not disclose exact dollar amounts, the federal government made it clear that the provinces and territories should lower their expectations about how much federal funding was going to be put on the table. The Premiers were furious at having been preempted by Ottawa. They viewed the “leak” as a political power-play by the federal government to undermine the already tenuous unity among the provincial and territorial leaders.<sup>94</sup> Tensions in intergovernmental relations were running high by early February.

Again, the key issue going into the 2003 meeting was Ottawa’s plan to make provinces and territories accountable for how federal funds were to be allocated. On the one hand, the provinces demanded more federal funding but with no strings attached. On the other hand, the federal government insisted that provincial accountability be the foundation for any new federal funding agreement. Ottawa focused its efforts specifically on the creation of the Health

Council of Canada and on the introduction of performance evaluation indicators, which the federal government had drafted in late January of 2003. Prime Minister Jean Chrétien laid out the federal position clearly when he stated: “Accountability, it’s a deal breaker, no doubt about it.”<sup>95</sup>

There seemed to be some rapprochement among the federal and provincial-territorial governments on the eve of the February 4-5 meetings. Public opinion in Canada favored increases in federal health spending and Ottawa conceded that it needed to play a bigger role in financing health. Ottawa also suggested that it was willing to negotiate the terms of the creation of Health Council of Canada. For instance, the federal government indicated that voting on the council would favor the provinces and territories with Ottawa having a minority vote.<sup>96</sup> The federal government would not lobby to have a veto on the council. Furthermore, Ottawa agreed that performance evaluation indicators would be designed collaboratively by federal, provincial, and territorial authorities and that provinces could allocate some portion of their new federal funds into areas outside the targeted priorities, thus giving them some flexibility. The provinces, meanwhile, believed that Ottawa was taking seriously their demands for more federal funding. Pre-summit reports indicated that the federal government was considering offering the provinces nearly \$24 billion over five years in new health care financing.<sup>97</sup>

### The Content of the Accord

The February 4-5 meetings were tense and acrimonious. Ottawa’s offer of a conditional \$12 billion over three years was much less than what the provinces demanded, and indeed expected given the Romanow Report’s recommendation that new federal funds should approach \$15 billion over three years. The provinces initially rejected the proposal, but they

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<sup>95</sup> Cited in Laghi, 2003.

<sup>96</sup> It was decided in December of 2003 that the Health Council would comprise 27 members: one representative from each of the ten provinces and three territories, an elected independent chair, and 13 non-governmental representatives selected and nominated by the two levels of government.

<sup>97</sup> Laghi, 2005.

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<sup>94</sup> Clark, 2003.

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were forced to acquiesce – grudgingly – at the eleventh hour when Prime Minister Chrétien issued a “take-it-or-leave-it” ultimatum to the Premiers. Ottawa made it clear that it was not going to move on its funding proposal. Any side deals with specific provinces or territories were similarly off the table.

The provinces were successful, however, in pressuring the federal government to create a dedicated Canada Health Transfer scheme immediately (for fiscal year 2004-2005) to replace the CHST mechanism that had been implemented in 1995. The provinces (minus Quebec and Alberta) also agreed to establish the Health Council of Canada, with assurances from the federal government that the provincial and territorial health authorities would be involved in developing performance evaluation indicators and benchmarks. To that end, the provinces also assented to federally mandated targets for new

health care spending, aimed specifically at primary health care, home care, and catastrophic drug coverage.

The provinces and territories, not surprisingly, were disappointed by the amount of new federal funding agreed to in the 2003 Accord. Indeed, the provinces and territories accepted the Accord only under conditions of political duress. Seven of the ten provincial Premiers were facing reelection that year, and therefore they could not politically afford to reject new federal money, no matter how underwhelming Ottawa’s proposal seemed at the time. Essentially, the federal government guaranteed \$10 billion in new funding over three years, with an additional \$2 billion depending on Ottawa’s fiscal situation at the end of the 2003-4 fiscal calendar. The provinces and territories had expected approximately \$24 billion over five years.

**Table 3: 2003 Health Accord Proposed Spending**

<b>Investment</b>	<b>Amount</b>	<b>Fiscal Year(s)</b>	<b>Duration</b>
Increase to CHST	\$9.5 billion	FY 2003-2008	5 years
Romanow Gap added to CHST	\$2.5 billion	FY 2003-2004	1 year
Health Reform Fund *	\$16 billion	FY 2003-2008	5 years
Diagnostic/Medical Equipment Fund	\$1.5 billion	FY 2003-2004	1 year
Health information technology	\$600 million	FY 2003-2004	1 year
Other investments **	\$1.6 billion	FY 2003-2009	6 years
Other investments (II) ***	\$1.3 billion	FY 2003-2008	5 years
Aboriginal health	\$1.3 billion	Unspecified	
Hospital research	\$500 million	Unspecified	

Notes: \* Targeted for primary health care, home care, and catastrophic drug coverage  
 \*\* Other “health accord initiatives”  
 \*\*\* Other budget initiatives.

Of this three-year \$10-12 billion commitment, \$2.5 billion was to be disbursed as an immediate cash infusion to make up the short-term so-called “Romanow Gap”. Over the next five years, the federal government also agreed to spend an additional \$16 billion (of which funding for years one to three would come out of the \$12 billion allocated from the Health Accord) toward a Health Reform Fund, disbursed on a per capita basis and focused on primary and home care and catastrophic drug coverage. The provinces and territories were given the responsibility for ensuring that 50 percent of Canadians have round-the-clock access to primary care health facilities by 2011. In addition, Ottawa created a \$1.5 billion fund for investing in diagnostic and medical

equipment as part of its national strategy for reducing waiting times.

The 2003 Health Accord was successful in so far as it secured more funding from the federal government, albeit less than anticipated by the provincial and territorial governments. The creation of the CHT furthermore ensured that federal commitments to health care renewal were longer-term and presumably more stable than in the past, as emphasized by the Romanow Report in 2002. However, many core issues remained unresolved.

Some analysts suggested that the amount of money that Ottawa committed was in fact far less than the federal government claimed, an

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interpretation that resonated among provincial and territorial leaders. They cited several reasons for holding this view. First, a significant portion of the “new” funds had already been accounted for by federal fiscal commitments from 2000.<sup>98</sup> Second, the way in which Prime Minister Chrétien forced provincial and territorial representatives at the 2003 summit to accept Ottawa’s proposal raised questions about the political legitimacy of the Accord. Many observers noted that, despite the additional funding commitments from Ottawa, the 2003 Accord did not repair or renew intergovernmental relations; in fact, most agreed that the February meetings exacerbated federal, provincial, and territorial tension. To be sure, territorial Premiers essentially walked out of the meetings. The Premiers of Quebec and Alberta expressed their opposition to the conditions that had been placed on new federal funds and withdrew from participating in the Health Council. Third, it was unclear at the conclusion of the 2003 meetings exactly how accountability measures were to be negotiated by the two orders of government and implemented thereafter. Timelines were established and all governmental stakeholders accepted the need for standardized comparable indicators. However, the extent to which the federal government or their sub-national counterparts would take the lead in formulating these performance measures and benchmarks remained undefined.

As was the case before the February 2003 meetings, tension remained at the center of intergovernmental conflict. Many provincial and territorial leaders agreed to the deal in the end because of political pressure from their constituents back home and, more importantly, in anticipation of coming federal elections and a new Prime Minister.

### **The 2004 First Ministers Meeting**

A First Ministers Meeting was scheduled for mid-September of 2004 to revisit many of the unresolved issues left over from the 2003 summit. It was thought at the time that the new federal government led by new Prime Minister Paul Martin would be more amenable to hearing and addressing the provinces’ concerns about

federal conditionals attached to the new funds and the development of countrywide accountability measures. As is typical in Canadian federalism, both Ottawa and the provincial/territorial governments politically postured throughout the run-up to the fall meeting.

After having met in July of 2004, the provincial and territorial Premiers collectively pitched a proposal for a new national pharmacare program, a scheme that would cost the federal government approximately \$10 billion per year. They hoped that by offsetting the costs of drug coverage, the provinces and territories could shift their limited fiscal resources to other health priorities outlined in the 2003 Accord. The federal government rejected the provinces’ proposal in August. Even Roy Romanow cautioned against the idea of a national pharmacare program. He lauded the proposal in principle, but argued that in the short term the federal government was not in any fiscal position to fund such an ambitious scheme. *Federal funds were not to be used to expand the existing scope of insured services.*

Ottawa attempted to take control of the renewal agenda by setting the terms of the ensuing debate over federal investments and the conditions put on those funds. Paul Martin campaigned in early 2004 on a health platform, promising voters \$9 billion in new funding in order to renew Canada’s health care system. This promise carried over into the fall after Paul Martin became Prime Minister.<sup>99</sup> Furthermore, the federal government focused its policy reform efforts on reducing waiting times, a proposal that was popular with both the electorate and the provincial governments. Specifically Ottawa highlighted its “five-in-five” plan, which aimed to reduce waiting times in five key areas – cancer, cardiac surgery, cataracts, diagnostic imaging (MRIs and CTs), and joint replacements – over the next five years. This was to be achieved by enabling the purchase of new diagnostic equipment and dedicated resources to clear existing backlogs.

Although the provinces and territories agreed with Ottawa’s desire to reduce waiting times,

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<sup>98</sup> See, for instance Ibbitson, 2003.

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<sup>99</sup> Fagan, 2004.

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they were nonetheless concerned about excessive meddling by the federal authorities in setting performance standards and benchmarks for the provinces. Just days before the September meetings, the federal government injected some flexibility into the process, saying that, while national benchmarks for waiting times reduction needed to be established, these benchmarks would be “a standard for which [provinces and territories] can aim, rather than a target they have to hit.”<sup>100</sup> The provinces and territories also showed some moderation by dropping their pharmacare proposal. Not surprisingly, they immediately turned their attention back to questions of new federal funding. Prime Minister Martin proposed \$13 billion over six years, with an escalator of 5 percent per year. The provinces and territories counter-offered with a request for \$36.5 billion over six years. *Globe and Mail* columnist Murray Campbell put it best when he wrote that the 2004 First Ministers Meeting was likely to be a “national bicker fest.”<sup>101</sup>

#### The 2004 Ten-Year Plan

Campbell was absolutely correct in his forecast. The September 14-15 meeting of the First Ministers again centered on how much new funding the federal government was offering and what strings would be attached to the funds. However, despite moments of acrimony among the two levels of government, the First Ministers did agree to a Ten-Year Plan to strengthen health care in Canada.

The provincial and territorial governments in the end accepted Ottawa’s proposal for increased federal funding of \$18 billion over six years, even though it was roughly half of the amount that they had asked for going into the meeting. The federal government re-affirmed its commitment to making up the short-term Romanow Gap with an immediate injection of \$3 billion between 2004 and 2006. Ottawa also agreed to create a new CHT base of \$19 billion beginning in the fiscal year 2005-6, which was almost \$5 billion more than the allocated transfer for 2004-5 (\$14.2 billion), an increase of more than 30 percent. A 6 percent escalator

clause for the CHT was also put into place, meaning that federal transfers for health care would reach over \$30 billion by fiscal year 2013-14. From the perspective of the provinces and territories, the 2004 Ten-Year Plan ensured that they would receive new federal funds and more importantly it signalled a long-term commitment on the part of the federal government to spend more on health care.

Of the \$18 billion in new investments promised by the federal government, \$5.5 billion was earmarked for a Wait Times Reduction Fund to be disbursed to the provinces and territories over 10 years and on a per capita basis. Despite Ottawa’s earlier insistence that the provinces and territories should be held accountable for how they allocated the targeted funds, the Ten-Year Plan effectively did away with any explicit conditions to be imposed by the federal government. The strategy for reducing waiting times that was discussed at the meeting demonstrates this point clearly. The federal government’s Ten-Year Plan, for instance, noted that “jurisdictional flexibility” was to be a core “principle” in the First Ministers’ action plan to facilitate “access to timely care.” The document further stated that the provinces and territories “commit to achieve meaningful reductions in waiting times in priority areas such as cancer, heart, diagnostic imaging, joint replacements, and sight restoration... recognizing the different starting points, priorities and strategies across jurisdictions.” In terms of accountability measures, the plan made provinces and territories responsible for establishing “comparable indicators of access” by December 2005. Benchmarks or targets for “medically acceptable waiting times” were to be jointly developed by the federal, provincial, and territorial ministers of health over the course of 2005, and each jurisdiction was to establish its own timelines for reaching those benchmarks by the end of 2007.<sup>102</sup> In this way, the emphasis on flexibility and on intergovernmental collaboration was a prerequisite for the development of performance measures and benchmarks. Moreover, provinces and territories were no longer accountable to Ottawa *per se* but rather to their own citizens and for their own timelines. This was an important political

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<sup>100</sup> Laghi 2004.

<sup>101</sup> Campbell, 2004.

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<sup>102</sup> Health Canada, 2004a, pp. 2-3 [emphasis added].

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breakthrough.

**Table 4: 2004 Ten-year Plan, Spending Proposals**

<b>Investment</b>	<b>Amount</b>	<b>Fiscal Year(s)</b>	<b>Duration</b>
New Canada Health Transfer (CHT) base *	\$19 billion / year	FY 2005-2014	9 years
Additional transfer **	\$500 million	FY 2005-2006	1 year
Romanow Gap added to CHT	\$3 billion	FY 2004-2006	2 years
Wait Times Reduction Fund (I)	\$4.5 billion	FY 2004-2010	6 years
Wait Times Reduction Fund (II)	\$1 billion	FY 2010-2014	4 years
Medical Equipment Investment	\$500 million	FY 2004-2005	1 year
Aboriginal health	\$700 million	Unspecified	

Notes: \* Base at \$19 billion for FY 2005-2006, 6 percent per year thereafter.

\*\* Targeted for home care and catastrophic drug coverage.

Given that a number of side deals were also concluded at the 2004 meeting between the federal government and specific provinces, the meeting was more broadly inclusive of diverse provincial and territorial concerns than the 2003 Accord had been. For instance, Prime Minister Martin offered a side deal to Quebec that affirmed the province's place within the Canadian federation and recognized its distinct health care program. In a separate communiqué from the Ten-Year Plan, the federal government recognized that "Quebec will apply its own wait time reduction plan, with the objectives, standards and criteria established by the relevant Quebec authorities."<sup>103</sup> In addition, Quebec would maintain its own pharmacare program, over and above the federal initiatives regarding catastrophic drug coverage. With respect to Canada's aboriginal communities, the federal government held a special meeting of First Ministers and Aboriginal leaders in mid-September 2004, during which Ottawa agreed to create and finance a \$700 million Aboriginal Health Transition Fund.<sup>104</sup>

The Ten-Year Plan for health care renewal indirectly set the stage for subsequent adjustments to the provincial Equalization and Territorial Financing Formula (TFF) schemes; these were finalized one month later in October 2004. Equalization payments from Ottawa to qualified provinces began in the 1970s to offset fiscal disparities among the 10 provinces. Payments were (and are) calculated according to each province's revenue generating capacity as

measured against a fiscal standard.<sup>105</sup> The purpose of equalization payments is essentially to raise the fiscal capacity of poorer provinces to the level of a set national standard. In fiscal year 2004-5, eight (of ten) provinces qualified for equalization payments, amounting to approximately \$9.7 billion in federal transfers.

As Table 5 demonstrates, smaller provinces with less fiscal capacity received more total federal transfers (per capita) than did the larger provinces such as Ontario and Alberta.<sup>106</sup> Disparities between the provinces and the territories have been even more striking, given the limited fiscal capacities of Canada's three territories. The federal government committed approximately \$1.8 billion for extra territorial financing in the fiscal year 2004-5.<sup>107</sup>

Recent adjustments to the equalization payments scheme and the territorial funding formula reflect a long-term financial commitment by the federal government to the provinces and territories, not unlike its renewed commitments in the specific area of health care transfers. In

<sup>105</sup> The fiscal standard is the average fiscal capacity of Quebec, Ontario, Manitoba, Saskatchewan, and British Columbia.

<sup>106</sup> The Department of Finance, Government of Canada, Website ([www.fin.gc.ca/fedprov/eqpe.html](http://www.fin.gc.ca/fedprov/eqpe.html)). Accessed March 10, 2005.

<sup>107</sup> For the fiscal year 2004-5, Nunavut received \$722 million through the federal TFF scheme, or about \$24,000 per capita; the Northwest Territories received \$633 million or \$14,960 per capita; and the Yukon received \$455 million in federal transfers, or approximately \$14,000 per capita. Health Canada, Government of Canada, Website ([www.hc-sc.gc.ca/english/hca2003/fmm/fund\\_territ\\_bk.html](http://www.hc-sc.gc.ca/english/hca2003/fmm/fund_territ_bk.html)). Accessed March 10, 2005.

<sup>103</sup> Health Canada, 2004b.

<sup>104</sup> Intergovernmental Conference Secretariat, 2004

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October 2004, Ottawa set a new funding floor of \$10 billion for equalization payments, and \$1.9 billion for territorial funding effective for the remainder of the 2004-5 fiscal year. Federal equalization payments to the provinces were set

**Table 5: Total Major Federal Transfers to Provinces, 2004-2005 (per capita)\***

Province	Transfer, per capita, in descending order	Fiscal Capacity (1999-2000) ** Index Average = 100
Prince Edward Island	2 930	67
New Brunswick	2 739	71
Nova Scotia	2 455	74
Newfoundland	2 449	61
Manitoba	2 428	80
Quebec	1 757	85
British Columbia	1 383	99
Saskatchewan	1 332	91
Ontario	1 322	108
Alberta	1 321	142

Sources: The Department of Finance, Government of Canada, Website ([www.fin.gc.ca/fedprov/eqpe.html](http://www.fin.gc.ca/fedprov/eqpe.html)). Accessed March 10, 2005.

<sup>1</sup> Stephen Barro, "Macroeconomic versus RTS Measures of Fiscal Capacity: Theoretical Foundations and Implications for Canada", *Institute of Intergovernmental Relations, Working Paper 2002 (7)*, Queen's University, 2002, pp. 5-7.

Notes: \* Includes CHT, CST, Health Reform Transfer, and Equalization

\*\* Fiscal Capacity based on 'representative tax system'. In Canada, the RTS Index is calculated from different tax revenue bases. For 1998-1999, 61 percent of the RTS index was based on weighted measures of personal income tax, general sales tax and property taxes.

to increase to \$10.9 billion and federal territorial funding to \$2 billion in the following year. From 2006 through to 2010, equalization payments for both provinces and territories are to be adjusted by a 3.5 percent annual escalator. Furthermore, in October 2004, the federal government initiated a review of the provincial and territorial equalization payment schemes, looking at ways to integrate provincial/territorial GDP and health expenditure growth rates into the existing equalization formula rather than relying solely on per capita disbursements.<sup>108</sup> For instance, demographic profiles (in other words, the age of the population), key factors in the allocation of health care resources, are not considered presently in the calculation of equalization payments.

#### How the Deal Was Done

In terms of actual policy reform, the 2004 Ten-Year Plan was scant on details. When seen as a political bargain over longer-term federal funding, however, the 2004 First Ministers

Meeting was an unequivocal and somewhat unexpected success. The acrimonious shadow cast by the heavy-handedness of the federal government and the deep-seated intergovernmental conflict that came out of the 2003 Accord was mitigated in 2004. As the *Globe and Mail* columnist John Ibbitson put it, the 2004 agreement "was a triumph for Canadian federalism. With all its flaws, imbalances, encumbrances, this country's political system can work, by achieving consensus rather than imposing solutions."<sup>109</sup> Several factors explain why such a bargain emerged at this particular moment.

The Romanow Report of 2002, despite its many recommendations for new financing arrangements and broader organizational changes, effectively *funnelled* the health policy debate to only a few key issues. The report highlighted two fundamental cleavages for governmental stakeholders: new federal commitments set against new measures for accountability. Therefore, the political effect of the report – and its impact in ensuing policy negotiations – was to narrow the scope of the

<sup>108</sup> Office of the Prime Minister, Government of Canada, Website ([www.pm.gc.ca/eng/news](http://www.pm.gc.ca/eng/news)). Accessed March 10, 2005.

<sup>109</sup> Ibbitson, 2004.

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policy agenda and to prevent “policy static” from interfering with or diverting attention away from the critical and doable policy initiatives at hand. To be sure, by the time the September 2004 meetings commenced, the provinces had taken their proposal for a national pharmacare plan off the agenda, and both federal and provincial actors had focused their attention on questions of funding and conditionality. Moreover, private sector alternatives (for example, extra billing and user fees) along with broader imperatives for cost containment were similarly off the agenda. To all intents and purposes, policy static was filtered out of the discussion agenda throughout the summer of 2004 leading up to the First Ministers Meeting.

In political terms, Prime Minister Martin had to get a deal done. His was a minority government, and the Liberal Party’s hold onto power was tenuous at best. Moreover, Martin had campaigned in the spring of 2004 on a platform that featured health care renewal as one of its center-pieces. Martin also needed to shed the Chrétien legacy in federal-provincial relations left over from 2003. Unlike Chrétien, for instance, Martin was willing to cut a side deal with Quebec to ensure the province’s principled inclusion in the Ten-Year Plan.

The provinces and territories also wanted to get a deal done, specifically with respect to securing long-term federal health funding. The creation of the inter-provincial Council of the Federation – an initiative headed by Quebec and Ontario in 2003 – made it possible for the provinces and territories to present a united front against Ottawa. Ontario’s Premier Dalton McGuinty skillfully crafted a consensus among the provinces, especially after the federal government jettisoned the provinces’ proposal for a national pharmacare program, and it seemed that Ottawa enjoyed the negotiating upper hand prior to the 2004 meetings. Quebec’s Premier Jean Charest was equally skillful in selling the federal proposal to his constituents while at the same time crafting an asymmetrical deal that was agreeable both to Ottawa and the other provincial governments.

