



International Association for the
Study of Insurance Economics

Health and Ageing

Research Programme on Health and Productive Ageing

Geneva Association Information Newsletter

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The Health and Ageing research programme of the Geneva Association seeks to bring together analyses, studies, facts and figures linked to issues in health provision and the role of insurance, with an emphasis on the changing demographic structure whereby the population over 60 years old largely exceeds that of other groups. The key is to test new and promising ideas, linking them to related works and initiatives in the health sector and to try to find solutions for the future financing of health care.

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- the impact of an ageing population in health insurance systems;
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- health issues for an ageing population in the workplace;
- factors that influence health status;
- factors responsible for the increase in health spending;
- factors that contain the increase in health cost.

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I. GUEST EDITORIAL

Cash for Care: Implications for Carers*

By Caroline Glendinning

Providing substantial amounts (particularly over 20 hours a week) of care to a disabled or elderly relative or friend is associated with reduced labour market participation, poverty and adverse psychological and physical health. Many countries have introduced “cash for care” measures. Sometimes their primary objective is to provide financial support for the older or disabled person to help meet the additional costs of needing care. In other instances “cash for care” aims at offering consumer-style choice to older and disabled people. In such instances, benefitting carers, if at all, is a secondary aim. Moreover, these measures differ widely in terms of target group, eligibility criteria, interactions with formal care services, payment levels and whether they are means-tested. Their impact on carers also varies, depending on local labour markets, the availability of formal long-term care services, and, critically important, social attitudes towards the roles of families (and women within families) in caring for older and disabled people. This article provides a critical overview of the main models.

Personal budgets or consumer-directed employment of carers

Instead of receiving services, an older or disabled person can choose to receive a personal budget of an equivalent value to purchase care themselves, either from an agency or by directly employing a carer. There is increasing interest in consumer-directed cash-for-care schemes as a means of increasing choice and flexibility in long-term care; such schemes exist in the U.K., the Netherlands, some U.S. States and the Flanders region of Belgium. In the Netherlands and the Flanders (and to some extent in the U.K.) the personal budget recipient can employ a close relative. The relationship between care receiver and carer thus becomes one of employer-employee. In the Netherlands, employment above a minimum number of hours per week is regulated by a formal contract setting out the carer's terms and conditions of employment. Personal budget schemes in England and many U.S. States involve intermediary agencies to manage payroll, taxes, recruitment and training.¹ Older people are more likely than younger disabled people to employ relatives as their service providers.²

The level of a personal budget is usually calculated by multiplying the number of hours of care needed against an hourly rate (at least the legal minimum wage), thus in principle offering appropriate economic rewards for care. However, carers employed in this way report increased feelings of obligation and difficulties in negotiating time off.³ Consequently the total value of the care provided usually far exceeds the payment received.

The reliability of the carer's income depends on continuing good relationships between employer and employee. Carers are also financially vulnerable if the older or disabled person dies or enters hospital or long-term care. Personal budgets may attract new family members, such as newly retired relatives, into care work. However, carers employed by personal budget-holders occupy a marginal position between the formal and informal care workforces; formal training or career advancement schemes are very rare. Carers who have spent periods employed by a personal budget holder may find themselves disadvantaged when they try to re-enter the formal labour market. Carers employed by personal budget holders may also find they are unable to access any formal care services to support or relieve them in their role.

Employing family carers through a personal budget is not universally popular. In the Netherlands, only about ten per cent of all those receiving social insurance-funded long-term care choose to receive this in the form of a personal budget. In 2007 one-third of budget holders relied only on care provided by

* A longer version of this article can be found in: C. Glendinning, F. Tjadens, H. Arksey, M. Morée, N. Moran and H. Nies (2009) *Care Provision within Families and its Socio-Economic Impact on Care Providers*, Report for the European Commission DG EMPL, available from: www.york.ac.uk/spru/research/summs/EUcarers.php.

¹ OECD (2005).

² Wiener *et al.* (2003).

³ Breda *et al.* (2006).

relatives, one-third only on care provided by care organisations and one-third on a combination of the two.⁴

Care or attendance allowances paid to the older or disabled person

Here the cash payment is made to the disabled or older person, sometimes with no formal requirement as to how it should be used. However, in many instances it is expected that the allowance will be given to or used by a family carer.

Care or attendance allowances are paid in Germany, Austria and France. In Germany, someone eligible for long-term care insurance can choose between service “assignments” up to a specified value or a lower, non-taxable cash benefit (or a combination of the two). The cash benefit option has always been more popular because beneficiaries prefer family care to formal services from strangers. However there is no obligation on the recipient to give the cash benefit to the carer; there is evidence that it is not always transferred in full;⁵ and in other households it may simply be added to the joint household income rather than constituting an independent income for the carer.

In Austria, lower income care allowance recipients are likely to use the benefit to support family carers; professional families are more likely to use it to employ live-in carers through the “grey” labour market. In both instances, the low level of the allowance institutionalises care-giving as women’s work.⁶

Care allowances have many of the drawbacks of personal budgets. Carers are likely to find themselves financially dependent on the person they are caring for. Lundsgaard⁷ also argues that such payments can create an incentive “trap”, attracting informal carers away from the formal labour market if interactions between care allowances, taxes, unemployment benefits and other income transfers are not well controlled.

On the other hand, it is possible to add measures specifically intended to benefit informal carers to a care allowance (although again these can only be accessed if the care recipient qualifies for the care allowance). In Germany, informal carers of care allowance recipients are entitled to four weeks’ break each year (with care insurance paying the costs of respite care). Their pension and accident insurance contributions are also paid if they are not in full-time paid work and providing 14-plus hours care per week. Recent German reforms have increased funding for voluntary sector respite care centres, reduced the threshold so that respite care can be received after six months instead of a year, and introduced training courses for carers and retraining courses for carers wishing to return to paid work.

It is in principle possible in both Austria and Germany for care allowance recipients to also use some formal services, which helps to relieve the burdens on carers. However, in Austria continuing shortages and high costs of formal services make extensive reliance on informal care inevitable.⁸

Care allowances paid directly to carers to replace lost earnings

The U.K., Ireland and Australia all offer benefits as part of their national social security systems to replace the earnings lost by working age carers who have no, or only minimal earnings, because of their care responsibilities. Here, care-giving is treated as a labour market-related risk similar to unemployment or sickness; carers are assumed to be members of the labour market and have entitlement to an income in their own right. However, the level of the payment is usually very low and eligibility often depends on a strict test of carers’ means and assets; it therefore offers only minimal social protection. Where such allowances also attract payment of carers’ State pension contributions, some longer-term protection may be provided as well.

This income maintenance model is not compatible with carers’ continuing labour market participation; eligibility criteria assume the carer has no paid work and probably no other source of income either. On the other hand, it does not preclude either carers or the people they support from also receiving services.

⁴ Da Roit and Le Bihan (2008).

⁵ Wiener *et al.* (2003).

⁶ Kreimer (2006).

⁷ Lundsgaard (2005).

⁸ Kreimer (2006).

A variation of this approach, in Sweden and Canada, is to provide carers with income during temporary absence from work, along with rights to return to the same job. This measure is targeted at carers of terminally ill people, but is not effective for longer-term care commitments.

Paying carers instead of formal social service provision

Here, care-giving is formalised within a quasi-employment relationship, but with the local authority as the employer rather than the care recipient (as in the personal budget model). This model operates in a number of Scandinavian countries.⁹ It reflects the high levels of female labour market participation in these countries, their continuing relatively high levels of publicly-funded services, and the challenges of delivering formal social services in sparsely populated rural areas.

In Finland, for example, the Informal Carer's Allowance is awarded on the basis of an older person's care needs but is paid directly to the carer, who contracts with the municipality to provide an agreed level of care according to a care plan. The majority of carers employed in this way are spouses or other close relatives and a third are aged 65 and over.¹⁰ Levels of Informal Carer's Allowances are lower than the value of formal home care services; they offer no incentive to continue caring, but are believed to encourage carers to continue their existing care-giving responsibilities.

Carers employed by Finnish municipalities are entitled to three free days a month during a period when the nature of the care they have provided has been demanding. The municipality is responsible for providing substitute care, usually in a nursing home, but there is a serious lack of personalised and suitable substitute care options. Some municipalities have developed alternative schemes whereby another relative or friend is paid by the municipality to provide "substitute" care in the older person's home to give the main Carer Allowance recipient a break.

