Health and Wellbeing for All: role of health and social policy

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1. VISION

a. Health and Long-term care

- healthy ageing
- universal access to quality health care and long-term care:
  broader perspective for UHC

b. Economic wellbeing

- income security, pension, labor market

c. Participation

- Community activities, social capital, social inclusion

2. CHALLENGES

a. Equity

- Within country and Across countries
- Increasing inequity in economic and social resources
- Unequal access to medical and care technology

• Social determinants of health:

Inequity in the social determinants results in inequity in health

• Life-course approach:

Health of childhood -> Adult health -> Health of older people

• Inequity can harm health and wellbeing: social capital

B. Multi-sectoral Approach and Coordination

- health, welfare, finance, environment, labor, urban, etc.

Inequality of Health of Older People

Compression of morbidity can occur for older people with higher socioeconomic status

Why can health inequality increase with age (e.g., up to their 70s)?

- Differential exposure to health risks across socioeconomic status accumulates with age
- Differential impact of exposure to health risks across socioeconomic status: with age, people become more vulnerable to health risks

Decreased health inequality after their 70s can be due to survival selection bias (Becket, 2000):

older people in worse health die early, and health outcome of those with lower socioeconomic status can be overestimated

-> underestimate of health inequality

3. Role of Government

Policy not only to improve the level of health and wellbeing
but also to reduce the gap/inequity
- Overall effort to minimize inequity in the social determinants of health

a. Public financing (tax or mandatory insurance)
for health care and long-term care to ensure UHC
- Private financing is inefficient and inequitable

b. Universal pension for all or basic pension for poor older people

c. Participation
- ageing in place, continuing education, minimize social exclusion

Coordination of HC and LTC for UHC

Coordination between health care and long-term care

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

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

-> Big challenge in many Asian countries

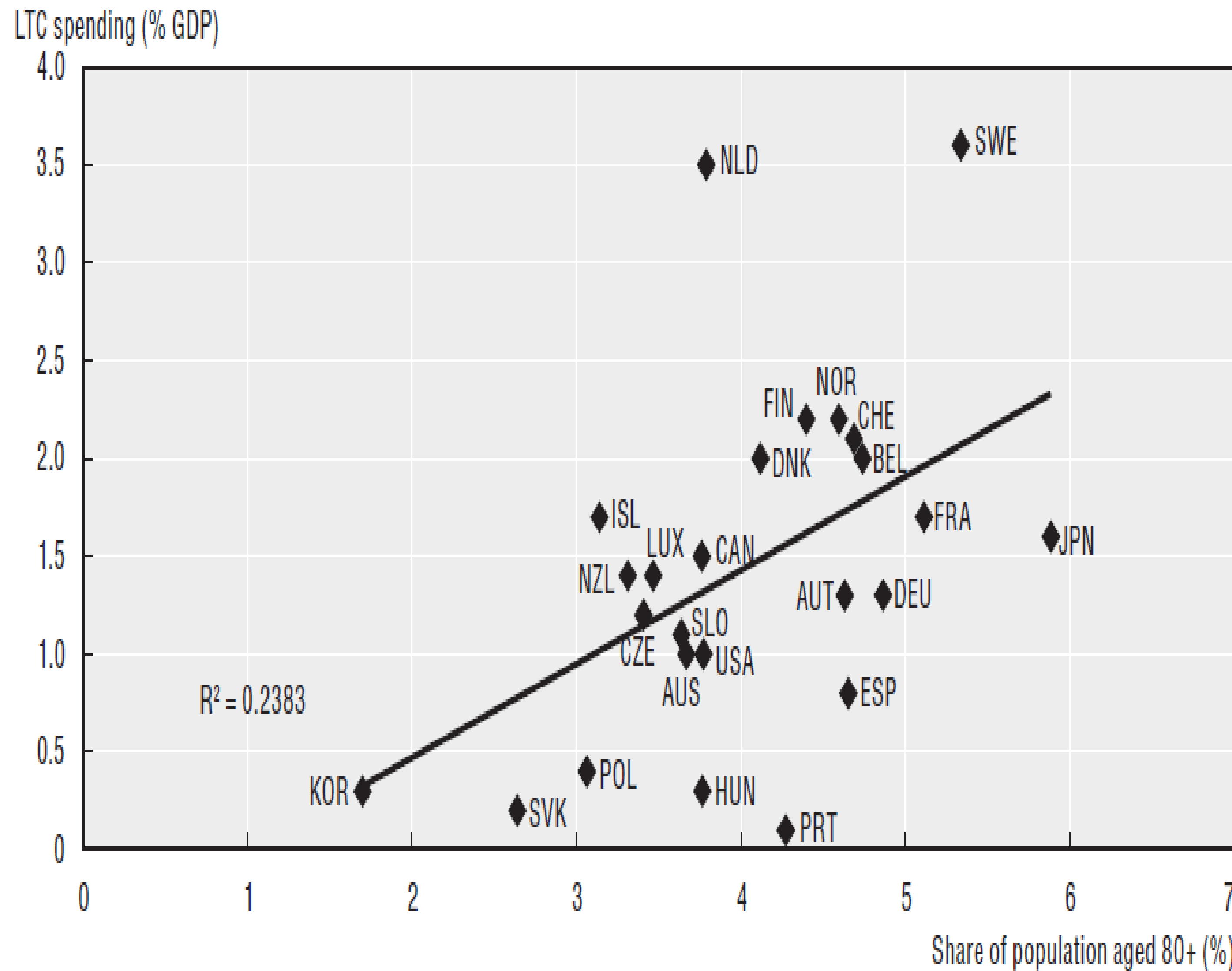
Long-term care system can reduce the (unnecessary) social admissions in health care/acute care hospitals