Most important was the fact that the provinces, territories, and Ottawa were never that far apart in their respective policy positions, despite appearances to the contrary. Put another way,

there had already been significant convergence among governmental stakeholders regarding the broad mandates of any new health deal. Both the federal and provincial/territorial governments, along with voters, recognized that Ottawa desperately needed to inject new federal funds into the health system; the question was how much. Both levels of government similarly recognized that new funding needed to be targeted, at least broadly. In fact, the provinces had already begun to restructure primary health care, reduce waiting times, and re-organize home care *prior to* the 2002 Romanow Report. As one observer at the 2004 meetings recounted, every Premier, irrespective of his or her partisan affiliation, spoke of the importance of reducing waiting times and of increasing access in the five key areas identified by the federal government in response to political demands from the general public. Simply put, “targeting” waiting times reduction was a deal done long before the 2004 meetings had even commenced.<sup>110</sup>

The key point here is that the 2004 deal was made possible in large part because the conditions and targets outlined by the federal government were already seen as priorities by citizen groups and provincial and territorial health policymakers. These were not, *de facto*, federally imposed conditions at all. Indeed, the provinces’ and territories’ opposition to federal conditions was a political tactic used to leverage their bargaining position vis-à-vis Ottawa over the latter’s long-term funding commitments rather than an opposition based on principle.

### **Provincial Health Reform Initiatives**

The 2003 Health Accord and the 2004 Ten-Year Plan were, at their core, funding agreements between Ottawa and the provincial/territorial governments. They were also political deals and as such, contained relatively little policy substance. This naturally fuelled skepticism among some observers. Senator Michael Kirby, the author of the 2002 Kirby Report on health care in Canada, offered his own critical appraisal of the 2004 meeting: “The debate focused on

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<sup>110</sup> Thanks to Dr. Alan Hudson – the Wait Times Reduction Strategy Lead at the Ministry of Health and Long-Term Care in the Ontario Government – for making this point.

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money because it is easy for the first ministers to talk about money and appear to be making progress. It also enables them to avoid the politically explosive issues of restructuring the health care system.”<sup>111</sup> The talk of money, specifically more money, made good political sense. On the other hand, others offered a more sanguine take on the 2003 and 2004 meetings, arguing that the federal government committed to new long-term funding arrangements and more importantly, agreed to a measure of flexible policy space within which the provinces and territories could continue to innovate in reform from below.

The policy grunt for care renewal on the ground remained, as before, with the provincial and territorial authorities. As alluded to above, many of the initiatives that the provinces and territories were experimenting with in primary health care, waiting times reduction, and home care reform pre-dated the recent funding agreements. However, while in the past, the efforts of provinces and territories health care restructuring had to be effectively “mortgaged” over the longer term because of then existing fiscal constraints, the 2003 Accord and the 2004 Ten-Year Plan provided them with the necessary funds to “buy change” in the nearer term.

The Local Primary Care Initiative in Alberta

The 2002 report of the Premier’s Advisory Council on Health in Alberta argued that reforming the delivery and financing of primary health care first required that changes be made to the existing regional health authorities (RHA) system. Hospital and acute care services in Alberta are organized and managed along regional jurisdictions, and in 2004-5 regional health authorities accounted for nearly 60 percent of the province’s health spending. RHAs purchase hospital care on behalf of patients. Presently, Alberta’s nine RHAs are funded by the Ministry of Health and Wellness through a per capita formula adjusted to reflect demographic variables and the flow (“import-export”) of services across regional jurisdictions. Until recently, primary care services were

organized exclusively outside the RHA system, with physician services accounting for 18 percent of provincial health spending in 2004-5.<sup>112</sup>

As a part of the 2000 federal-provincial agreement, Ottawa created an \$800 million Primary Health Care Transition Fund, which was used in Alberta to establish its provincial Primary Health Care Capacity Building Fund. The principal objective of the fund was to provide round-the-clock access to primary care services, a target that was agreed upon by both orders of government. The Local Primary Care Initiative (LPCI) was one of the projects that emerged out of the fund.

In December 2003, the Alberta Medical Association, the Ministry of Health and Wellness, and the nine RHAs forged an eight-year trilateral funding agreement. Physicians negotiated a fee increase as part of this deal. Furthermore, the agreement earmarked \$100 million over three years to fund the creation of LPCIs, a plan to integrate the delivery and purchasing of primary care within the existing RHA structure. An LPCI is essentially a provider-purchaser network. RHAs enter into contracts with primary care physician groups that provide primary care for an agreed upon list of services on a round-the-clock basis. The precise composition of the LPCI (in terms of providers) is flexible and is supposed to reflect local needs and priorities. Physicians are compensated either through a fee-for-service scheme or an alternative relationship plan (a salary). Participating physicians also receive an additional \$50 for every patient enrolled in an LPCI network. The LPCI program is intended to improve coordination between primary care and hospital services (and to reduce any overlaps and redundancies), to facilitate greater access for patients, and to integrate the entire chain of services from the family physician to post-operation care in conjunction with Alberta’s new

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<sup>111</sup> Kirby, 2004.

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<sup>112</sup> See 2004/2005 Regional Health Authority Global Funding: Methodology and Funding Manual (Government of Alberta, Ministry of Health and Wellness, September 2004); Government of Alberta, Website ([www.health.gov.ab.ca/regions/index.html](http://www.health.gov.ab.ca/regions/index.html)). Accessed March 8, 2005.

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waiting times registry initiative.<sup>113</sup> In this respect, the LCPI initiative is primarily about organizational change.

Family Health Teams in Ontario

The Ontario Ministry of Health and Long-Term Care (MOHLTC), in an effort to increase access to care, has been similarly re-organizing primary health care delivery at the local level. There is an emerging consensus among health policy officials that effective delivery in Ontario requires more coordination and a fuller integration of existing services. As it is now, primary health care delivery is organizationally decentralized, which many argue means that there is no discernible “system” for delivering primary care delivery in Ontario. With the creation of Local Health Integration Networks (LHINs) from the summer of 2004 onwards, health policymakers began looking for ways to connect disparate providers and services. The LHINs are to replace the existing District Health Councils in April 2005 as the primary unit of medical care planning at the sub-provincial level.

Which services to integrate and how to integrate them are two of the key questions that Ontario health policymakers are currently considering. In the fall of 2004, the Ontario MOHLTC hosted workshops and launched several surveys of health care stakeholders (including the general public and providers) to establish planning priorities for integrating the spectrum of health care services. Primary care provision emerged as a high priority for both citizens and providers alike.

Beginning in late 2004, the MOHLTC began laying the groundwork for establishing Family Health Teams (FHT), which would essentially re-organize primary care delivery. Each FHT is to integrate and coordinate services among a network of primary care providers, comprising a family doctor, a nurse practitioner, a registered nurse, a dietician, and a pharmacist. Establishing an FHT is voluntary on the part of providers, though each team must provide comprehensive care (according to a mandated list of services), expand access (ideally round-

the-clock care), and exchange information within each the team and with local hospitals. Each FHT must register with the MOHLTC either as a non-profit organization or as a corporation. Unlike the Alberta model, where provider compensation (purchasing) is paid by the decentralized regional health authorities, providers in FHTs will continue to be compensated by the MOHLTC through a capitation formula, a complement-based formula, or individual salaries. Similar to the Alberta initiative, however, the Ontario FHT program intends to increase coordination among different services, increase patients’ access to care, and expand the flow of patient information within the team, thus delivering services more efficiently. The ministry has offered start-up funding to prospective FHTs, and it expects to have launched 45 teams by April of 2005.<sup>114</sup>

Waiting Times Reduction in Ontario

In large part because of political and media pressure, the Ministry of Health and Long-Term Care (MOHLTC) in Ontario has committed to reducing waiting times in five key areas – cardiac care, cancer surgery, sight restoration (cataracts), diagnostic imaging, and joint replacements. These are also known as the “big five.”. A contributing factor to long waiting times in Ontario and, more importantly, to the inefficient management of waiting times is the lack of surgical and clinical data available to health decision-makers within the Ontario MOHLTC and to front-line health care providers. Consequently, there are no systematic performance indicators and thus few checks on systemic efficiency in the allocation of surgical or diagnostic resources. Moreover, the lack of data (and indicators for such data collection) undermines efforts to coordinate access and clinical priority setting (such as which cases should go first and which cases should go where). At present, physician decisions to treat and refer patients to specific hospitals are, for all intents and purposes, made “blind.”

Ontario’s waiting times reduction strategy has three parts. First, the MOHLTC has begun to

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<sup>113</sup> Comm, 2003.

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<sup>114</sup> Ministry of Health and Long-Term Care, Government of Ontario, 2004a.

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collect data in six-month intervals, creating a new data flow (the time between “decision to treat” and “treatment”) from the surgeon’s office through the hospital board and ultimately to the ministry. Second, new federal investments – such as from the dedicated Wait Times Reduction Fund established at the 2004 First Ministers Meeting – have been used to clear out waiting-list backlogs by purchasing new equipment and by increasing the volume of surgical procedures. In late 2004, the Ontario government allocated \$107 million for waiting times reduction, of which \$26 million targeted surgical backlogs alone.<sup>115</sup> The number of MRI exams performed in Ontario is also expected to increase by nearly 20 percent between 2003-4 and 2005-6.<sup>116</sup> Third, Ontario’s strategy involves organizational change. As Alan Hudson of the ministry points out, waiting times are not just a symptom of funding gaps from the federal government but also a function of irrational “access management.” To facilitate organizational change, planners of Ontario’s Wait Times Reduction Strategy have adopted the Saskatchewan model, which was originally imported from the Cardiac Care Network of Ontario during the mid-1990s. The ministry has set up purchase agreements with hospitals in which the hospitals provide specific surgical/diagnostic procedures for a fixed price over and above each hospital’s overall budget. The purchase agreements stipulate, however, that hospitals must provide in-house data to the ministry, thus allowing the government to evaluate each provider’s efficiency (and cost), their capacity, and their waiting lists. This data is then to be channelled into centralized registries and waiting lists, which will be made accessible to the public and to physicians. The flow of information thus will be centrally disbursed to all stakeholders, while actual clinical decision-making and priority-setting are to remain in the hands of medical professionals. The government’s intention is to refer patients to providers (hospitals) through a centralized information clearing house, which will in turn maximize allocative efficiency on the basis of clinical need and providers’ capacity to perform

required procedures.<sup>117</sup>

## **Conclusion**

The significance of the health policy events of 2002 through to the fall of 2004 cannot be overstated. Although there remains considerable skepticism on all sides of the political spectrum and among myriad stakeholders regarding the future of Canadian health care – as there always will be in an area as politically contested as health – the 2002 Romanow Report, the 2003 Health Accord, and the 2004 Ten-Year Plan have nonetheless produced significant changes in both the politics and policy of health care in Canada. In this conclusion, I focus on four key aspects of Canada’s recent efforts at health care renewal.

### Federal Funding Commitment

First and foremost, the 2003 and 2004 agreements resulted in long-term federal funding commitments specifically earmarked for health. As we know, federal investments in health had dwindled from the late 1970s and into the 1990s. The Established Programs Financing scheme (EPF) and later the Canada Health and Social Transfer program (CHST) allowed Ottawa to essentially pass the buck to increasingly cash-strapped provincial and territorial authorities. Ottawa desperately attempted to frame the deal as flexible federalism, though in reality provincial and territorial governments were left without the fiscal capacity to effect any real health care improvements, having to be innovative just to maintain their existing levels of health provision. There was simply not enough money to spend flexibly.

Public opinion began to challenge these arrangements during the late 1990s, and the 2002 Romanow Report re-oriented the “governmental agenda” towards health care renewal.<sup>118</sup> Indeed, regardless of one’s interpretation of Romanow’s broader normative message, as an agenda-setting mechanism, his 2002 report effectively narrowed intergovernmental debates to the inter-related

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<sup>115</sup> Ministry of Health and Long-Term Care, Government of Ontario, 2004b.

<sup>116</sup> Ministry of Health and Long-Term Care, Government of Ontario, 2005.

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<sup>117</sup> Thanks to Alan Hudson of the Ministry of Health and Long-Term Care for clarifying Ontario’s waiting times reduction strategy.

<sup>118</sup> Kingdon, 1995.

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issues of federal funding and accountability. This funnelling effect, combined with a sizable federal fiscal surplus at the end of the 1990s, resulted in a large injection of federal funds, and with the 2004 Ten-Year Plan, a federal commitment that is supposed to last until fiscal year 2013-14.

The federal government's health (and social) transfers to the provinces remained flat prior to the fiscal year 2003-2004 (see Table 6). However, in the first year after the Romanow Commission recommended that Ottawa take on a larger role in financing health care, federal transfers to the provinces increased markedly, by an average of 17 percent growth across the board. The provinces also felt the fiscal impact of the 2003 Health Accord immediately, as they received an average 20 percent increase in the fiscal year 2004-2005. Moreover, new sources of targeted funding from Ottawa – for medical equipment, the health reform fund, the Romanow Gap, waiting times reduction, and public health (and immunization) – accounted for a sizable portion of federal transfers. In Ontario, for instance, targeted funds equalled 36 percent of the province's dedicated Canada Health Transfer in 2004-2005.

Re-Casting Federalism: Lessons from Canada?

The 2003 and 2004 funding agreements fundamentally altered the politics of health care policymaking in Canada. These two deals, combined with the powerful normative appeals embedded in the 2002 Romanow Report, moved health care policymaking closer to a collaborative model of federalism. For instance, the conditions attached to the new federal funds have been relaxed considerably, especially with the convergence of federal and provincial priorities in health care reform. In the area of waiting times reduction, benchmarks and targets are to be developed through intergovernmental collaboration over the course of 2005. They will not to be imposed unilaterally by the federal government, as the provinces initially feared in 2002.<sup>119</sup> Moreover, regular meetings of the

provincial and territorial Ministers of Health, along with parallel meetings of ministry bureaucrats, have facilitated inter-provincial policy learning and policy adaptation across jurisdictions. The fact that Ontario is adapting Saskatchewan's waiting times reduction strategy suggests that "leaders" and "followers" in health policy innovation can emerge from anywhere and that collaboration between the two orders of government and among provinces is the engine of health policy change and innovation.

When it comes to making federalism work, what can we learn from Canada?

First, the 2004 agreement among the First Ministers re-cast federalism and health policy innovation away from past practices of "prohibitive" federalism and towards a *more positive federal-provincial-territorial pact*. Although the 1984 Canada Health Act (CHA) was rhetorically framed as a national affirmation of core Canadian values and principles in health care, politically speaking, the federal government intended the CHA to prohibit the provinces and territories from enacting certain policies. Specifically, the CHA forbade provinces from institutionalizing mechanisms for parallel private sector care for extra-billing by for-profit providers. The 2004 pact between the two orders of government was fundamentally different, however. The 2004 Ten-Year Plan was motivated by a mutual desire to meet agreed goals and objectives (in other words, round-the-clock access to primary care, reductions in waiting times, home care, and catastrophic drug coverage) and less by the need to prohibit certain policy innovations (as it was in 1984).

Second, the idea of accountability in federalism had changed by 2004, which altered the political and policy dynamics between Ottawa and the provincial/territorial governments. Accountability in the 2004 agreement was understood to be less about provincial and

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should first establish a proposal for targets and then present this to the federal government in subsequent meetings. Thanks to Ken Chan of the Minister's Office (Ontario Ministry of Health and Long-Term Care) for pointing this out.

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<sup>119</sup> The main issue presently is whether or not Ottawa should be at the negotiating table from the very beginning. Some provinces – Quebec, Alberta and British Columbia – maintain that the provinces

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**Table 6: Federal Health (and Social) Transfer to Provinces, 2001-2005 (by province; \$ millions)**

	Newfld	P.E.I.	N.S.	N.B.	Quebec	Ontario	Man.	Sask.	Alberta	B.C.
<b>2001-2002</b>										
CHST Base	306	82	555	455	4479	6147	698	607	1411	2503
Supplement	17	4.5	30.3	24.2	238	380	37	33	98	135
Med Equip	9	2.3	15.2	12.2	119	190	19	17	49	66
Health Ref	--	--	--	--	--	--	--	--	--	--
<b>• TOTAL</b>	<b>332</b>	<b>88</b>	<b>600</b>	<b>491</b>	<b>4837</b>	<b>6717</b>	<b>753</b>	<b>656</b>	<b>1557</b>	<b>2704</b>
<b>2002-2003</b>										
CHST Base	323	86	589	473	4690	6706	728	616	1543	2784
Supplement	8.4	2.2	15	12	119	191	18	16	50	67
Med Equip	--	--	--	--	--	--	--	--	--	--
Health Ref	--	--	--	--	--	--	--	--	--	--
<b>• TOTAL</b>	<b>331</b>	<b>89</b>	<b>604</b>	<b>485</b>	<b>4809</b>	<b>6897</b>	<b>747</b>	<b>633</b>	<b>1593</b>	<b>2851</b>
<b>2003-2004</b>										
CHST Base	334	90	611	490	4890	7048	758	666	1664	2710
Supplement	25	6.6	44.8	35.8	354	577	55	48	149	200
Med Equip	8.4	2.2	15	12	118	193	18	16	50	66
Health Ref	16.4	4.3	29.6	23.7	237	387	37	31	100	131
<b>• TOTAL</b>	<b>384</b>	<b>103</b>	<b>701</b>	<b>562</b>	<b>5599</b>	<b>8204</b>	<b>868</b>	<b>762</b>	<b>1962</b>	<b>3107</b>
	(+16%)	(+16%)	(+16%)	(+16%)	(+16%)	(+19%)	(+16%)	(+20%)	(+23%)	(+9%)
<b>2004-2005</b>										
CHT Base	219	58	397	318	3190	4628	495	421	1107	1774
Supplement	33	9	59	47	471	775	73	63	199	264
Med Equip	16	4	30	24	235	387	36	32	100	133
Health Ref	24	6	44	35	354	582	55	47	150	197
Rom Gap	16	4	29	24	236	388	37	31	100	131
Wait Time	10	3	18	15	148	242	23	19	63	82
Pub Health	2	1	4	3	31	50	5	4	13	17
CST	140	37	253	203	2037	2971	316	269	713	1133
<b>• TOTAL</b>	<b>461</b>	<b>123</b>	<b>834</b>	<b>669</b>	<b>6702</b>	<b>10024</b>	<b>1039</b>	<b>886</b>	<b>2446</b>	<b>3731</b>
	(+20%)	(+19%)	(+19%)	(+19%)	(+20%)	(+22%)	(+20%)	(+16%)	(+25%)	(+20%)

territorial accountability to *Ottawa* and more about governmental accountability and responsiveness to citizens generally, reflecting provincial and territorial priorities specifically.<sup>120</sup>

This conceptual and political development was not insignificant. It compelled *Ottawa*, for instance, to accommodate greater flexibility in the allocation of federal funds within provincial and territorial jurisdictions. From the perspective of the provinces and territories, the new emphasis on public accountability rather than on their governmental accountability to *Ottawa* provided them with more political and

policy space within which to pursue their particular health care priorities and to implement their context-specific reform strategies. The fact that both levels of government and, to a certain extent, the general population agreed on which priorities were most pressing helped to reinforce these accountability/responsibility commitments.<sup>121</sup>

Third, the recent 2003 and 2004 agreements highlight how intergovernmental pacts that are *goal-oriented rather than solution-based* can promote national standards in health objectives (such as in the 1984 Canada Health Act) while also allowing for a diversity of solutions among

<sup>120</sup> As Ken Chan from the Ontario Ministry of Health and Long-Term Care puts it: Accountability “goes beyond fulfilling our responsibilities to the federal government; it is about fulfilling our platform and commitment to the people of Ontario.”

<sup>121</sup> Thanks to Dr. Phil Jackson of the Ontario Ministry of Health and Long-Term Care’s Public Health Division for emphasizing this point.

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sub-national jurisdictions.<sup>122</sup> Provinces and territories need the legitimate space and resources with which to address local priorities and to implement strategic plans. Thus, federalism works best when federal funds are combined with collaborative efforts among governments towards fulfilling national goals and principles. On the flipside, federalist policy innovation is circumscribed when goals are *a priori* trumped by the federal imposition of nationally prescribed means. This is amplified in federal systems where sub-national jurisdictions are diverse in their respective social, economic, and demographic profiles. Therefore, goal-oriented federalism requires that policy objectives be defined broadly. For political actors, this sort of breadth and flexibility facilitates political consensus-building over policy “first principles” among the two orders of government. For jurisdictional policymakers (for instance, bureaucrats), such breadth allows for some latitude in policy design and innovation towards meeting agreed upon objectives.

Finally, the Canadian experience in health care renewal offers an important cautionary note. In negotiating and establishing common health objectives, governmental stakeholders must ensure that the standards and benchmarks of health care performance reflect national health goals and not the lowest common denominator agreeable to federal, provincial and territorial governments. Put another way, ingenuous goal-setting in the first place is crucial in order to stem purely politically instrumental incentives for meeting scaled-down benchmarks. To compromise the exercise of effective benchmark setting in the interests of political expediency may come ultimately at the cost of national health.

Unpacking “Investment”

Overall, the increase in federal spending has amounted to a new wave of “investments” in Canada’s health care system. However, it is important to define exactly what these new investments are and, accordingly, what they are not, and also to untangle the myriad political and

policy motivations that lie behind these investments.<sup>123</sup> Investments in health can: (i) *expand* the scope of benefits beyond current levels, (ii) *maintain* (or return to) pre-existing levels of health care provision, or (iii) *increase the productivity of provision* in terms of efficiency, quality, equity, and accessibility.

Recent federal investments into Canadian health have not been about expanding the bundle of benefits already provided by the public system. The 2002 Romanow Report was quite explicit in this regard. The report’s recommendation for new federal funding were essentially to plug the holes in what the Commission (and others) saw to be Canada’s sinking Medicare ship. In terms of policy, many saw the 2002 Report as a reinforcement of the status quo, albeit a more financially stable one, in health. Nevertheless, the Romanow Report was crucial in alerting the general public to the federal government’s waning responsibility for health care financing and also in initiating a broader discussion on governmental accountability in health care provision. In these important ways, the 2002 report set the stage for subsequent rounds of intergovernmental negotiation.