Paying carers in recognition of their care-giving responsibilities

There are a few examples of payments to carers simply in recognition of their care-giving work.

In the Netherlands an annual "Carer Compliment" payment was introduced in 2007. All carers supporting people eligible for long-term care insurance benefits can receive the Carer Compliment, which is worth €250 (tax-free). However, in its first year only ten per cent of those expected to be eligible applied; this was believed to be partly due to the lengthy and bureaucratic application process. Eligibility criteria have therefore been relaxed somewhat; it is now estimated that 266,332 carers might receive the Compliment, although its value may be reduced slightly.¹¹

The Australian Carer Allowance is an income supplement paid simply in recognition of the carer's role and to help with the extra costs associated with care-giving. It is paid directly to carers who provide full-time daily care for a disabled adult, older person or child and can be claimed for each person who is cared for. It is a universal, non-taxable benefit, and is not dependent on the carer's income or assets, or whether or not they have paid work. There is therefore no loss of benefit and potential disincentive for carers who remain in, or move into, paid work.

Conclusions

The various cash-for-care models have different implications for carers' ability to undertake other, remunerative, work, and for their ability to access formal services that substitute for family care and therefore provide a break from care-giving. Most restrictive in both respects are cash-for-care models that assume informal care-giving to be a full-time role that is therefore incompatible with mainstream labour market participation and is also assumed to substitute for formal care services.

All the cash-for-care models offer low levels of financial reward in comparison to the actual level of care provided. Even where hourly payment rates are at or above the legal minimum wage, the total volume of care provided usually far exceeds the hours that are actually paid for. Income replacement benefits for carers wholly unable to work are typically means-tested as well as paid at very low levels. Low levels of payments for informal care reinforce existing gender inequalities and have little potential to

⁹ Jenson and Jacobzone (2000); OECD (2005).

¹⁰ Martimo (1998).

¹¹ Vijfvinkel *et al.* (2008).

alter the gender distribution of care work. "An unequal distribution of caring work contributes to income inequality, inequalities in retirement incomes and in participation in social life."¹²

Cash-for-care models also do little to bridge the boundaries between informal care and formal labour market participation, for example by explicitly encouraging carers to retain contact with the labour market while caring. There is also little evidence of measures to formalise the skills acquired in informal care-giving as potential assets for future employment,¹³ even where carers have previously been employed by care recipients holding a personal budget, although a scheme along these lines has recently been introduced in Spain. Some workplace-based measures do offer carers leave for an extended period with their jobs protected, but long-term paid leave is unusual.

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II. INVITED ARTICLE I

Rational Behaviour of Insurance Intermediaries and Private Health Insurance Coverage in India

By Sukumar Vellakkal *

Introduction

In India, out-of-pocket spending by households on health care occupies about 72 per cent of the total health expenditure¹⁴ and it pushes 2.2 per cent of the population below the poverty line each year.¹⁵ Health insurance can be a viable and feasible financial solution; however, only less than 3 per cent of Indians have health insurance coverage,¹⁶ and the underlying reasons for such low coverage are mostly unexplained. With special reference to the private health insurance, this paper examines the role

¹² Jenson and Jacobzone (2000): 34.

¹³ Fujisawa and Colombo (2009).

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¹⁴ WHR (2006).

¹⁵ Peters *et al.* (2002).

¹⁶ World Health Survey (2003).

of insurance intermediaries in explaining the low level of health insurance coverage, inequity in health insurance coverage as well as no adverse selection in the health insurance market.

Structure of Indian health insurance and role of insurance intermediaries

There are three types of health insurance in India:

1. **Public health insurance.** These schemes are provided by the government and are limited to the people employed in the relevant sector. There are four major schemes: i) Central Government Health Scheme (CGHS) for central government employees and pensioners, and to their eligible dependants, ii) Ex-servicemen Contributory Health Schemes (ECHS) for retired military people and their eligible dependants, iii) Employees State Insurance Scheme (ESIS) for industrial labourers, and iv) special health insurance schemes such as Rashtriya Swasthya Bima Yojana (RSBY) for people below the poverty line (weavers health insurance for weavers and their family, etc).
2. **Community-based health insurance.** These schemes target low-income people and are being promoted by civil society organisations. These schemes are confined to some specific geographical localities.
3. **Private health insurance.** At present, more than 12 insurance companies, including both the public and private insurance companies, provide private health insurance. The Mediclaim policy of the four largest public sector general insurance companies (NIC, UIC, NIIC and OIC), which is a hospitalisation scheme, is one of oldest and most popular private health insurance schemes in India. After the privatisation of the insurance industry in the year 2000 in the country, many private sector insurance companies entered the market and began to introduce hospitalisation schemes that are in many ways similar to the Mediclaim Policy.

In India, private health insurance schemes fall under non-life (general) insurance categories. Private health insurance in India is based on the partner-agent model and insurance intermediaries are important stakeholders between the insurer and the clients. Apart from their agency role, insurance intermediaries also provide various other services to clients such as premium collection and assistance in claims. As per the law, insurance products can be sold or bought through licensed insurance intermediaries only.

Rational behaviour of insurance intermediaries

In general, insurance intermediaries face a situation of promoting “after sales service” oriented policies like health insurance versus high income or net profit oriented “other forms of insurance policies” (such as the life insurance policy). For insurance intermediaries, selling “other forms of insurance” is more profitable than selling health insurance. Selling health insurance involves a lot of effort since the majority of the population is not familiar with health insurance schemes that are in risk-pooling forms. Moreover, health insurance schemes have a term of one year and can be renewed every year subject to the approval of the insurance company, which means that insurance intermediaries have to spend time and effort on this every year. So as to bypass this issue, people are familiar with “other forms of insurance” that not only have risk components, but also saving components. Furthermore, most of the “other forms of insurance”, such as life (non-general) insurance policies, are long-term schemes, for example ranging from 1 to 15 years and more, which ensures a continuous income flow for insurance intermediaries.

Under normal circumstances, giving their individual choice and rationality, insurance intermediaries may choose to only promote and sell “other forms of insurance” policies. However, either because of official compulsions (due to the clause of a 5 per cent rural/social quota), social obligations and moral commitments, they may choose to promote some health insurance policies. As a result, they try to maximise their net income subject to the fixed amount of time and effort (and energy) at their disposal in a situation of promoting both types of insurance schemes by using the following strategies.

Strategy 1 - Minimise Adverse Selection: There is a high probability that insurance intermediaries will incur some costs in the form of time and effort, and even monetary costs while helping their clients make insurance claims (though they can directly make claims, the clients expect the assistance of insurance intermediaries in reimbursement procedures). As the high-risk clients are more likely to (and

often) make claims, it would take a lot of time and effort on the part of insurance intermediaries to help such clients in the claims procedure. So insurance intermediaries may try to sell health insurance mainly to low-risk people and thereby avoid adverse selection.

Strategy 2 - Selling health insurance to high insurance users: Selling health insurance to those who have a high insurance use (those clients who already have enrolment with other forms of insurance schemes) may reduce the average cost of selling health insurance for insurance intermediaries. This is possible because much less time and effort will be required to sell a health insurance policy to those who are familiar with the insurance system. Nevertheless, clients with a high insurance use may be representative of the average health risk of the general population, which in turn means that they are not high-risk people. Therefore, it will not result in adverse selection.

Strategy 3 - Selling health insurance to high-income clients: One can expect a high-income household to buy a higher amount of health insurance than a low-income household. As the income for insurance intermediaries is proportional to the insurance amount sold and as high-income people are more likely to buy high amount insurance, this means a high return per business deal with minimum time and effort spent for insurance intermediaries.

Results and conclusion

The above propositions are empirically tested by applying a maximum likelihood estimate of probit model using the primary data collected by the author. The primary survey was conducted among the insured (those who have bought the Medclaim policy) and uninsured households (those who do not have the Medclaim policy). The peer group discussions with insurance intermediaries revealed that health insurance schemes are a less profit, but high-risk oriented business for insurance intermediaries as compared to “other forms of insurance” schemes including life insurance schemes. We found that the rational behaviour of insurance intermediaries result not only in low levels of health insurance coverage, but also in an inequitable coverage. Moreover, as against the general theoretical expectation as well as in contrast to prevailing empirical evidence—but in par with our theoretical model, our results show that there is no adverse selection.

We also found that the demand for health insurance is determined by the rational behaviour of insurance intermediaries on the one hand and the insurance use of people on the other hand. In fact, we can consider income and education as necessary conditions, but the significant conditions are mainly the net-income maximising behaviour of insurance intermediaries and the insurance use of the people.

