



International Association for the  
Study of Insurance Economics

# 18

April 2008

## Health and Ageing

Research Programme on Health and Productive Ageing

### Geneva Association Information Newsletter

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The International Association for the Study of Insurance Economics, or by its short name "The Geneva Association", is a unique world organisation formed by a maximum of 80 chief executive officers from the most important insurance companies in the world (Europe, North and South America, Asia, Africa and Australia). Our main goal is to research the growing importance of worldwide insurance activities in all sectors of the economy. We try to identify fundamental trends and strategic issues where insurance plays a substantial role or which influence the insurance sector. In parallel, we develop and encourage various initiatives concerning the evolution – in economic and cultural terms – of risk management and the notion of uncertainty in the modern economy.

The Geneva Association also acts as a forum for its members, providing a worldwide unique platform for the top insurance CEOs. We organise the framework for our members in order that they may exchange ideas and discuss key strategic issues, especially at the General Assembly where once per year over 50 of the top insurance CEOs gather. The Geneva Association serves as a catalyst for progress in this unprecedented period of fundamental change in the insurance industry and its growing importance for the further development of the modern economy. It is a non-profit organisation.

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- The interaction of public and private systems in health provision.
- Performance of health systems.
- 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

### Making Long-Term Care Affordable in the U.S.

By Jeanne Lambrew\*

America is in desperate need of a long-term care solution. Nearly 30 percent of men and 44 percent of women turning age 65 are likely to need nursing home care at some point before they die. The cost of this care can be devastating; nursing home care averages \$70,000 annually (2003 figure). Yet long-term care financing is the only area of the health system in which we under-spend compared to peer nations. On the verge of the Baby Boomers' retirement, the 65+ population will increase by some 30 million over the next 20 years, a three-fold increase over the previous two decades.

However, the problem is more than just the magnitude of long-term care costs; it is also who pays. Medicare, the primary insurer of medical costs for the elderly, has very limited long-term care coverage. Private insurance coverage is even more constrained. While growing, the private long-term care insurance market finances even fewer people's care. Although premiums in the group market average less than half as much as policies in the individual market, the vast majority of people with long-term care insurance purchase it individually. Some of the suggested reasons for why so few people purchase long-term care insurance include: a mistaken belief that Medicare will fully cover long-term care; personal denial of the potential risk of ending up in a nursing home; competing, more immediate demands (e.g., cost of children's education, mortgage payments); and lack of knowledge or ease in taking advantage of existing options. The state of the current long-term care insurance market also contributes to the problem. The cost of quality products is high, consumer protections are weak, and insurers sell primarily through the more expensive, individual rather than group market.

As a result, many seniors pay for long-term care costs out of income and savings, and their low and diminished resources then qualify them for Medicaid (joint federal and state program that provides medical assistance for the poor). Indeed, Medicaid has become the default payer for long-term care, assisting three out of five nursing home residents. This avoidable impoverishment and reliance on Medicaid not only strains public budgets, but also erodes retirement security.

While few people are covered under private long-term care insurance policies, almost everyone has access to home health benefits when they become eligible for Medicare. Spending on Medicare home health has grown quickly over the past decade but the benefit has significant limitations that prevent it from serving as comprehensive community-based long-term care coverage. The Medicare home health benefit is restricted to a narrow set of benefits that require a person to be homebound and to have some need for skilled care. As a result, the benefits are often provided expensively and inefficiently relative to the needs of the people receiving care. Many experts agree that some of the spending for Medicare home health benefits could be redirected to provide more effective and efficient home and community-based services.

Recently, policy has begun to address some of these issues. Federal and state policy changes in the 1990s provided tax credits or deductions for qualified long-term care insurance premiums. In 2000, the Federal government was authorized to offer long-term care insurance to its 20 million employees and dependents. And, education efforts were initiated by the Federal government about the limits of Medicare long-term care benefits. In 2005, the Medicaid Partnership for Long-Term Care Program was expanded to promote long-term care insurance, allowing participants access to Medicaid while maintaining their assets. Yet these policies affect only a small number of people.

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A better approach uses Medicare, rather than Medicaid, to leverage long-term care insurance. This would be achieved by creating a new catastrophic, long-term-care benefit for seniors who also purchase a private long-term care insurance policy—the Medicare Long-Term Care Partnership. The benefit would be “triggered” by the exhaustion of the insurance coverage, i.e., once the fixed-dollar amount of lifetime coverage has been spent. The trigger would be reduced for low-income seniors. Medicare would, in effect, be a reinsurer for long-term care insurers.