Unlike the 2002 Romanow recommendations, however, the 2003 and 2004 federal health agreements put more emphasis on “buying change” in the health sector and on increasing productivity in health care provision. To be sure, new sources of capital investment (in other words, dedicated investments in human capital development and medical equipment) account for a significant share of new federal transfers to the provinces and territories. Provincial health policymakers have also begun to initiate organizational reforms in primary care delivery, the networking of care providers more generally, and reducing surgical waiting times in order to increase the accessibility and efficiency of health care provision. Yet, as in 2002, there was little intergovernmental discussion about expanding the scope of pre-existing benefits. Proposals for a national pharmacare program and for more comprehensive long-term care coverage, for instance, were shelved because of federal fiscal constraints.

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<sup>122</sup> Thanks to Richard Simeon for clarifying this point.

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<sup>123</sup> I am indebted to Joe White for clarifying this point.

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What then motivated these specific “investment” decisions? How did government decision-makers rationalize this particular allocation of investment resources? In 2003 and 2004, for both the federal and provincial/territorial governments, the key objective, short of privatizing the health care system *in toto*, was to increase productive efficiency through organizational change (such as in primary health care reform). This strategy, however, meant that the general public was unlikely to notice any tangible or measurable improvements, especially in the short term. Politically, then, making organizational changes to increase efficiency would not win back the public’s confidence in the governments’ ability to manage Canada’s public health care system. Because of this, addressing the waiting times issue, for instance, became a key governmental objective, and as such, there have been significant new policy initiatives (in other words, organizational reform) and more importantly *visible investments* (in other words, explicitly targeted transfers) aimed at reducing waiting times. Each province has purchased new diagnostic equipment (such as MRIs and CT scanners) and spent more resources to clear surgical backlogs. As alluded to above, this particular policy area, while comparatively low on health policymakers’ list of priorities, emerged as one of the critical benchmarks for evaluating both the federal and the provincial governments’ performance in health care reform. Thus, what investments were made in 2003 and 2004 was determined in part by what was doable fiscally and in part by what was politically expedient, especially in the near term.

Political Uncertainty

Effective federalism entails effective political deal-making. The centralization or decentralization of policy authority and fiscal capacity are not simply matters of public administration. Rather, they are about politics. As such, any compromise in a federal system is subject to the vagaries and uncertainties of politics. To be sure, the present moment of collaborative federalism in Canada is not the norm. Indeed, to most Canadians, the present is

a surprising but welcome anomaly in the continued evolution of Canada’s intergovernmental relations.

Intergovernmental agreement over the 2004 Ten-Year Plan ultimately depended on the political skills and personalities of Prime Minister Paul Martin, and Premiers McGuinty (Ontario), Charest (Quebec), and Klein (Alberta). The acrimony associated with the 2003 Accord compared with the goodwill associated with the 2004 Ten-Year Plan, for example, reflected differences in leadership styles between Jean Chrétien and his successor as federal Prime Minister, Paul Martin. Chrétien had been less willing to compromise with the provincial and territorial premiers in 2003 than Martin was to forge side deals with Quebec and aboriginal leaders in 2004.

Still, the political basis of the 2004 agreement was, and remains, precarious. The 2003 and 2004 health care financing deals are not guaranteed beyond the term of the current sitting government. Given the weak hold that Martin’s minority government has in the national legislature, it is not inconceivable that his party will be defeated in the next general election. There is no safeguard that the next government in Ottawa will honor the funding agreements reached in 2003 and 2004.

Finally, it needs to be stressed that Ottawa’s fiscal surplus at the end of the 1990s was the supply-side impetus behind the recent health care financing deals. There are no guarantees that the federal coffers will remain as full over the next decade. Cynics will therefore rightfully point out that social policy programs, and the politics of collaborative federalism that underpin them, run more smoothly in times of fiscal surpluses. History has shown us that, under conditions of fiscal deficits, funding commitments for social programs, and especially for expensive ones such as health, are the first to be clawed back. Indeed, as the Canadian case demonstrates, in times of fiscal restraint, the already thin line between productive federalism and the political game of blame avoidance becomes razor thin.

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## Summary of the Discussion

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### Commentary

This session opened with the presentation of two papers by Alan Maynard and Joseph Wong that described the experiences of two countries – the UK and Canada – in increasing spending on their health care systems. Their presentations raised some intriguing questions, including what exactly constitutes the concept of investment and whether “investment” is any different from “increased spending.”

One conclusion could be that there is no difference. Perhaps “investment” is a better label than “spending more” because:

- Investment sounds better than consumption to anybody in the budget or evaluation business
- It promises benefits in the future as well as in the present
- It suggests that there will be value for money – a “return” – in a way that “spending more” does not.

By this definition, “investment” would not involve any obvious economic standard for evaluation. Some extra output might be expected in return for the investment, but there might not be a clear standard for how much extra output should be realized from the extra spending. This can be called *investment as labelling*.

Alternatively, one might expect “investment” to increase the productivity of a health care system beyond its previous level. For example, advocates claim that “investment” in information technology will improve quality and control costs in ways that will eventually allow systems to produce more of whatever good that they produce per unit of money spent than they are producing now. “Investment” in information technology in particular looks less like “consumption” than other spending does because money is not being spent directly on providing health care. So by this standard, one would expect production to increase by

relatively more than the increase in spending. The period during which the Canadian federal government was promoting the idea that new spending would somehow increase efficiency fits this definition. This can be called *investment for productivity*.

This second meaning may approach an ordinary understanding of what “investment” by firms or individuals is supposed to accomplish – an increase in production. However, that is not in fact what all capital spending does. Often, capital spending is necessary to replace depreciated plant. In that situation, investment is necessary largely to maintain current levels of services; the failure to “invest” would lead to fewer or lower-quality services in the future. In short, if we conceive of investment as any capital spending, then whether this will lead to increased production is likely to depend on the previous history of capital spending. If the plant has been depreciating, new capital spending will look like a total spending increase but will in fact just maintain current levels of service. Then, relative to previous years, “investment” will seem to increase spending to no obvious effect, yet it may be quite necessary. Clearly some advocates in both the UK and Canada think that some spending increases were necessary simply to make up for previous depreciation; Alan Maynard is generally skeptical of spending increases for the reasons given in his report, yet he suggests that there were some genuine needs. So this can be called *investment for deferred maintenance*.

### Evaluating These Different Types of Investment

There are probably other purposes of investment, but these three should be enough to show the complexities involved in evaluating expenditures. In some cases, the standard for *investment as labelling* may be political, for example, if politicians decide to spend more and the voters approve of this decision, then the decision is appropriate. There are, of course, many economists and other analysts who do not like “politics” and presume that politicians

## Summary of the Discussion

spend “too much,” but as a matter of public finance, it is inappropriate to make that assumption. At a minimum, only a quite right-wing economist would say that governments that have surpluses cannot choose to reduce those surpluses in order to buy valued public consumption, as was the situation in Canada. Similarly, it is unreasonable to object to voters choosing to pay extra taxes to cover the cost of the spending, as in the UK. In both these cases, one could argue that, if the voters re-elect the government that decided to spend more, then the “investment” was successful – end of story.

Now consider *investment for productivity*. This appears to be the default standard for health service researchers and economists. However, it involves a wide range of difficulties that Alan Maynard discusses and that help to explain why provincial policymakers in Canada were not particularly interested in standards set by Health Canada. Among these problems are:

- 1) The lack of a metric with which to compare different services. In the classic formulation of the problem, is an increase in cardiac surgery or hip replacements more “productive?”. Many scholars have been promoting QALYs for a couple of decades now, and in the UK, the NICE process does apply QALY logic to some new coverage decisions, but it seems fair to say that this thinking has had at best only a limited effect on health care systems.<sup>124</sup>
- 2) A lack of agreement on the object of productivity. Alan Maynard has argued that the point of investment should be improvements in the health of the population. As he notes in his report, however, what seems obvious to economists may not be so to others. I do not think the improved health of the population is the purpose of national health care/insurance systems. I will return to this question later.
- 3) A lack of agreement on how to conceptualize and then measure productivity even at the individual patient level. Should

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<sup>124</sup> I was more skeptical in the original draft that I shared with Alan Maynard, Joseph Wong, and Naoki Ikegami; in response to comments from Alan Maynard and Pauline Rosenau, I will give QALYs more of the benefit of the doubt.

services be the measure? Or cures? Or some measurement of amelioration (QALYs again)? In other words, we not only do not know how to compare hip replacements to cardiac surgery, we are not sure exactly what an increase in spending on hip replacements is supposed to buy. To put this another way, even if we know we want cures or amelioration, we may only know how to buy services that are ostensibly supposed to yield these outcomes. Then what?

- 4) A lack of agreement on the extent to which amenities and convenience should be considered part of the product. If people have less frightening and alienating experiences in the hospital because the nursing staff is nicer, even if there is no measurable difference in post-operative mortality, is spending that improves patients’ hospital experience “unproductive?” What about waiting times – should they matter and how much? And who should get to make such judgments? If a better experience is something most voters want, do health services researchers have a right to dismiss that?
- 5) The fact that there are long causal chains from any “investment” to any result. Maybe spending on information technology will eventually lead to fewer medical errors and the development of treatment guidelines that increase value for money. But the odds that anything of the sort could occur within the time frame being applied for evaluating recent Canadian and British spending increases are close to zero. Over the longer term, it will be very hard to untangle the effects of information technology from the effects of other developments.

In short, even if we were to agree on the investment for productivity standard, evaluating it would be quite difficult. Yet Alan Maynard’s paper provides an interesting sideways answer to that problem by identifying outputs that are at best very weakly linked to production. If extra spending results in providers receiving higher incomes for doing the same work as before, this would not qualify as extra productivity by much of any standard (but see below).

This brings us to *investment for deferred*

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*maintenance.* From one perspective, the difference between investment for deferred maintenance and investment for productivity is an illusion. In each case, more will be produced with the investment than without. The only difference is that the effect will be less visible when the spending is for deferred maintenance than for productivity because levels of production may not increase from year to year. But visibility should make a big difference for the purposes of both evaluation and politics. As nobody can measure how production would otherwise have declined, it is hard to assess the effects of the work done to make up the decline. In addition, if voters do not benefit visibly from the spending, then they may not be convinced that it was worthwhile (which, of course, is why the maintenance was deferred in the first place).<sup>125</sup>

Although the concept of maintenance can be applied most obviously to capital plant, it can also be applied to human capital. Someone who wanted to justify the use of spending increases to raise the salaries of Canadian physicians or nurses might argue that caregivers otherwise might respond by moving to the United States. So higher pay would be an investment in maintaining their participation in the Canadian health care system. Alternatively, if higher spending were used to hire more nurses, then this might reduce burnout among the existing nursing staff, thus keeping them as part of the system. Again, this would be a form of human capital conservation.

It should be obvious that the value of arguments in favor of deferred maintenance is especially difficult to assess. First, this requires making guesses about what would have happened otherwise. Second, when arguments are made in favor of deferred maintenance in the area of human capital, they are often extremely self-serving and accompanied by all sorts of political manipulation. However, sometimes when calls for investment are made simply to prevent the health system from going into decline, these

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<sup>125</sup> On the other hand, if investment is spent on making facilities more attractive, then the public might perceive an improvement that health researchers would not. So deferred maintenance might be valued by the public for the “wrong” reasons!

arguments are legitimate, even if also self-serving. There can be little doubt that some of the political pressures that led to the increased “investment” in the UK and Canadian health care systems involved versions of deferred maintenance claims.

### Lessons for Whom? The Problem with “Population Health”

Let us imagine for the moment that we could draw lessons from the UK and Canadian experiences with “investment” and that those lessons would be of use to other policymakers. What might they want to learn about?

I mentioned earlier that measuring whether spending has increased the health of the population is not the right standard for judging investments. By that I mean it is not the right standard for voters or for politicians, nor is it the right standard for most policy analysts. Yet it might be the right standard for decision-makers at the World Bank. The reason is the Bank’s concerns are different from those of ordinary citizens or politicians in a “rich democracy” (the term is Hal Wilensky’s simpler version of “Advanced Industrial Democracy”).

Why do we have national health care/insurance systems? Does anybody vote for them, and did national political leaders from Bismarck onward work to create them in order to increase “population health”? The answer is yes, but only to a minor extent in that some leaders wanted to make sure that their nation’s potential soldiers were able-bodied. Yet basically national health care/insurance systems have been pursued and adopted because of concerns about equity and social peace. They are not created and operated explicitly to raise population averages in health status. They are created and operated to provide a socially acceptable level of medical services to all individuals. Voters do not care about population health as much as they care about their own access to medical care. Nobody ever died of short life expectancy, while lots of people can die or suffer pain from inadequate medical care.

Hence, political support for national health care/insurance systems derives from two beliefs. The first is that access to medical care when in need is an extremely significant aspect of one’s

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life chances. The second belief is that, while it is acceptable to distribute lots of life chances unequally, significant differences in access to medical care when in pain or danger are simply indecent, an unsupportable inequality. This belief may derive from the seriousness of consequences, or the immediacy of the consequences, or an ability to imagine the consequences. In all these dimensions, access to medical care is very different from issues such as the size of a pension or even the kind of education provided. Hence, while every system has inequalities, support for some decent social minimum has resulted in substantial equity in all rich democracies other than the US.

I do not think anybody should seriously doubt that this equity concern is one reason for the “investment” policies in Canada and the UK. In each case, the government feared that some individuals would use their private options in such a way that would make them far better off than their fellow citizens, that this would be very visible, and that the majority of the population would even prefer (somewhat) higher taxes (on somebody) than to increase inequality in this way.

But limiting inequality is only one part of the political pressure for higher health care spending (under any circumstances, whether this spending is called “investment” or not). The other source of pressure is the development of notions about what “necessary” care involves. “Necessary,” as health services researchers will tell us, need not mean “effective” or certainly “cost-effective.” Instead, it is a social expectation, a compound of beliefs about effectiveness and decency. For example, the concept of “necessity” as defined in the United States probably includes an expectation of two-bed rooms for hospital patients instead of the old open-ward structure, whereas in other countries the accepted standard includes more beds in a room. The standard of “necessary” nursing care and hotel services is reportedly much lower in Japan than in other countries. It is clear that the definitions of those services that are “medically necessary” and of “appropriate levels of amenity”, and that therefore should be subject to social sharing and norms of equity, can vary from country to country.

These and other kinds of national variations

mean that technological advances do not automatically translate into similar service expectations across all countries. “Technology” does not automatically drive health care costs up at similar rates across all rich democracies. If it did, there would be similar rates of use in all countries and similar costs, whereas in fact there are significant differences. Nevertheless two kinds of pressure make it difficult for any of these countries to resist adopting these new services.

The first pressure comes from the fact that wealthier people within any country can afford to buy private health care. To the extent that people can get private care of a supposedly higher standard, this creates an *equity* concern that may force managers of the public health system to make a service available if it is already available in the private sector. The second pressure comes from international comparisons. It is not so much that policymakers (never mind citizens) look to other rich democracies for new ideas but that in particular circumstances, there can be direct competitive pressures.

For example, the Canadian government benefits from the fact that the difference between the US and Canadian health systems has become a point of fundamental national pride and identity in Canada. Yet physicians can fairly easily move to the US to practice, the American media are widely prevalent in Canada, and lots of Canadians spend significant parts of the year in the US. As a result, the public exerts pressure on the government to make the Canadian standard of services resemble the American (Medicare beneficiary) standard. Citizens in the UK did not have a similar reference group in the past, but the development of the EU has made the possibility of patients going to other EU countries for treatment a real concern, and the difference in access to services an embarrassment to the Labor government.

Thus, there are several likely motives for the governments of the UK and Canada to have increased spending on health services regardless of any concern for population health – notions of equity, national pride, and comparisons with the standards that prevail in other countries. Indeed, I strongly suspect that the fact that both the UK and Canada have neighbors that spend more and deliver more services (to those who are served)

## Summary of the Discussion

helps to explain why these are the two cases of “investment” that have arisen and are being discussed at this seminar.

From this perspective, the relevant lessons to draw about the impact of the investment would not include its impact on public health. Instead, the relevant lessons would involve whether and under what circumstances greater spending actually translates into what the public views as greater equity either within a country or between its own citizens and those of the reference country or countries. I think that is the right set of questions for policymakers in other rich democracies who want to learn from the current British and Canadian experiences. For example, Japanese policymakers might use the information from this session to reflect on the possible consequences of new investments in the Japanese health care system on political support for the health care finance system and for themselves.

The World Bank’s decision-makers are more likely to be interested in which of its many potential investments in any given country will cause the greatest improvement in national well-being? The Bank’s decision-makers usually seem to define national well-being in material terms and usually care more about averages than equity. Therefore, they may legitimately care more about the population’s health than, in my view, national policymakers in rich democracies.

In that case, I fear that these papers will not tell the Bank’s decision-makers much that they do not already know. Rich democracies are very different from the countries that the Bank is supposed to serve, and their governments have to adopt policies for many different purposes and with far different resources. Most rich democracies, have done most of the important public health spending, so they do not face having to choose between providing universal medical services and improving public health indicators in the same way as policymakers in the Global South do. In any event, the investments in Canada and the UK are highly unlikely to tell the Bank much about the wisdom of investing in Morocco or Zambia or even Argentina.

At the same time, if I am right about the reasons why nations have adopted national health

care/insurance systems, then the Bank’s decision-makers should pay attention to the possibility that violating notions of equity can have nasty consequences for any governments being advised by the Bank. This should be a particular concern in nations that have some history of broadly distributed medical care (for example, in Eastern Europe and in some of Latin America).

### Lessons for Rich Democracies from the Case Studies

From the standpoint of policymakers in rich democracies, the first lesson from these papers is that they are about investment as labeling or as deferred maintenance at least as much as they are about investment for productivity. Thus, they should be evaluated for what they are, which means their effect on perceptions of equity rather than for any visible effects they may have had on population health.

If those are the real issues, then the papers have some quite useful findings. For example, both papers make it clear that what the public really cares about are outputs that are less significant to analysts, particularly waiting times. The argument made by analysts that reduced waiting times do not necessarily increase the quality of care is not of great interest to patients. For them, equity in access to services is the crucial issue because they feel that having to wait 18 months for a service (especially when their cousin in Cleveland or Brussels was treated within three) just is not fair. Not surprisingly, politicians tend to pay more attention to patients than to analysts.

Joseph Wong’s Canada paper seems to indicate that measuring outputs and outcomes (other than waiting times) does not get much support (except from analysts). This is completely understandable given that, as we have established, increased spending should create a presumption that the government is increasing equity, and measurement is more likely to give bad news than good on that front. If there is a political argument for measurements, it is a “who gets the credit” argument. Because the national government in question wants to be able to make a credible claim that *its* spending increase is causing services to increase, it wants

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to be able to measure results in the provinces. However, when put to the test, even the government might figure out that it is better to be safe (unmeasured) than sorry (measured and found wanting). Moreover, in the Canadian case, one of the major reasons for increasing spending was to reduce the chance that provincial governments might decide to opt out of the equity constraints created by the Canada Health Act. If the spending has that result, then it is successful regardless of any effect it may have on actual medical services.

Alan Maynard's UK analysis provides a series of extremely cogent warnings about the risks that rent-seeking (actually, rent-appropriation, not just seeking) will reduce the increase in services (never mind in population health) that new spending will buy. Health care systems are no different from other government programs or, for that matter, market activities in that it is possible to throw more money at them than they can use productively without substantial waste. Good examples of this are American federal spending on the "drug war" in the 1980s or on telecommunications in the 1990s. It is very difficult to monitor how the money is spent and perhaps even more difficult to know in advance how it should be spent. Moreover, the "adequacy" of services is to some extent a perception on the part of voters that is based on the extent to which physicians have been complaining publicly. To that extent, even the "waste" in the form of increased rents to medical providers may be perceived as "success" by voters who hear fewer (or less vociferous) complaints from the medical community. Given these difficulties, governments can be expected to focus on outputs that the public thinks it understands and are relatively easy to measure (and manipulate) like waiting lists.

Given my skepticism about measuring results, I was actually pleasantly surprised by the degree of success that Alan Maynard reported in his account of events in the UK. I may be more favorably impressed than he is because I care a bit more about things like waiting lists and public perceptions of amenities. I also may have even lower expectations than he does. Yet I also found his enumeration of the rent-seeking problems to be particularly useful for thinking about the difficulties of managing spending increases (or any spending) in any system.

I was not at all surprised by the lack of evidence of results in Canada, for two reasons. First, the "investment" is far too recent to have had any obvious effects yet. Second, in any federal system, there is a primary rent-seeking opportunity, namely that the provinces may use the new national funds to replace their own. National policymakers in Canada who seek "results" from their investments are in an even worse position than are their counterparts in the UK. Yet, as I mentioned, if the real purpose of national "investment" is to enforce the Canada Health Act's equity goals, then what provincial governments or providers really do with the money is not so important.

Policymakers who are considering making "investments" in their health care systems could do worse than to give careful thought to the issues of both rent-seeking and equity.

### **The Discussion**

The discussion in this session had three components. After each paper was presented, there was a period when participants could ask questions about its contents. Then, after both papers had been presented and a break, there was an open discussion of themes raised by both papers.<sup>126</sup>

#### Discussion 1: Alan Maynard's Paper

One theme in the discussion of Alan Maynard's paper was why the British government decided to expand the National Health Service (NHS). Regardless of the substantive reasons, what political considerations caused the government to make that decision at that time, reversing decades of much more stringent policies?

Alan Maynard emphasized four factors: some embarrassment at comparisons to the health systems of other Western European countries;

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<sup>126</sup> I prepared this summary based on both my own notes and notes kindly provided by the conference secretariat. I would like to thank Naoki Ikegami and the secretariat for their hospitality and help, and all participants in the conference for providing a discussion that made summarizing the contents a pleasure.

real deterioration of plant and facilities (what I have called the “deferred maintenance” argument); pressure from the medical profession to raise standards; and the fact that the budget and the economy of the UK were in unusually good shape.