The government should force insurance companies to provide special incentives (such as higher monetary rewards, special prizes, etc.) to insurance intermediaries for selling health insurance and also for selling health insurance to low-income households. Moreover, the term of health insurance should be converted to a long-term one (say for example 15 years) instead of the current practice of renewal every year. Apart from this, participation of non-profit entities like self-help-groups should also be encouraged to sell health insurance.

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III. INVITED ARTICLE II

Individual Cross-border Medical Demand and its Limitations

By Daniel Lukas*

Introduction

The process of internationalisation has widely advanced in almost all sectors of the economy. Since 1995, when the General Agreement on Trade in Services (GATS) was signed, the health care sector has also been in focus as a potential globalising service sector.¹⁷ Specifically, patient migration is a central mode of trade in medical services and has an important relevance in the context of free choice in treatment locations and in the inclusion of it in cross-border insurance contracts.

Measured on the global trade in services and on the total health care expenditures, the activities of patient migration in different OECD countries are low and without a recognisable trend.¹⁸ Normally, national governments deny the support of cross-border migration, and therefore the portability of insurance benefits for tradable medical services.¹⁹ However, insurance companies as well as patients are sceptical about how advantageous foreign medical care and the potential cost-savings are. Even within supranational systems like the European Union, agreements have not been reached contrary to the general principle of free mobility of capital, labour, citizens and trade in goods and services. Political barriers and particular unfounded anxieties regarding irreversible impacts of cross-border care on the national medical provision are characteristic of the health care sector. Furthermore, economic literature does not provide an acceptable framework of detailed discussions with accurate results about the effectiveness of cross-border care. Hence, a first step has to be taken in terms of analysis of the real potential of cross-border demands. The finding could be that it is limited even if an option of free location choice would exist. Besides any impacts on the medical health care system as a whole, the individual behaviour according to medical demand has to be analysed in order to create a starting point for further discussions about specific insurance contracts which implement foreign providers and allow a free choice for them. The following discussion represents determinants of medical demand abroad as well as their impacts on efficiency, and refers to Lukas.²⁰

Determinants of medical demand abroad

Some dynamics have developed in the field of patient migration, sometimes called "health tourism". Countries such as Thailand, Malaysia and India delivered health services for around 350,000 foreign patients in 2003.²¹ Generally, the motivation for this demand can be separated into a price and a quality gradient. The price gradient should mainly be valid for patients from countries with a highly developed health care provision. Busse *et al.*²² compare cost for specific treatments among a number of States in the European Union and show a strong variance between them, caused by differences in wages and the technologies used. Fujisawa/Lafortune²³ analyse the wages of general practitioners and specialists in 14 OECD countries. Measured in purchasing power parities, there exists a wide range and variance, especially for medical specialists, for whom the highest wages are paid in the U.S. and the Netherlands, and the lowest in Eastern Europe, as in Hungary and the Czech Republic. Mattoo/Rathindran²⁴ calculate price differences between the U.S. and countries of South East Asia up to a factor of ten for relatively standardised and tradable medical services of comparable quality. For example, a skin lesion excision has an inpatient price in the U.S. of US\$ 6,240. The average of the three lowest foreign prices is US\$ 812, in which the travel costs are included. They estimate a savings potential of US\$ 1.4 billion if 10 per cent of concerned patients would demand the relevant treatment abroad. Measured on the total expenditures of almost US\$ 2 trillion,²⁵ this number appears small.

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¹⁷ Adlung/Carzaniga (2001).

¹⁸ Waeger (2007).

¹⁹ Mattoo/Rathindran (2006).

²⁰ Lukas (2009).

²¹ Mattoo/Rathindran (2005).

²² Busse *et al.* (2008).

²³ Fujisawa/Lafortune (2008).

²⁴ Mattoo/Rathindran (2005).

²⁵ Smith *et al.* (2006).

However, considering the degree of out-of-pocket payments in the U.S. and the chronic cost pressures in a number of other countries, price gradients could be useful instruments in the debate about options for making health systems more efficient.

Besides a quality and a price gradient, further determinants of demand are of specific importance, which Lukas²⁶ discusses theoretically in a micro-economical framework.

Transaction costs

Transaction costs, separated into monetary and non-monetary, as well as variable and fixed costs, play a significant role due to an increase of total costs and, hence, a reduction of demand. Transaction costs are typical for trade, also or even more so in medical services. Effort of organisation, travelling and interfaces between the different stages of treatment at home and abroad are important sources of such costs. The question is whether these costs can be reduced below a prohibitive level. A better integration of international health care markets could be a promising step. The integration has to be organised on a political as well as on a private level. This process is still in its infancy. Attention has to be paid to non-monetary transaction costs, which are specific for the demand of medical services abroad, such as physical and psychological stress. These costs are closely connected to the specific character of a medical treatment. They are also a parameter for mobility, especially connected to different kinds of illnesses, not all of them being eligible for trade, such as illnesses with an acute character.

Lack of trust

Another central component is trust, or rather a lack of trust over the provided quality abroad which is discussed by Lukas more extensively. Health care provisions can be represented as a local assurance good deviated from basic characteristics of medical goods, from trust as a general determinant of economic transactions, as well as the role of trust within trade relations. A change in locality of medical provision can generate a subjective lack of trust over the foreign provider, without any objective evidence. As a conclusion, a subjective adjustment of treatment cost upwards, leading to lack of trust in the individual demand decision, takes place. The consequence is a reduction of demand and an inducement of a demand bias despite an existing cost-saving potential abroad. Hospital networks and transferred standards to hospitals abroad could enlarge the familiar care of a health care system at home on a foreign country which could reduce the level of lack of trust. Schroth and Khawaja²⁷ discuss the need to validate quality in the form of accreditation as it is done, for example, by the Joint Commission International, which sets quality standards in U.S. but also has accredited a number of foreign medical providers. As could be learned from Rauch,²⁸ a higher degree of standardisation, for instance through certification of specific treatments, could reduce the lack of trust. Furthermore, the trust literature identifies reputation and experiences as central determinants of trust. Hence, it becomes necessary to develop familiarity between patients and providers over a specific period. The success of such a process might depend on numerous further determinants, such as characteristics of the target country and of the individuals involved.

Patients' health level and unknown quality of health care

The demand for health care abroad may also depend on how healthy or unhealthy a patient is. The healthier a patient is, the more likely it is that he/she will be inclined to choosing a foreign medical provider. However, this is counter-balanced by fixed transaction costs. A flight ticket to a foreign destination carries a greater proportion of total costs for a simple influenza than for a bypass operation. Bad health generates a structural disadvantage based on a lack of trust and uncertainty as to the quality of foreign health care services, despite the fact that they have a higher potential for cost savings. These negative perceptions are based on the possible limitation of foreign medical service quality or of a specific medical provision; they are also based on a lack of trust. This means that there is an adjustment in demand to compensate for this lack of trust. There is a limitation to this: as in the case of a lack of trust pertaining to the quality of a five-star hotel abroad, where an individual cannot demand a seven-star hotel in the hope of getting a good five-star hotel, simply because seven-star hotels do not exist. Therefore, an individual would exclude getting foreign medical care in the case of severe illness, despite a potential financial advantage, based on a subjective adjustment of the provided quality.

²⁶ Lukas (2009).

²⁷ Schroth and Khawaja (2007).

²⁸ Rauch (1999).

The impact of transaction costs, lack of trust and quality restrictions could be compensated by a foreign cost advantage. Then the foreign costs must fall short of a threshold level. However, such compensation can only have a demand-inducing effect if the individual is ready to compensate monetary, versus non-monetary, utility elements one-to-one. If this is not the case, the individual will base his or her decision on a minimum quality of medical services abroad.

Insurance and a foreign medical provision

Similar to Mattoo/Rathindran,²⁹ Lukas³⁰ discusses a lump-sum insurance framework. As a result, a mixed insurance tariff connected with a free choice of preferable providers at home and abroad could stimulate the use of foreign medical care and maximise the individual's utility. This means a kind of pitching on utility, maximising treatment locations in a context of the presented inefficiency sources. Based on these sources, the foreign supply is purchased inefficiently/expensively or an existing cost-advantage cannot be fully realised. Another important result is a remaining income-risk, despite the installed insurance contract based on an induced risk on the gross-income, as well as on the cost side. This is a product of non-insurable cost, as non-monetary transaction costs and a biased demand due to a lack of trust. As the objective of insurance is to equalise cross-border demands, a co-payment insurance is implemented, where insurance is determined as a pre-existing social insurance system in which the patient is involved. This insurance is able to differentiate between domestic and foreign co-payments. An adjustment of foreign co-payment reduces the degree of moral hazard behaviour. Then cost savings can be realised; however, they have to be shared with the patient via a lump-sum payment to induce demand abroad. If complete insurance coverage exists domestically, a reduction, but not an abstraction, of the incentive to demand abroad would take place due to a reduced sensitivity over foreign costs. If there is no insurance coverage abroad, the critical level of marginal and fixed costs is of interest to induce demand abroad.