The new benefit would be available only to those who purchased high-quality coverage. As with Medigap, which covers about one-fourth of seniors, Medicare would set standards for the policies to ensure access, fairly set premiums, plan stability, and seamless coverage with Medicare. Insurers that agree to these terms would benefit from Medicare’s marketing, imprimatur, and back-stop financing capacity.

The policy would be optional and available only during an open-enrollment period, upon joining Medicare at age 65, or for a limited time upon enactment. People already needing long-term care could not enroll. This limits the potential for adverse selection and ensures time for premium payments to accrue. The Partnership could be linked to the federally backed reverse mortgage program, allowing seniors to use their home equity to pay for premiums and enhanced home- and community-based care. Low-income seniors would need less insurance coverage due to the new catastrophic benefit, and thus would pay lower premiums. States could buy qualifying Medicaid beneficiaries into this program as well by paying for their premiums and cost sharing.

To offset its new federal costs, the Partnership would be a “swap”: Beneficiaries who opt for it would forfeit Medicare’s home-health benefit, which would be covered by the private insurance plan. In addition, the increase in Medicare spending would be partially paid for by the resulting decrease in Medicaid spending.

This proposal has several potential disadvantages and advantages. The disadvantages of this option are that, despite its potential benefits, Medicare beneficiaries may not choose to give up a home health benefit and pay an additional premium — one that may still be relatively expensive. As a result, the number of people choosing this option may be relatively small. In addition, the resources redirected from a Medicare home health benefit may not be adequate to cover the costs of the catastrophic long-term care Medicare benefits — necessitating additional general revenue or offsets like eliminating the Part A home health benefit for participants to secure budget neutrality. In addition, insurers may not participate in large enough numbers to guarantee beneficiaries access to a second insurance plan if their initial plan raises the premium. It may be unrealistic to expect a second insurer to enroll a new beneficiary if their previous premium was set too low in the first place. As a result, a major difficulty of this program is guaranteeing beneficiaries that their premiums will not increase. Finally, this program does not offer solutions to the cost issues facing people currently needing long-term care, especially people with disabilities under age 65.

That said, we hope that its potential advantages outweigh its disadvantages. It takes significant steps to reduce the price of long-term care insurance for low- and middle-income individuals through an income-related catastrophic benefit. It permits all elderly (within six months of enrolling in Medicare Parts A and B) to enroll as long as they are not currently receiving long-term care benefits. It requires all policies to provide long-lasting and reliable benefits through automatic compound inflation protection and no forfeiture benefits. It redirects existing Medicare and Medicaid spending to guarantee flexible, lifetime long-term care coverage through private insurance and Medicare. And, it offers private insurers the opportunity to offer more benefits for lower prices and receive an endorsement from a large government health care program. This proposal, like many in the area of long-term care, has some risks and uncertainty, but the risk of the status quo, given the imminent retirement of the baby boom generation, may be greater.

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## II. INVITED ARTICLE I

### Expenditure on Long-term Care in Europe

By Manfred Huber\*

#### Introduction

Demand for long-term care services continues to increase across Europe as the number of people aged 80 years and older increases faster than any other age group. But the evolution of public services in response to this growing demand has been uneven. The need for long-term care usually includes a range of services for people who depend on ongoing help for an extended period of time with the activities of daily living, due to chronic conditions of physical or mental disability. A comprehensive package of these services would include help with everyday activities of housekeeping, transport, self-management and social activities, together with more intensive personal care such as bathing, dressing, getting in and out of bed, and using the bathroom.

In addition, public support to informal care giving in the family plays an increasing role in many countries. There is also growing awareness that co-operation of long-term care services with health care and other social services (such as housing) is crucial for efficiency and quality of services. Two studies, however, have shown strong evidence that the continuity of services, the range of services available and their quality is often not up to the growing expectations of users and their families (OECD 2005, Huber et al 2008). These studies have also argued that the need to improve the quality of services and to reach out to an increasing number of very old people has been among the main spending drivers of public spending growth for long-term care in recent years.

How far do countries differ in their current spending levels for publicly funded long-term care programmes? And how have these evolved? This article summarises selected findings from recent work at the European Centre for Social Welfare Policy and Research on trends in long-term care services in Europe to answer these questions.

