

Long Term Care Insurance

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Abstract

This paper considers the case for long term care insurance specifically designed to address what the World Bank describes as the 'looming old age crisis'. It has been suggested that if such insurance is fully funded then this will simultaneously assist with the problem of Australia's low savings ratio. It is argued that the ageing of Australia's population cannot be described as a 'looming crisis' and that the benefit of funded health insurance could be achieved as easily by an increase in taxation or the health insurance levy.

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Introduction

The objectives of this paper are to explore options for long term care insurance in Australia subject to the maintenance of Medicare entitlements. The perceived problem this seeks to address is twofold. First, the ageing of Australia's population will increase the dependency ratio and the burden of the dependant upon the working population. This is particularly true in the case of health services where the elderly consume a disproportionate share of resources. The problems is exacerbated by the anticipated increase in the size of the health sector. The transfer of resources to the future elderly by the future working population is often perceived as being inequitable as well as politically and economically difficult. Secondly, Australia's national savings ratio is low. Part replacement of a pay as you go health scheme with funded insurance could possibly help alleviate this problem.

Before considering the options for new long term care arrangements the dimensions of the problem are discussed below.

The Problem of Ageing

Long term care is primarily concerned with the aged and it is here that the perceived problem arises. By 2021 about twenty per cent of Australia's population will be over 65 and the dependency rate (dependency per hundred persons of working age) will have risen from 50 to 55. The problem this could cause in both Australia and in other ageing populations has been highlighted, in particular, by the World Bank which argues that there is 'a looming old age crisis that threatens not only the old but also their children and grandchildren, who must shoulder, directly or indirectly, much of the increasingly heavy burden of providing for the aged', (World Bank 1994 p3).

Despite the dramatic language, repeated by numerous newspaper columnists, there are reasons for doubting that the social adjustment that must occur should be described as a 'crisis' and especially in Australia. Firstly, Australia is still relatively young by Western (not by Asian) standards. By the middle of the next century its demographic profile will be similar to the current profile in the UK and several other European countries which have maintained economic growth and not encountered a crisis.

Secondly, the high dependency ratio does not in itself imply an unsustainable burden. In 1901 the rate was 65 - the rate projected for 2041 (Johnson 1996). Rather the burden depends upon the productivity of the remaining population. As Creedy and Taylor (1993) have shown the burden arising from future ageing depends almost entirely upon growth rates, unemployment and the participation rate of the workforce (including, of course, the participation rate by the elderly).

Johnson's more balanced assessment of the impact of ageing is summarised as follows:

Future changes in the age structure of population will be no greater than those already experienced and accommodated in the last fifty years and estimates of demographic dependency ratios provide an unreliable basis for future economic projections (p261).

Ageing and Health Expenditures

The health sector has several unusual features relevant to this problem. As noted, the elderly consume a disproportionate share of health resources and the health sector appears to be inexorably expanding. This implies that any problem associated with ageing will be particularly acute in the health sector. There are, however, two important caveats. First, a transition to a more elderly population will occur slowly and the rate at which health services would have to expand to provide the projected aged population with the level of health care currently provided to the elderly is significantly less than the historical expansion of the health sector. Even with a technologically induced increase in the service use by the elderly their needs could be absorbed at the present rate of increase in service provision.

Secondly, crisis scenarios are often premised on the implicit assumption that there is a simple mechanistic relationship between age and necessary expenditures. This is unambiguously false. International expenditures vary enormously and the UK with its much more elderly population spends significantly less on health. Within Australia the variation in the supply of nursing home beds between states similarly indicates the flexibility in the level of possible provision for the aged. Flexibility in the level of servicing is generally true in the health sector and particularly where the indications for specific services are unclear, as in the case of long term care.