Conclusion

The potential of cross-border medical care is limited as long as the discussed sources of inefficiency exist, or as long as they are too high to create a net advantage and the use of a comparative advantage abroad. As a result, cross-border care is usually only possible, if at all, between countries with a high degree of proximity. In this context, the legal resources abroad are also an important element. As Cortez³¹ shows, patients from the U.S. are often neither able to judge the legal risks abroad, nor at home. Furthermore, it is often a show of strength to obtain compensations when malpractices take place abroad and at home. These aspects could have an important influence as a specific risk. Another important point is the insurance itself for which a foreign option is currently not available in most cases. This is also based on a kind of trust according to the quality of foreign health care and the difficulty of its' assessment.

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²⁹ Mattoo/Rathindran (2005).

³⁰ Lukas (2009).

³¹ Cortez (2009).

IV. INVITED ARTICLE III

Role of Health Insurance in Averting Economic Hardship in Families Following Acute Stroke in China^{*}

By Emma Heeley *et al.*

Introduction

Over the last three decades, market reforms and trade liberalisation policies have brought significant wealth and economic prosperity to the people of China. The downside to these changes, though, has been a decline in access to health care for the poor and increasing levels of out-of-pocket payments for health care.³² The high costs of health care has meant that many people face the tragic choice of either forgoing treatment or incurring financial hardship with the onset of illness.³³

Stroke is an enormous health issue in China, as the second most common cause of death, accounting for almost 20 per cent of all deaths in both rural and urban settings.³⁴ As its huge population undergoes rapid ageing, urbanisation and other lifestyle and social changes, stroke is an ever increasing burden on the Chinese health care system. In common with other forms of cardiovascular disease, stroke can have serious economic consequences to families due to loss of income and the cost of health care. In China, where 60 per cent of health care expenditure is financed from out-of-pocket payments, illness is a major cause of economic hardship and poverty.³⁵

It is estimated that 13.7 per cent of the population of China have incomes below a poverty threshold of US\$ 1.08 per day and 44.6 per cent below a threshold of US\$ 2.15 per day. Out-of-pocket payments for health care have been shown to result in 32 million individuals (2.6 per cent increase) being pushed below the US\$ 1.08 a day income threshold and 23 million individuals (1.8 per cent increase) pushed below the US\$ 2.15 threshold.³⁶

Health insurance is seen as an important means of offering financial protection from such economic catastrophe. In urban areas of China, social health insurance schemes based on employment were introduced in 1998, with coverage provided principally to employees of State enterprises and some areas of the private sector. In its early phase, the urban health insurance initiative was shown to have had some success in reducing the financial burden on patients³⁷ and in reducing overall cost pressures.³⁸ However, recent data suggests that the anticipated expansion of coverage has not materialised and that levels of participation amongst vulnerable groups, such as women, low income earners, rural to urban migrant workers, and employees on short-term contracts, has been falling.³⁹ Furthermore, co-payments and gaps in benefit packages can lead to potentially significant out-of-pocket costs, even for those with insurance. The effects are being felt by the population: health care was the social issue of most concern for people interviewed as part of a recent nationwide survey of 101,029 families conducted by the National Bureau of Statistics of China.⁴⁰

^{*} This text is extracted from: Heeley, E. *et al.*, *Role of health insurance in averting economic hardship in families after acute stroke in China*, *Stroke*, 2009, 40(6): 2149-56.

³² Liu (2006)

³³ *Ibid.*

³⁴ WHO Representative Office in China.

³⁵ van Doorslaer *et al.* (2007).

³⁶ van Doorslaer *et al.* (2006).

³⁷ Liu *et al.* (2002).

³⁸ Meng (2004).

³⁹ Xu (2007).

⁴⁰ National Bureau of Statistics of China (2008).

Methods

In this nation-wide prospective 62 hospital registry study of acute stroke in China, we recorded information on patient demographics, clinical features, socioeconomic factors, management and costs of medical care. Information on out-of-pocket health expenses was obtained in surviving patients at three and 12 months follow-up. Catastrophic health care payments, defined as $\geq 30\%$ of total household annual income, were estimated from reported household annual income. A comprehensive description of the methods can be found in the full journal version of this paper.⁴¹

Results

Of 5,557 patients who were alive and available for interview at three months post-stroke, 818 were excluded from the analyses due to missing data on income or health care expenditure. Although these patients had the same distribution of gender, age, baseline stroke severity and level of disability at hospital discharge as the 4,739 patients with complete information, they were more often from the wealthy provinces and less likely to report difficulties in making payments for food, accommodation and other necessities.

Among 4,739 three-month survivors of stroke with outcome data, average hospital and medication costs were 16,525 Chinese Yuan Renminbi (CNY) (US\$ 2,361) and out-of-pocket costs were 14,478 CNY (US\$ 2,068). Overall, 3,384 (71 per cent) patients had experienced catastrophic out-of-pocket expenditure. Workers without health insurance were seven times more likely to experience catastrophic payments than workers with insurance. Health insurance also protected against catastrophic payments in patients who were either retired or not working (those without health insurance were 4.7 and 1.8 times respectively more likely to experience catastrophic health care payments).

Another approach to examining the impact of out-of-pocket health expenses is to consider the extent to which households with incomes above the poverty level are brought below this level once such expenses are deducted. On the basis of this measure, we found that 37 per cent of patients (and their families) fell below the poverty line set at US\$ 1 per day, and 39 per cent when it was set at US\$ 2 per day, following the stroke. However, having health insurance was protective (23 per cent, compared to 62 per cent without health insurance falling below the poverty line of US\$ 1 per day).

Discussion

Our large, country-wide study provides evidence to support growing concerns of rising economic burden from health care costs in the general population of China. We have shown that acute stroke imposes catastrophic health care payments in the majority of households with an affected individual, with many at risk of impoverishment. Health insurance can avert these risks albeit provided there is high enough level of coverage (>75 per cent), as was present in nearly half of the patients in this study. Given the looming regional epidemic of strokes and other chronic diseases, our findings re-emphasise the need for initiatives to expand health insurance coverage in both rural and urban settings in China, and also in other developing countries where out-of-pocket expenses comprise a significant proportion of health care financing. Such initiatives would need to be augmented by efforts to ensure that the level of coverage offered provides adequate levels of financial protection.

Greater financial autonomy in the health sector and reduced government subsidies to hospitals and health centres in China has led to market-oriented financing strategies for health providers that have driven up costs, reduced the provision of primary care and preventative services, and moved resources away from rural areas where the majority of the population resides. These and other changes have led to a fragmentation of the health care system, the emergence of health inequities, and exposure of individuals, their families, and communities, to increased stress from the impact of chronic diseases, such as stroke. Our study shows that health insurance provides protection from such effects, particularly in workers; whilst those with no health insurance but still presenting to hospital tend to be those with higher incomes and thus potentially have sufficient confidence in their ability to access resources to pay hospital bills. A previous multi-city population-based study showed that generally the number of stroke cases hospitalised in China was high (83 per cent); it was higher in developed urban

⁴¹ Heeley *et al.* (2009).

populations and lower for rural populations.⁴² It is possible that patients with low household incomes and without health insurance who experience strokes are not presenting to hospital, but our study was not designed to address the pathways of care outside hospital. The level of health insurance coverage has been highlighted as being an important aspect to the protection from experiencing catastrophic payments offered to households. Even so, the cost of the initial co-payment and medication costs in the first three months post-stroke alone (which are generally not covered by health insurance) can still constitute a catastrophic payment for many patients despite them having the nominal “100 per cent coverage” of health insurance.