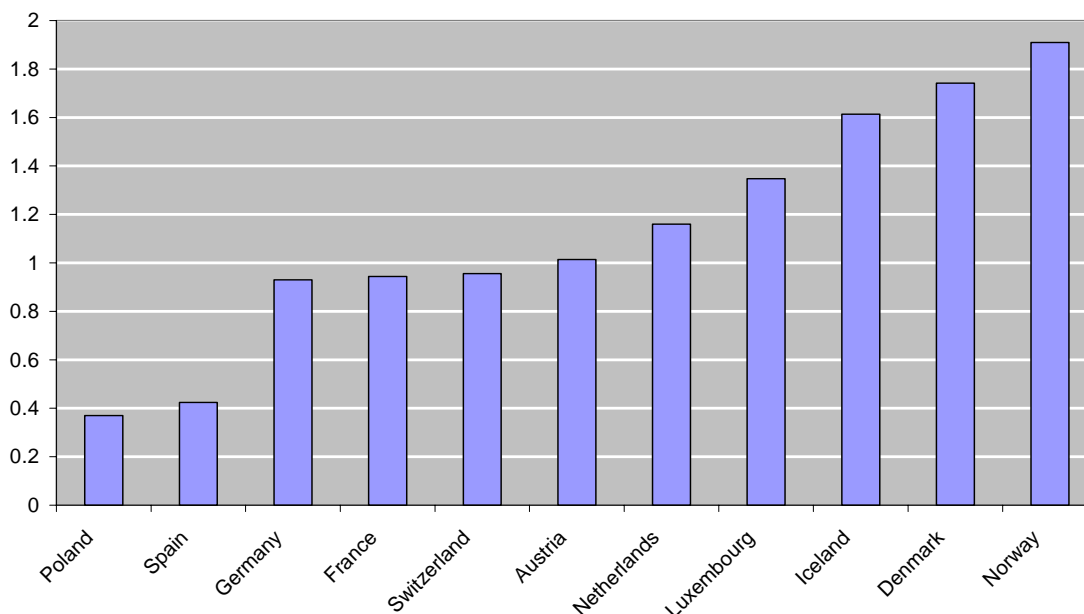
#### Public expenditure on long-term care

While public programmes to fund long-term care services are well developed in some countries, it is only an emerging spending – and a coordinated policy - field in other countries. This is illustrated by important differences in spending levels (Figure 1). Several of the Nordic countries, for example, have public spending levels that are several times higher than that found in a number of southern European countries or among the new Member States of the EU.

Although higher numbers of older people may play some role, the main reasons for the expenditure differences observed have been found to be the generosity of services, the amount of private involvement in both financing and informal care provided, and in the quality of services (such as amenities in institutional care). Even if some of the observed expenditure variation may be due to measurement errors, there is no doubt that public spending on long-term care in Europe differs much more than for acute health care spending.<sup>1</sup> Countries also differ in the ways public spending is used. While some countries have opted for universal social insurance programmes combined with care allowances or a choice between benefits in cash or in kind (Austria, Germany), tax-based publicly provided services are predominant in other countries (Nordic countries, UK). Higher cost (and shares of spending) on care provided in institutions seems to be an important factor for relatively high spending levels in some Nordic countries.

\* European Centre for Social Welfare Policy and Research, [www.euro.centre.org](http://www.euro.centre.org)

<sup>1</sup> The expenditure boundaries for long-term care used in the OECD data set are narrower than those used in ESSPROS or in national social spending accounts. It excludes part of lower-level care of personal assistance.

Figure 1. Difference in public expenditure on long-term care as % of GDP, 2005<sup>2</sup>

Source: OECD Health Data 2007

### Trends in public expenditure

For long-term care, there is no uniform trend in public spending across Europe. Expenditures have been growing fast in some countries like Iceland, Luxembourg and Norway. At least in the case of Luxembourg, this was mainly due to the introduction of universal long-term care insurance. In other countries (Austria, Germany) public expenditure ratios to GDP remained remarkably flat over the past ten years. Partially, this has been achieved by capping public spending in various ways, for example by not adjusting the level of care allowances to inflation or to increasing salaries in long-term care less than in the rest of the economy. As a result, over an extended period of time, this has reduced service availability and/or affordability and might have put pressure on increasing private spending. In response, both Austria and Germany have recently implemented policies for increasing benefits – and consequently spending levels.

