



Health and Long-Term Care (LTC) Insurance in Eastern and Central European Countries —A summary

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On 26th and 27th November the 6th Geneva Association Health and Ageing Conference took place in Warsaw, Poland. It was hosted by PZU, a privatised health insurance company in Warsaw. The title was “Health and Long-Term Care Insurance in Eastern and Central European Countries”.

The “double greying” of almost all countries puts existing public systems for health and long-term care (LTC) under increasing pressure. However, there are different ways out of this dilemma. One may be that the problem may not become so serious at all because—despite growing older, we and the upcoming generations will be healthier in old ages than our parents or grandparents; in the scientific discussion this is connected with the compression hypothesis. Another way out is to have more money in old age to spend for the needed services via income growth, via insurance or via reversed mortgages. However, it is a long-standing fact that—despite of the awareness in the public—LTC insurance is seldom bought although several countries pay subsidies or give special tax treatment.

The organisers have bounded the programme together under for headings: Health and LTC Systems in ECE countries; National Perspectives of Financing Health and LTC in ECE countries; Rationalising LTC in ECE countries; and Insuring and Funding Health and LTC Risks.

Health and LTC systems in ECE countries

After a warm welcome by A. Kleszyk, President and CEO of PZU, and C. Courbage, Research Director with The Geneva Association, the first session started with a presentation by J. Koettl, an economist at the Human Development Department of the World Bank’s Europe and Central Asia Unit. He talked about “Challenges of Financing and Provisioning of LTC in Eastern Europe”. He presented interesting figures, in particular for Poland, about the ageing of societies, stressing that this development will be in pronounced wave: starting in 2011 for the 65 to 74 years old and again in the end of the 2030s or for the 75+ starting in 2021 and again in the late 2040s. Combining this with the clearly age-dependent dependency ratio (e.g. 39.9 or 45.0 for the 85+ in 2006 or 2007 in Poland), he showed that the demographic waves will lead to wave-like and sudden increases in the number of dependent people while the number of non-hampered people will constantly decrease. He then asked: Who will care and who will pay for the care? Even taken the moderate figures of LTC spending in ECE countries, he argued for a sharp increase in spending during the “shock” years (i. e. during the 2020s and the late 2040s). Mentioning the problems of private and social LTC insurance, he pleaded for an increase in private savings for retirement and dependency now, pointing to two practical solutions: enhanced annuities (i.e. life insurance payments increase in case of dependency) and reversed mortgages, a theme taken up by the last speaker of the conference, C. Murray from the Institute of Actuaries.

The second presentation, by P. Mihalyi, Head of the Department of Finance of the University of Pannonia (Veszprin), Hungary, was about “The Financial Implications of Ageing in Post-Communist Health Care Systems” or the transition problems of the post-communist countries: from a basically free health care system to an insurance-based fee-for-service model! Here two models rival: gradualism versus shock therapy in handling also health (and LTC) financing. However, in many countries the old

Shemashko system still works, other countries turned to a Bismarckian system, only Slovakia switched to a “real” health insurance scheme based on competition and full coverage. Hungary, where the referent was the chairman of the Health Care Working Group within the State Reform Committee, tried to copy this model but failed.

T. Hermanovsky, Head of the Department of Pharmaeconomics of Warsaw Medical University, was the third presenter of this first session speaking about “Financing Systems’ Effect on Quality, Equity and Utilisation of Health Care”. He started by pointing out the overuse of resources and the low quality of health care in EEC countries, with an extraordinarily large hospital sector. Therefore, access to innovative methods was not existing or lagging behind the EU. The Shemashko system was focused on output quantities and proved relatively efficient up to the late 1960s. The hierarchical structure proved unable to adequately cope with more complex diseases, such as cancer, diabetes and cardiovascular diseases. In his second part, T. Hermanowski criticised the present drug reimbursement system in Poland, in particular the high co-payment rate of patients. This system also discriminates innovations, promotes generics instead of cost-effective drugs and focuses on cost-containment while disregarding outcomes and case-mix. Hence, he pleaded for a change in the reimbursement system: there is a need for deductibles to reduce moral hazard but there must be a cap according to income and health status. The now provider-dominated financing model seems to lack a countervailing power, representing patients, taxpayers, health insurers. However, the political system seems to be unable to change the status quo, defended by strong vested interests! Nevertheless, T. Hermanowski presented in his third part the research programme “InterQuality” financed under EU FP 7, to investigate the effects of different financing models on quality, effectiveness and equity of access to outpatient care, hospital care and pharmaceuticals, to implement some Disease Management Programme and innovative pay-for-performance (P4P) financing models. It is expected that the results of the research programme will have a major impact on organising the health care system in order to achieve better health with available resources.

