Ageing and Long Term Care – A Perspective from Singapore

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Overview

• Introduction
• Population Ageing in East Asia and Singapore
• Population Ageing and Impact on Health
• Health and Long Term Care Financing in East Asia and Singapore
• Policy Implications for East Asia
• Conclusion
Comparative Ageing in Asia
1995 and 2025

Graph showing the percentage of the population aged 65 and over, and the percentage of the population aged 85 and over, for different regions of Asia.

- South Asia
- Southeast Asia
- East Asia
- Asia

Graph showing the percentage of the population aged 85 and over, with 2025 data in yellow and 1995 data in black.

Graph showing the percentage of the population aged 65 and over, with 2025 data in yellow and 1995 data in black.
Improving Life Expectancies in South East Asia

South-East Asia

Life expectancy (years)

- Brunei
- Indonesia
- Lao PDR
- Malaysia
- Myanmar
- Philippines
- Singapore
- Thailand
- Vietnam

Population Ageing Issues and Impact on Health

Complex Inter-relationships
- Socio-economic Development
- Population Dynamics
- Health Status

Rate of Population Ageing
Rate of Health Care Costs
Population Ageing: Impact on Health Expenditure

- Health expenditure will increase with growing proportion of the aged
- Health expenditure will increase with longer survival of the aged population
- Health expenditure will increase with widening periods of morbidity and disability before death
Ageing and Health Expenditure

Health Expenditure as % of GDP

Aged Dependency Ratio (>65/Aged 15-64)
## Comparative Health Expenditure and Ageing in Asia

<table>
<thead>
<tr>
<th>Country</th>
<th>$/capita</th>
<th>(Int $)</th>
<th>Public/Total</th>
<th>%GNP</th>
<th>%Pop&gt;60</th>
<th>DALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>2373</td>
<td>(1759)</td>
<td>80.2</td>
<td>7.1</td>
<td>22.6</td>
<td>74.5</td>
</tr>
<tr>
<td>Singapore</td>
<td>843</td>
<td>(750)</td>
<td>35.8</td>
<td>3.1</td>
<td>10.3</td>
<td>69.3</td>
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<tr>
<td>Korea</td>
<td>700</td>
<td>(862)</td>
<td>37.8</td>
<td>6.7</td>
<td>10.2</td>
<td>65.0</td>
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<tr>
<td>China</td>
<td>20</td>
<td>(74)</td>
<td>24.9</td>
<td>2.7</td>
<td>10.0</td>
<td>62.3</td>
</tr>
<tr>
<td>Brunei</td>
<td>-</td>
<td>(857)</td>
<td>40.6</td>
<td>5.4</td>
<td>5.0</td>
<td>64.4</td>
</tr>
<tr>
<td>Malaysia</td>
<td>110</td>
<td>(202)</td>
<td>57.6</td>
<td>2.4</td>
<td>6.5</td>
<td>61.4</td>
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<tr>
<td>Thailand</td>
<td>133</td>
<td>(327)</td>
<td>33.0</td>
<td>5.7</td>
<td>8.5</td>
<td>60.2</td>
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<tr>
<td>Philippines</td>
<td>40</td>
<td>(100)</td>
<td>48.5</td>
<td>3.4</td>
<td>5.6</td>
<td>58.9</td>
</tr>
<tr>
<td>Indonesia</td>
<td>18</td>
<td>(56)</td>
<td>36.8</td>
<td>1.7</td>
<td>7.3</td>
<td>59.7</td>
</tr>
<tr>
<td>Vietnam</td>
<td>17</td>
<td>(65)</td>
<td>20.0</td>
<td>4.8</td>
<td>7.5</td>
<td>58.2</td>
</tr>
<tr>
<td>Myanmar</td>
<td>100</td>
<td>(78)</td>
<td>12.6</td>
<td>2.6</td>
<td>7.4</td>
<td>51.6</td>
</tr>
<tr>
<td>Cambodia</td>
<td>21</td>
<td>(73)</td>
<td>9.4</td>
<td>7.2</td>
<td>4.8</td>
<td>45.7</td>
</tr>
<tr>
<td>Laos</td>
<td>13</td>
<td>(53)</td>
<td>62.7</td>
<td>3.6</td>
<td>5.2</td>
<td>46.1</td>
</tr>
</tbody>
</table>