A forthcoming report on social services in the European Union provides additional evidence on long-term care spending trends for additional countries, and on the drivers behind expenditure growth (Huber et al., 2008). In France, for example, expenditure of health insurance for the elderly in institutions and at home increased at an annual rate of more than 9 percent (in nominal terms) between 2000 and 2005. In England, expenditures on social services for older people have increased by more than 100 percent (in nominal terms) during the period of 1994 to 2004. This study also observes that budget constraints on social services, including long-term care have limited the expansion of services in several new Member States of the EU, for example in the Czech Republic.

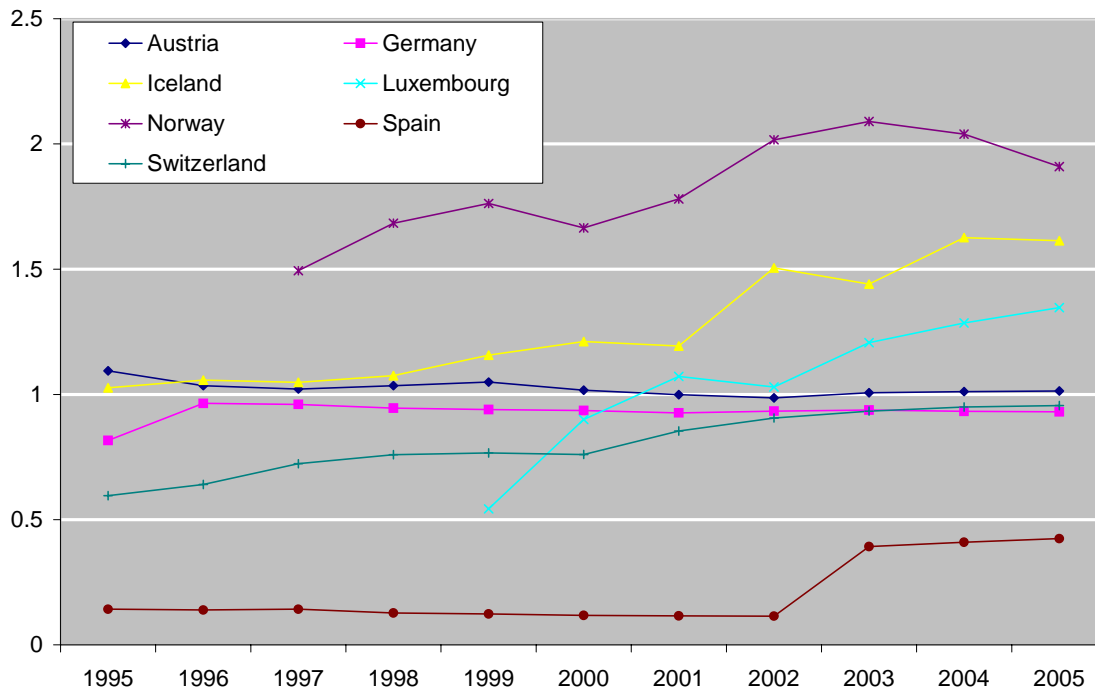
### Private expenditures play an important role

In all European countries, private households are requested to heavily share the burden of care, both financially, and by providing the majority of hours of care that people with long-term care need to receive. Private payments comprise co-payments for care provided under public programmes

<sup>2</sup> Measuring long-term care expenditure is still fraught with problems. The country cases and data presented in this article have, however, been checked against other international data sources, and countries with the most reliable data were selected. See, for example, the discussion in Huber (2007 a and b, Table 7).

and out-of-pocket payments. The share of private expenditures on care in total spending seems to be lower for a number of Nordic countries (Figure #3).

