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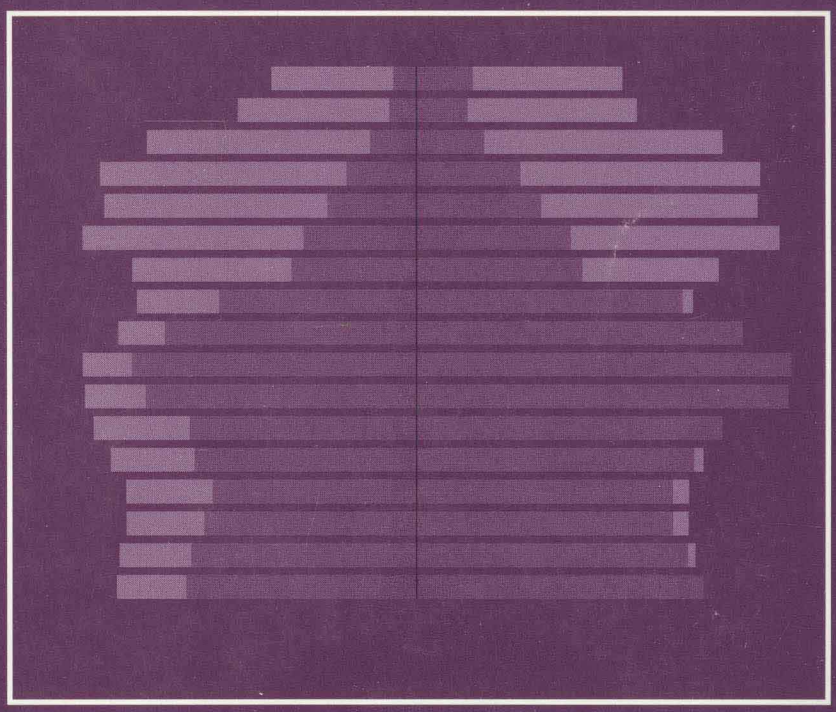
Choices in Financing Health Care and Old Age Security

Proceedings of a Conference Sponsored by the Institute of Policy Studies, Singapore, and the World Bank, November 8, 1997



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The figure on the cover illustrates the changes in age distributions that will occur in Singapore between 1995 (shown with dark purple bars) and 2030 (light purple bars). Each bar represents five years of the age distribution (0–4, 5–9, and so on, through 80 and over) and shows the number of people of that age. Men are on the left side of the figure; women are on the right. By 2030 Singapore's population will be larger and much older.

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Foreword

Asian societies face several financing challenges. In the next few years two will have to be confronted: providing security for rapidly aging populations and restructuring health care systems stressed by longer lifespans and weaker family care systems.

In November 1997 the World Bank and Singapore's Institute of Policy Studies sponsored a conference, Financing Health Care and Old Age Security, to assess and identify potential solutions to these concerns. Speakers from the World Bank, Singapore, and the International Labour Organization examined policy issues affecting the development of health care and social security systems in aging societies, providing valuable lessons for Singapore and other countries. The conference was attended by about 150 participants drawn from government, the private sector, academia, and the social services.

Several conclusions were reached. First, the world's rapidly aging population will cause the ratio of working taxpayers to elderly retirees to fall dramatically, requiring policymakers to manage resources in a way that preserves the financial viability of old age security systems. Singapore, with one of the world's fastest-aging populations, is studying how to finance long-term care for the elderly and what incentives to use to encourage family members and communities to provide such care. The country's past experience—combining provident funds with medical savings accounts—shows that acting early pays off.

Second, there is no single best model of resource management—but there are clearly bad models. In pensions the bad model uses defined benefits financed on a pay as you go basis from taxes. In health care the bad model combines a comprehensive benefit guarantee with fee-for-service payments. Because the model selected depends on a society's values and expectations, public education on costs and benefits is extremely important.

Finally, financing of both pensions and health care should establish a close link between contributions paid and benefits received, as well as promote individual responsibility. Financing reform in aging societies should focus on defined contribution funding for pensions, and defined contributions with targeted subsidies for health care.