Currently the Chinese government is consulting on a multipronged initiative to improve the health of China's 1.3 billion residents by 2020. The key to this round of health system reform is to increase government spending on health and committing to health insurance for the whole population of China, including people in rural areas and non-workers. This is a massive undertaking and must be encouraged as this should help reduce the inequities in health care that we have documented for strokes. In the interim the rolling out of health insurance schemes nationwide to workers and non-workers should help avoid such catastrophic payments being experienced by many families, although it is likely that the coverage provided through the design of current schemes will alone not be enough to remove the risk of economic catastrophe.

These findings in relation to the extent of out-of-pocket payments and levels of economic catastrophe associated with strokes can be generalised to urban China. For rural China, however, where there are greater levels of poverty and lower levels of health insurance coverage, it is likely that a greater proportion of patients will fail to present to hospital; and when they do, are more likely to face greater risk of economic catastrophe from stroke and similar acute disabling illnesses.

Conclusion

In summary, as health care costs are high relative to income in China, families face considerable economic hardship following stroke. Health insurance protects families against catastrophic health care payments, thus highlighting the need to accelerate the ongoing process of building a comprehensive health care system in both urban and rural settings in China.

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⁴² Zhang *et al.* (2003).

V. INVITED ARTICLE IV

Statutory and Informal Care Partnership Policies: a United Kingdom Perspective

By Kate Davidson*

Introduction

In the U.K., the 1990 *National Health Service and Community Care Act* (NHS and CC Act) (DH 1990) was the first major legislation to acknowledge the importance of a partnership between State and individuals in assessing and responding to the need for care in the community, most of whom are older people. Local Authorities (LAs) had a duty to consult with the older person and their family in order to set up costed “care packages” of social service provisions which enabled older people to remain in their home for as long as possible. The most recent social care reform legislation allows for direct payments to individuals who have been assessed as needing services, in lieu of social service provisions. The aim of a direct payment is to give more flexibility in how services are provided. By giving individuals money in lieu of social care services, people have greater choice and control over their lives, and are able to make their own decisions about how their care is delivered. This article examines the development of the policy decisions in the U.K. which have altered the emphasis from State-led to person-led response to care needs, and speculates on how successful this shift has been in the 21st century.

The balance of responsibility between the State and the family in caring for vulnerable persons, regardless of age, depends upon the welfare policy ideologies of the Nation State and its incumbent government. The principal drivers of welfare policy decisions are reflected in the political weighting attached to concepts such as citizen rights and responsibilities, equality and equity, independence and choice, control and flexibility, and to what extent benefits can be afforded and sustained within that society. The recent global recession has challenged the budgetary and fiscal policies of all Welfare States.

Welfare State ideologies

Esping-Andersen⁴³ described three main types of welfare régimes within capitalist economies: *corporatist* régimes which are work-oriented and based on individual contribution; *social democratic* régimes which favour universalist values and *liberal* régimes which tend to be residualist. The U.K. can be described as having a foot in the last two camps: some welfare is provided to all citizens as a right, whilst other provision is needs-based (assessed) and means-tested. A prime example of this dichotomy is the historical division between health and social care. Health provision by NHS is funded from general taxation and free at the point of delivery for all citizens. Social care on the other hand is the responsibility of social services within LAs, and largely dependent upon local taxation and provision is rationed. When “care” is discussed in this article, it refers to “social” care and not “health” care, since the latter is universally available and although there are current debates as to the quality of health delivery in the U.K., these are not at issue here. Nevertheless, it is the most vulnerable people in society who blur the boundaries between health and social services. For the purposes of this article I will be referring to vulnerable adults who have physical or mental disabilities, the vast majority of whom are elderly and cared for by family and relatives.

As in most Christian-based societies, the concept of family care is predicated on the organising principle of “subsidiarity”:

It is a fundamental principle of social philosophy, fixed and unchangeable, that one should not withdraw from individuals and commit to the community what they can accomplish by their own

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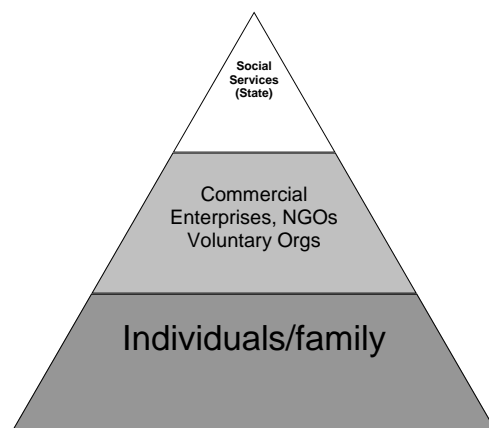
⁴³ Esping-Andersen (1990).

enterprise and industry. So, too, it is an injustice and at the same time a grave evil and a disturbance of right order, to transfer to the larger and higher collectivity functions which can be performed and provided for by lesser and subordinate bodies. In as much as every social activity should, by its very nature, prove a help to members of the body social, it should never destroy or absorb them.

Quadragesimo Anno: Para 79, 1931 (de Torre, 1997))

There is therefore an expectation that families will provide the major share of caring for their vulnerable members in their own home, whether non-resident or co-resident, and only call on the statutory bodies when they encounter serious difficulties and/or are no longer able to look after their relative(s). Figure 1 offers a simplistic model of the ideal share of responsibility for caring within the community.

Figure 1. Sharing the responsibility



The apex of the triangle represents the minimal (and diminishing) formal State provision for vulnerable elderly people and includes LA residential care homes and sheltered accommodation (assisted living) and some domiciliary care. In the middle, an increasing proportion of non-family support, such as domiciliary care has been “outsourced” through competitive tender to commercial enterprises—the need for these services are assessed by Social Services and means tested. Private (for profit) and not-for-profit organisations (such as NGOs) have undertaken a greater involvement in residential provision and domiciliary care and again, payment depends on the capital and income of the person in need. Included in the middle section are those organisations whose voluntary members carry out a vast amount of unpaid work, aid and support for vulnerable people in the community. Often, the organisations get grants and funding from local authorities and parish councils, but the majority of the funding is from donations and they depend on the goodwill of the volunteers. Interestingly, the majority of these are retirees themselves, wanting to “give something back to the community” and of course, tend to have the time to do so.

The base of the triangle represents by far the largest contribution to caring for vulnerable adults from neighbours, relatives and family, and the informal care of people over the age of 65 is estimated to save in excess of £60 billion per annum to U.K. taxpayers.⁴⁴

Care in the community

During the neo-liberalist Conservative government of the U.K. in the 1980s, there was an increasing awareness that this “reserve army” of carers should and must be acknowledged and consulted if they are to be retained to continue their cost-saving (to the state/tax payer) labour. Originally, Care in the Community directives were central to Mental Health policy as the numbers of inpatient beds in psychiatric institutions declined dramatically from the 1970s, principally because of the development of effective psychotropic drugs. There was a need to support and monitor ex-patients, not only for regular and appropriate medication use but for their accommodation, safety and well-being. In the 1980s and 1990s, the remit took in all vulnerable people in the community including people with disabilities and older people. The problem was that people with disabilities, many of whom were also old, had complex

⁴⁴ www.helptheaged.org.uk.

health **and** social care needs, but the NHS (centralised) and Social Services (localised) did not communicate with each other. Hitherto, the “top-down” approach from health and social services professional meant very little input was considered or encouraged from the older person and their family, especially for example on discharge from hospital once the medical condition had been treated or ameliorated. The NHS and CC Act (1990) attempted to address this dilemma and set up communication channels between these two welfare giants. The enormity of this total paradigm shift is reflected by the fact that the Community Care component of this vast legislation was enacted three years after the NHS element, in April 1993. Nevertheless there was a firm commitment to personalising services and to consult not only the older person themselves, but also their carers including family, friends and neighbours—anyone involved in their care on a regular, frequent basis—within certain timescales of hours per week.

Health and social services are enormous bureaucratic organisations and have quite different methods of information collection through forms, questionnaires, procedures and storage of data. Take the example of an older person who had a fall requiring hospitalisation for a fractured neck of femur (broken hip) and subsequently discharged home or into special living accommodation after physiotherapy and occupational therapy (OT). They may be on several databases—general practitioner, hospital (medical and physiotherapy and OT), district nurse, health visitor and Social Services. This person would most likely have been asked the same questions about his or her medical and social history for each of these services, and as pointed out above, little or no inter-provision communication. One of the methods employed to address the problem was the instigation of the “Single Assessment Process” (SAP)⁴⁵ which aimed at ensuring integrated commissioning arrangements between health and social care. This entailed the generation of a standard form holding basic information which followed the older person from one section of service provision to another. The underlying philosophy is to ensure not only continuity of care but the opportunity for older people as individuals to make choices about their care, and for all the professionals to know the wishes of the older person and their carers.