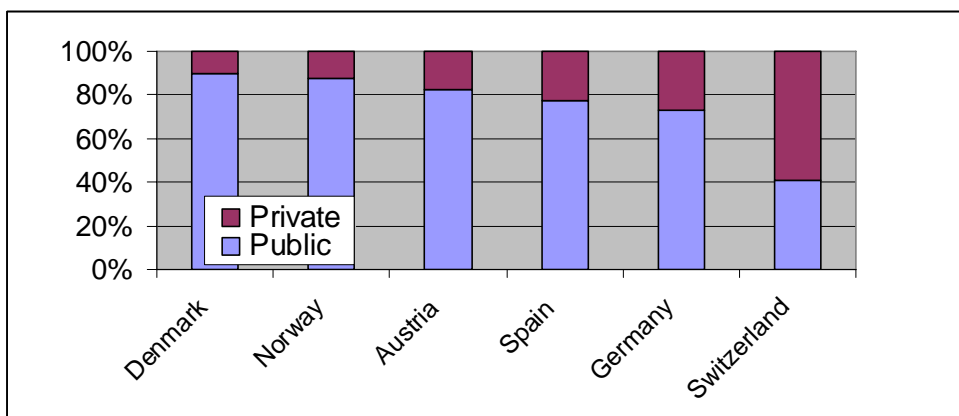
Figure 2. Public expenditure on long-term care, 1995 to 2005



Source: OECD Health Data 2007

Cost-sharing is an important contribution to long-term care financing in other countries. In Germany, for example, long-term care insurance only covers the service part of expenditure on nursing homes. For private households that are not able to pay for the cost of board and lodging, social assistance can provide additional funding, but only in the form of means-tested benefits. The original goal behind the introduction of universal long-term care insurance, to replace means-tested benefits, has therefore been only partially achieved. In interpreting the numbers in Figure 3, it is important to keep in mind that it is currently difficult to estimate the full amount of private spending on care at home. In a number of countries (eg: Austria, Germany and Italy), many households that are entitled to care allowances are using these to pay for carers on a grey market of unlicensed care personnel, often combined with additional out-of-pocket expenditure, the scope of which is obviously difficult to grasp.

Figure 3. Private expenditure on long-term care as share of total spending, 2005



Source: OECD Health Data 2007

## **Discussion**

The aggregate expenditure numbers presented in this article hide the fact that there can be large variations between regions in the way long-term care services are organised and funded, or in the way eligibility for services is implemented. This is obvious for countries where regional governments have chosen to establish different systems for long-term care, such as in Italy or in the UK. But even in countries with a relatively uniform system, such as in Sweden, service availability and generosity can depend on where service users live, and there are important variations between rural and urban areas in other countries, including in some of the new Member States of the EU (Huber et al. 2008).

Projections of future long-term care spending seem to agree that substantial additional investment in long-term care will be needed in response to the growing number of very old persons in the population. Based mainly on demographic scenarios, long-term care spending has been estimated to double or triple until 2050 (relative to overall growth of the economy) (Huber 2007a, Table 7). However, these estimates basically extrapolate current service arrangements in countries and do not take into account other factors, such as a convergence of living conditions in the European Union. Moreover, the quest for better quality of services, and the need to improve working conditions for care personnel will likely act as additional important drivers of future spending.

There are, however, a number of ways in which governments can prepare for this growing demand for better quality services. Service provision is all too often still fragmented and there is some evidence that efficiency and effectiveness gains can be achieved if services of prevention and rehabilitation were used more intensively, in particular for older people. Age rationing of health care for these services means that opportunities are lost for preventing or postponing dependency and functional limitations that lead to frailty and long-term care needs.

Home-care services are in many cases less developed compared with institutional solutions, such as nursing homes, and more could be done to provide part-time inpatient and short-term care facilities, as well as other services that support informal care giving in private households. The question of whether available public resources should be better targeted on those most in need remains an important issue for the future. An immediate, urgent concern, in most countries is how to train and maintain a sufficient number of adequately trained staff for the care professions.

A number of projects at the European Centre for Social Welfare Policy and Research will continue to work on improving the evidence base on long-term care policies in a European comparative perspective, including a stock-taking and improvement of available care indicators.

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### III. INVITED ARTICLE II

## Health Insurance Market Organisation in Colombia

By David Bardey\* and Dario Maldonado†

### Introduction

The Colombian health organisation is probably one of the most innovative health systems that can be observed in developing countries. Indeed, the application of the *Law 100* in 1993 has constituted a dramatic change in the organisation and the spirit of the Colombian health system. For instance, between 1993 and 2000, the coverage rate grew up from 19.1% to 53.8%. Nevertheless, life expectancy in Colombia is still at the level of developing countries, at about 70.6, but with a significant heterogeneity between men and women.