This observation has a twofold implication. First the level of expenditure on future long term care is quite uncertain. It depends as much upon how the health sector organises the financing and delivery of care as it does upon ageing per se. Secondly, and following from this, it is absolutely essential that the reform of long term care should have as a central objective the achievement of efficiency - minimum cost for fixed benefits or maximum benefits for fixed cost. Reforms which focussed exclusively upon raising funds could be counter-productive. Unnecessary costs could result in a greater and not smaller burden despite higher revenue. That is, the overall burden depends as much upon the services delivered and their cost as upon revenue.

In this respect the international evidence is relevant and clear. Reform has been primarily associated with government and cost control associated with government imposed budget caps. The chief exceptions to this rule are the HMOs in the USA and the recent US private sector initiatives with respect to managed care (a belated response to health care costs which have now risen to more than double the Australian level). Generally, private enterprise has been passive in the health sector and, as in Australia, private health insurance has shown no capacity to bring about

sensible reform. Both theory and evidence suggest that cost control and efficiency in the health sector requires a very significant government role. This need not imply a fully run government scheme (although OECD data suggest that these have to date been cheaper). It does imply careful regulation of the private sector and, in particular, definition of the benefits for which public funding will be available.

Delivery

The delivery of services is relevant here for two reasons. First, and as noted above, efficient delivery is as important for the overall burden of long term care as revenue. Second, any reform which has the possibility of private sector involvement must have an attractive package to offer patients.

While there has been little research into the variation in the cost of long term care per dependent in Australia it is almost certainly subject to the same or greater variation as exhibited elsewhere. As in the case of chronic illnesses access to different treatment options is highly uneven as a result of both geographic and financial barriers, the latter arising because of the erratic coverage of relevant services under Medicare and existing social services. There is no mechanism for achieving efficiency and service delivery is based upon historical patterns of care and the arbitrary demarcation of responsibilities for different care options. The core task in service delivery is to determine best practice in different settings - a task already commenced in the coordinated care trials.

Any new long term care insurance arrangement should build upon and in no way jeopardise the continuation or extension of these initiatives. There has been no better model for the delivery of long term care proposed and the challenge is to integrate the best variant of this model with a supporting system of finance.

One option in this respect is the adoption of managed competition exclusively for long term care. The advantage of this option is that it maximises choice, flexibility and (at least in theory) the impetus for the experimentation and innovation needed for the determination of best practice. The chief obstacle to date has been the lack of experience with such a scheme and, in particular with the determination of the risk related premium that is necessary to prevent cream skinning. In the Netherlands van der Ven et al (1994) have argued that this latter obstacle may make long term care incompatible with managed competition. This objection may not be fatal. While individual risks may not be accurately predicted the risks associated with a larger population group can be predicted and such groups could form the basis for the implementation of managed competition in long term care (Scotton 1995). As a minimum the principles of the purchaser/provider split could be adopted to obtain some of the advantages of managed competition (particularly diversity and experimentation) while overcoming the chief obstacles.

Financing Long Term Care

Several issues arise in the funding of long term care; viz, (1) compulsion versus voluntarism; (2) pay as you go versus a fully funded scheme; (3) private or public management of funds in a funded insurance scheme; (4) public or private determination of eligibility and scope of benefits; (5) public or private claims management; (6) the basis for revenue.

Importantly, these are separable issues. For example there is no reason why the management of the funds arising from a funded scheme by, for example, private insurance companies needs to imply their involvement in other aspects of health insurance. Indeed, pressure from insurance companies to be involved in the financing of health should be resisted as their primary interest and expertise is funds management and not health or health care delivery.

Voluntarism versus Compulsion

In principle long term care insurance could be offered on a voluntary basis. In practice this is not feasible nor could it contribute significantly to the problem motivating this paper. The reason for this is that voluntary insurance would be competing with a high level of public care through Medicare. There would be the same dilemma as encountered by private health insurance; viz, that the (full) cost of the private option would far exceed the (marginal) benefits that could be offered. Private and voluntary long term insurance could be made attractive if (1) Medicare benefits were reduced which would violate a political commitment; (2) private sector benefits were substantially increased or; (3) the private sector received a significant public subsidy. The last two options would do little to reduce the funding problem envisaged in the long term. At best the additional revenue raised for the health sector would be very marginal and would not make a quantitatively significant contribution to long term care.