Loraine Hawkins and Heinz Rothgang mentioned some other catalytic events. Loraine Hawkins referred to accidents or scandals that heightened the already substantial public concern about the quality of the NHS. Heinz Rothgang mentioned that the European Union Court of Justice had issued a ruling about rights to health services that seemed to say British citizens who had to wait too long in the NHS should be able to get NHS-paid services in other member states. And Loraine Hawkins emphasized that the Chancellor of the Exchequer, Gordon Brown, publicly pushed for more spending as part of his own political competition with the Prime Minister. This meant that the institution that normally put up obstacles to spending in any system (the Treasury) was supporting spending, which made it difficult for Prime Minister Blair to refuse.

A second theme was how the budget was allocated and how the extra spending might be evaluated.<sup>127</sup> In response to a query from Peter Berman, Alan Maynard said the funds were allocated proportionally to the local purchasers, who then decided how to use them. In that sense, the decisions were decentralized except that the central government provided significant direction in the form of requirements to hit particular service targets and to fund specific initiatives in the form of contract provisions for providers.

In our discussion of how to evaluate spending, Naoki Ikegami suggested that it might be difficult to evaluate outcomes at the provider level because that would require adjusting for the level of risk for each provider’s set of patients. In his talk, Alan Maynard had described the use of performance evaluation

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<sup>127</sup> Note that Alan Maynard’s paper on implementation, and therefore the discussion, focused on England. The decision to expand spending, however, applied to all four “nations” within the United Kingdom, so to Scotland, Wales, and Northern Ireland as well.

measures by the main private insurer, BUPA, and had reported that the NHS was beginning to use similar measures. Responding to Naoki Ikegami, Alan Maynard explained that these evaluations were being used less to sanction providers than to identify outliers who could be counselled and urged to adjust their practices.<sup>128</sup>

Manfred Huber suggested that, when guidelines exist, it is likely to take some time for providers to change their behavior, so one should not expect to be able to observe results quickly. Alan Maynard responded that physicians in England in fact have been responding very quickly to new incentives that link their behavior to their fees. One reason is, with GPs mainly practicing in groups, any doctor who does not meet targets and so reduces the income of his or her colleagues is likely to be pressured by those colleagues to improve his or her performance.<sup>129</sup>

Of course, the problem with any standard is that the targets themselves might not be appropriate. Alan Maynard’s assessment was that, despite of the well-known difficulties, there are some pretty good guidelines for some medical conditions, particularly for chronic conditions.

#### Discussion 2: Joseph Wong’s Paper

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<sup>128</sup> This emphasis on outliers is similar to the use of profiling in various other situations, such as how spending records are used to identify outliers among German physicians – though in the extreme this can be linked to payment reductions in Germany. In Wendy Edgar’s presentation the following day, she argued that guidelines were being used the same way in New Zealand.

<sup>129</sup> Pressure from other members of a group can be seen elsewhere. For example, I once interviewed a member of a 13-physician pediatric practice within Kaiser Permanente’s Washington, D.C. organization. He explained that the physicians took turns taking calls in the hospital. (In the US, care in the hospital is normally supervised by a physician who also practices in the ambulatory sector; so a physician might be called into the hospital at night to see patients, and someone from a practice will have to visit each hospitalized patient in the morning.) Hence, other physicians would notice if one doctor seemed to hospitalize patients unnecessarily, and since that would mean extra work for the other physicians, they tend to pressure such colleagues to be more careful about hospitalizing patients.

## Summary of the Discussion

As with the discussion of the first paper, the first questions raised in this discussion involved politics. What was the pressure for privatization in Canada, to which the spending increase seemed to be a response? The upshot of this discussion was to say that there *was* ideologically based pressure for privatization, particularly from the Premier of the province of Alberta, Ralph Klein. However, this was clearly not a position held by a majority of politicians in the country. Instead, other provincial premiers threatened to defect from the Canada Health Act (by allowing extra-billing or private cover) as a political tactic in an attempt to push the federal government to increase the amount of funding it would provide to the provinces.

A second issue was what was supposed to be done with the extra money. What were the priorities? Joseph Wong emphasized that waiting times were the issue that captured public imagination and to which the largest allocation of money was allocated. There were some other smaller, stated priorities, such as reform or improvement of primary care and of care for aboriginal populations. However, most of the new funding was not allocated for any specific purpose.

John Campbell suggested that both papers were about changes in tax-based systems. The discussions both at this point and after the break suggested that these systems are likely to receive larger increases *or* decreases in spending than systems with more dedicated financing (such as sickness fund contributions). Both Canada and the UK, for example, had reduced their health spending quite severely before the current period of significant increases.<sup>130</sup>

Yet Canada and the UK, while similar in their ability to change their financing trends quickly, appear to differ in their ability to implement substantive changes. Joseph Wong emphasized that, because Canada has a federal political system and the UK does not, it is much harder to get the Canadian provinces to use the money in any particular way. In fact, they have not even agreed on benchmark standards for goals on

<sup>130</sup> Also, Sweden's tax-funded system remains probably the most impressive example of dramatic cost control, reducing spending sharply as a share of GDP over several years.

which there is ostensible agreement, such as reduction of waiting times.

This part of the discussion concluded with two other questions. First, why is there no general pharmaceutical benefit under Canadian Medicare? One reason is that it costs a lot to provide such a benefit, and neither the federal nor the provincial governments have been willing to add the expense to their budgets. Also there is a lot of private cover anyway (for example, through employer-provided supplemental insurance). Recently, the provinces did call on the Commonwealth to sponsor a universal pharmaceutical program with substantial national contributions, but this was in essence a bargaining tactic, an excessive demand meant to be bargained away and make the remaining (large) demand for extra funds look more modest.

The second question was raised by Peter Berman, who asked about the new ruling by the Canadian Supreme Court. In this ruling, the Court decided that waiting lists in Quebec are so long that they violate the right to health care (as stated in Quebec's Charter of Rights) and, therefore, that the national ban on private insurance for services allegedly covered by the government was unconstitutional in Quebec.<sup>131</sup> While the "right" involved is only stated in the Quebec charter, Joseph Wong replied that the ruling is a concern both because it involves a huge leap in judicial activism and because the Court's logic left a lot to be desired.<sup>132</sup>

### Discussion 3: Both Papers

In the open discussion, the first theme raised was

<sup>131</sup> The plaintiff's claim was that it should be possible to buy private insurance for services, since they were not in fact available in an acceptable way through the province's health insurance system. The Court held that the "prohibition on obtaining private insurance... is not constitutional where the public system fails to deliver reasonable services." For an interesting discussion of the logic and implications of this ruling, see Ted Marmor, "Supreme Ironies," *TIME Canada*, June 20, 2005, p. 35.

<sup>132</sup> If the Court's reasoning had been stronger, activism might have seemed more attractive. But of course judgments about reasoning involve preferences about policy; the plaintiffs might welcome activism, at least until the next case.

## Summary of the Discussion

the fact that politicians have cited public concern about long waiting times as one reason for increasing spending. Health policy analysts tend not to be concerned about long waiting times. Yet, as John Campbell pointed out, even where waiting times take an entirely different form, they are what the public complains about. In Japan, the complaints focus on the time that patients have to spend waiting in the outpatient departments of hospitals for ambulatory care. Since such services tend to be run on a first-come/first-served basis rather than through an appointment system, their complaint is that they show up at 9 am and have to wait until noon or 2 pm.

Michael Reich argued that waiting times shape popular perceptions of quality even if they do not change outcomes. So they are a measure of consumer satisfaction, and this raised the question of whether consumer satisfaction is an output that we should care about. William Hsiao responded that, since consumers are voters, their views are going to affect health policy decisions whether analysts like it or not. He reemphasized a point made in earlier sessions, which is that there are three basic standards for evaluation: health outcomes, consumer satisfaction, and financial protection for individuals from the costs of treatment for illness.<sup>133</sup>

Loraine Hawkins cautioned against assuming that waiting times and “consumer satisfaction” are both entirely separate from health outcomes.<sup>134</sup> Peter Berman pointed out that both Canada and the UK are countries in which citizens were already doing pretty well in terms of population health and financial protection. He also suggested that politicians might emphasize waiting lists and (supposedly) consumer satisfaction because priorities at any moment in any system are not based on the inherent relative importance of issues but on the extent to which they are most visible at the time. Michael Reich

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<sup>133</sup> I think “consumer satisfaction” is too narrow a way of stating the second concern, which I think involves perceptions of equity as much as personal utility, as I explain above.

<sup>134</sup> My personal view is that the amount of time any individual spends with a painful or unpleasant condition looks like an outcome to them, so the whole idea that waiting times are unrelated to quality of care and outcomes should be questioned.

had already argued that waiting times might be more prominent than more systematic health outcomes in part because waiting is more visible than those outcomes.

Another issue about waiting is the extent to which this problem can be solved by money as opposed to by changing how care is delivered and what incentives are offered within the system. Both Joseph Wong and Alan Maynard emphasized that organizational factors might be more important than money.<sup>135</sup> Organizational change, however, is difficult to effect. It requires that people in the organizations change their behavior, which they often resist, and it is hard to devise good systems even when people are willing to cooperate. Moreover, spending increases are a much more visible response to demand for change than a reorganization would be, so increasing spending is a more viable response to pressures to “do something” about the waiting list problem.<sup>136</sup> Soonman Kwon pointed out that in any system physicians are likely to think that the proper solution to a problem is to spend more, adding that this is certainly how it works in Korea. In Korea,

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<sup>135</sup> One example of how to change how care is delivered would be to create better appointment-scheduling routines or to make GPs aware of how busy various consultants are so the GPs could steer patients to the more available consultants. One example of misplaced incentives is the fact that specialists in the UK have the option of seeing patients in their private practices for which they are paid a version of their salary for providing service in the public sector. This arguably creates an incentive for them to do less work in their public practice and to tell patients that they can jump the queue if they choose to pay privately. Another example, this time from the US, involves ambulatory surgical centers. These freestanding centers can provide surgery and aftercare faster for elective surgeries than a major hospital can because, among other reasons, any major hospital has some of its operating theatres pre-empted by emergencies. This cannot happen in a surgical center as these entities do not provide emergency care. Hence a family friend of ours chose to have her breast cancer treatment at a suburban facility owned by the Cleveland Clinic rather than at the Clinic’s renowned hospital center.

<sup>136</sup> Unless no money is available, in which case policymakers are likely to announce a reorganization initiative!

waiting times *per se* are not an issue. Certainly, for the uninsured in the US, “waiting times” are not defined as the major problem. The main problem is the inability of some people to access any services at all.

A third theme in this general discussion was how evaluation is used in policymaking. Alan Maynard had criticized the NHS for its continual disinterest in evaluation, for its habit of “Get Ready, Fire, Aim.” He mentioned in his talk that when some evaluation measures were suggested to Prime Minister Blair, Blair’s immediate response was that it could backfire on the government.<sup>137</sup> John Campbell pointed out that policy analysis and evaluation in the United States generally has a conservative effect, because it highlights problems, which makes it harder to pass legislation.<sup>138</sup> Manfred Huber argued that systems nonetheless should want to evaluate their own performance, so policymakers should ensure the existence of good information systems.

I pointed out that in practice it is easier to evaluate the potential application of new technology, whether procedures or drugs, than of ongoing activities (and is more likely to happen). There are two reasons for this. First, in the case of new technology or drugs, the object of evaluation is more discrete and easily defined (as opposed to, say, “how we should treat diabetes”). Second, if the evaluation leads to a decision not to apply the new technology, then it will not take away anything that is already being used. Alan Maynard emphasized that systems should evaluate their existing activities but agreed that the vast majority of the new evaluations in England (through the NICE process) has involved new technology. Another aspect of this subject is who really cares about evaluating the cost-effectiveness of expenditures. We agreed that the public does not see things in these terms whereas economists and health services researchers (and probably bureaucrats) usually do think in these terms. But what about politicians who are stuck in the

middle, advised by experts but at least somewhat dependent on the public? Manfred Huber reported that Health and Finance Ministers in their private deliberations do agree that cost-effectiveness is important, and he defined the problem as how to “educate” the public to think so too. I suggested that the Canadian case is an example of this problem but that it also shows the countervailing pressure imposed on politicians by the public’s views. Thus, in the early stages of the discussion of a spending increase, there was more emphasis on targets and standards and value for money than eventually emerged in the final agreement between the federal government and the provinces. Joseph Wong agreed with this summary of his story and added that it is simply hard to set up evaluative standards in a political system where everything is interpreted as part of a competition between officials of each of the two levels of government. In other words, provincial officials want standards they can easily meet while federal officials worry that they will be too easy and so not change provincial behavior.

Alan Maynard had explained at one point that, in the UK, hospital managers could lose their jobs if they did not reach targets. So the key issue here was that standards and measurements affect peoples’ interests, whether the person in question is a hospital manager in the NHS, a provincial premier in Canada, or Tony Blair. They all know it, and act accordingly. And, as Berman added, it is also very hard to find examples where one could make “uncontestable statements based on evidence” about the proper use of funds. If it is important “there will be three strong and well-financed sides on the question.”

Our discussion concluded by returning to the question of what we (and our societies) want health systems to accomplish. Heinz Rothgang emphasized the difference between positive and normative evaluation. Alan Maynard reiterated his (normative) emphasis on outcomes, saying that underlying his whole presentation was his skepticism about spending on health care. This skepticism derives in part from his belief that, for the same money as the current NHS increase, one could get a lot more health improvements in

<sup>137</sup> See also the comments on evaluation in Canada in my commentary.

<sup>138</sup> The classic description of this dynamic is contained in Henry J. Aaron, *Politics and the Professors: The Great Society in Perspective* (Washington, DC: The Brookings Institution, 1978).

other ways, for example, by spending more on child nutrition.<sup>139</sup>

Talking about us (the group) as much as about systems, Heinz Rothgang suggested that economists seem to put more faith in experts or to expect a larger role for experts in policymaking than political scientists do. Thus, we pay more attention to health outcomes while political scientists seem more willing to allow systems to evolve according to public preferences. While there is probably some truth to that, the economists in this group in particular held a broader range of views about the purposes of health systems than another group of economists might.

### **Conclusion: Implications for Other Topics**

What did this discussion suggest for other topics considered at this seminar? Most obviously, it highlighted the fact that the general question of what health spending is for is fundamental, whether the subject in question is what to cover and the extent of user charges as in the first session, long-term care as in the second, or reforming the Indian and Chinese systems in the concluding session. To some extent, where one stands on this basic question depends on one's perspective including one's job and training. As a result, the difference between the position of public health professionals and economists (who emphasize population health statistics) and the public (who tend to focus on access to and equity of medical services) probably exists in virtually all situations.

Second, there is the question of the effectiveness of increasing spending versus reorganizing. For example, re-creating rural health clinics in China might greatly improve health indicators without increasing spending by very much. Advocates of home health care have long argued for this as a way to reorganize long-term care away from the nursing home model. However, as that example shows, even reorganization arguments tend to be substantially influenced by budget

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<sup>139</sup> As I mentioned in my commentary, knowing this about Alan Maynard's beliefs leads me to think that, when he acknowledges a need for deferred maintenance in the UK, they must *really* need the money!

concerns. Thus, home health care has long been sold as a cheaper way to provide care than nursing homes (and, conversely, has been resisted by some budget experts out of concern that demand for home health care is potential immensely larger than demand for nursing home care).

Third, evaluation is difficult for purely substantive reasons (it is very hard to craft useable guidelines in most situations) and because it is normally politicized. Interests are at stake, and it is hard to overcome that fact with objective evaluation because evaluation usually does not have enough analytic power. I therefore would warn policymakers in Japan or elsewhere against expecting much in the way of savings from emphasizing benchmarking and guidelines.

Finally, the fact that the populations of the UK and Canada had other nearby health systems with which to compare their own influenced the demands they made for their own systems raises an issue that applies to policymaking in many other countries. In the US, it seems to apply in reverse in that many Americans think that the US explicitly should not adopt any policy that has been adopted elsewhere.<sup>140</sup> As for Japan, which lacks any obvious comparison country, some Japanese policymakers tend to believe that any problem that occurs elsewhere simply cannot happen in Japan. One very unfortunate example of this syndrome involved the failure of

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<sup>140</sup> Some American policy analysts – obviously including the ones at this conference -- tend to look abroad, but arguing that the US should copy foreign practice is not feasible politically. American political culture includes a strong strain of belief that the United States is inherently different and better than all other countries – the “last, best hope of mankind” – implying that other countries should copy the US rather than the other way around. This view dates to the origins of the United States as a country founded by people who were escaping the problems of Europe, and then populated by immigrants fleeing the misery of their homelands to pass through the “golden door” mentioned in the poem inscribed on the Statue of Liberty. The current US President represents an extreme example of that view, and the fact that he got re-elected shows that it is pretty attractive to a portion of the electorate.

### *Summary of the Discussion*

the Japanese government to protect the supply of blood treatment products for hemophiliacs from contamination by the HIV virus.<sup>141</sup> Nevertheless, our own discussion revealed that ideas about both what works and what should be expected from health systems can be affected by what people believe about systems in other countries – whether the Korean experience is an example of how cost-sharing might work in Japan, the clear evidence that widespread

knowledge of health systems in neighboring countries put pressure on politicians in the UK and Canada to increase health spending, and the Supreme Court of Canada's decision in the case about private insurance for Quebec. This means that, at a minimum, it is important to have accurate understanding of what those systems do and how they work. I hope that this discussion and the seminar as a whole has contributed to that understanding.

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<sup>141</sup> See Eric Feldman's chapter in Feldman and Ronald Bayer eds., *Blood Feuds: AIDS, Blood, and the Politics of Medical Disaster* (New York: Oxford University Press, 1999).

## Chapter 4: Social Security in Rapidly Industrializing Nations Health System Issues, Challenges, and Options: Reflections on China, India, and Kerala

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### Background

The health systems of India and China are very interesting cases, not only because of their ability to influence the health outcomes of a large majority in the world due to their huge populations, but also because their stories present a fair amount of evidence on “what to do and what not to do” in the health sector. India’s health system has been running through rough weather for quite some time and at this moment, needs a radical progressive transformation if it is to improve the well being of its population. Soon after Independence, India’s national planners committed themselves to developing the country and its people within a socialist framework, and health was an obvious component in this process. The country’s post-Independent plans and policies on health care were much influenced by visionaries like Bhore whose committee on Health and Development in India made the primary care approach the bedrock of Indian health care system. The committee laid down the principle that access to primary care is a basic right and that the ability to pay or any other socioeconomic consideration should not be a barrier to accessing care.

Since then, the country has made tremendous progress in such important health outcomes as increased life expectancy at birth and reduced infant and maternal mortality rates and death rates in general. However, these achievements are not so significant when we compare them with the achievements of other countries at a similar stage of economic development. Internationally, demand for health care has been undergoing tremendous changes, while the resources needed to finance these services are

greater than ever before. The rate of progress is such that almost every day another new drug or treatment or a further advance in medicine and health technology is announced (WHO, 2000). Yet, for a state that promised to provide universal health care through the public health care system, India has allocated only a meagre fraction of public resources to health care. Ambitious plans were made for the health system, but the government did not make enough resources available to fulfil even the minimum commitments made in the initial plans and even this low level of resources came down substantially in successive plans. It is time that policymakers put health care high on their agenda and greatly increase the budget allocation for the health care sector and for monitoring the performance of public and private health care providers and the differences in access to and use of care by the different socioeconomic groups.

As for China, its health system during Chairman Mao’s rule served as a model for developing and low-income countries for how to provide egalitarian and low-cost health care to a vast population. The period from 1950 to 1970 was characterized by significant achievements in China’s population health indicators despite the population’s low-income levels. Making primary health care the cornerstone of the health care delivery system helped China to attain far better health indicators by the early 1970s than could be expected given the country’s stage of economic development (World Bank, 1994). The government’s commitment to equity for all citizens and to ensuring the near universal availability of adequate food, education, housing, jobs, and accessible and affordable health care services also contributed to this achievement (Yang et al, 1991).

The philosophy that had governed the

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government's attitude to public services (planning as the principal agent of economic growth and the market as a supplementary part) was reversed in the late 1970s when China began its transition into becoming a market economy. This heralded a series of profound changes in the organization and delivery of rural health care services in China. The concomitant economic changes that followed the reforms, including changes to the political structure of the health service and the internal problems of the Co-operative Medical Service (CMS), contributed to the rapid decline of the system. As a result, there is hardly any disagreement among scholars that any economic reforms that have put unquestioned faith in the market have not had a positive impact on equity in health care in most countries.

The present paper is an attempt to understand the Indian health care system in terms of its equity and efficiency in the post-Independent period. Any discussion on the health services of China or India would be incomplete if we failed to take a look at the Indian state (equivalent to province) of Kerala, which has carved its own way in the health care field. Therefore, we also discuss the Kerala health care delivery system to try to understand what is possible even within these adverse conditions.

### **Issues and Challenges**

#### Chinese Health Services in Transition

China has had a lot of success in the development of preventive medicine, public health, and socialized services, whereas India has lagged behind. The basic structure of the Chinese health system that evolved during the command economy era consisted of a comprehensive health insurance and health delivery system mainly funded by the state and organized according to an administrative hierarchy. The Cooperative Medical Services (CMS), which operated under the collective communes, provided services like primary, preventive, and some curative care. The CMS was organized into a three-tier structure comprising the barefoot doctors at the primary level, township health centers at the secondary

level, and county hospitals at the upper level. The Maoist model of medicine relied on political mobilization and patriotic health campaigns in support of the public health and community medicine approach to health care. In rural areas, mass mobilization encouraged communities to help to improve environmental sanitation, increase immunization rates, and prevent diseases. The authoritarianism of the regime with its powerful bureaucracy that mandated universal access to low-cost health care controlled the training and job assignments of medical personnel and caused many of the public health programs to be highly effective in achieving their objectives. However, after the reforms in the early 1980s, the CMS, which had provided cost-effective health care to a vast majority of rural population, went into a rapid decline. The later disappearance of the collectives led to the closure of welfare funds, which had been the main source of financing for the CMS. Since there is another paper in the same session that discusses the Chinese health care delivery system in more detail, any further discussion on China in this paper is superfluous.