The main features of the health insurance system in Colombia are related to the existence of a dual regime, financed through a constant payroll tax and which can be complemented through a supplementary system. The system has particular characteristics regarding the competition by the different providers and implications that can be potentially very important in the functioning of the labor market.

### Institutional features of the health insurance system in Colombia

The extent of the coverage rate imposed by the *Law 100* has followed a managed care approach (Enthoven, 1990), applied to two distinct regimes: the contributory and the subsidised regimes. The two regimes follow more or less the same organisation. The main difference deals with the fact that the beneficiaries of the subsidised regime do not pay tax, this regime being funded by taxes paid by the contributory regime's policy holders, completed by some local taxes. Basically, the subsidised regime has been created for families characterised by very low wealth.<sup>3</sup> Initially, the aim of the *Law 100* was the implementation of a 100% coverage rate. However, confronted with recurrent budget constraint difficulties, the Colombian State had to find a rationing scheme in order to select the beneficiaries of the subsidised regime. Therefore, the Colombian State uses the Sisben, a household income survey that allows ranking of the households according to their wealth levels. Households of the levels 1 and 2, the poorest levels, must be selected as beneficiaries of the subsidised regime. The policy holders of the contributory regime pay tax to a State organism called Fosyga. After that, the Fosyga redistributes taxes to the health insurers, called EPS, through capitation payments. With these capitation payments, the EPSs are supposed to deliver a basket of health care, called POS and POSS, respectively for the contributory and subsidised regimes, to their policy holders. Both baskets are defined by the Colombian State, with a higher health care supply in the POS. As policy holders do not pay directly premiums to EPSs, EPSs only compete in quality.

Policy holders may complement the POS and POSS by other health insurance contracts that intervene in a supplementary way. The first type of health insurers is called "Pre-paid medicines". In the American health care system jargon, they correspond to Managed Care Organisations in the sense that they develop networks of health care providers that limit policy holders in their choice of providers. Moreover, as severe diseases are excluded from reimbursement during a period of time, "Pre-paid medicines" can be interpreted as a kind of medical saving account. On the contrary, the second type of supplementary health insurers corresponds much more to indemnity plans and lets its policy holders totally free to choose their providers.

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<sup>3</sup> The system is also covering individuals from the informal labor market. The subsidised regime has important similarities with Medicaid in the USA.

It is worth noticing that the Colombian health organisation system is very close to other health systems such as the Netherlands, Chile or Israel. Actually, the main difference focuses on the presence of the subsidised regime and the informal sector.

The following figure sums-up the organisation inside each regime. As they are close, we only provide one figure. The only difference is that beneficiaries of the subsidised sector do not pay taxes.

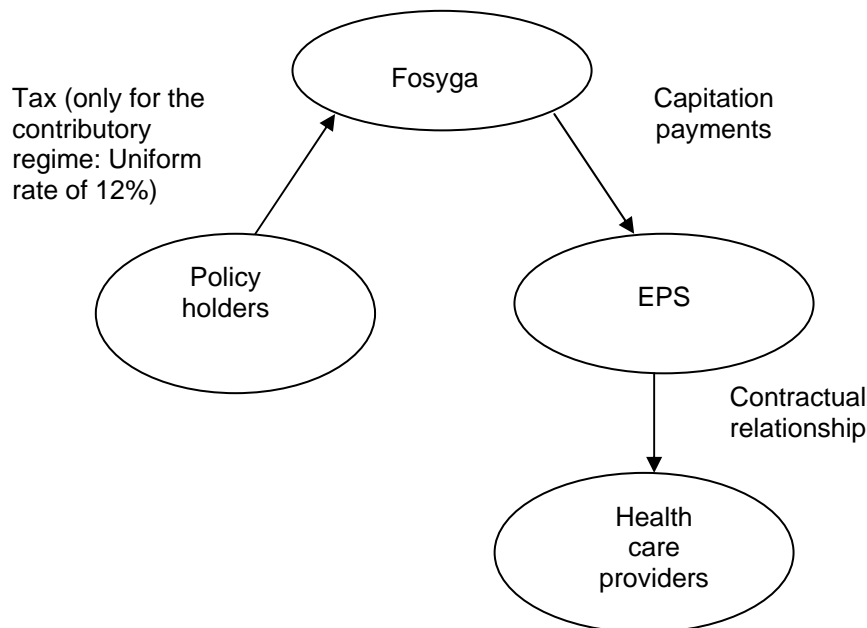


Figure 1: Organisation of the Colombian health insurance market.