Private sector benefits could possibly be made more attractive through managed care but this is a public sector initiative and it is unlikely that the perceived benefits of this would offset the cost disadvantage.

A subsidy to private insurance could certainly be considered in the context of a coherent and regulated system of managed competition. Outside this context the promotion of this option does not appear sensible in view of the performance of private health insurance in Australia and overseas.

The conclusion drawn from this discussion is that a quantitatively significant contribution to the financing of long term care will only be achieved through compulsion and without a corresponding increase in the costliness of the benefits offered.

Funded Schemes

It is tempting to envisage a solution to the funding problem that is based upon the model of life insurance; *viz* that individual contributions be paid into a fund that will subsequently pay for the individual's long term care. This oversimplifies the funding of long term care in four respects. First, the benefits paid from superannuation are strictly limited by contributions. By contrast long term care must pay according to current costs (unless real benefits were withdrawn whenever costs were greater than anticipated which would represent a radical and political doubtful departure from current practice). Second, the future costs of long term care are largely unpredictable not simply individually but collectively. The impact of future technological developments upon cost is unknown. Third, and most fundamentally, the benefits of superannuation are obtained directly by the contributor and there is no cross-subsidisation or pooling. The essence of long term care *insurance* is that there is pooling. Those who develop medical dependence must be assisted by those who do not. Fourth, and following from this, eligibility criteria are necessary for the receipt of long term care. This generates moral hazard. As persons become eligible demand is likely to increase.

This indicates that the management of long term care and the prediction of funding requirements is significantly more difficult than in the case of superannuation. It is still possible, however, to part fund long term care; that is, to create a surplus above current outlays that may be invested and subsequently used for long term care.

The case for such a scheme is less compelling than often claimed. The equity argument is dubious. The present workforce is supporting the current recipients of long term care who far exceed those supported a generation ago. The equity argument implies that the present workforce support *both* the present and future population of long term care recipients! Further, as noted, the burden to the future workforce depends largely upon the productivity of the economy created by the present workforce.

A funded scheme may, however, be justified upon efficiency grounds as, *ceteris paribus*, it implies a greater supply of funds to the capital market. However the evidence is that all else does not remain equal and there is no empirical support for the belief that funded superannuation increases national savings (Johnson 1996).

Finally, the potentially beneficial effects of a fund upon the capital market is indistinguishable from the impact of a budget surplus or a reduction in the deficit. This implies that the creation of a fund is no more beneficial than any other measure to improve the budgetary balance and, within the health portfolio, these measures include constraints upon expenditures.

This discussion implies that from an economic viewpoint the choice between an increase in tax in a pay as you go scheme and the creation of an independent fund is largely a matter of selling the idea to the public. There is, however, one potential advantage in the creation of a fund. In the present political environment an unearmarked surplus is likely to lead to tax cuts and offsetting consumption elsewhere. A quarantined fund makes this more difficult. Further, the existence of a

(publicised) fund will create the expectation of future benefits. This is an equivocal advantage as it may lessen the scope of policy makers to adjust benefits.

Revenue Options

The first option for increasing revenue is some form of voluntary contribution. As noted this is not a serious option if Medicare benefits are to be preserved. Individuals will compare additional costs with additional benefits and be unwilling to make any quantitatively significant contribution to revenue.

Whatever the term used in order to market the idea, a compulsory contribution to revenue is a form of taxation. The usual criteria for a tax should therefore apply. These are that the tax incurred should (1) be broad based; (2) create minimum distortion elsewhere in the economy; (3) be difficult to avoid; (4) be simple and economical to administer; (5) be equitable; and (6) be politically feasible. A common criteria in the health sector is that community rating should apply, ie that contributions should not be based upon need.