#### Health in Post-Independent India: A Loser in the Public Policy Agenda

Soon after India achieved Independence from the British Empire in 1947, the country's policymakers, especially Jawaharlal Nehru, had ambitious plans for the country's future, which was evident in his speeches to the public and in the Constituent Assembly. He acknowledged health care to be a major component in "eradicating poverty, inequities, and diseases." The Indian National Congress was fully in favor of providing free care to all of the population through the states (Narayana, 1983). Each Five-Year Plan reiterated the government's intention to provide high-quality, community-centered health care at the lowest possible cost. However, this never materialized in practice and, although there was much criticism of the inability of the government to provide care to all, there was no real attempt to understand the factors that lay behind this failure (Narayana, 1983). Rather than a proper plan on health care, the Indian government had established a range of *ad hoc* committees that had issued some

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guidelines that were not clear in their objectives. With hindsight, it would appear that some of the factors responsible for the failure of the Indian government to achieve universal health care are:

- 1) According to the Constitution, health care was the responsibility of the states and, in the absence of a strong national policy emphasizing the importance of health care, this meant that different states assigned a different degree of importance to providing health services. Thus, the states also differed widely in terms of the amount of resources that they allocated to the health sector, which resulted in wide inequities in the distribution of public health care. Health outcomes in many states were very poor at the outset, and the lack of adequate resources made the situation even worse as time went on.
- 2) The development strategy of the national government was heavily oriented towards industrializing the economy, which demanded huge amount of resources. This reduced the amount that was available to allocate to health care. The First Plan gave only 3.3 percent of its designated resources to health care, and unfortunately, this low percentage has been dropping ever since and now hovers at around 1 percent of the Plan funds (Government of India, 2002). Rather than increasing the distributional equity among the population, it has increased inequity by making employment less elastic.
- 3) The state has never attempted to intervene in the provision of private health services not only in the hospital sector but also in other critical areas such as the pharmaceutical industry or the medical equipment industry. Also, medical education was not oriented towards meeting the main health care needs of the rural population but took a disease-centric approach with an emphasis on Western orthodox medicine that was not accepted by the rural population.

- 4) The media in post-Independent India did not emphasize the role and the responsibility of the state in providing the kind of services that the population wanted and deserved. For example, Drèze and Sen (2000) reviewed a range of articles in a national daily newspaper in 2000 and found that health care issues were hardly ever covered.

The result is that health care in India is increasingly becoming seen as the responsibility of individuals and not of the state. This trend certainly does not augur well for the health status of the population, particularly as the health sector is facing many practical problems on top of its lack of funding.

The Daunting Challenge of Ensuring Equity and Efficiency

Indian health care is often dubbed as pro-rich and pro-urban as the majority of health institutions, both public and private, are concentrated in urban areas. The burden of health care in India is inversely related to the economic status of the household; the poorer the household, the more prone it is to receive inadequate and expensive care (Visaria and Gumber, 1994 and Gumber, 1997). Their already thin household budgets are stretched by having to pay out-of-pocket payments for the treatment received by the sick family member, and this is compounded by the loss of that family member's income while he or she is ill. While private household out-of-pocket expenses constitute more than 80 percent of total health expenditure in India, government expenditure on health is less than 17 percent, which is one of the lowest levels in the world. Only 0.16 percent of population have private health insurance, which is, in any case, tends to be available only in urban areas. Social insurance covers only another 2 percent of the population, mainly through the Central Government Health Scheme (CGHS) and the Employees State Insurance Scheme (ESIS).

Studies reveal that out-of-pocket payments for health care in India are highly regressive, and it is clear that it will not be possible to reduce the

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Indian poverty rate without tackling the issue of how health care is financed. India's health care system is currently market-based in that diagnoses and drugs are treated much like any other commodity (Drèze and Sen, 2002). In comparison with other countries shows that India's health care system is most privatized in the world. Even in the so-called capitalist industrialized countries, the state is heavily involved in financing and providing health care. The involvement of the state is necessary at minimum to deal with problems like the spread of communicable diseases, which the private sector has no incentive to tackle because of what the economics literature calls "market failure."

As a result of the lack of state involvement in the health sector, India has failed to control communicable diseases, despite the availability of cost-effective and relatively simple technologies. These diseases, the treatment and prevention of which have very high positive externalities, still constitute more than half of the disease burden (as measured by DALYs) in India. While the country has implemented measures to reduce mortality and enhance life expectancy at birth, the challenges thrown up by the ongoing health transition have important implications for the public health structure and population health in the country. The demographic, epidemiological, and social changes involved in this transition are likely to change the outcomes of any health policy actions, increase the costs of treatment, and increase pressure on the health system to deliver satisfactory care. The main element of the demographic transition is that the elderly constitute an increasingly high proportion of the population. This is going to increase the cost of medical care in the sense that the elderly tend to be ill more than younger people. For example, several studies have revealed that high levels of health expenditures in certain households is explained by the number of elderly members in the family (Narayana, 2001). This change is happening in conjunction with epidemiological changes in which non-communicable diseases (including cardiovascular diseases, diabetes, neoplasm, and neurological disorders) now constitute an increasing proportion of the burden of disease. The treatment and management of

these diseases is exorbitantly costly and often require long-term care, which will put a strain on the health system. The social transition involves the rising expectations of the population about the quality of care, which causes costs to rise even further. Fresh challenges including HIV/AIDS, the resurgence of diseases that were earlier thought to have been eradicated (such as tuberculosis), and drug resistance to some diseases add to the woes of the health sector in India.

### **Urban Health System**

#### Urban Health Services: Not Much to Cheer

Health conditions in urban areas are different than in other areas of India. They are more often a consequence of factors outside the health system, including a lack of decent housing, poor sanitation, noise and air pollution, and unsafe drinking water. A majority of the urban poor work in the informal sector, which is characterized by self-employed and low-paid workers with no fixed employer-employee relationship or statutory social security protection. In addition, the presence of risk factors such as pollution and poverty make the urban poor more vulnerable to diseases. The high rate of growth of the urban population and the consequent increase in the slum population has strained infrastructure and caused health problems (Gupta and Mitra, 2002). Slums constitute about 22 percent of the total urban population and are characterized by poor living conditions and a lack of proper water and sanitation facilities, making the urban poor vulnerable to a host of diseases (Dilip and Duggal, 2004). So any strategy designed to influence urban health outcomes will have to incorporate these non-biomedical factors into consideration. Wide disparities exist between and within the ranks of the poor especially in terms of caste and gender. Social exclusion increases the vulnerability of the poor to ill-health and violence. As a result, the urban poor face higher risks of getting sexually transmitted infections and HIV/AIDS and of being in poor reproductive health. Workers in the informal sector do not get any health care benefits as insurance coverage in India is heavily skewed in

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favor of the upper and middle class and employees working in the formal sector. So when these informal workers fall ill, especially when they have to be hospitalized, not only do they have to pay the high medical fees out of their own pockets in the absence of any formal risk pooling mechanism but they also lose out on their daily earnings. So although the urban poor have more access to health facilities than their rural counterparts, the higher average cost of these health services makes them just as disadvantaged as their rural counterparts. A very large number of people cannot even afford to access the “free” government services because of the opportunity costs involved such as forgone income and the price of transportation. Instead, they depend heavily on poor-quality services provided by local unqualified practitioners. Despite this, poor households tend to spend nearly one-fifth of their income on medical treatment. These are the critical factors in explaining why the urban poor are living in poverty.

How “Free” are Urban Public Health Services?

It is often believed that the publicly provided health services are free of charge. However, especially in recent times, almost all the state governments have either introduced or increased user charges for these services. Thus, the patients seeking care are charged both explicitly and implicitly. The explicit charges mainly take the form of user fees. Estimates by Krishnan (1995) show that, in the rural sector, fewer than 3 percent of patients in Haryana and Punjab and only about 7 percent in Uttar Pradesh get free treatment as inpatients in hospitals. Even fewer numbers receive free treatment in the urban areas than in the rural areas in all states. Of rural patients, 70 and 54 percent receive free treatment in Jammu and Kashmir and Tamil Nadu respectively. This proportion is 46 percent in Orissa and Rajasthan, and 34 percent in West Bengal. In other states, it varies between 12 and 17 percent – Andhra Pradesh (12.2), Gujarat (15.97), Karnataka (16.78), Kerala (15.08), and Maharashtra (16.71). In urban areas, 47 percent of patients in Tamil Nadu and between 6 and 12 percent in Gujarat, Karnataka, Kerala, and Maharashtra receive free treatment. Of course

the patients attending public hospitals may also face large indirect costs including, for example, the cost of any medicines that they may have to purchase from the private sector or bribes for hospital staff. Since a large number of patients who use health services in the urban India are from rural areas, they may have to spend money on transportation charges and lodging as well. Since the cost of treatment in the public sector indirectly influences the cost of treatment in the private sector, the increased user charges in public hospitals may also be a reason for costs going up in private hospitals.

Statistics clearly show that the bed population ratio is higher in urban areas than in rural areas and that there has been no significant decline in these disparities over time (Duggal et al, 1995). This regional imbalance is present both in the government-run public sector and in the private sector. Public spending on health care is also disproportionately higher in urban areas. Although the urban population has better access to health care facilities than their rural counterparts, there is widespread inequality between the poor and the rich within urban areas, even though the proportion of those living in poverty appears to be declining. The density of providers in urban areas is much higher than in rural areas. The urban health system in India consists of medical colleges, middle-level government hospitals, maternity homes, dispensaries, hospitals and dispensaries run by the ESIS, many private practitioners, and private hospitals of varying size and variety. Although urban areas have better health indicators than rural areas, survey-based data has shown wide inequalities in access to services even within urban areas. The urban health care system is primarily curative in nature and tends to lack primary health care workers (Jay Satia et al, 1999). The NSSO survey reveals very high rates of use of the private sector for both inpatient and outpatient care in urban areas (NSSO, 1998). According to the survey, 20 percent of patients seeking outpatient care in urban areas used the public sector, while the equivalent figure for inpatient care was 43 percent (see Tables 1 and 2).

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**Table 1: Public-Private Sector Use of Outpatient Care, All-India**  
(Percentage distribution)

	Rural		Urban	
	1986-87	1995-96	1986-87	1995-96
Share of Public Sector	25.6	19.0	27.2	19.0
Share of Private Sector	74.5	80.0	72.9	81.0
Private hospitals	15.2	12.0	16.2	16.0
Private doctors (Private practitioners)	53.0	55.0	51.8	55.0
Others	5.2	10.0	2.9	7.0
Total	100.1	99.0	100.0	100.0

*Sources:* Sen et al, 2002, NSSO, 1992, Statements 13R and 13U, pp 67-68, Statement 2R and 2U, pp 53-54. NSSO, 1998, Table 4.10, p22; Table 4.16, p28.

**Table 2: Public-Private Sector Use of Inpatient Care, All-India**  
(Percentage distribution)

	Rural		Urban	
	1986-87	1995-96	1986-87	1995-96
Share of public sector	59.7	45.2	60.3	43.1
Share of private sector	40.3	54.7	39.7	56.9
Others	1.7	0.8	1.2	0.6
Total	100.0	99.9	100.0	100.0

*Sources:* NSSO, 1992, Statements 13R and 13U, pp 67-68, Statement 2R and 2U, pp 53-54. NSSO, 1998, Table 4.10, p22; Table 4.16, p28.

Although most people consult private practitioners for minor illnesses, they depend on public facilities for acute illnesses that require hospitalization and for maternal care (Yesudian, 1999). However, a recent study of the pattern of use of municipal health services in Mumbai showed that a majority of households in all socioeconomic groups used the private sector for both minor and chronic ailments. There are probably several reasons for why public services are used so little, including the large number of different agencies that run public health facilities, the absence of any proper coordination among them, and the resulting inefficiency. Some other factors that might be responsible for this pattern are inconvenient opening times, long waiting times, the non-availability of medicines, and the feeling that the services provided by

private practitioners and teaching hospitals are better (Renu, 1995).

Some micro-level studies have lent empirical support to the NSSO's conclusion that a majority of urban residents use the private sector for both inpatient and outpatient care. For example, in places like Mumbai, the municipal corporation has not been able to expand its medical infrastructure to cover the suburbs, which ultimately led to private facilities emerging in those areas in response to that unmet need (Yesudian, 1999). Where public facilities did exist in Mumbai, the higher levels of services tended to be used more than the lower level services because they were perceived to provide services of better quality in terms of manpower and supply of drugs (Yesudian, 1994). This has often over-burdened

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these higher-level facilities, leading them to become inefficient and causing their quality to slide. At that point, the private practitioners in the vicinity are available to provide personalized care immediately (Renu Garg, 1995). So we can see that the model of health care in urban areas is heavily dualistic, in which the rich can afford the health care necessary to extend their lives whereas the poor are barely able to survive.

The general increase in health care demand coupled with the inability of public hospitals to provide adequate medical services has accelerated the growth of the private health sector in India. The demand-supply gap for public health care delivery is large and growing, and this gap is increasingly being bridged by private health care institutions. The general increase in personal income levels and the corporatization of care in urban areas have turned health care into a commodity like any other, available only to those who can afford to pay for it. The urban health care industry is booming, with a host of private hospitals offering state-of-the-art services for the rich and the middle class. The increasing availability of advanced medical technologies has increased demand for these services. The changes in disease patterns due to the epidemiological transition, the easy availability of financial resources, and the easing of import restrictions have all contributed significantly to this rapid influx of medical technology.

This increase in the private health sector has given rise to some problems. These include the fact that the private sector has no profit incentive to get involved in disease prevention, that they tend to over-charge, that they induce unnecessary demand for certain services, and that there is no genuine quality assurance mechanism to govern their operation. The private sector is so heterogeneous that it ranges from large corporate hospitals to small five-bed nursing homes and from solo practitioners with questionable qualifications to practitioners who have medical degrees in indigenous medical systems but also practice modern medicine. It also includes diagnostic centers offering numerous services. Various studies have established that the vast majority of private

health care providers in urban areas do not follow any norms either with regard to the use of physical infrastructure (such as the amount of space per bed or the provision of certain utilities) or the structural aspects of care (what medical and paramedical personnel they employ or what services they offer). The important problems cited by these studies are a lack of physical standards, inadequate space within hospitals (a majority of nursing homes are substandard, most of them being housed in tiny flats), the absence of trained personnel (especially qualified nurses), a lack of labor rooms in maternity homes, poorly lit and dirty wards and beds, and the failure to keep records of diseases, births, and deaths (Nandaraj and Duggal, 1997 and Muraleedharan, 2001). This has led to the medically unjustified use of technology and the existence of a complex network of arrangements between the physicians in the government sector, the private hospitals, and local diagnostic centers. These types of mutual arrangements have a definite bearing on the cost of care since most payments are made by patients out of their own pockets on a fee-for-service basis. This complexity makes it extremely difficult to frame policies to regulate private health facilities. Even in areas where private provision seems to be theoretically harmless, there are many ways in which this market works against the consumer, such as the asymmetry of information between the provider and the patient and a lack of recorded information about the incidence and outcomes of treatment. In such chaotic markets, the user is helpless (Berman, 1997), and competition by itself is a poor efficiency-enhancing device, especially when the consumer is unable to judge the quality of the services being offered (Drèze and Sen, 2002).

Rural Health: A Pathetic Plight

Although this paper deals with urban health services, it might be helpful to have a quick look at the situation in the rural health sector before we move on to question of what happened to the Indian health services in the 1990s. According to the National Sample Survey Organization data, more than 53 percent of the rural population (Table 1) have their health care needs met by private practitioners (NSSO, 1998).

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Although rural areas are poorer than urban ones and absolute poverty dominates in rural areas, some private practitioners do exist in the rural areas. There are other estimates that 1 million illegal practitioners are managing 50 to 70 percent of primary consultations in rural India (Misra et al, 2003). Their existence is often a result of the non-availability and inaccessibility of public health services of decent quality, and these practitioners are somehow meeting the unmet needs of the rural residents. However, existing data sets do not adequately answer such important questions as what types of private providers exist in rural areas and how much they are used by each different income group.

Several studies have confirmed that the main determinant of the establishment of private practice are the purchasing power of the local consumers (Baru, 2000). Since health care is often a necessity, even the poor tend to over-commit their resources, and this becomes the source of the livelihoods of these practitioners. Other reasons for the popularity of the private medical practitioners in rural areas are that they dispense medicines that are culturally appropriate (though not necessarily effective) and that they accept fees in instalments and even on credit. This is an indication of the dire state of the health sector in the rural areas of India (which is where the majority of the Indian poor live), characterized by a lack of choice and the potential for exploitation by unregulated private providers.

### **Indian Health Care Scenario in the 1990s**

#### A Changing Landscape

The health care sector in India has changed during last two decades as the private sector has come to play a growing role in providing both inpatient and outpatient care (NSSO, 1998). The decline in the use of public health care services is mainly a function of the decline in public health investment during the same period (GOI, 2001). The private sector is not only used by the upper and middle classes alone but also by the poorer classes (Dileep, 2002). Studies have shown that the non-availability of public health

care services is forcing the poor to seek care from the private sector, even if they would prefer to be treated at public sector facilities (Dilip and Duggal, 2002). A recent analysis has revealed disturbing details about Indian public health expenditure in the 1980s and 1990s. For example, the share of health expenditure in the major states fell significantly in proportion to total government expenditure from 6 to 7 percent in the 1980s to just over 5 percent in the 1990s (Selvaraju, 2001). In real per capita terms, public expenditure on health has increased, but the distribution of resources among primary, secondary, and tertiary care does not accord with national policy as the allocation for primary and secondary care is growing more slowly than the allocation for tertiary care. Also in many states, the growth in health expenditure was fully absorbed by the salary bill, leaving little left over to finance development activities, maintenance, drugs, and other consumables. This situation is very alarming with regard to the quality of care, user satisfaction and use, and the performance of the system. While there had been a steady expansion in the number of facilities at least until the mid-1980s, there is widespread evidence that quality has deteriorated substantially in recent years. Many health centers are in desperate need of repairs, physicians and supporting staff are either not available or not accessible, drugs are available only occasionally, and facilities are characterized by inconvenient opening times and an absence of privacy. Meanwhile, this period of decline in investment in public health infrastructure in the 1980s and 1990s has led to a steady increase in the growth of the private sector (Narayana, 2001), which may be reducing access to health care in poorer regions and states in India (Krishnan, 1995). This growth is manifesting itself as the expansion of existing facilities, the establishment of new ones, and investment in buildings, equipment, diagnostic facilities, and plush surroundings (Narayana, 2001).

#### Increasing Cost of Treatment: Equity in Access Suffers Further

An analysis by Sen et al (2002) contains some

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interesting findings on the cost of seeking care in the 1990s. For example, with regard to seeking outpatient care, the difference in cost was only 5 percent less in the public sector than in the private sector in rural areas and while it was 8 percent lower in urban areas. However, with regard to seeking hospital care, the difference in expenditure was 129 percent and 213 percent less in the rural and urban public sector hospitals respectively compared with the private sector. Although use of public hospitals varied considerably across states, public hospitals provided an important alternative to the private sector and at significantly lower cost. Inequality between the rich and poor in their use of in-patient care was also considerably less indicating that even the middle classes could not afford the price of inpatient treatment. This may be a reason for the continuing popularity of public sector for inpatient services in the 1980s and 1990s.

from private health services, and this happened even in poorer states. The biggest fall in use of the public sector for outpatient care has been in the public hospitals whose share decreased from 22.6 to 15 percent in the urban areas between mid 1980s and the mid-1990s (NSSO, 1998). Compared with the mid-1980s, the costs of both outpatient and inpatient care have risen in both rural and urban areas. A study by Sen et al (2002) revealed that between 1986-87 and 1995-96 outpatient costs per illness episode in rural areas went up by 142 percent in the private sector and 77 percent in the public sector. In urban areas, private outpatient costs increased by 150 percent compared with 124 percent in the public sector. The urban-rural price differential for outpatient care rose from 1.04 in 1986-87 to 1.10 in 1995-96. The trends in the costs of in-patient care between 1986 and 1996 are more dramatic. Average costs spiralled by 436 percent in rural areas and by 320 percent in urban areas (Table 3).

In the 1990s, large numbers of people were forced to leave the public sector and seek care

**Table 3: Average Expenditure on Medical Care: All-India, A Comparative Picture, 1980s and 1990s  
(Rs per illness episode/hospitalization)**

	Rural			Urban			Urban-Rural Ratio*	
	1986-87	1995-96	Percent change	1986-87	1995-96	Percent change	1986-87	1995-96
<b>Outpatient care</b>								
Public sector	73	129	77	74	166	124	1.01	1.29
Private sector	77	186	142	80	200	150	1.04	1.08
Total	76	176	132	79	194	146	1.04	1.10
<b>Private: Public Ratio @</b>	1.05	1.44		1.08	1.20			
<b>In-Patient Care</b>								
Public sector	320	2080	549	385	2195	470	1.20	1.06
Private sector	733	4300	486	1206	5344	343	1.64	1.24
Total	597	3202	436	933	3921	320	1.56	1.22
<b>Private: Public Ratio @</b>	2.29	2.07		3.13	2.43		--	--

Notes: @Measures the private-public differential in average expenditure.

\*Measures the urban-rural differential in average expenditure

Sources: NSSO, 1992, Source Table 11.00, p S-516, Statement 6, p 59.

NSSO, 1998, Table 4.19, p32; Table 4.21, p33.