National perspectives of financing health and LTC in ECE countries

The second session, entitled “National Perspectives of Financing Health and LTC in EEC Countries”, started with a presentation by P. Kalbarczyk, Director of Health Insurance Department of PZU Life, and P. Kuszewski, Vice-President of PZU Life, on “Polish Health Care System in Transition—Insurance Perspective”. They emphasised that the Polish health care system is still in transition: from the Shemashko system up to 1989 to a Bismarckian system with sickness funds back to a “State monopoly financing system” with private delivery. Despite this, there exist some private health insurance companies—and there is an announcement that in 2012 private third party payers’ competition will be implemented. In summary, after 10 years of transformation the progress is modest! Furthermore, they mentioned also different models to develop the health care system; the central idea being a basic public health care system with complementary services by private health insurers, similar to the Dutch system, however, mixed up with some Polish and some still “open” parts.

As could be expected, a lively discussion followed the presentation pointing to some problems with respect to competition between providers and between the insurance companies and the State, to risk adjustment (when there are no reliable data) and to the definition of the “basic” public system.

The presentation of P. Pazitny, Partner and Managing Director of Health Policy Institute, Bratislava, was about “Economic Impacts of Ageing and LTC—Evidence from Slovakia”. He started with two interesting graphs showing first the relationship between GDP (measured in US\$ in PPP) and life expectancy and second between GDP and total health expenditures as percentage of GDP. Both figures show almost parallel developments for OECD and the four Visegrad States, but there is a lag of 15 years. However, the problem is the structure of expenditures: pharma expenditures are much higher, in-patient are lower and out-patient expenditures lag behind in the four Visegrad States than economic performance measured by OECD averages. P. Pazitny then analysed the driving forces: expectations, age structure (showing a lag of 11 years) and fertility rates, technology and ability to spend. This last point led him to show some modelling of health expenditures, either following the EU 10 or with more weight on home care. The starting point was today’s expenditures: 32 per cent by the State via taxes, 14 per cent by private expenditures and 54 per cent paid by health insurance. Taking this structure, he developed four scenarios: growth or fall in GDP, lower or higher expenditures; and four strategies: increasing insurance premium, keeping health insurance neutrality; increasing payments of State, or increasing private

expenditures. He concluded with a matrix showing the results of the four scenarios on business environment, on fiscal position and—last but not least—on policy implementation!

T. Machacek, Chairman of the Board of HealthReform.cz and CEO of KlientPRO Ltd, Prague, discussed “LTC Financing and Solidarity: Lessons from the Czech Health Reform Proposal”. In the beginning he stressed four key messages: (1) the age wave is also coming soon to the CR; (2) it will lead (along with other things) to huge changes in health and social service structure; (3) this challenge will require a radical reshaping of public funding of health and social services; and (4) the proposal of HealthReform.cz is a public sponsored Health Savings Account (HSA) system. In the following he supported this with some statistical facts about the public share in financing, the “age wave”, age/sex profiles in health and LTC spending. He then argued for the “reshaping of public resources” via a “public sponsored Health Savings Account (HSA)” system, where the deductible should reflect probabilities and cost distribution (frequent but cheap versus seldom but expensive), stressing that there is a difference between cost sharing if one looks not at one-year balances but at five-year balances, using the time-smoothing effect. The model then was presented in two steps: the first step showed a detailed co-payment structure which is nevertheless easy to handle, resulting—as before—in a one-third co-payment ratio. The second step consisted of a risk-adjusted public contribution, where age, sex and health status are used. Behind there is a “debt management department”, if the HSA do not balance. Taking a range of +/- 6000 CZK the HSA balance for 91.1 per cent of the population (for a one-year balance or 95.19 per cent for a five-year balance), and there are 6.86 per cent (or only 3.28 per cent) losers and 2.04 per cent (or 1.53 per cent) winners. Taking into account some (reasonable) effectiveness gains, the losers are only 2.88 per cent and the winners are 1.69 per cent of the population.

Rationalising LTC in ECE countries

The second day was devoted to two sessions, one about “Rationalising LTC in ECE Countries”, the other about “Insuring and Funding Health and LTC Risks”. The first session started with a presentation by A. Skalska, Department of Internal Medicine and Gerontology, and K. Szczerbinska, Health Promotion Department, Institute of Public Health, both of Jagiellonian University Medical College, Krakow, on “Long-term Care in Poland—Current Status and Future Perspectives”. The authors are physicians, therefore, their special stress was on disability rates and on types of services and trends in use of LTC. It is interesting to note at the beginning that the age distribution shows marked regional differences, also the increase in number of older people is more pronounced with men (+ 150 per cent between 2002 and 2030) than with women (+ 99 per cent); 49 per cent of the disabled are over 60, 25 per cent between 50 and 59, and 50.6 per cent are 80+, showing that disability is very much related to very old age. LTC services are provided by the NHF, by welfare, by commercial and other entities, and by informal caregivers, in particular the family. In the second part, the authors presented very interesting statistics about institutional and informal care. At the end they reported of a rising demand for home care because of shortening length of stay in different institutions and family co-payments, and highlighted nine queries concerning LTC, inter alia low support for family caregivers.