The second option is to include the cost of long term care in the global reform of taxation and possibly introduce some form of GST earmarked for health and social security.

The third option is to require a contribution from employers for each employee or, following the example of the superannuation guarantee charge, to create a fund using contributions from both employers and employees (supplemented in the case of the SGC by government subsidy). The attraction of this option is that such a tax may be more palatable to the workforce. Employers will be seen to be contributing and there will be perceived benefits in the form of the fund.

These 'benefits' have more to do with marketing the idea than with economic performance. In the US where employers pay for the majority of insurance, it has been shown that wages fall correspondingly. That is, the final incidence of the tax is (not inappropriately) upon the workforce. However there is a twofold real disadvantage in the proposal. If the employers contribution was arranged to bypass the government budget then the proposal would introduce the opportunity for the type of cost shifting that is commonly believed to contribute to the US health care inflation. It will become easier for governments to raise the employers contribution than to tackle costs directly; to limit benefits, to tackle provider over-servicing and excess medical incomes. Any measures that reduce the government's resolve to tackle these issues directly is undesirable.

Secondly, it is generally recognised that this form of contribution - indistinguishable in its effect from a payroll tax - significantly violates the criterion that a tax should have minimum distortionary effects. Taxes on labour discourage employment and there is pressure for 'reform' in the form of eliminating not increasing such taxes.

The fourth option is to increase the Medicare levy or, in order to sell the idea, to introduce a second 'aged care levy' similar to the Medicare levy but earmarked for aged care. Once again this option fulfils the criteria for a good tax, and, in particular would be perceived as being equitable. The chief disadvantage is that it could be

perceived as being indistinguishable from an increase in the Medicare levy and be perceived by the young as inequitable as future benefits would be heavily discounted.

The fifth option is a variant of the fourth in that the aged care levy would commence only at age forty. The attraction of this option is that it overcomes the two objections to a simple levy. It would be structurally distinct and therefore perceived as different from the Medicare levy. It would be imposed only on those who were more likely to receive benefits in the foreseeable future. This implies a smaller period of time for establishing a fund and the need for a correspondingly higher rate. This could, however, be politically feasible because of the perception of greater personal relevance of the benefits.

Summary

Any new health insurance scheme for long term care must consider both the financing of care and its impact upon delivery. It is a simple but potentially disastrous error to regard delivery and expenditure as being mechanistically determined and that the task of health insurance is only to raise revenue. For this reason simple proposals to harness the private sector should be resisted. Both (correct) economic theory and the experience of health sectors worldwide suggest that such proposals will increase the problems they purport to solve. At best, privatisation will shift expenditures from the government sector but at increasing cost to the economy.

There is the potential for a more sophisticated use of the private sector by adapting the ideas of managed competition to long term care insurance. Such a model has yet to be fully developed.

The overall impact of long term care upon national savings depends equally upon revenue and cost. As cost minimisation is not a sensible objective long term policy should be directed to achieving efficiency in the delivery of long term care. There is no better current suggestion than the adoption of some form of managed care. There is an enormous potential for improved efficiency and cost control via case management. However, this is, and should be, developed independently of a new insurance proposal.

An important conclusion of the paper is that there is no scope for achieving a quantitatively significant increase in revenue voluntarily. This implies the introduction of a new tax (although it may not receive this name). This could be earmarked for the creation of a long term care fund designed to finance future expenditures of the current workforce. Both the equity and efficiency arguments for such a fund are less clear cut than commonly argued and depend primarily on the political judgment that governments cannot run surplus budgets.

The most sensible economic strategy would be to introduce global tax reform, to increase taxes and to run a surplus budget. The alternative strategy of creating a fund is a covert means of achieving the same macro-economic objective albeit a sensible strategy if the alternative is politically unpalatable.

Of the tax options considered here the most desirable, as judged by the normal criteria for assessing taxation, is a further income related levy. For political reasons it may be desirable to limit this to persons over the age of 40.

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