The spiralling costs of inpatient care were also particularly evident in institutions in the public

sector compared with the private sector in both rural and urban areas. Between 1986-87

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and 1995-96, the private-public cost ratio for outpatient care increased from 1.05 to 1.44 in rural areas and from 1.08 to 1.20 in urban areas. For inpatient care in contrast, the private-public cost ratio actually fell from 2.29 to 2.07 in rural areas and from 3.13 to 2.43 in urban areas (Sen et al, 2002). This narrowing of the public-private expenditure ratio may partially explain why patients have abandoned public services in favor of private ones. Studies by KSSP (2000) of Kerala and Prabhu and a few others showed that the proportion of spending on treatment by households in the poorest income groups had risen sharply between the 1960s and the 1990s. Although these studies are silent on the quality of care as a factor in this total expenditure, they do present evidence of rising expenditures and increasing inequity in medical spending by the population of these states.

**The Kerala Health Care System - the Trailblazer**

Kerala's health system is a very interesting case in that it has produced improving social and health outcomes even while the state has been experiencing comparatively low income growth. This has caused the State of Kerala to be described as a trailblazer in the area of social and human development in India. The success of Kerala's health system is due to its accessibility to the people of the state in three dimensions – geographical, economic, and social. The state government ensured that health services were physically accessible by improving the transportation system connecting the interior areas of the state and encouraging the establishment of many health care institutions by both the public and private sectors in rural areas. It ensured financial accessibility by enabling public health services to provide more and better services, thus minimizing the extent to which patients had to resort to expensive private sector care. At the same time, the progressive social organizations in the state played a vital role in ensuring social accessibility by means of effective political participation and increased literary and awareness programs. The rural health system

performs better than its urban counterpart, which is not the case in many other states. The kind of social development that occurred in Kerala (a high physical quality of life despite low rates of economic growth) has been described as the “Kerala model” although it has increasingly become fashionable to disown the same even by its own parents. In effect, Kerala has offered something new in the area of health care delivery, which can be called “good health at low cost.”

Is the “Kerala Model” Vanishing?

Even before the Indian states began to be run by elected governments in the 1950s, there was a strong foundation of public health services in Kerala (Kutty, 2000). This led the policymakers of the new state to accept that health care had to be an important component of the social development of the population. The socialist governments that took power in the early days made tremendous efforts towards reducing poverty and other forms of inequality by not only by investing in health services but also by introducing land reforms and educational reforms. They did this partly as a result of pressure from the public in the form of popular debates in the press, public opinion as expressed through electoral politics, and public rallies and strikes. This was reflected in the increased resource allocation to the social sectors, thus making per capita public health care spending in Kerala the highest in the country. For example, the annual compound growth rate of government health expenditure for the period (at current prices) was 13.04 percent, and this expenditure was growing by 12.45 percent. The government's increasing allocations to the health sector continued until at least the mid-1980s. This is also the period in which there was the largest increase in public sector hospital beds (Table 4).

**Table 4: Growth in Number of Government Beds in Kerala**

<i>Year</i>	1961	1971	1986	1996
<b>Number of Beds</b>	13000	20000	36000	38000

*Source:* Kutty (2000)

However, after this period, the state government's allocation to the health sector began to decline, and after the mid-1980s, the expansion of the sector began to slow down substantially. There were at least two main reasons for this decline in public resources for health care. First, the state economy went into decline with the stagnation of both the agricultural and industrial sectors, which caused state government resources to shrink even as its commitments increased substantially. By the late 1980s, capital expansion in the health sector had come almost to a standstill and the recurrent budget, while still going up, was almost completely dominated by salaries, leaving little money available for supplies and equipment. As could be expected, the quality of care in the public sector went down, and the private sector exploited this opportunity by expanding.

The second reason why public resources for the health sector decreased was that the public in general and the political parties in particular no longer put health care at the top of their agendas. Political discourse in the state had become much more preoccupied with matters of "power politics" including those related to caste and community issues. The media, which had played a critical role in the past in promoting funding for the social sectors, failed to keep the pressure on the political parties on these social development issues. This has allowed the state government to let health care services slip down its list of priorities.

#### Achievements Shaken

Thus, the Kerala "model" public health care system is facing serious problems, including

inadequate resources and reduced efficiency, which have led to a decline in the quality of care. This is happening at a time when the cost of health care is increasing at a rate much higher than that of general commodities due to the increasing availability of expensive diagnostic technologies (Varatharajan, 2004). By the mid-1990s, the fiscal crisis had assumed such serious proportions that the government's checks bounced because of the paucity of funds in their accounts. Nor was the government able to pay the suppliers of medicines and consumables for hospitals (Varatharajan, 2004). Since that time, there has been a virtual halt to the creation of new health care infrastructure, and maintenance of the existing structures has also suffered a set back in the last decade. This has put an increasing financial burden on patients because.

While government revenue stagnated compared to its expenses, health care was not affected much. However, analyses have shown that the increased budget allocation for health care in recent times was spent on increased salary expenditure and not on maintenance or drugs and supplies. Also, the changes in the delivery system put a tremendous financial burden on the population because of the higher costs of treatment. Some estimates from the state show that the poor spend 40 percent of their income on health care, an almost five-fold rise between 1987 and 1996, while the rich had to spend only around 2.4 percent, almost the same proportion as they were spending in 1987 (Kunhikkannan and Aravindan, 2000). Besides, national-level data highlight the fact that the state has one of the highest level of user fees for public health services in the country, which must be having a

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negative effect on the affordability of health care (Peters et al, 2002 and Government of India, 2002). There is no exemption mechanism, which means that few of the poor can afford to access public health care any longer.

The picture on the pattern of diseases in Kerala is complex. Diseases that tend to affect the poor such as TB, malaria, and other infectious diseases coexist with a rising incidence of non-communicable diseases and injuries as a result of the state's premature epidemiological transition. Leaving aside the debate on the methodology of morbidity measurement in the state for the time being,<sup>142</sup> health surveys reveal that the state has high morbidity at 110 per 1,000 population but with generally low mortality. However, the prevalence of morbidity among the elderly is disturbingly high at 234 per 1,000 population with chronic ailments accounting for the major share (in 1995-96). The hospitalization rate in Kerala is also quite high compared with other Indian provinces. Once again, there is a higher level of hospitalization among the elderly who have a prevalence of 155 per 1,000 while the average for the state is 68 per 1,000 (in 1995-96).

This has important implications for the care of the elderly. First, as the elderly have higher hospitalization and morbidity rates, they need more medical care, which can put a heavy burden on their household's finances. For example, one study (Narayana, 2001) has found that the presence of an elder member in a household explains its high health care expenditure. Second, since a large number of old people are economically dependent on others, the care they get is often sub-optimal. Evidence for this assertion can be found in the many studies of how household decisions are made, which have shown that the intra-household allocation of money and time varies depending on the age, sex, and social status of the household member. In other words, women, children and the elderly tend to lose out. Clearly, the state or any other third party with a pure non-profit motive has got a vital role to

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<sup>142</sup> See Kumar, 1993 and Panikkar and Soman, 1984 for better insights on this issue.

play in offering the elderly a hassle-free existence at the end of their life. This may mean providing them with better social security arrangements (Kerala has a better track record in this respect than the rest of India but not by international standards), free public health care for those over 60 or 65, and/or more extended care units attached to health facilities.

Some scholars feel that a tolerably efficient and almost equitable public health service often serve as an important competitive factor in how private hospitals determine their treatment prices. In an analysis of NSSO data, Krishnan (1995) reached the conclusion that however high the charge in government hospitals may be, the price in private hospitals will be even higher. He further pointed out that one of the considerations that private hospitals take into account in determining their inpatient charges is to add a mark-up over and above the cost of treatment in government facilities. Public hospitals act as "shock absorbers" for a large majority of people who incur catastrophic and impoverishing medical expenditures. High user charges based on the principle of cost pricing may have both indirect and direct effects on the efficiency and equity of health service provision in the state as well as on access to and use of health services.

The inequity that crept into the system slowly but steadily has given rise to issues of grave concern. The belated realization by the state that the centralization of the decision-making process might be one reason for the inefficiency of governance and management as well as for the inefficiency and rising inequity of the public health care sector led to a paradigm shift in thinking. Policymakers began to embrace a decentralized development philosophy based upon the needs and aspirations of local communities.

**Political Decentralization -The New Development Rhetoric**

Decentralization, if implemented effectively, is a mechanism capable of changing governance at a fundamental level and can be an engine of change especially in rural areas. Ideally,

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decentralized structures are geared towards achieving national goals while responding to local needs. In principle, the central government would provide the maximum possible resources and other technical expertise to regional and local governments, which in turn would be responsible for responding to and meeting its community's needs (Segall, 2003). Effective democratic decentralization requires some of the important following elements: (i) devolving adequate resources to lower levels of government; (ii) giving functional and financial autonomy to all levels of government; (iii) requiring that these funds are used in accordance with a democratically decided and pre-specified development plan, and (iv) building the capabilities of regional and local governments to use resources effectively and transforming civic culture to encourage democratic participation by people at the grassroots (Chandrasekhar, 2004).

Decentralization - the Kerala Way

The media have depicted Kerala's experiment with decentralization as an alternative development model for developing countries in the face of globalization. It has also been seen as a new development paradigm in which participation is to prevail over pressure group politics.

Political decentralization as it has evolved in Kerala departs from the model outlined above in several important ways (Issac, 2000). The decentralization process was converted into a mass movement within a broad legislative framework in the state. It has also followed a pure bottom-to-top approach, which in practice means that the local population is empowered to discuss, decide, and implement programs on their own. Because of previous land reforms in Kerala, the lower socioeconomic groups are freer to participate in this decision-making than their counterparts in other states who are severely restricted by their dependence on their landlords. As for the health sector, an analysis of the development reports prepared by a few *panchayats* in the state shows that the local populations view issues related to health care, especially preventive care, as one of their

highest priorities (Nayar, 2001).

However, for the last few years, there have been several major hurdles that have prevented decentralization from being implemented effectively in the state. These include the timing of the allocation of funds, conflicts of interests among the people, politicians, and bureaucracy, the inability of the local political leadership to convince health service policymakers at the national level, and a lack of clarity about the roles of the *panchayat* in the implementation of state-level and central government programs. Bureaucrats at the national level usually resist any erosion of their power, and this is a continuing problem for Kerala. Notwithstanding these problems, the decentralized political structure has facilitated progressive changes in many sectors.

**Action Plan for Health Financing in Kerala within the Decentralized Government Structure**

From the above discussion, it is clear that access to health care in Kerala is severely limited by a lack of a financing mechanism that takes into account the disease priorities of the population. Tax-based financing, community financing, and social insurance are the major alternatives that are feasible in the Kerala context. The decentralized government has to play a key role in both organizations as well as in mobilizing resources especially from taxes and community financing. Tax based financing is likely to be the most feasible option because the other mechanisms have been found to be less effective in meeting health care needs. Although government spending on health in Kerala is higher than in other states, it still accounts for less than 1.25 percent of the state's GDP. Overall, the state needs to increase this allocation as both the state and the central governments have elastic and buoyant tax revenues. Moreover, tax-based resource allocations have been shown to enhance the efficiency and equity of health services. As for user fees, they cannot be raised any more as they are already at higher levels and it is certainly not feasible to introduce them at the level of primary care. Since estimates reveal that majority of out-

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of-pocket health care expenditure (more than 50-60 percent) is spent on ambulatory care, it ought to be possible for a well-functioning public health services with a strong emphasis on the rural and urban primary and curative care to reduce the financial burden on patients. The strength of the state is that it is already doing well with regard to equity and efficiency compared with other states. Community health insurance or any other insurance usually fails because administering small cases is costly for the insurers who do not generally cover high probability events like ambulatory care. So pumping fresh resources into regulating private practice would go a long way towards helping patients to access and afford care. The decentralized government of Kerala has a vital role to play in looking after the management aspects and ensuring the quality of care by ensuring the timely and uninterrupted supply of drugs and medicines, maintenance of facilities, and other important components of recurrent expenditure.

As for the funding of inpatient care, the picture becomes more complex because there is a need for more public and private facilities. In the formal sector, where around 10 percent of the state's workforce is employed, patients may be covered by the existing social and group insurance mechanisms, and the need here lies in increasing the efficiency of the providers and the organization. Community financing could be an important way to reduce expenditures on catastrophic illness for people in rural areas and in the informal sector. Community financing schemes organized by LSGs with a community risk rating can be a complementary financing method. All the individuals in a respective *panchayat* area can be members by paying a nominal premium per month. These schemes can cover both secondary and tertiary care up to a certain amount and can include costly outpatient care as well. Two years is a good period of time for piloting the project, and five years is appropriate for full-fledged implementation. The household has to be the minimum unit for entering the scheme to avoid adverse selection and the question of intra-household allocation of resources as much as possible. The poor have to be fully exempt from

any payment obligations. The larger the number the citizens who participate, the better the check on different types of fraud.

Kerala's specific advantages include a literate population, a high level of public participation, better administration and governance because of decentralization, and a relatively empowered female population. The financial situation of the local self-governments is relatively satisfactory. However, the obvious constraints of LSGs should be borne in mind. For example, major decisions cannot be left to their sole discretion as this may lead to a loss of direction. They may not also be able to function as independent units, as this might result in geographically poor and underdeveloped areas suffering even further. The decentralized governments cannot also be expected to deliver all levels of care, particularly, specialist tertiary care.

**Conclusion: Whither Health Care Financing?**

This analysis of India's health services in general and the Kerala health system in particular has shown that the country has a long way to go in achieving acceptable levels of health outcomes. The available data show that the Chinese health system, which used to be seen as an encouraging example for many other developing countries, seems to have faltered in recent years. As for India, although policymakers after Independence planned to build a strong foundation for an egalitarian health care system, its implementation has fallen far short of this goal. However, there is no dearth of ideas as well as success stories in the country. The stories of Kerala and, more recently, of Tamil Nadu and Himachal Pradesh have shown that wherever there has been public pressure coupled with progressive state action, there have been tangible and encouraging results on the ground.

To bring about sustainable improvements in the health status of their populations, both China and India are going to have to reduce their reliance on household financing and ensure that in future a large share of the health system's budget comes from the state and from employers. Since the market often fails in the

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health sector, effective state action is essential to ensure efficiency. However, it is not enough to solve financing issues alone; broader issues like human resources management and the structure and content of medical education may also need a fresh look. Revising the current “essential drug strategy” that takes into consideration the changing epidemiological and demographic profile of the country (as has been done by WHO) may increase access to essential

medicines. The drug procurement and delivery system in India needs a thorough overhaul, and the country can learn from the experiences of the State of Tamil Nadu in this respect. As for the State of Kerala, its past achievements are indeed satisfying, but a lot more needs to be done in the future. As health and health care are integral to the survival of the individual, inequities in access to health care based on ability to pay or any other factor will undoubtedly affect the health of the population and the development of the nation itself.

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## Summary of the Discussion

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Following the presentation of the two papers, there was a wide-ranging discussion about the two country cases – China and India – and the broader issues that they raised.

### **The Importance of Providing Health Social Security in Rapidly Industrializing Countries**

The participants were in agreement that providing health social security in rapidly industrializing countries is vital. The discussion examined this question from two key perspectives. First, whatever approaches are taken by China and India to provide health care to their populations will have global economic ramifications. Both countries are rapidly emerged economic powers that increasingly compete with the more established industrialized countries. The rising costs of health social security in the more advanced countries are increasingly threatening their economic competitiveness. Similarly, the ways chosen by newly industrializing nations to provide health care will affect their ability to compete with the wealthier economies either negatively or positively.

Second, both India and China, by dint of their size and relatively low income levels, have major effects on global welfare outcomes in terms of both health and financial protection. The World Bank recently estimated that India's progress in achieving the Millennium Development Goals for health and poverty reduction will largely determine the world's success in achieving these goals. And as this session's featured papers made clear, there are currently high levels of household out-of-pocket spending on health in both countries, which is a major cause of impoverishment.

### **The Unsustainability of Past Efforts**

Most countries in the developing world have followed similar patterns in providing health care to their populations. The dominant international model has been of a national health service – a tax-financed, government-owned and

operated health care system intended to provide universal coverage of a fairly comprehensive package of benefits. However, as of today, there are few examples of such systems that have been sustainable in developing countries.

The papers on India and China provided different examples of the development and subsequent decay of such systems. In China, the state initially succeeded in delivering services that achieved substantial and widespread health improvements. However, since the Chinese government decided to embrace market economics on the advice of the Cato Institute, it gradually began to limit the extent to which these services were financed from the public budget even as health expenditures as a percentage of GDP increased and few health improvements were achieved. Today, while most health care is still delivered by the government, health facilities function largely as quasi-private entities and are largely financed by private, out-of-pocket spending. Joseph Wong noted that the Chinese may tolerate social inequality if it is merit-based but not if it is based on unfair economic policies.

In India, ambitious goals to develop a national health service were set in the early years of the independent state. However, the state never provided sufficient financing to develop these services. Even in Kerala, which historically had a strong state commitment and many early gains in health indicators, economic realities have undermined these ambitious goals. Today, the health care systems in India in general and in Kerala in particular are largely privately owned and financed by household out-of-pocket spending.

The experience of both countries suggests that it is difficult for state-oriented health care strategies to succeed in liberal and pluralistic developing countries. Both China and India are now having very significant problems providing financial risk protection to their populations, as unexpected increases in health care expenses are emerging as one of the main causes of rising

household impoverishment. While China's overall health achievement currently exceeds India's, both countries face significant challenges in maintaining health gains as well.

### **Ways Forward?**

The discussion then focused on alternative ways to provide health services and financial risk protection and to ensure consumer satisfaction.

In China, the government has recently recognized that there is an urgent need to address the deterioration of the health system in terms of its ability to provide widespread benefits. However, the government also increasingly accepts the realities of market conditions. William Hsiao noted that under these conditions in China health care inflation has exceeded economic growth by a wide margin. Shaoguang Wang noted that even the more affluent are struggling in the new system. This gives an impetus to the argument that the state should play a bigger role in raising financing and regulating and guiding the health system, while making use of market-based mechanisms such as financial incentives to try to improve outcomes. William Hsiao also noted that local authorities have recently had some success in providing care to rural populations at very modest costs.

In India, the health system has not yet been seen as a high priority for the state, and government funding for health care remains very limited. Some Indians are now arguing for returning to a model in which the state is responsible for health social security, even though in urban areas of India, there is a thriving and dynamic private health sector that looks to international sources of technology and even patients. One strategy that is currently being developed, especially in Kerala, is decentralization – giving greater control to local authorities over government health care – as a way to increase its positive impact.

John Campbell and Joseph White raised questions about precisely what problem needed to be solved – the problem of increasing access to care or providing effective financial risk protection? The necessary strategy in each case was likely to vary widely. For example, increasing access to care might require the existence of a well-run basic health care service, whereas providing effective financial risk protection would require more sophisticated risk pooling and purchasing systems. But John Campbell wondered whether a widespread or universal insurance system was even possible in societies with such high levels of inequality?

Participants also noted the importance of the strategic decisions that are being taken today for the future of health in these countries. Michael Reich, Soonman Kwon, and others noted the issues of “stickiness” and “path dependence.” Michael Reich expressed the opinion that it was not possible to envisage going back to the pre-reform ways of doing things. Naoki Ikegami wondered if, once providers became accustomed to higher earnings, this could ever be reversed. How the governments of China and India balance the roles played by the state and the private sector in health is likely to have an impact far into the future. Shigeru Tanaka linked this issue with how to ensure that a market-based system is fair and allows equality of access to care. William Hsiao stressed the need for a two-tier system in China, one based on social insurance for urban areas and the other based on community pre-payments for rural areas.

One interesting issue was the difference between India and China in terms of the amount of political attention each government was giving to health sector issues. What makes leaders recognize a problem that needs their attention? Is it easier for clear and effective strategies to emerge under more authoritarian regimes than under more democratic ones?

## Chapter 5: Summary and Interactions of the Key Points

### Practical Issues in Priority Setting in Health Care

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As a public servant working for the Government in New Zealand, I am always conscious that health funding is finite. The health sector in New Zealand receives a defined annual allocation of funding and must achieve the best possible outcomes from that funding. Therefore, priorities must be set.

These brief remarks will focus on two aspects of priority setting, with practical examples from New Zealand but with generic issues in mind. The two aspects are the resource allocation process and setting priorities on the delivery side.

#### **The Resource Allocation Process – “Core Services”**

Some countries identify the services to be covered by health funding by drawing up a list of “core services.” However, these countries usually fail to devise a priority list of services taken out of context of the clinical situation. Even cosmetic surgery, seen as a low priority by many people, should be publicly funded in certain clinical circumstances (for example, for people who have suffered severe facial disfigurement). The state of Oregon is the best known example of a jurisdiction that has taken the list approach, but in Oregon, the list is supported by guidelines that define clinical factors for access to the condition-treatment pairs in the list.

In New Zealand, the National Health Committee (NHC)<sup>143</sup> advised the government

that a simple list of services was not sufficient because it was too black and white, it would rapidly become out of date as new technologies and treatments developed, and it implied a guarantee of access to any listed service regardless of a person’s health need or clinical ability to benefit. The NHC recommended that the government should develop “qualified lists” based on evidence of clinical benefit rather than a simple list of core services.

Although different from the original task set for the NHC, the government accepted the committee’s advice not to adopt a list approach but instead to define or qualify the terms of access to services that are already funded and provided. The NHC was given additional funding of NZ\$4 million over three years to work closely with clinicians and service funders to define *when* services should be publicly funded - that is, in what clinical circumstances the services would be beneficial, *who* should receive the services first, and *how long* they should have to wait.

After the three-year pilot phase from 1993 to 1995, responsibility for developing guidelines was devolved to an independent organization, the New Zealand Guidelines Group, which works with clinicians, academics, other experts, and consumers. The Group takes the cost-effectiveness of interventions into account as well as their clinical effectiveness in devising the guidelines. The government continues to fund the development of the guidelines a decade after the NHC recommended this approach and advised against a simple list of core services.

Two examples of New Zealand service

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charged to lead the discussion on setting health priorities.