F. Colombo, Senior Health Care Policy Assistant with the OECD, Paris, reported on “LTC Workforce in EE and OECD Countries”, pointing to great problems of the current model with low status, low pay, low productivity, high turnover and high migration despite high physical and mental stress. After giving some hints on the demand side for LTC, i.e. demographics and life expectancy, share of 65+ and share of disabled with more than two ADL¹ limitations, and stressing that there is not much hope in the compression hypothesis, she turned to the supply side. Caring is done mostly informal by the family and here overwhelmingly by females (about 65 per cent), providing especially iADL support. One of the consequences is a lower labour market participation of informal caregivers (mainly aged 50-64). She then discussed the possible shortage of LTC workers because of demographics, and then possible policy strategies: rely 1) on migration from EEC to Germany, Austria, Italy and Greece? 2) on better domestic recruitment strategies? 3) on using the workforce more efficiently by redefining skill mix? 4) on encouraging coordination between formal and informal care systems via financial or non-financial benefits? The discussion focused on the low image and low payment, compared e. g. to acute care.

¹ ADL = Activities of daily living, and iADL = instrumental activities of daily living, such as continence, dressing, eating, washing, mobility and transferring.

M. Kalenska-Jaskiewicz, CEO of Inter Partner Assistance Poland, Warsaw, discussed “Services and Consulting Engineering: Dependency and Bodily Injury Cases”, in particular the assistance model of AXA, which goes beyond the pure financial compensation after an accident with bodily injury. She developed the case management structure, from medical assessment to Assistance/Care to medical, social and vocational rehabilitation using professional coaching centres with interesting cost savings.

Insuring and funding health and LTC risks

The last session comprised also three presentations. The first by D. Dominkus, Ministry of Labour, Family and Social Affairs, Ljubljana, was about “Reform of LTC System in Slovenia”. He gave an overview over the current situation: there are services within the social (care) system, within the health care system, and different cash benefits for some groups but not for all in need. The financing is via taxes (6.8 per cent) or via (compulsory) health (47 per cent) and pension insurance (29 per cent) or via private LTC insurance. After pointing to some problems of the existing system, in particular inadequate financing, lack of coordination and underdevelopment of home (local) environment, he presented the National Report on Strategies for Social Protection and Social Inclusion for 2008—2010 with the aims of introducing a new compulsory LTC insurance and an additional private LTC insurance to cover higher standards and “hotel costs of institutional care”! There will be contributions by employers/employees, and part will be covered by taxes. There will be cash and in-kind benefits, help to adjust housing and technical assistance (up to a certain amount); and there will be an entrance threshold (need of assistance in ADL and iADL for more than three months and more than three hours per week). The differences in costs between today’s and the new system will be covered by taxes; and people have two years to decide whether they want to stay with the old system or enter the new one.

The last two presentations were about more general themes, in particular how to increase access to LTC insurance. T. Eppert, Product Specialist LTC, and Chr. Ball, Consultant Medical Officer, GenRe LifeHealth, Cologne and London respectively, talked about “Developing and Pricing LTC Products”, starting with the need about LTC insurance and the “benefit trigger” based on ADLs, however noting that ADLs do not cover all persons in need! T. Eppert then presented very different product features, ranging from individual to joint lives or group insurance, additional or accelerated benefits, cash payments or reimbursement, annuity or lump-sum, with a strict trigger or stepwise benefits. For the model one has to take into account the incidence rates which are exponential with age, the different mortality rates by gender, and whether there is already a disability. Furthermore, small unexpected increases in expenditures lead to dramatic increases of the risk premium. In the second part, C. Ball talked about the complex concept of frailty and its differences to traditional life underwriting.

C. Murray, Consulting Actuary, Watson Wyatt, Dublin, gave an interesting tour over “Using Reverse Mortgages to Cover LTC Risks”. Firstly, he defined reverse mortgage (RM) as a payment to an individual in exchange for a charge on her property while she can stay in the house, and interest rolls up on the property which is sold on death or entry to LTC institution where the value of the mortgage cannot (never?) be greater than the value of the property. The benefit to plan-holders who are “asset rich” but “income poor” is that the RM provides additional income. However, the pitfalls are a low mortgage compared to the value of property, compound interest so that mortgage can consume whole property, fixed interest is (now) high while variable rates lead to further uncertainty. For the provider there is the advantage of diversification of mortgage risk, but also the risk of house prices and longevity risk. It is interesting to see that many such RM are sold in the Irish/U.K. and Australian market, nevertheless sales did not reach full potential and recently are going back due to different reasons, not least the scandals of the 80s/90s in the U.K. The great advantage for LTC is that care can be tailored to needs, and society can gain because investing in RM is—according to Murray—a hedge against longevity. Finally he pointed to the Nursing Home Support Scheme of Ireland introduced in 2009 with its pros and cons, where the State and private providers can compete.

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