Since the NHS and CC Act (1990) there have been a flurry of government directives, too numerous to mention here, but in essence they share the ambition to enable people to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual needs for independence, well-being and dignity. Probably the most important recent protocol is “Putting People First” (December 2007). This is a collaborative document which addresses all adult services, but recognises the demographic reality of an increasing ageing population. This ministerial concordat establishes the collaboration between central and local government, the sector’s professional leadership providers and the regulator. It sets out the shared aims and values which will guide the transformation of adult social care, and recognises that the sector will work across agendas with users and carers to transform people’s experience of local support and services.⁴⁶

People want, and have a right to expect, services with dignity and respect at their heart. Older people, disabled people and people with mental health problems demand equality of citizenship in every aspect of their lives, from housing to employment to leisure. The vast majority of people want to live in their own homes for as long as possible. (Putting People First, 2007, p. 1).

Developing from “Putting People First” was the introduction of “Direct Payments” in 2008.⁴⁷ Direct payments are local council payments for people who have been assessed as needing help from social services, and who would like to arrange and pay for their own care and support services instead of receiving them directly from the local council. A person must be able to give their consent to receiving direct payments and be able to manage them, even if they need help to do this on a day-to-day basis. They are a success for those who have them. Unfortunately many people are simply not being offered them when they should be. There are wide variations in uptake, both between local council schemes and across the different groups of individuals. Nevertheless, it is an important step in the direction of “marrying” formal and informal care in the U.K. and a belated recognition that services should be “bottom up” and not “top down”, that is client rather than professional led.

⁴⁵ www.cpa.org.uk.

⁴⁶ www.dh.gov.uk.

⁴⁷ www.dh.gov.uk.

Counting the cost

The partnership of formal and informal caring within the community envisaged a saving on costs: the longer people stayed in their own home, the less had to be spent on institutional care. It is estimated that approximately 5 per cent of the older population (over 65) are in care homes or long-stay hospitals, although this does increase to about 20 per cent of people over the age of 85. These data demonstrate that people who do enter residential care are older and frailer and are thus more likely to require costly care. Also, about 75 per cent of people in care homes have some level of dementia, again needing specialised care.⁴⁸ The demographic realities—increased longevity and chronic morbidity, lower fertility and the greater expectations of the baby-boomer generation for their parents and themselves—mean that a call for increased rather than decreased State support is likely.

Added into the mix is the fall-out from the recent worldwide recession. Governments are looking for ways to cut public funding. Older people on fixed incomes, diminishing value of pensions and/or dependent on savings will have suffered disproportionately from the economic downturn. Since social care is means-tested, they will require more, not less State support. And so in the time of recession and the post-recession recovery, there are more questions than answers in the formal-informal care debate. How can we afford to keep the partnership balanced and fair for all citizens (tax payers and recipients of care)? How do we address the social and political dilemmas for prioritising funding for vulnerable people in the community?

Since the middle of the 20th century and the inception of the post-World War II welfare state in the U.K., welfare provision is driven by a shared commitment to social justice. Therefore, I remain optimistic that within our social-democratic ideology, older people will be listened to, responded to and that the experience of growing old will be improved by a continued obligation to care for the most vulnerable members in society.

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ANNOUNCEMENT – GENEVA PAPERS

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www.genevaassociation.org/Publications/Geneva_Papers_on_Risk_and_Insurance.aspx

Past issues from 2000 to April 2006 are now available on The Geneva Association's website. Former issues up to No. 1 (January 1976) will be added in the coming months.

Note also that past issues of *The Geneva Risk and Insurance Review* will also be available soon.

⁴⁸ www.carehomesguide.com.

VI. RESEARCH SUMMARY

How Can we Manage the Health Impacts of Climate Change? Summary of Lancet and University College London Institute for Global Health Commission Report*

Climate change is the greatest health threat of the 21st century, according to this recent report. It stands to threaten people's health across the globe, with the world's poorest suffering the severest consequences, even though they have contributed least to the problem.

The report calls for an immediate and urgent response involving all sectors of society. Governments, international agencies, non-governmental organisations, communities and academics need to work together to develop and implement health strategies adapted to the effects of climate change. These efforts should be implemented alongside mitigation strategies to reduce Green House Gases (GHG) emissions. Public health systems should be strengthened to deal with the consequences of climate change, particularly in vulnerable countries.

The report suggests there are six major threats to health from climate change:

- **Disease.** Patterns of infection, insect and rodent-borne diseases and mortality will be affected by changing weather, not only in developing countries which already have populations with poor health, but also in developed countries. For example, heat waves were estimated to have killed up to 70,000 people in Europe in 2003.
- **Food.** Climate change affects health by causing changes in diet, leading to malnutrition and hunger from greater food insecurity, particularly in poorer areas.
- **Water and sanitation.** Clean water, suitable sanitation and drainage will be threatened. Increased droughts will cause water shortages and floods will increase the occurrence of water-borne diseases, such as diarrhoea.
- **Shelter and settlements.** People living in urban slums and poor conditions will be especially vulnerable.
- **Extreme events.** More and stronger cyclones, hurricanes and storm surges will cause flooding and injury.
- **Population and migration.** Migration is likely to occur on a large scale as people flee from inhospitable conditions.

Five key challenges have been identified for policy-makers, scientists and health care professionals to prevent the catastrophic health consequences of climate change:

- A need to generate and disseminate more reliable, relevant and up-to-date information at global, national and local levels, on how to tackle the harmful health effects of climate change, particularly in developing countries.
- The harshest effects of climate change will be felt most by the poor. Inadequate health care systems in vulnerable and under-resourced countries must be strengthened and greater efforts must be made to address poverty and inequality.
- Many technological innovations need to be encouraged to address the impact of climate change on health. More funding is needed for climate science and related technological solutions, such as for food security, safe water supply and better buildings. Surveillance must be improved in the poorest countries and technological solutions need to be integrated across a wide range of social and cultural groups throughout the world.
- Political structures must be in place to encourage a switch to low carbon living, which will not only have global health benefits (less stress, obesity, diabetes and heart disease, better air quality) but would also ensure a more sustainable way of life which is fairer for all.
- As a priority, governments and international institutions should be better coordinated and more accountable for dealing with climate change.

Empowering poor countries, local governments and communities to understand and act on climate change is one of the most urgent steps to take.

* The report can be accessed at www.ucl.ac.uk/global-health/ucl-lancet-climate-change.pdf Lancet and University College London Institute for Global Health Commission. See also Costello, A., *et al.* (2009) "Managing the health effects of climate change", *Lancet*, 373: 1693–733.

VII. SIXTH GENEVA ASSOCIATION HEALTH & AGEING CONFERENCE

Health and Long-Term Care Insurance in Eastern and Central European Countries

26-27 November 2009, Warsaw

Hosted by PZU (*Powszechny Zakład Ubezpieczeń*)

26 November 2009

13.00 Welcome / Opening Remarks

13.30–15.30 Session 1: Health and long-term care systems in ECE countries

- *Financing and provisioning of long-term care in Eastern Europe*
Johannes Koettl, Europe and Central Asia Region, Human Development Sector, The World Bank, Washington DC
- *The financial implications of ageing in post-communist health care systems*
Prof. Peter Mihalyi, Central European University, Budapest
- *Financing systems effect on quality, equity of access and utilization of health care*
Prof. Tomasz Hermanowski, Warsaw Medical University, Warsaw

15.30–16.00 Coffee Break

16.00–18.00 Session 2: National perspectives of financing health and LTC in ECE countries

- *Polish health care system in transition – insurance perspective*
Piotr Kuszewski, Vice-President PZU Life, Warsaw
- *Economic impacts of ageing and LTC – Evidence from Slovakia*
Peter Pazitny, Partner and Managing Director, Health Policy Institute, Bratislava
- *Public LTC financing and solidarity – Lesson from the Czech health reform proposal*
Tomas Machacek, Chairman of the Board, HealthReform.cz and CEO, Klient PRO Ltd, Prague

19.30 Conference Dinner

27 November 2009

9.00–11.00 Session 3: Rationalizing long-term care in ECE countries

- *Long-term care in Poland – current status and future perspectives*
Dr. Anna Skalska, Department of Internal Medicine and Gerontology, Jagiellonian University Medical College, Krakow / Dr Katarzyna Szczerbinska, Health Promotion Department, Institute of Public Health, Jagiellonian University Medical College, Krakow
- *Long-term care workforce in Eastern and Central European countries*
Francesca Colombo, OECD, Paris
- *Insurance/assistance company as long-term care providers in Poland*
Philippe Rambaud/Marta Kalenska-Jaskiewicz, AXA Assistance, Paris/Warsaw

11.00–11.30 Coffee Break

11.30–13.30 Session 4: Insuring and funding health and LTC risks

- *Development of the LTC insurance system in Slovenia*
Davor Dominkus, Labour, Family and Social Affairs Ministry, Ljubljana
- *Underwriting, developing and pricing long-term care insurance products*
Dr. Chris Ball, Consultant Medical Officer, Gen Re LifeHealth, London
Tim Eppert, Product Specialist LTC, Gen Re LifeHealth, Cologne
- *On reverse mortgage as a way to cover long-term care risks*
Colin Murray, Watson Wyatt, Dublin

13.30 Farewell lunch buffet

VIII. NEW BOOK ON THE ECONOMICS OF NEW HEALTH TECHNOLOGY

The Economics of New Health Technology – Incentives, Organisation, and Financing

Edited by Joan Costa-Font, Christophe Courbage and Alistair McGuire, 2009, Oxford University Press, ISBN: 0199550689.