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<sup>143</sup> The National Advisory Committee on Health and Disability (NHC) was set up by the New Zealand Government in 1992 to advise the government on the health and disability services that are a high priority for public funding. It is a highly credible body, made up of leading health professionals, academics, and representatives of communities and consumers,

guidelines follow.<sup>144</sup>

### **Guideline for the Management of Mildly Raised Blood Pressure**

Raised blood pressure has been regarded as a disease that must be treated. The guideline recommends a different approach for *mildly* raised blood pressure – that it should be regarded as one of a number of risk factors for heart attack or stroke. Making a decision about treatment would then require a doctor to assess all risk factors and to estimate each individual's total risk of stroke or myocardial infarction. The guidelines recommend taking the same approach to decisions about how to manage raised blood lipids.

The guideline contains a very simple risk chart (see Figure 1). Doctors use the chart to discuss treatment options with their patients, informed by an understanding of the absolute five-year risk of a cardiovascular event.

Younger patients with a low risk of such an event may choose to reduce their weight, get more exercise, stop smoking, and reduce the amount of salt and fats in their diet in preference to going on medication immediately. This approach has obvious benefits including involving patients in their own wellness, limiting pharmaceutical use in clinically appropriate circumstances, and thereby reducing costs. The patient's condition is monitored regularly to assess whether the treatment decision needs to change.

There was some controversy about this advice. First published in 1992, the guideline was revised in 1994 after some practitioners expressed concern about the recommended approach. During the revision process, all views were reviewed in a public process, and eventually the review panel confirmed the original advice to take a total risk approach to

mildly raised blood pressure. Thus, the NHC's original advice is still current today.

### Guideline on Population Screening for Prostate Cancer

The advent of the Prostate Specific Antigen (PSA) test has led to growing calls for a national prostate cancer screening program, even for men without symptoms. However, the PSA test can result in false positives and false negatives, requiring patients to undergo further examinations including biopsies to get a definitive diagnosis. People without cancer may be needlessly worried, and there are risks associated with the further examinations.

The guideline clearly recommends further examinations for men *with* symptoms. It also acknowledges that prostate cancer remains an important public health problem in New Zealand.

However, after weighing the risks and benefits of a national screening program for men without symptoms, the guideline states “there is still no conclusive evidence to demonstrate whether screening for prostate cancer reduces mortality or morbidity, and there is significant potential for harm. The National Health Committee *does not currently support population-based screening for prostate cancer or opportunistic screening using PSA or digital rectal examination for asymptomatic men in New Zealand.* Men considering a PSA test need to be fully informed of the potential risks of prostate screening and be provided with detailed information about its limitations, the possible diagnostic and treatment choices, and outcomes.”<sup>145</sup>

This advice is also controversial, and the National Health Committee has undertaken to review the guideline regularly in the light of any new evidence.

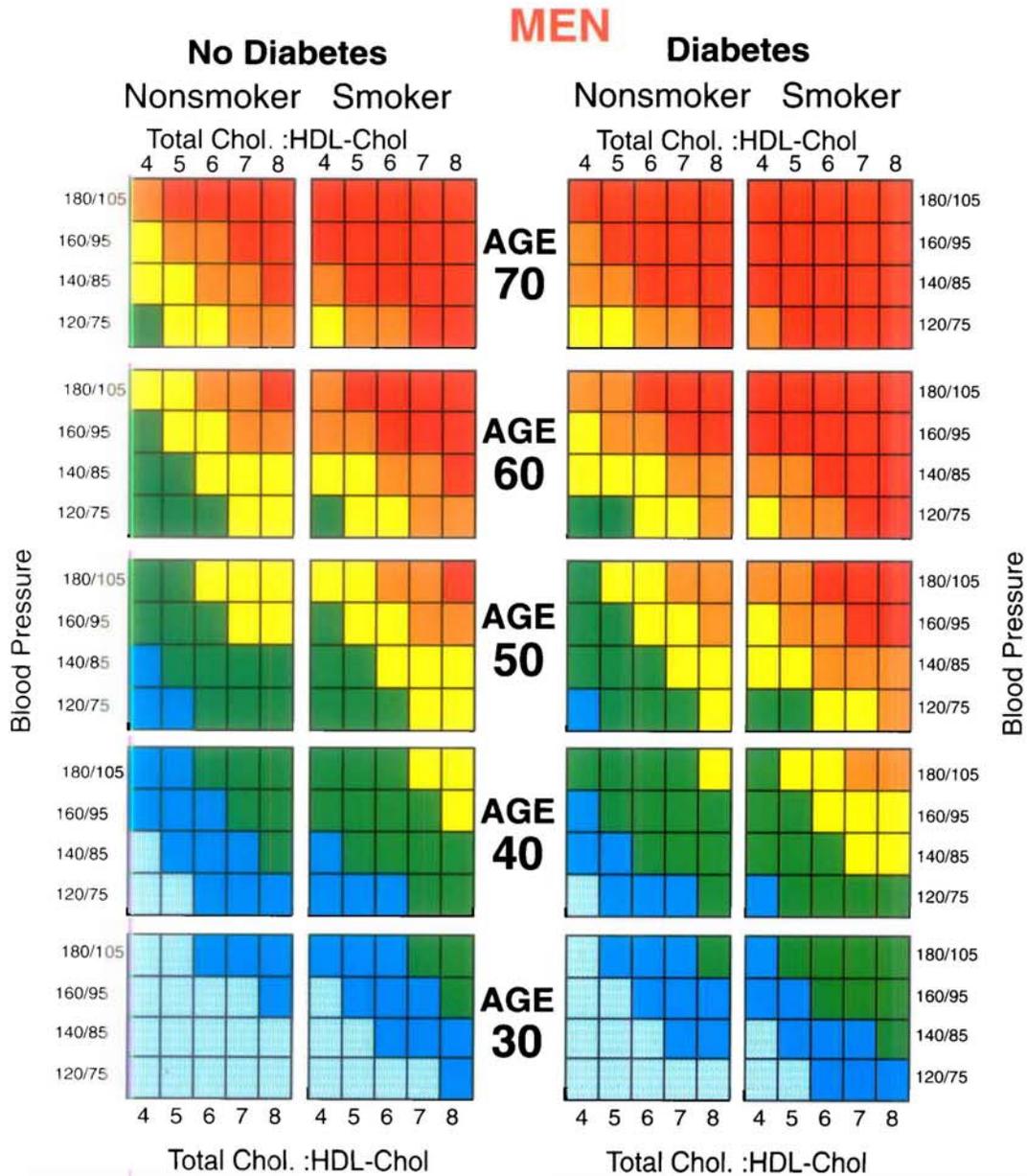
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<sup>144</sup> A significant number of other guidelines have been developed or adapted in New Zealand. These are accessible at the following websites: <http://www.nhc.govt.nz> and [www.nzgg.org.nz](http://www.nzgg.org.nz).

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<sup>145</sup> National Health Committee, *Prostate Cancer Screening in New Zealand: Report to the Minister of Health*, NHC, Wellington, April 2004.

Figure 1: Risk Chart of Cardiovascular Event



<b>Risk Level</b> Percent chance of cardiovascular event in 5 years	Very High	[Red]	>20%
	High	[Orange]	15-20%
	Moderate	[Yellow]	10-15%
	Mild	[Green]	5-10%
	Low	[Blue]	2.5-5%
	Very Low	[Light Blue]	<2.5%

<b>How to use the Risk Tables</b>	
1. To estimate a person's absolute 5-year risk of a cardiovascular event (newly diagnosed angina, MI, CHD death, stroke or TIA), identify the table relating to person's sex, diabetic status, smoking status and age.	
2. Within the table find the cell nearest to the person's blood pressure and TC:HDL-C	
3. Compare cell colour with risk level	
4. For patients with symptomatic or familial hypercholesterolaemia. The level of risk should be raised by 2 categories	

If a man insists on being tested for PSA despite questionable grounds, this is allowed but the patient has to pay for the test. In the case of some practitioners who are not convinced of the risks or harm of screening, compliance with the guideline is an issue. However, there is a consumer pamphlet that gives clear information to patients, and with that and the guideline for health professionals, an informed discussion can take place between patient and doctor about the risks and benefits of PSA testing.

### **Status of Guidelines and Practitioner Compliance**

Practice guidelines in New Zealand are advice, not protocols. They apply in usual circumstances and always require doctors to use their clinical judgment about when and how to apply them. They are not prescriptive and have no regulatory implications.

However, doctors are increasingly seeing the guidelines as an authoritative summary of clinical evidence to guide their treatment decisions. The level of confidence in the evidence is clearly indicated. The New Zealand Guidelines Group provides the guidelines either in hard copy or on a website to any person free of charge.

The New Zealand experience suggests that the extent to which doctors adhere to such guidelines and comply with their advice depends on the following factors:

- The moral authority and reputation of the guideline developers, based on the strength of the evidence that they present in support of their guidelines
- Whether there is anonymous peer review of prescribing and treatment decisions and whether formal discussion groups are conducted for professionals in a practice to explore the reasons for treatment decisions
- Whether research findings exist to back up the guideline; for example in the case of the blood pressure guideline in New Zealand, research on the effects of guidelines indicated a change in doctors' prescribing intentions for first line treatment, towards increased use of low-dose diuretics, alone or in combination

with beta blockers, replacing the pre-guideline preference for ACE Inhibitors, and calcium channel blockers

- Whether incentives are put in place to encourage primary care practices to adhere to the guidelines (such as budget-holding for pharmaceuticals, where a primary care practice manages an annual allocation of funding for all pharmaceutical needs of the patients in that practice, which has influenced doctors' prescribing patterns and made them give more consideration to cost-effectiveness).

### **Priority Setting on the Delivery Side – Increased Emphasis on Primary Care**

In New Zealand, hospital services are free but patients are subject to substantial co-payments for primary care. This has prevented patients from seeking care in the early stages of their medical conditions. Instead, this has encouraged them to use the emergency services of the local hospital (which are free to them but are expensive to the government) or to delay seeking treatment until they are much sicker, which often results in avoidable admissions to hospital.

Since October 2003, the government has made a conscious decision to substantially increase funding for primary care. Its objectives are to:

- Increase access to and the affordability of primary care services
- Ensure that people receive care as early as possible to reduce avoidable hospital admissions
- Encourage doctors to increase their emphasis on wellness
- Promote greater patient participation in their own wellness
- Improve health status indicators and close health status gaps or disparities between population groups
- Reduce disability associated with chronic conditions and increase the independence of disabled patients.

While the problems of affordability of primary care and late access had been around for many years, the center-left government that was

elected in 1999 made a number of “credit card pledges”, which included substantial increases of funding for primary care to increase access to health services.

The economy in New Zealand improved. In simple terms, there was more money to spend.

The health sector is funded on a three-year basis but with annual increases in the total allocation to adjust for inflation and for demographic and technological changes. This increase applies to all services. Health spending as a proportion of government expenses is forecast to increase from 18.2 in 2000/01 to 20 percent by 2005/06.

In response to the economic improvements of the 1990s, the government decided to put substantial additional funding (from new money) into primary care, as this level of health care – the level used most often by most people – was receiving a very limited share of public funding by 1999.

Since 2002, the majority of *new* funding has been spent on primary care. A small proportion of new funding has been allocated to other services (for example, to elective surgery to reduce waiting times). This increased primary care funding has been provided in phases, targeted first to the very young, to older people, and people with the highest health needs. Increased subsidies will cover the whole population by 2007.

Actual funding for other services has not declined, but, with the deliberate allocation of new funding to primary care, the *proportion of spending on primary care and on all other services in total health funding has changed*. In 2003/04, 11.79 percent of health funding was allocated to primary care. By the following year (2004/05), the percentage had increased to 12.93 percent.

Since 2002, Primary Health Organizations (which are similar to primary care HMOs) have been set up across the country funded on a capitation basis to provide preventive health

steadily through the mid- to late-1990s. By early 2002, the country’s level of overseas debt had reduced significantly due to the growing strength of the New Zealand dollar. Budget surpluses had increased as a result of higher rates of employment and higher tax revenues. services and early care and to emphasize wellness education. Their services include diabetes awareness, nutrition education, retinal screening, foot care, and Pacific and Maori support services, as well as the curative and treatment services traditionally delivered by fee-for-service primary care teams (including GPs, nurses, physiotherapists, dieticians, pharmacists, and counsellors). This initiative is a major change from the fee-for-service payment model in which the majority of patients were seen by a GP.

Specialists have expressed concern about the current adequacy of funding for secondary and tertiary care. They have called for more of the new funding to be allocated to those areas. There has also been strong resistance to the changes from some primary care practitioners who argue that their clinical autonomy is being infringed by the capitation payment method. They also feel that funding increases should be used to address the significant under-funding of some aspects of primary care, such as the income levels of GPs and the business costs of private practice, rather than increasing the subsidies for patients. Concern has also been raised about the competence of nurses and other members of the primary care team to deliver services instead of GPs.

Participants in a national primary care conference in 2002 were strongly critical of the proposed changes. Three years later, in March 2005, increasing levels of funding have been made available for primary care, which means that Primary Health Organizations are now in place around the country covering most of the population (95 percent). Increasing numbers of practitioners are becoming convinced of the value of the changes, although significant issues still remain. An independent evaluation of the changes has reported that reducing fees has increased access to primary health care, and GPs are reporting increased patient visits.

Changing the responsibilities of the primary care team has provided nurses with more opportunities for skill development and more varied career paths. However, the report also says that high patient fees are still a concern, with not all of the increased funding being used to the benefit of patients as originally envisaged. There are challenges arising from the differing sizes of the PHOs, in creating cooperation between PHOs, and in developing the capacity and skills of the PHO staff. Also, the increase in the number of visits may be attributable to the worried well rather than by patients with significant health needs.

This example gives a flavor of how difficult it can be to change how resources are allocated across different health services. Had this rebalancing in New Zealand required a reduction in funding for some existing services to increase funding for others, it is likely that there would have been even more dissent.

### **Conclusion**

Priority setting in health care within services and between services is a challenging task.

Based on the New Zealand experience, the following factors are needed if the exercise is to be successful:

- If increasing funding for one level or kind of service does not require a reduction in funding for current services)
- If funders and providers have common goals (for example, an agreed focus on improving the health of the greatest number of the population and a willingness to balance the needs of individual patients),
- If consumers are involved and understand which services are more or less effective clinically
- If all relevant interests or viewpoints are represented and there is an authoritative and credible mechanism for mediating different points of view
- If there are organized public forums available for ongoing discussions as evidence, priorities, and trade-offs change.

There are no easy solutions, and goodwill is key.

## Summary of the Discussion

Michael Reich  
Harvard University

The final session of the International Seminar on Reforming Health Social Security began with a presentation by Wendy Edgar on “Practical Issues in Priority Setting in Health Care,” in which she reviewed the work of the New Zealand Core Services Committee. Next, the chairs of the seminar’s four sessions presented the major lessons that had emerged from each session. William Hsiao focused on the implications of the experience of introducing extra billing in Korea for the current policy debate now underway in Japan. Kotaro Tanaka presented the main points of the discussion about long-term care, giving particular attention to issues of cost control and financing. Joseph White spelled out the major issues that had arisen in the discussion about additional health expenditures in Canada and the United Kingdom, including the question of why so much attention is paid to waiting times and what we want health systems and health expenditure to achieve. Finally, Peter Berman examined the commonalities between the health system experiences of China and India, especially their similar origins, their shifts toward market-based systems, and their governments’ ability to deal with the serious disparities that have arisen in those countries.

The participants then explored two major themes that had emerged from the sessions: – first, the role of values played by health system reform and, second, the challenges involved in making technical analysis useful to policy debates.

The discussion about values and ideas in health system reform complemented the seminar’s focus on the economic and political dimensions of health social security. It was noted that specific ideas sometimes become dominant in the policy debate, making them the conventional wisdom and making it hard for alternative views to be heard. These dominant views and values are often promoted by specific organizations or interest groups, as has happened with the emphasis on freedom and choice and market-

oriented social systems (such as the role that the Cato Institute has played in China). In short, ideas and values matter in the debate over health system reform. The radical transformations in the former socialist countries and many developing countries over the past 10 to 15 years, with the shift toward emphasizing the market rather than the state, illustrate how such changes can occur. On the other hand, many rich countries (such as Canada) have protected core values that are embedded in the institutions of the health system. Rich countries, it was suggested, have not experienced the same transformation in values as has been witnessed in the former socialist countries and developing countries. Caution, therefore, is needed in making generalizations based on the experiences of certain countries.

The second theme for discussion was the challenges involved in using technical analysis in policy debates about health system reform. The discussion began with the question of how to interpret the Soonman Kwon’s analysis of extra billing in Korea in the context of the ongoing policy debate about this issue in Japan. It was noted that the Korean analysis was only partial and did not include an assessment of the impact of extra billing on health outcomes. Academic analysis often has various unavoidable limitations due to a lack of complete information or time or money constraints. Many academics, therefore, are reluctant to enter policy debates in case their studies are misinterpreted or misused. It is often difficult to present the complexities and subtleties of academic studies in public discussions and political controversies. Other academics, on the other hand, are willing to enter these public debates and use their studies (and the research of other scholars) to affect public thinking and policymaking. This illustrates some of the challenges of “speaking truth to power” (in the words of political scientist Aaron Wildavsky), especially in using the experiences of one country to shape social

### *Summary of the Discussion*

policy in another country. The discussion concluded with a reminder that academic researchers not only have an important role to play in the pursuit of truth and the production of evidence through their research but they also have an important obligation to help

policymakers to understand and interpret their findings. Thus, the discussion returned to the importance of values and ideas in shaping public policy about health systems and long-term care – which was one of the major objectives of holding this international seminar in Japan.

**Appendix 1- Program**  
**International Seminar on Reforming Health Social Security**

**Program**

June 27-29, 2005

Keio University Mita Campus  
Tokyo, Japan

Sponsored by  
A Joint Grant from the Ministry of Education & Science, Japan, and Keio University

Co-sponsored by  
The World Bank

Supported by  
The Asahi Shimbun Company  
Japan Medical Association  
Japanese Society of Clinical Economics  
National Federation of Health Insurance Societies

*Appendix 1 - Program*

**Sunday, 26 June 2005**

**Welcome Reception**

**Time: 18:30 onwards**

**Monday, June 27, 2005**

9:00 – 9:30 Welcome, Introduction and Logistic Announcements  
Professor Naoki Ikegami  
Keio University

*Closed Sessions*

**Venue: Conference Room, 4<sup>th</sup> Floor, North Building**

**Session 1: Choosing to Cover Comprehensive or Basic Medical Services under Universal Social Health Insurance**

Chairperson: Professor William Hsiao  
Harvard University

9:30 – 11:00 1<sup>st</sup> Paper: Should Providers Be Allowed to Extra-bill for Uncovered Services?  
Debate, Resolution, and the Future in Japan  
Professor Naoki Ikegami  
Keio University  
2<sup>nd</sup> Paper: The Billing of Medical Services and the Financial Burden on Patients in  
Korea  
Professor Soonman Kwon  
Seoul National University

11:00 – 11:15 Coffee Break

*Appendix 1 - Program*

11:15 – 12:45 Discussion

12:45 – 14:00 Lunch

**Session 2: Financing Long-term Care**

Chairperson: Professor Kotaro Tanaka

Yamaguchi Prefectural University

14:00 – 15:30 Financing Long-term Care: Lessons from 19 OECD Countries

Dr. Manfred Huber

Organization for Economic Co-operation and Development

1<sup>st</sup> Paper: Long-term Care in Germany

Professor Heinz Rothgang

University of Applied Sciences in Fulda

2<sup>nd</sup> Paper: Sustaining Long-term Care Insurance in Japan and Beyond

Professor John C. Campbell

University of Michigan

15:30 – 15:45 Coffee Break

15:45 – 17:15 Discussion

*Tuesday, June 28, 2005*

**Session 3: Increasing Public Expenditures on Health Care**

Chairperson: Professor Joseph White

Case Western Reserve University

9:00 – 10:30 1<sup>st</sup> Paper: Increasing Investment in the UK-NHS: Some Policy Challenges

Professor Alan Maynard

*Appendix 1 - Program*

York University

2<sup>nd</sup> Paper: Re-Casting Canadian Federalism: Health Care Financing in the New Century

Professor Joseph Wong

Toronto University

10:30 – 10:45 Coffee Break

10:45 – 12:15 Discussion

12:15 – 13:15 Lunch

**Session 4: Social Security in Rapidly Industrializing Nations**

Chairperson: Professor Peter Berman

The World Bank and Harvard University

13:15 – 14:45 1<sup>st</sup> Paper: State Extractive Capacity, Policy Orientation, and Inequity in the Financing and Delivery of Health Care in Urban China

Professor Shaoguang Wang

Chinese University of Hong Kong

2<sup>nd</sup> Paper: Health System Issues, Challenges, and Options: Reflections on China, India, and Kerala

Professor Kottilil Mohandas

Sree Chitra Tirunal Institute for Medical Sciences and Technology

14:45 – 15:00 Coffee Break

15:00 – 16:30 Discussion

16:45 – 17:15 Campus Walk

*Appendix 1 - Program*

**Wednesday, June 29, 2005**

**Session 5: Summary and Interactions of the Key Points**

Chairperson: Professor Michael R. Reich

Harvard University

9:00 – 9:10 Practical Issues in Priority Setting in Health Care

Ms. Wendy Edgar

Past-president, Society on Priorities in Health Care,

Ministry of Health, New Zealand

9:10 – 10:15 Summary of the Key Discussion Points from Each Session by the Four Chairs

Professor William Hsiao

Harvard University

Professor Kotaro Tanaka

Yamaguchi Prefectural University

Professor Joseph White

Case Western Reserve University

Professor Peter Berman

The World Bank and Harvard University

10:15 – 10:30 Coffee Break

10:30 – 12:00 Interrelationship among the Topics of the Four Sessions

12:00 – 13:00 Lunch

13:00 – 13:30 Meeting with Translators

(Chairs and Speakers of the Open Symposium)

*Appendix 1 - Program*

*Open Symposium*

**Venue: Conference Hall 518, Ground Floor, West Building**

**Time: 13:30 – 16:45**

Co-chairpersons: Honorable Keizo Takemi  
Member, House of Councillors  
and  
Professor John C. Campbell  
University of Michigan

- 13:30 – 13:40 Opening Greeting  
Director Aftab Seth  
Global Security Research Institute, Keio University
- 13:40 – 13:55 Fundamental Issues in Health Social Security  
Professor William Hsiao  
Harvard University
- 13:55 – 14:10 Billing of Medical Services and the Financial Burden on Patients in Korea  
Professor Soonman Kwon  
Seoul National University
- 14:10 – 14:25 Long-term Care in Germany  
Professor Heinz Rothgang  
University of Applied Sciences in Fulda
- 14:25 – 14:40 Federalism and Health Care Financing in Canada  
Professor Joseph Wong  
Toronto University

*Appendix 1 - Program*

14:40 – 14:55 Inequity in the Financing and Delivery of Health Care in Urban China

Professor Shaoguang Wang

Chinese University of Hong Kong

14:55 – 15:10 Break

15:10 – 15:25 Summary of the Discussions in the Closed Session

Professor Naoki Ikegami

Keio University

15:25 – 16:40 Questions and Answers from the Floor

Panelists: Professor William Hsiao

Professor Naoki Ikegami

Professor Soonman Kwon

Professor Heinz Rothgang

Professor Shaoguang Wang

Professor Joseph Wong

16:40 – 16:45 Summary

Honorable Keizo Takemi

Professor John C. Campbell

Farewell Reception

Time: 17:30 onwards

## Appendix 2-Biographies of Participants (in Alphabetical Order)

### **Berman, Peter**

Peter Berman (MSc, PhD) is a health economist and has been co-director of the Flagship Program Core Course on Health Sector Reform and Sustainable Financing run jointly by Harvard University and the World Bank Institute. He also co-directs Harvard's course on "Private Sector Health Care: Developing Successful Policies and Programs." He joined the World Bank's New Delhi office as Lead Economist for Health, Nutrition, and Population in July 2004 on leave from the Harvard School of Public Health, where he was Professor of Population and International Health Economics and Director of International Health Systems. His areas of expertise include analyzing the performance of health systems and the design of reform strategies; assessing the supply side of health care delivery and the role of private health care provision in health systems and developing strategies to improve outcomes through public-private sector collaboration; and using national health accounts as a policy and planning tool. Among his five authored/co-edited books include *Getting Health Reform Right: A Guide to Improving Performance and Equity* (Roberts et al, Oxford University Press, 2003).