The conference contributed to our understanding of financing issues facing governments everywhere. We hope that the papers presented in this volume further contribute to the public discussion and debate on these important issues.

Jean-Michel Severino
Vice President
East Asia and the Pacific Region
World Bank

Lee Tsao Yuan
Director
Institute of Policy Studies
Singapore

Abstract

This volume contains the keynote address (delivered by Singapore's minister for health and for the environment), six papers, and four comments prepared for the Institute of Policy Studies, Singapore–World Bank conference on Financing Health Care and Old Age Security, held in Singapore on 8 November 1997. Conference participants addressed a looming problem for nearly every country, developing and industrial: how to deal with the implications rapidly aging populations have for the financing of medical care and income security for the elderly. The issues identified and the solutions proposed can provide insight and guidance for policymakers, researchers, and others interested in addressing these challenges now, when they are manageable—rather than later, when they have the potential to create increasingly serious financial, social, political, and cultural problems.

Of special interest are the contributors' analyses of Singapore's unique, integrated approach to managing social risk, which is based on mandatory individual savings accounts. Singapore's pioneering model unifies medical savings accounts for acute medical care in old age with a provident fund for retirement income. While the lessons of Singapore's experience are of worldwide interest given current efforts to reform social security systems, the minister's keynote address highlights the continuing need for innovations to refine the basic model—calling for the development of a new approach to financing the growing problem of long-term medical care for the elderly.

Acknowledgments

The organizers of the conference are grateful to Singapore's Minister for Health and for the Environment, Yeo Cheow Tong, for opening the conference and delivering the keynote address. In addition, they wish to acknowledge Michael Walton and Javad Khalilzadeh-Shirazi for their support of the World Bank's partnership with the Institute of Policy Studies. Special thanks are also due to the administrative staff of the Institute of Policy Studies, who put in a tremendous effort to ensure that the conference would run smoothly for all participants.

In addition, the Institute of Policy Studies gratefully acknowledges the financial support of The Shaw Foundation, Singapore, without whose support the conference would not have been possible.

This volume was edited by Paul Holtz and laid out by Damon Iacovelli, both with Communications Development Incorporated.

Contents

Keynote Address

Yeo Cheow Tong

I am pleased to welcome you to the Institute of Policy Studies–World Bank conference on Financing Health Care and Old Age Security. The topic of this conference is relevant not only to Singapore but to many other countries as well. Health care is consuming an increasing share of the national wealth in many countries. In industrial countries health care expenditures range from 6.9 percent of GDP in the United Kingdom to 14.5 percent in the United States. In Singapore, with our relatively young population, health care expenditures are still modest—about 3 percent of GDP over the past few years. But this spending should increase as our population ages.

An aging population brings many challenges, and even more when the number of elderly is increasing rapidly. Singapore has one of the world's fastest-aging populations. By 2030 the portion of our population age 65 and above will nearly triple, from the current 7 percent to 18 percent.

In absolute terms the number of elderly will jump from 210,000 today to nearly 310,000 by 2010, then to 530,000 by 2020 and 800,000 by 2030. By 2030 the elderly dependency ratio will hit 1 in 3, from 1 in 10 today. The implications of such dramatic changes, particularly in terms of old age security and health care financing, are tremendous.

With higher living standards and good preventive and curative medicine, the elderly can expect to live even longer in the future. This begs the question: How will the elderly support themselves financially for the 20 to 25 years after retirement? While a healthy lifestyle will delay the onset of poor health, the elderly tend to have more health problems than the young. The medical expenditures of the elderly are closely linked to the type of health care available in a country. For example, defensive medicine—in which patients are subjected to a battery of hi-tech tests and treatments each time they become ill, or are hospitalized longer than is necessary—inevitably increases medical expenditures.

Over the next few years Singapore will need to address these and other issues related to the elderly, so that we have an appropriate system in place well before the number of elderly increases significantly. Here I outline some of the challenges related to looking after the health care needs of the elderly in Singapore, and the financial issues that will have to be addressed.