But general health indicators reflect socio-economic and living conditions and not just health expenditure!
Health Care Financing Reforms in East Asia

• JAPAN
  Universal health insurance (1922/1939)

• KOREA
  Universal health insurance (1976/1989)
  Health Care Reform Committee (1994/1997)
  Long term care insurance (2008)

• SINGAPORE
  National Health Plan (1983)
Singapore Health Statistics  
- Past and Present

<table>
<thead>
<tr>
<th></th>
<th>1980</th>
<th>2005</th>
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</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td>70 years</td>
<td>80 years</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>12/`000</td>
<td>2/`000</td>
</tr>
<tr>
<td>Aged/total population</td>
<td>5 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Public hospital mix</td>
<td>85 %</td>
<td>80 %</td>
</tr>
<tr>
<td>Health expenditure/GDP</td>
<td>3 %</td>
<td>4 %</td>
</tr>
<tr>
<td>Health expenditure/</td>
<td>6 %</td>
<td>7 %</td>
</tr>
<tr>
<td>government budget</td>
<td></td>
<td></td>
</tr>
<tr>
<td>User fees recovered /</td>
<td>3 %</td>
<td>60%</td>
</tr>
<tr>
<td>public expenditure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Singapore’s health expenditure projected to increase between 6-8% of GDP by 2030.

Healthcare Cost-Sharing Strategies in Singapore

- Instill personal and family responsibility
- Ensure future sustainability with ageing (Savings)
- Enhance risk-pooling and social protection (Insurance)
- Target subsidy and equitable distribution (Taxation)
Health Care Financing in Singapore

Financing Method
- Taxes
- Private Payment
- Compulsory Savings
- Social/Private Insurance

PUBLIC HEALTH SERVICES

- PRIMARY CARE
- ACUTE CARE
- CATASTROPHIC (LONG TERM CARE)

PUBLIC SUBSIDIES

Medisave
Medishiel (Eldershield)
Medifund (Eldercare fund)

Source: Dr. Phua Kai Hong
The Unfinished Agenda - Health Care Financing Reforms

1983  Blue Paper - National Health Plan
1984  Medisave
1990  Medishield
1993  Medifund
1993  White Paper - Affordable Health Care
2000  Eldercare Fund
2002  Eldershield
2005  Enhanced Medishield/Private Insurance
      Enhanced Eldershield/Private Insurance
Health and Long Term Care Financing in Singapore

FINANCING METHOD
• Personal savings
• Compulsory savings
• Catastrophic insurance
• Disability insurance
• Endowment
• Taxation

3-M SYSTEM + 2E
• MEDISAVE (1984)
• MEDISHIELD (1990)
• + ELDERSHIELD (2002)
• MEDIFUND (1992)
• + ELDERCARE FUND (2000)
Similar Approaches to Old Age Security and Health Care Financing

World Bank`s 3 Pillars for Old Age Security
- Redistribution
- Savings
- Insurance

Singapore`s 3M for Health Care Financing
- Savings (avoids inter-generational transfers)
- Insurance (pools risks for catastrophic care)
- Taxation (subsidizes the poor and indigent)
Past Financing System for Long Term Care

Community care / long term care
- Direct payment by individuals and families
- Community assistance
  - Voluntary Welfare Organizations` fund-raising
    (Up to 50% or more of recurrent expenditure)
- Government funding
  - Grants-in-aid or subventions
    - Capital funding (up to 90%)
    - Recurrent funding (up to 50% of cost norms; 75% for public assistance cases)
Inter-Ministerial Committee on Health Care for the Elderly 1998