### **Campbell, John Creighton.**

John Campbell is Professor of Political Science at the Department of Political Science at the University of Michigan where he has taught since 1973. His BA and PhD are from Columbia University. He specializes in Japanese politics in general and in organizational decision-making and social policy. He is the author of several books including *Contemporary Japanese Budget Politics, How Policies Change: The Japanese Government and the Aging Society* (University of California Press, 1977) and *The Art of Balance in Health Policy: Maintaining Japan's Egalitarian, Low-cost System* (co-author with Naoki Ikegami, Cambridge University Press, 1998). These books and many of his other writings have also been published in Japanese.

He has also served in administrative posts at the Social Science Research Council and as Secretary-Treasurer of the Association for Asian Studies.

### **Chan, Chee Khoon**

Chee Khoon Chan is an Associate Professor in the Development Studies Program of the School of Social Sciences at the Universiti Sains Malaysia. He graduated from the Massachusetts Institute of Technology with Bachelor and Master's degrees in life sciences and has a Doctor of Science degree in epidemiology from Harvard University. His research publications in cancer epidemiology, eugenics and bioethics, health care financing policy, and environmental health and development have appeared in international and local journals such as *Cancer Causes and Control*, *the Lancet*, and *the International Journal of Health Services*. Dr. Chan has served as a consultant and technical adviser to several international and domestic institutions including the World Bank and the Malaysian Institute of Economic Research. He was a founding member of the Penang Cancer Registry and a co-founder and coordinator of the Citizens' Health Initiative, which drafted A Citizens' Health Manifesto for Malaysia. His current research interests include emerging and re-emerging infectious diseases, policy issues in science and technology, the environment and development, and health care financing policy in Malaysia.

### **Conrad, Harald**

Harald Conrad is a Research Fellow at the German Institute for Japanese Studies and is based in Tokyo. His main areas of research are Japanese social and labor market policies, human resource management, and products and services for senior citizens. His recent publications include the book *The Japanese Social Security System in Transition - An Evaluation of Recent Pension Reforms* (Erscheinungsjahr, 2001) and the co-edited volume *Aging and Social Policies - A German-*

## *Appendix 2 - Biographies of Participants*

*Japanese Comparison* (Iudicium Verlag, 2003). After working for three years in the book industry, Dr. Conrad studied Economics and Marketing at the University of Cologne, Hitotsubashi University (Tokyo), and Keio University (Tokyo). He holds a PhD in Economics from Cologne University, which awarded him the Erhardt-Imelmann-Award 2001 for outstanding scientific research. Dr. Conrad has teaching assignments in Japanese and business studies at Bonn University, Munich University, and Sophia University (Tokyo).

### **Edgar, Wendy**

Wendy Edgar has a BA in English and Education, an MA in early childhood education, and a Diploma in Health Economics. Her career has included five years working in curriculum development in Canberra, Australia, five years in the Select Committee Office of the New Zealand Parliament (dealing with a wide range of policy issues including disarmament and arms control, employment equity, and the quality of teaching), and 15 years in health policy and management. From 1992 to 1999, she was Program Director for the Core Services Committee established by the New Zealand Government. Ms Edgar's most recent positions have included being a Health Advisor in the Office of the Minister of Health, leading policy work on the funding of long-term care for older people in New Zealand, and Senior Advisor International with the responsibility for policy work to support New Zealand's commitments in International Health. She is a Founder Member and the Immediate Past Chairperson (2000-2003) of the International Society on Priorities in Health Care, which was established in Stockholm in 1996.

### **Hawkins, Loraine**

Loraine Hawkins is a Lead Health Specialist in the East Asia and Pacific Human Development Unit of the World Bank and is currently the Human Development Sector Coordinator for the World Bank's program in the Philippines. Much of her work experience, both inside and outside the Bank, has focused on the interface among health systems, other social insurance, and social

services financing and between health expenditure and general public expenditure management. Her work outside the Bank has included secondments to the England Department of Health in England and to the United Kingdom Treasury to work on financing and system reform in health and social services during two of the current UK Government's medium-term spending reviews. She also spent 12 years in the New Zealand civil service, part of the time as an economist at the Treasury. Ms. Hawkins is a graduate in economics and public policy of the Woodrow Wilson School of Public and International Affairs at Princeton University (USA) and of Otago University (New Zealand).

### **Hsiao, William**

William Hsiao is the K.T. Li Professor of Economics at the Harvard School of Public Health and directs the Program in Healthcare Financing. He received his PhD in Economics from Harvard University. Prior to his appointment at Harvard, Dr. Hsiao was the Deputy Chief Actuary of the US government. He has advised many governments and international organizations on health sector reforms, including giving policy advice to three US presidents and to the US Congress on the planning of national health insurance, the payment of physicians, social security, and pension reforms. His current research focuses on finding a viable and sustainable model for funding and delivering basic health care to farmers in poor and low-income nations. He has won many awards, including honorary professorships by the leading Chinese universities. Dr. Hsiao is the author of more than 150 papers and several books.

### **Huber, Manfred**

Manfred Huber is a senior economist (Principal Administrator) in the Health Division within the Directorate for Employment, Labor, and Social Affairs of the Organization for Economic Cooperation and Development (OECD). He is currently in charge of work on long-term care policy and data and on output and price measurement in health care. Prior to this, he led a team in charge of health indicators. Among the regular outputs of this work were two of

## Appendix 2 - Biographies of Participants

OECD's flagship publications: *OECD Health Data* and *Health at a Glance*. Dr. Huber is the author of the OECD manual *A System of Health Accounts* and has provided advice to administrations in numerous countries on how to improve health information systems. Among his other research interests are macro-economic simulations for health care reform and international comparisons. He graduated from the University of Munich with a Master of Science in Mathematics. He was a Lecturer and Research Assistant in economic statistics at the University of Munich where he received a PhD in Economics.

### **Iguchi, Naoki**

Naoki Iguchi has been Director General for Policy Planning and Evaluation (in charge of Health and Welfare) at the Ministry of Health, Labor, and Welfare since 2004. He previously served as director of divisions of the Ministry of Health, Labor, and Welfare, as Councilor at the Cabinet Office, Councilor for the MHLW Minister, and Assistant Minister. His areas of expertise include aging, pensions, social insurance, and policy planning. Mr. Iguchi graduated from the Faculty of Economy at Tokyo University in 1974.

### **Ii, Masako**

Masako Ii, PhD, is a professor in the Asian Public Policy Program at Hitotsubashi University. She received her bachelor's degree from International Christian University in Tokyo and her PhD in Economics from the University of Wisconsin, Madison. She worked in the Population and Human Resources Department at the World Bank in Washington DC and in the Ministry of Planning, the Ministry of Health, and the National Institute of Statistics in La Paz, Bolivia. She was also a visiting scholar in the Faculty of Economics at the University of the Philippines and an associate professor at Yokohama National University. She is currently a member of the Medical Care Insurance Meeting of the Social Security Council.

### **Ikegami, Naoki**

Naoki Ikegami is Professor and Chair of the Department of Health Policy and Management

at the Keio School of Medicine, from which he received his MD and PhD. He also received a Master of Arts degree in health services studies with Distinction from Leeds University (United Kingdom). During 1990-1991, he was a visiting professor at the University of Pennsylvania's Wharton School and Medical School and has continued to be a Senior Fellow at Wharton. He is a board member of interRAI (a non-profit international consortium of researchers and clinicians focused on care planning instruments) and has sat on various national and state government committees. His publications include *The Art of Balance in Health Policy - Maintaining Japan's Low-cost Egalitarian System* (Cambridge University Press, 1998) with John C. Campbell and *Measuring the Quality of Long-term Care in Institutional and Community Settings* (OECD, 2002) with John Hirdes and Iain Carpenter.

### **Kwon, Soonman**

Soonman Kwon has worked at the Seoul National University, South Korea since 1997 where he is currently the Chair of the Department of Health Policy and Management at the School of Public Health. He received his PhD from the Wharton School of the University of Pennsylvania and was Assistant Professor of Public Policy at the University of Southern California. Professor Kwon has held visiting positions at the Harvard School of Public Health (Takemi Fellow), London School of Economics and Political Science, University of Duisburg (Germany), University of Trier (Germany), University of Bremen (Germany), Hosei University (Japan), and the Danish National Institute of Social Research. He has served on numerous government health policy committees in Korea. Dr. Kwon's main areas of interest are health economics and finance, pharmaceuticals, comparative health policy and the welfare state, and aging and long-term care. He has published numerous articles in international journals.

### **Maynard, Alan**

Alan Maynard is Professor of Health Economics and Director of the York Health Policy Group in the Department of Health Sciences, University of York. He is also an Honorary Professor of Health Economics at the University of Aberdeen, Visiting Professor at the London

## Appendix 2 - Biographies of Participants

School of Economics, and Adjunct Professor at the Centre for Health Economics Research and Evaluation, University of Technology, Sydney, Australia. He was Founding Director of the Centre for Health Economics at the University of York (1983-95) and Founding Editor of the journal *Health Economics*. He has worked as a consultant for the World Health Organization, the European Union, the World Bank, and the UK Government's Department for International Development. Dr. Maynard has published widely in books, specialist journals, and the media. His most recent publication is *Public-Private Mix for Health Care: Plus Ça Change, Plus C'est le Même Chose* (Radcliffe Publishing for the Nuffield Trust, 2005). He has been Chair of the York NHS Health Services Trust since 1997 and has been involved in NHS management since 1983.

### **Mohandas, Kottilil**

Kottilil Mohandas is Director (Academic Head and Chief Executive Officer) of Sree Chitra Tirunal Institute for Medical Sciences and Technology in Kerala, India. He was formerly Professor and Head of the Department of Anesthesiology and Dean of the Institute. After he assumed the Director's position in 1994, the Institute initiatives and achievements included starting India's first school of public health and first MPH program, developing innovative, cost-effective comprehensive care programs for epilepsy, coronary heart disease, and movement disorders, winning the National Technology Award, and getting ISO accreditation for the first laboratory for testing and evaluating medical devices in India. Professor Mohandas is a member of the editorial board of several professional journals and of the Board of Governors of several science and technology institutions and advisory bodies of university-level institutions. He is the immediate past President of the Association of Indian Universities (established in 1925) and is currently the Chairperson of the Association of Commonwealth Universities (established in 1913), with a current membership of over 500 universities from the 37 Commonwealth countries.

### **Omori, Koichi**

Koichi Omori is Communications Officer at the World Bank's Tokyo Office. His main responsibilities include building partnerships with civil society organizations and the private sector in Japan. He also serves as the Bank's liaison with those groups in the areas of the environment, social development, and rural/agricultural development. Prior to joining the World Bank, he was Chair Research Associate and Assistant to the Director of International Research Center for Environment and Development at Ritsumeikan University in Kyoto, Japan.

### **Reich, Michael R.**

Michael R. Reich is Taro Takemi Professor of International Health and Director of the Takemi Program in International Health at the Harvard School of Public Health. He has written widely on international health policy and politics, including various aspects of global pharmaceutical policy. His recent books include *Public-Private Partnerships for Public Health* (editor, distributed by Harvard University Press, 2002); *Getting Health Reform Right* (co-author with M.J. Roberts, W. Hsiao, and P. Berman, Oxford University Press, 2004); and *Wounds of War* (co-author with J.M. Lamb and M. Levy, distributed by Harvard University Press, 2004). He recently served as Director of the Harvard Center for Population and Development Studies. From August 1 2005, he will be a visiting scholar at the National Institute of Public Health in Cuernavaca, Mexico. He received his PhD in Political Science from Yale University in 1981 and his MA in East Asian Studies and BA in Molecular Biophysics and Biochemistry also from Yale University.

### **Rothgang, Heinz**

Heinz Rothgang is Professor for Health Economics at the University of Applied Sciences in Fulda, Germany. He is also a fellow at the Center for Social Policy Research and principle researcher at the Research Center on the Transformation of the State at the University of Bremen. He holds a diploma and a PhD in Economics from the University of Cologne. Dr. Rothgang has authored several reports for federal and state departments and parliaments in

## Appendix 2 - Biographies of Participants

Germany, the EU, and Germany's Supreme Court. His recent publications in English include "The Changing Role of the State in OECD Health Care Systems (co-author with M. Cacace, S. Grimmeisen, and C. Wendt) in *European Review*, Vol. 13, No. 1, 2005; "Future Long-term Care Expenditure in Germany, Spain, Italy, and the United Kingdom" (co-author with A. Comas-Herrera, R. Wittenberg, J. Costa-Font, C. Gori, A. Maio, C. Patxot, L. Pickard, and A. Pozzi) in *Aging and Society*, forthcoming; "Projections on Public Long-term Care Insurance Financing" in *Aging and Social Policy - A German-Japanese Comparison* edited by H. Conrad and R. Lützel, Munich: Iudicum, 251-273.

### **Shimada, Haruo**

Haruo Shimada, Professor of Economics at Keio University, is one of the most active and outspoken economists in Japan. He is a Special Adviser to the Cabinet Officer and chairman of the Economic Research Center at the Fujitsu Research Institute. He is a member of the National Tax Commission, the Fiscal System Council, the Japan Investment Council, the Industrial Structure Council, and several other committees and academic associations. Dr. Shimada is the author of numerous books on the Japanese economy and on international management and labor problems. His expertise is in labor economics and industrial relations, international management, and economic policies. He has published many books and articles in his profession and has also written many commentaries and essays for newspapers and popular magazines. He appears frequently on TV programs both in Japan and abroad, including CNN, NBC, ABC, CBS, and the BBC.

### **Takagi, Yasuo**

Yasuo Takagi is Professor of Health Management at the Graduate School of Health Management at Keio University. He joined Keio University in April 2005 after serving as a professor in various other schools, including the Faculty of Medical Sciences at Kyushu University. Earlier, he served as Director of Research and Statistics at the Social Development Research Institute. Professor Takagi's research centers on health care financing and long-term care. His writings in

Japanese include "Increases in Medical Costs Resulting from an Aging Population and Issues in Health Care Policy" in *Health Security and Health Care Costs* by Iryou Hoshou To Iryouhi (University of Tokyo Press, 1996).

### **Takemi, Keizo**

Keizo Takemi is a member of the House of Councilors for the Liberal Democratic Party (LDP) in Japan. He is serving his second term as Executive Member of the Committee on Health, Welfare, and Labor, as Member of the Committee on Audits, as Executive Member of the Joint Meeting of Both Houses on the Reform of Pension and Other Social Security Systems, and as Executive Member of the Research Commission on the Constitution. He was appointed as State Secretary for Foreign Affairs during his first term. In the LDP, he serves as Deputy Chairman of the Medical Care Committee of the Research Commission on Social Security System and as Deputy Chairman of the Research Commission on Foreign Affairs. He received his undergraduate and graduate degrees from the Faculty of Law, Keio University. In 1980, he started teaching at the School of Political Science and Economics, Tokai University, where he became a professor in 1995. He has also been a visiting scholar at Harvard University.

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Kotaro Tanaka is Professor of Social Policy in the Faculty of Social Work at Yamaguchi Prefectural University. After graduating from the Faculty of Law at Kyoto University, he entered the Ministry of Health and Welfare in 1974 where his areas of responsibility included pharmaceutical affairs and medical economy before beginning his career at the Prefectural University in 1995. His major field of research is the comparison of the social security systems of Japan and Germany, focusing on health care, long-term care, and the pension systems. His publications include *Financing Increasing Medical Expenditures and Allocation of Specific Risks in Health Insurance* (Duncker and Humblot, Berlin, 2000) with von Maydell et al, *Solidarität und der Wettbewerb in der Gesetzlichen Krankenversicherung* (Luchterhand, 2002) in German with Winfried Boecken et al, and *Introduction to Social*

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*Security* (Yuhikaku, 2001) in Japanese with Mukuno.

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Shaoguang Wang is professor of political science at the Chinese University of Hong Kong and is the chief editor of the *China Review*, an interdisciplinary journal dealing with greater China. He studied for his LLB at Peking University and his PhD at Cornell University. He taught at Tijiao High School in Wuhan from 1972 to 1977 and at Yale University from 1990 to 2000. He has authored, co-authored, and edited 19 books in Chinese and English. In addition, he has contributed to numerous edited volumes and journals. His research interests include political economy, comparative politics, fiscal politics, democratization, and economic and political development in former socialist and

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Joseph White is Luxenberg Family Professor of Public Policy, Director of the Center for Policy Studies, and chair of the Department of Political Science at Case Western Reserve University in Cleveland, Ohio. He received an AB from the University of Chicago and an MA and PhD from the University of California, Berkeley, all in Political Science. Before coming to Case, he was Associate Professor of Health Systems Management at Tulane University School of Public Health and Tropical Medicine, and before that, he was first Research Associate and then Senior Fellow in Governmental Studies at The Brookings Institution in Washington DC. Dr. White's research has focused on American federal budget politics and policies, health care finance policy and politics, and the "reform" of Social Security and Medicare. Among his books are *False Alarm: Why the Greatest Threat to Social Security and Medicare is the Campaign to 'Save' Them*, (Johns Hopkins University Press, 2001 and 2003), and *Competing Solutions: American Health Care Proposals and International Experience* (Brookings, 1995).

### **Wong, Joseph**

Joseph Wong received his PhD in political science from the University of Wisconsin-Madison in 2001. Before joining the faculty at the University of Toronto, Wong was a visiting associate in research at the Fairbank Center at Harvard University (1999-2001). He has also been a visiting fellow at the Institute for National Policy Research in Taipei and the Graduate School of Public Administration at the Seoul National University. Wong most recently finished a collaborative project on welfare states in East Asia with the United Nations Research Institute for Social Development. Wong has published widely (in the journals *Comparative Political Studies*, *International Political Science Review*, *Studies in Comparative International Development*, *the Journal of East Asian Studies*, *Pacific Affairs*, and *Nature Biotechnology* among others) and, most notably, he is the author of *Healthy Democracies: Welfare Politics*

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in *Taiwan and South Korea* (Cornell University Press, 2004). From 2005, Professor Wong will be the Book Review Editor for the journal *Governance*.

### **Yoshimura, Yukio**

Yukio Yoshimura has been Vice President and Special Representative for Japan at the World Bank since 2002. He was previously Senior Advisor to the President of the World Bank (2001-2002) and Executive Director for Japan at the International Monetary Fund (1997-2001), and held various important positions in Japanese Ministry of Finance's International Bureau,

including Director of the International Division (1991) and Director of the International Banking Division. He has held a number of overseas positions, including First Secretary at the Japanese Embassy in Cairo and Second Secretary at the Japanese Embassy in London. Mr. Yoshimura is the author of many articles on the issue of international finance, including "Lessons from the Asian Crisis for the International Financial System" in *The Asian Financial Crisis: Origins, Implications, and Solutions* (Federal Reserve Bank of Chicago and the International Monetary Fund, 1999).

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Mr. Kodate is currently a researcher at the Political Science Division of the Faculty of Law at the University of Tokyo majoring in European and comparative politics. In 2002, he joined the MRes/PhD course in Political Science at the London School of Economics and taught senior undergraduate tutorials on the politics of the European Union and comparative executive government in advanced industrial countries. In 2004, he was granted PhD candidacy status and is now undertaking a comparative analysis of British and Japanese health policies and politics in the light of hospital reconfigurations.

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Naoko Tomita is a PhD candidate in Public Health and Policy at the London School of Hygiene and Tropical Medicine, University of London. She is also a visiting research associate at the Department of Health Policy and Management at the School of Medicine of Keio University. Her current research focuses on the policymaking process in the separation of prescribing and dispensing in Japan and South Korea. Her other research interests include the politics of health policy and pharmaceutical policy and comparative health policy. Ms. Tomita received an MA and a BA in Political Science from Kobe University.

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