Medical Care for the Elderly

All the types of care required by the elderly are already available in Singapore. These include acute hospitals, day hospitals, day care and day rehab services, community hospitals for those requiring further convalescence and rehabilitation, nursing homes for those who cannot manage in their own homes, and home medical, home nursing, and home help services to help the sick elderly live in their own homes. Voluntary welfare organizations, like the Home Nursing Foundation, are making an increasingly important contribution in this regard.

While the list of services is fairly complete, many elements in the care chain need to be further addressed. Only acute care in acute hospitals provides the type of care that is needed—and as a result, patients are staying in hospitals longer than is necessary. More than 7 percent of the beds

Yeo Cheow Tong is Singapore's minister for health and for the environment.

in acute hospitals are occupied by long-stay patients. Many of these patients are healthy enough to be discharged to their homes or to rehabilitative care settings.

The family members of these patients are often reluctant to take them home because of lack of family support, or because appropriate downstream health care facilities and services—such as home medical or home help services—may not be readily available. Such instances of "social hospitalization" can also result from poor family relationships or when the family is living alone. The need for downstream health care facilities will increase even more rapidly in the future. This is because more elderly will be from small families, and with more dual-income families, their family members will likely be working and therefore unable to help nurse them at home.

Thus over the next decade the health care system must provide a continuum of services to suit older people with different needs. The elderly who no longer need acute hospital care but who still need some nursing care and rehabilitation should be able to recuperate in nursing homes and community hospitals. They will then be discharged home when they are capable of looking after themselves, and be followed up by home nursing and other community-based services. As they recover, the elderly will need a lower intensity of services. By using the appropriate level of care, elderly patients will also benefit from more holistic care and lower fees.

But while we strive to develop the various elements of elderly care, we must not fall into the trap of relying only on institutional care. The family setting is still the best approach—it provides the elderly with the warmth and companionship of family members and a level of emotional support that cannot be replicated elsewhere. The elderly are also more comfortable in their own homes.

We also have to encourage more Singaporeans—especially healthy older people—to volunteer for community-based services. With fewer working persons supporting each elderly person, having the healthy elderly provide many community-based services will impose less strain on the economy and increase the availability of these services. In the future the healthy elderly will be quite capable of not only providing services, but also organizing and managing them. We will need to change the mindset of the healthy elderly in the coming years, so that they see such activities not only as self-help, but also as something that enriches their retirement.

Health Care Financing

Individual responsibility has been the cornerstone of Singapore's health care philosophy, and this approach has served us well. We believe that having a good, sustainable health care system requires getting people to invest in their own health and to pay, if not all, at least a fair share of their medical costs. It was with this objective in mind that the government established the Medisave scheme in the 1980s. We subsequently introduced Medishield, a low-cost catastrophic illness insurance scheme, followed by Medifund, an endowment fund designed to meet the health care needs of the poor and indigent. Medifund ensures that no Singaporean will be denied basic medical care because they are unable to pay.

Medisave, Medishield, and Medifund have helped provide Singaporeans with the means to save and pay for their health care. But the three schemes were designed primarily to help Singaporeans and their families pay for expensive acute hospital care—not for long-term care. As the population ages, and with better acute care, expenditures on long-term care will likely increase rapidly. Thus we will need to determine how to fill the void left by Medisave, Medishield, and Medifund. Otherwise the development and use of medical services for the elderly will be distorted.

For example, current public health subsidies provide substantial subvention for acute hospital care, through the heavily subsidized class B2 and C wards in acute hospitals. The destitute are also provided with long-term institutional care through voluntary welfare organizations. Still, the health care financing scheme does not cover long-term institutional care for the bulk of the population. Thus we are examining the funding of long-term care for the elderly.

Another challenge is how to implement a funding mechanism that will encourage communities and families to participate in the long-term care of the elderly. The current funding arrangement provides no incentive for family members to play a more active role. In fact, family members may want to leave their elderly in acute hospitals because the wards are heavily subsidized.