Technological change in healthcare has led to huge improvements in health services and the health status of populations. Although offering remarkable benefits, these changes often entail significant financial, physical and social risks. This book analyses the impact of advances in medical technology from an economic perspective and addresses the following important objectives: to provide a detailed analysis of what technological change is; to identify drivers of innovation in several health care areas; to present existing mechanisms and processes for ensuring and valuing efficiency and development in the use of medical technologies; and to analyse the impact of advances in medical technology on health, health care expenditure, and health insurance. Each of the 17 chapters summarises an important issue concerning the innovation debate and contributes to a better understanding of the role innovation has, both at the macro level and at the delivery (meso) and micro level in the health care sector.

Part I. Introduction

1: What do we know about the role of health care technology in driving healthcare expenditure growth?, *by Alistair McGuire and Victoria Serra*

Part II. Innovation, diffusion and technology change

2: The process of innovation: incentives, behaviour and organisation, *by Davide Consoli, Andrew McMeekin, J. Stan Metcalfe, Andrea Mina and Ronnie Ramlogan*

3: Technology - scientific force or power force, *by Nick Bosanquet*

4: Diffusion of health technologies: evidence from the pharmaceutical sector, *by Victoria Serra-Sastre and Alistair McGuire*

Part III. Technological change and health insurance

5: Insurance and new health technology, *by Mark Pauly and Adam Isen*

6: Technological change and health insurance, *by Peter Zweifel*

7: Health insurance and the uptake of new drugs in the United States, *by Marin Gemmill, Victoria Serra and Joan Costa-Font*

8: Genetic advances and health insurance, *by Lilia Filipova and Michael Hoy*

Part IV. Innovation, social demand and valuation

9: Ageing and pharmaceutical innovation, *by Roland Eisen and Yasemin Ilgin*

10: New approaches to healthcare innovation: information for chronic patients, *by Manuel García-Goñi and Paul Windrum*

11: The convergence of nano-, bio- and information technologies in healthcare, *by Nicola Pangher*

12: Treatment uncertainty and irreversibility in medical care: implications for cost-effectiveness analysis, *by Joshua Graff Zivin, Matthew Neidell, and Lauri Feldman*

13: The limits and challenges to the economic evaluation of health technologies, *by Adam Oliver and Corinna Sorenson*

Part V. Incentives, mechanisms and processes

14: Intellectual property rights and pharmaceuticals development, *by Joan Rovira*

15: Home, or nursing home? The effect of medical innovation on the demand for long-term care, *by Frank R. Lichtenberg*

16: Demand for health information on the internet, *by Joan Costa-Font, Caroline Rudisill and Elias Mossialos*

17: Institutional pathways for integrating genetic testing into mainstream healthcare, *by Hristina Petkova*

For further information, please visit The Geneva Association website on

http://www.genevaassociation.org/Research_Programme/Health_and_Ageing.aspx

or go to ukcatalogue.oup.com/product/9780199550685.do.

IX. SPECIAL ISSUE ON HEALTH OF THE GENEVA PAPERS



CALL FOR PAPERS

The Geneva Association Health and Ageing Research Programme
is pleased to announce a

Special issue on Health in:

***The Geneva Papers on Risk and Insurance –
Issues and Practice***

October 2010

We encourage you to submit contributions related to the following areas:

- ◆ The impact of integrating an ageing population in health insurance systems;
- ◆ New health technology and insurance;
- ◆ Development of health care systems and the capitalization debate;
- ◆ The interaction of public and private systems in health care provision;
- ◆ Insuring and managing long-term care risks;
- ◆ Health issues for an ageing population in the workplace;
- ◆ Climate change and its impact on health and insurance.

Suggestions for other topics will be considered by the editor.

All contributions will go through a refereeing process. Papers should be submitted electronically (Word or Adobe format only) by **1 February 2010** at the latest to Christophe Courbage (christophe_courbage@genevaassociation.org).

For further information on *The Geneva Papers*, visit www.palgrave-journals.com/gpp/.

X. PUBLICATIONS ON HEALTH ISSUES

Financing health care in the European Union Challenges and policy responses, by Sarah Thomson, Thomas Foubister and Elias Mossialos, WHO Press on behalf of the European Observatory of Health Systems and Policy, 2009. Focusing on the three health care financing functions—collection, pooling and purchasing—as well as on coverage, this book analyses the organisation of health care financing in the Member States of the European Union, discusses the principal financing reform trends of recent years, and assesses their capacity to help ensure fiscal sustainability. Available on line at: www.euro.who.int/document/E92469.pdf.

Managing Long-term Conditions and Chronic Illness in Primary Care—A Guide to Good Practice, by Judith Carrier, Routledge, 2009. This book draws together the key issues in managing long-term conditions and provides a practical and accessible guide for nurses and allied health professionals in the primary care environment. It covers background context and policy in the U.K. and further afield, as well as practical guidance for all key aspects of long-term condition management.

The globalization of Managerial Innovation in Health Care, edited by J.R. Kimberly, G. de Pourville, T. D'Aunno, Cambridge University Press, 2008. This book examines patient classification systems in 15 countries throughout the world. The result is a collection of case studies of how change can be introduced effectively into national health systems as well as a careful synthesis of what can be learned from these studies.

Caring for People with Chronic Conditions: A Health System Perspective, edited by E. Nolte and M. Mckee, Open University Press for the European Observatory on Health Systems and Policies, 2008. The book systematically examines some of the key issues involved in the care of those with chronic diseases. It synthesises the evidence on what we know works (or does not) in different circumstances. From an international perspective, it addresses the prerequisites for effective policies and management of chronic disease. Available online at: www.euro.who.int/Document/E91878.pdf.

Predictive Diagnostics and Personalized Treatment: Dream or Reality, edited by Olga Golubnitschaja, Nova Publishers, 2009. Predictive, preventive and personalised medicine offer great promise for the future practice of medicine. Essential components of this approach include well-organised population screening protocols utilising novel diagnostic biomarkers of disease states, targeted prevention of common human pathologies, optimal treatment planning and personalised medicine thereby resulting in substantial improvement in the quality of life. Should molecular diagnostic approaches be considered complementary or substitutive measures to conventional approaches? How reliable are biomarkers for any given pathology? How to distinguish between the highly predictive power of innovation and quackery in diagnostics? How to correctly educate the new generation of experts in bio- and predictive medicine? The book addresses these highly relevant issues and provides some clues for plausible solutions.

Investing in hospitals of the future, edited by Bernd Rechel, Stephen Wright, Nigel Edwards, Barrie Dowdeswell, WHO Press on behalf of the European Observatory of Health Systems and Policy, 2009. This book brings together current knowledge about key dimensions of capital investment in the health sector. A number of issues are examined, including new models of long-term care, capacity planning, the impact of capital investment on the health care workforce, markets and competition, systems used for procurement and financing, the whole life cycle of health facilities, facility management, the wider impact of capital investment on the local community and economy, how care models can be translated into capital asset solutions, and issues of therapeutic and sustainable design. Available on line at: www.euro.who.int/Document/E92354.pdf.