Quality long-term care improves prevention and promotion

-> Decreases the need for health care of older people

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

Why Different Spending on LTC?



- % of people +80 years
- Value, culture, informal care
- Different comprehensiveness of LTC coverage

 - Eligibility rules: universal or targeting

 - Service Coverage

 - Cost sharing (copayment)

- Difference between HC and LTC, path dependency

Source: Colombo et al., 2011

4. Public Financing for LTC: Tax or Public Insurance

a. Tax-based financing for LT care

- More than 90% of LTC expenditure is funded by tax in Sweden, New Zealand, Australia, Denmark
- Usually based on public delivery: performance and quality of public providers is crucial
- Universal coverage/entitlements (e.g., Scandinavian countries) or targeting older people in greater need, e.g., low income, high severity/dependency, or living alone
- Or use *income-related cost sharing* in case of universal coverage
- Can be combined with personal budget, and consumers have choice of providers

Tax or Public Insurance (continued)

b. Public insurance for LT care

- Purchasing mechanism (by LTC Insurance), contracting with public and private providers
- Eligibility based on *need* (through a formal assessment process),

  not on capacity to pay, in general:

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

  Universality vs. targeting
- *Use of cash benefits, Ceiling on benefits,* :

  Health insurance – LT care insurance - Pension
- Tax/budget can be still important to provide subsidy for the poor who cannot afford to pay contribution for LTC insurance

5. Institutional Stickiness (Path Dependency)

- **Similarity** between health care and LT care system

e.g., Tax-based financing for HC and LTC
in Sweden, Australia, New Zealand, UK

e.g., Same insurer for HC and LTC: save administrative costs
-> Sickness funds in Germany, NHIS in Korea,
Local governments in Japan

- **Difference**: generosity of benefits, eligibility
-> targeting (income, need) or copayment in the tax-funded LTC

Governance of Public Financing for LTC

- For efficiency of risk pooling and equity of benefits, centralized financing (single pool) is preferred to decentralized financing, in general

- However, compared with HC, LTC providers are smaller in size and more decentralized

-> Role of local governments and community-based approach in LTC

- Boundary between HC and LTC depends on policy, culture, etc. and can be arranged in different ways in different countries

- Example of UK: nursing care in LTC facilities is funded by NHS with no user fee, social care by local authorities with means test
- The most important consideration should be person-centeredness and the coordination between HC and LTC
- Inter-ministerial coordination is a challenge in Asia