Singapore is not alone in facing these challenges. Populations are aging the world over, allowing us to review the approaches taken by other countries. Japan, for instance, has introduced a nursing care insurance bill for implementation in 2000. The scheme requires all persons over 40 to make monthly contributions to a central fund. Insured individuals are then entitled to receive nursing care once they reach 65, and are required to pay only 10 percent of the cost incurred.

The United States has Medicare, a national health insurance program for people 65 and older and for disabled individuals. Medicare covers both inpatient and outpatient care and services. But the scheme, sometimes described as one of the most successful social achievements in U.S. history, is running into financial difficulties. Medicare trustees recently reported that the Medicare trust fund may go bankrupt in 2001, as expenses continue to exceed revenues.

The experiences of the United States and other countries that rely on a largely tax-funded approach show that such schemes are not sustainable over the long term. This is because as the dependency ratio rises, the elderly have fewer working persons to provide the tax dollars needed to fund their medical care. What is needed is a multipronged approach—one that incorporates alternative means of financing health care, ways of moderating health care consumption, and mechanisms for lowering health care costs. Given that the dependency ratio will be rising in Singapore in the near future, we must learn from these experiences and avoid the potholes that other countries have encountered.

Conclusion

The number of elderly in Singapore will increase rapidly starting in 2010—just 12 years from now. Still, we have more than enough time to review what is needed and implement a new framework for elderly care. It is with this objective in mind that the government has set up the Inter-Ministerial Committee on Health Care for the Elderly. The committee includes several members of Parliament as well as representatives of relevant ministries and professional, grassroots, and voluntary welfare organizations. The committee has been meeting since August 1997, and is expected to issue a report and recommendations in early 1998.

Though the issues related to an aging population are complex, Singapore need not start from scratch in identifying solutions. Many countries have gone further down the road than us, and we should learn from their experiences. But we need to assess carefully, and adapt effective elements of their approaches to our local conditions. Thus conferences like this are valuable, because they facilitate an exchange of ideas and experiences. I hope that you will be able to provide ideas that will help us prepare the health care and financing system for the elderly in the years ahead. I wish all of you an interesting and fruitful conference.

Health Care

Health Care for Aging Populations: Issues and Options

Jacques van der Gaag and Alexander Preker

The world's population is aging. Of the various indicators used to show this, the most common is the percentage of the population over 65. Globally, this measure increased from 5.3 percent in 1965 to 6.6 percent in 1995. It is expected to increase by almost 1 percentage point between 1995 and 2010, and by more than 5 percentage points between 2010 and 2040, reaching 12.6 percent (table 1).[1]

Aging is proceeding more rapidly in East Asia and the Pacific. In 1965 just 4.1 percent of the population was over 65. By 1995 this share had jumped to 5.8 percent, and by 2040 it will be 16.9 percent—more than four times the 1965 level. Singapore's demographic transition is projected to be even more dramatic. The elderly population in Singapore is projected to grow by about 3.8 percent a year between now and 2010. Between 2010 and 2025 this growth will exceed 5 percent a year, compared with overall population growth of 0.5 percent. By 2040 the elderly will account for 23.6 percent of Singapore's population—more than 11 times the 1965 level.

While Singapore's elderly population has been increasing rapidly, the number of people of working age has also increased, and now stands at a favorable 70 percent of the total population. This proportion is expected to peak around 2010 at 72 percent, after which it is projected to decline rapidly. Thus, while the increasing proportion of old people has so far been accompanied by an increasing proportion of working-age adults, after 2010 the effects of an aging population will likely become more noticeable.

These dramatic demographic changes have important economic implications—for savings, labor supply, and pensions, among other concerns. This paper focuses on the implications of an aging population for the health care sector. Different health needs at different ages result in large differences in health care expenditures by age. Thus demographic changes are expected to alter both the overall level and the composition of health care expenditures.