The long-term care workforce, by Francesca Columbo, OECD Health Working Papers N° 44, 2009. This work discusses demographic trends and societal and labour market changes, and presents available data on LTC workers collected by OECD. It also explains how OECD countries respond in different ways: some rely increasingly on foreign-born care workers, some set up mechanisms to improve recruitment and retention, whereas others choose to reduce the demand for LTC workers. Available at [www.ois.oecd.org/olis/2009doc.nsf/LinkTo/NT00000F0A/\\$FILE/JT03261422.PDF](http://www.ois.oecd.org/olis/2009doc.nsf/LinkTo/NT00000F0A/$FILE/JT03261422.PDF).

XI. GENEVA ASSOCIATION PUBLICATIONS

The Geneva Papers on Risk and Insurance – Issues and Practice

Volume 34 - No. 4 – October 2009

- Editorial - The Four Pillars, the Financial Crisis and Demographic Challenges and Opportunities, *by Orio Giarini*
- Editorial, *by Geneviève Reday-Mulvey*

THE FUTURE OF PENSIONS AND RETIREMENT INCOME

- Two Decades of Pension Reform: What Has Been Achieved and What Remains to be Done, *by Edward Whitehouse, Anna D'Addio, Rafal Chomik and Andrew Reilly*
- Pensions during the Crisis: Impact on Retirement-income Systems and Policy Responses, *by Edward Whitehouse*
- 15 Years of Pension Reform in Germany: Old Successes and New Threats, *by Holger Bonin*
- Switzerland: High Replacement Rates and Generous Subsistence as a Barrier to Work in Old Age, *by Monika Bütler*
- Retirement, Pensions and Work in Sweden, *by Gabriella Sjögren Lindquist and Eskil Wadensjö*
- How to Strengthen the Credibility of Italian Pension Reform, *by Elsa Fornero and Flavia Coda Moscarola*
- Re-reform of Latin American Private Pensions Systems: Argentinean and Chilean Models and Lessons, *by Carmelo Mesa-Lago*
- Trends in the Retirement System of the United States, *by Lucy apRoberts*

TECHNICAL ISSUES OF PENSION PROVISION

- On Fifty Million Floating Pension Records in Japan, *by Noriyuki Takayama*
- Impact on Growth and Inter-Generational Redistributive Effects in Pension Reforms in France, *by Florence Legros and Frédéric Gonand*
- The Impact of Longevity Risk on the Optimal Contribution Rate and Asset Allocation for Defined Contribution Pension Plans (UK), *by Yang Sharon*

Vol. 34 – No. 3 – July 2009

SPECIAL ISSUE ON CLIMATE CHANGE AND INSURANCE

- Editorial - A Pro-Active Insurance Approach to Climate Change, *by Walter Stahel*
- A Global Review of Insurance Industry Responses to Climate Change, *by Evan Mills*
- Adaptation to Climate Change: Threats and Opportunities for the Insurance Industry, *by Celine Herweijer, Nicola Ranger and Robert E.T. Ward*
- Insurance, Developing Countries and Climate Change, *by Joanne Linnerooth-Bayer, Koko Warner, Christoph Bals, Peter Höppe, Ian Burton, Thomas Loster and Armin Haas*
- Weather Index Insurance and Climate Change: Opportunities and Challenges in Lower Income Countries, *by Benjamin Collier*
- Measuring Non-Catastrophic Weather Risks for Businesses, *by Juliusz Pres*

OTHER ARTICLES

- WTO and the Chinese Insurance Industry, *by J. Tyler Leverty*
- Foreign Participation in Life Insurance Markets - Evidence from OECD Countries, *by Dezhu Ye, Zhian Chen, Donghui Li, Fariborz Moshirian and Timothy Wee*
- Determinants of Efficiency and Productivity in German Property-Liability Insurance: Evidence for 1995-2006, *by Michael Luhn*

The Geneva Risk and Insurance Review

Vol. 34 – No. 1 – June 2009

- Empirical Evidence for Advantageous Selection in the Commercial Fire Insurance Market, *by Kili C. Wang, Rachel J. Huang and Larry Y. Tzeng*
- Reinsurance Brokers and Advice Quality: Is There a Need for Regulation?, *by Sebastian Friese, Michael Sonnenholzner and J.-Matthias Graf v. d. Schulenburg*
- Bargaining Power and Efficiency in Insurance Contracts, *by John Quiggin and Robert G. Chambers*
- The Role of Repetition and Observability in Deterring Insurance Fraud, *by Michal Krawczyk*

Recent Working Papers Series “Etudes et Dossiers”**No. 352 / August 2009**

The 25th PROGRES International Seminar

Towards Efficient Regulatory Regimes: Balancing Regulations and Market Forces

Montreux, Switzerland, 6-7 April 2009

No. 351 / March 2009

The AXA MPS Annual Forum 2008

Rome, 10 October 2008

&

11th Meeting of The Geneva Association’s Amsterdam Circle of Chief Economists

Amsterdam, 5-6 February 2009

&

Special Geneva Association Documents on the Credit Crisis

No. 350 / February 2009

5th Insurance and Finance Seminar of The Geneva Association

London, 8-9 December 2008

No. 349 / January 2009

Istanbul International Insurance Conference

Challenges & Opportunities: Insurance Sector in Emerging Countries and Turkey’s Potential

Istanbul, 7 October 2008

&

5th International Liability Regimes Conference

The Influence of Insurance on Liability Regimes & Public Policy

Zurich, 6-7 November 2008

No. 348 / November 2008

5th Geneva Association Health & Ageing Conference

Long-Term Care – Risk Profiles, Determinants and Financing

London 6-7 November 2008

***The insurance industry and climate change –
Contribution to the global debate***

Geneva Report No. 2, The Geneva Association, July 2009

Climate change brings new risks but also new opportunities for the insurance sector. The insurance industry is forward-looking by nature, and has a long-term comprehensive approach shared by few other economic actors.

In the context of insurance and climate change, two main issues are addressed in this report:

- Climate change is happening and calls for mitigation and adaptation measures. These differ between industrial countries and developing countries. From an insurance perspective, specific weather-related hazards will need to be identified, quantified and prioritized on a local level.
- A low-carbon economy is the agreed societal vision, and a transition to a more sustainable economy is inevitable for industrial countries to reach a low-carbon future. The transition to these low-carbon approaches will change the economic structure of industrial countries, hence the risks and opportunities for the insurance industry as well as its relationship with the economic actors involved.

The report shows that climate change is about more than just extreme weather events. It analyses what insurance companies are already doing, what they could do in the future and where they need the cooperation of governments and other partners to succeed. The report can be downloaded for free at [http://www.genevaassociation.org/PDF/Geneva_Reports/Geneva_report\[2\].pdf](http://www.genevaassociation.org/PDF/Geneva_Reports/Geneva_report[2].pdf).

Visit our website section on climate change: www.genevaassociation.org/Home/Climate_Change.aspx.

XII. CONFERENCES ORGANISED AND/OR SPONSORED BY THE GENEVA ASSOCIATION

2009

October

- | | | |
|-------|--------|---|
| 16 | Rome | AXA/MPS Vita Forum , organised by AXA/MPS and The Geneva Association |
| 19-20 | Bogotá | The M.O.R.E. 23 Seminar on Climate Change and its Economic Impact on Insurance , hosted by Suramericana de Seguros |
| 26-27 | Zurich | 6th Liability Regimes Conference , hosted by Swiss Re |

November

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| 11-12 | Rüschlikon | 5th CRO Assembly , jointly organised with Swiss Re |
| 26-27 | Warsaw | 6th Health & Ageing Conference – Development of Health and Long-term Care Insurance in Central and Eastern European Countries , jointly organized with PZU |

December

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| 14-15 | London | 6th International Insurance and Finance Seminar of The Geneva Association |
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2010

January

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| 13 | New York | Joint Industry Forum for P&C Insurance Industry , co-sponsored by The Geneva Association |
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February

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| <i>tba</i> | Amsterdam | 12th Meeting of the Amsterdam Circle of Chief Economists , hosted by ING (<i>ACCE members only</i>) |
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March

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| 22-23 | Singapore | 10th Asia CEO Insurance Summit co-organised by Asia Insurance Review and The Geneva Association |
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April

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| 15-16 | Montreux | 26th PROGRES Seminar on Insurance Regulation and Supervision |
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June

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| 2-5 | Zurich | 37th General Assembly of The Geneva Association (<i>members only</i>) |
| 6-9 | Madrid | The Geneva Association/IIS Research Award Partnership |

July

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| 25-29 | Singapore | World Risk and Insurance Economics Congress (WRIEC) |
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