- VWOs to include middle-income clientele, charge higher fees and raise quality of care
- Government funding for 90% of capital costs does not differentiate types of residential care
- Government funding for recurrent costs does not differentiate the case-mix and affordability
- Difficulties in administering means test
- Subventions for home medical care/nursing services not yet available
- Lack of incentives for private sector participation
Inter-Ministerial Committee on the Ageing Population 1999

• Social Integration of the Elderly
• Health Care
• Financial Security
• Employment and Employability
• Housing and Land Use
• Cohesion & Conflict in an Ageing Society
IMC on the Ageing Population - Sub-Committee for Resource Funding

Roles of the Public, Private and People Sectors in providing and financing healthcare for the elderly

- Impact of IMC on Health Care for the Elderly recommendations on Government’s expenditure
- Financial capabilities of VWOs
- New approaches/options for cost-effective and sustainable provision of health care for the elderly
  - structural strengthening of the voluntary sector
  - VWOs as partially private rather than charities
  - role of private sector operators
- Financial planning for long term care
Recommendations of IMC on the Aged Population - Health Care

- Study further health care needs
- Review standards for service delivery
- Strengthen service providers
- Develop appropriate manpower
- Financing health care for Senior Citizens
  - Government funding for VWO step-down care and insurance for severe disabilities
  - Public education on insurance scheme with research and evaluation
  - Consider extending subsidies to lower-income
Community Eldercare Model in Singapore

- Involvement of voluntary welfare organizations
- Co-financing from government of 3:1 ratio, based on piece-rate and program funding
- Within grassroots structure of local government - Community Development Councils (CDC)
- Multi-service centres to be co-located with existing Community Clubs and Centres (CC)
- Networks of neighbourhood Residents Activity Centres (RAC) & Seniors Activity Centres (SAC)

Committee on Ageing Issues (CAI) formed in 2004

Vision: Successful Ageing for Singapore
- Individuals to assume personal responsibility
- Government policies and programs to empower Singaporeans to lead meaningful lives in old age

• Outcome 1: Elder-Friendly Housing
• Outcome 2: Barrier-Free Society
• Outcome 3: Holistic Affordable Health/Eldercare
• Outcome 4: Active Lifestyles and Well-Being
Recent Population Ageing Policies

- Appointment of Minister for Ageing Issues
- Extend working age from 60 to 65
- Raise savings and interest rates
- Proposal for annuity or longevity insurance
  - opposite of health insurance
  - integrated with provident funds (CPF Life)
  - public vs private management?
  - compulsory or voluntary?
  - defined contributions or benefits?
Policy Implications - Financing the Levels of Care

- Family support for home care
- Personal savings and community services for primary health care
- Compulsory savings for hospitalization and acute care
- Insurance and institutional support for catastrophic and long term care
- Taxation and state welfare as safety net
Policy Implications - Towards Cost-effective Care

• Avoid hospitalization and institutions
• Provide substitutes and alternatives eg. day care, home nursing, hospice, etc
• Develop community-based services
• Strengthen family support and home care
• Improve housing and living arrangements
The Future of Eldercare?

The `many helping hands` approach in communitarian community care:

- Public, Private & People (3P) Partnerships
- Joint responsibilities of the individual and family, community and the state
- Shift from state welfarism to greater cost-sharing by a more diversified mix of financing methods, e.g. prepayment, savings, insurance, annuities and targeted subsidies (means-test)
Special Conditions in Asia

- Fastest pace of socio-economic transition
- Highest rates of population ageing and population growth
- Great propensity for savings and sharing
- Strong traditional social support systems

Health and social care reform policies must contend with such considerations
Selected References

- WHO, *Social Health Insurance: Selected Case Studies from Asia and the Pacific*, Western Pacific Region and South East Asia Region, March 2005