Differences in health care expenditures among age groups are far from stable. In the Unites States real per capita health care expenditures for the elderly grew 7.5 percent a year during 1965–70, compared with 5.6 percent a year for the nonelderly (table 2). But during 1970–76 growth rates for the two groups were about the same, only to accelerate again for the elderly after 1976. Differences in per capita spending growth are even more pronounced when public and private expenditures are separated. Public expenditures for the elderly grew by an incredible 21.8 percent a year during 1965–70, almost twice the rate for the nonelderly. Private expenditures by the elderly actually declined during this period.

These results illustrate that reliable projections of health care expenditures cannot be obtained by simply applying cross-sectional data on age-specific health care expenditures to demographic projections. While long-term demographic projections are fairly reliable and stable, differences in age-specific health expenditures vary widely over time. Among the many causes of these changes, the most important are the various aspects of health care policy—that is, the way the health care system is organized and evolving.

The rapid growth in public health care expenditures for the elderly in the United States during the late 1960s coin-

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TABLE 1

Population by age group in the world, East Asia and the Pacific, and Singapore, 1965–2040

Location, age group	1965	1980	1995	2010	2025	2040
World						
0–14	37.7	35.2	31.3	26.8	24.2	21.8
15–64	57.0	58.9	62.1	65.7	65.7	64.9
65+	5.3	5.9	6.6	7.5	10.1	12.6
East Asia and the Pacific						
0–14	40.1	35.9	28.4	23.2	20.9	19.7
15–64	55.8	59.4	65.8	69.7	68.1	63.5
65+	4.1	4.7	5.8	7.1	11.0	16.9
Singapore						
0–14	43.7	27.1	23.8	19.0	18.2	17.6
15–64	54.2	68.1	70.1	71.8	63.1	58.8
65+	2.1	4.7	6.1	9.2	18.7	23.6

Source: World Bank data.

cided with the introduction of Medicare, the U.S. insurance system for the aged. This development also explains the corresponding decline in private expenditures.[2] But many other factors influence changes in age-specific health expenditures, not all of which are well understood.

Determinants of Health Care Expenditures

Total health care expenditures are largely determined by growth in expenditures over time, endogenous technological change, and health expenditures by age group.

Growth in expenditures over time

Not until the first antibody—penicillin—was mass produced after World War II did Western medicine begin to benefit large portions of the population. Until then most people went without medical attention, and the medical facilities that existed provided more care than cure (van der Gaag 1995). Health expenditures were less than 1 percent of GDP. Today the health care industry accounts for 4.1 percent of GDP in low-income countries, 5.5 percent in middle-income countries, and 6.8 percent in high-income countries (table 3). In OECD countries the range is from 7 percent in the United Kingdom to 14 percent in the United States.

Some stylized facts about these data are worth keeping in mind for the discussion that follows. First, the percentage of GDP devoted to health care increases with a country's income. In an economic sense, health care is a luxury good with an income elasticity (estimated from cross-country data) of demand of about 1.1. Second, the public share of total health expenditures also increases with income. With the notable exception of the United States, when economies grow, countries increasingly rely on public resources (such as general revenues or mandated public health insurance) for health care. Indeed, most OECD countries show a public share of total expenditures in excess of 80 percent.[3] Low-income countries, by contrast, may have a private share as high as 80 percent (for example, India).

Finally, equity—in health care financing, access to health care, and health outcomes—also increases with income (Van Doorslaer, Wagstaff, and Rutten 1993). Equity is a major issue in every debate about health care reform. For financing, it refers to a political desire for progressivity (in

TABLE 2

Annual growth in real health care expenditures per capita in the United States, 1965–81
(percent)

Sector, age group	1965–70	1970–76	1976–81
Total			
<65	5.6	4.1	3.5
65+	7.5	4.5	5.8
Public			
<65	11.3	6.9	3.5
65+	21.8	5.3	5.7
Private			
<65	4.1	3.1	3.5
65+	–4.3	3.0	6.2

Source: Adapted from Fuchs 1984.