### The impact of the health insurance system on the health care and the labor markets

The health insurance system in Colombia is financed from payroll taxes charged to employers and employees. Overall the total contribution to the system amounts to 12% of the payroll; the contribution rate is independent from income or from any other characteristic of the worker or her family. This 12% is split between 4% paid by the worker and 8% by the employer. Self-employed workers have to pay the complete contribution. However, belonging to the system does not give immediate rights to medical attention. When they need medical attention individuals have to pay a copayment which does depend progressively on the wage of workers (the system introduces income brackets, and for each bracket there is a different copayment level). The presence of the supplementary system has as a consequence that high income people (who are the ones affiliated to that system) end up not paying the copayment (the supplementary system has also a copayment but this goes to a different account than the account used to finance de POS and the POSS). The existence of the supplementary mechanism makes the whole system, in the end, less redistributive than it appears. Supplementary systems are used only to finance the charges not financed by the POS; even for people who use the supplementary mechanisms, part of their health expenditures (those accepted by the POS) are financed with resources from the POS. This means that people who use the supplementary systems end up benefitting from the POS but their copayment goes to the provider of the supplementary services and is exclusive for people affiliated with that provider.

With frictionless labor markets and without enforcement problems the distribution of this burden between employers and employees does not make any difference. However with a pervasive informal sector as in Colombia and the difficulties of separating labor and capital income for self-employed people things are different.

As it is traditional with this organisation of the health care sector that disconnects the financing from the health insurance competition, EPSs have incentives to develop risk selection strategies (see for instance Newhouse, 1996). The aim of these strategies is to attract policy holders who are expected to generate health expenditures below their corresponding capitation payment *i.e.* the so-called risk-creaming, or to get rid of policy holders who generate health expenditures above their capitation payments (risk selection). As in Colombia capitation payments basically depend on demographic variables, the EPS can easily detect the “rentable policy holders” (Ellis and Van de Ven, 2000). In order to reduce these incentives, the *Law 1122* imposes the creation of an *ex ante*

risk sharing mechanism in which policy holders, characterised by some risk factors known to generate dramatic health expenditure, are pooled together in a Common Fund. It is expected that this mechanism reduces the EPSs' risk selection strategies (Van Barneveld, 2002).

Another characteristic of this health system has to do with the Colombian constitution and its implications. Indeed, the Constitution stipulates that health care and medical attention is a *fundamental* right of all Colombian citizens. Because of this, everybody can go to the *Supreme Court* when they need health care that does not belong to the POS or POSS. If this situation ensures a good level of protection for the Colombian citizens, obviously this situation generates conflicts between EPSs and the State in order to determine who has to finance the "extra health expenditure" not included in the defined baskets of health care. Even if the court has been introduced to a clearer environment it ends up generating uncertainty for all players (government, EPSs, policy holders) since the criteria that guide the decisions of the Supreme Court are not very clear.

According to the constitution and to *Law 100* individuals in the subsidised regime are entitled to the same health care rights as those individuals in the contributory system; by law health coverage levels should not depend on the system. However the same budget pressures we mentioned above have made the government introduce the POS and the POSS with smaller benefits for individuals in the POSS. The dual nature of the system (which because of the fact that people in the POSS do not contribute also reduces copayment for these people) generates a series of inefficiencies in the system and in the labor market. In particular the incentives to contribute are reduced by the existence of the POSS. Besides reducing resources available for health care this also reduces incentives to enter the formal economy. If, as many in Colombia believe, jobs in the formal sector receive higher wages not only because they are more skilled but also because the activities in which they are concentrated are more capital intensive, the system also generates poverty traps that prevent individuals from going into the formal sector with higher wages.

A final element of the system, which has some benefits for workers but may also bring incentives for reduced affiliation and may keep people out of the formal labor market, is the benefits the system gives not only to the worker but also to her family. Participation to the system by a worker also gives the same rights to his family. In particular the husband or wife of a worker who is contributing to the system will have the same rights as any worker even if he is not contributing. Again this creates incentives to remain in the informal sector for at least some members of the family.

## Conclusion

Most analyses devoted to the evaluation of the *Law 100*'s results conclude that it has allowed an extension of the coverage, especially for the low income populations. However, there is still an important gap between the original objectives and the results obtained. For instance, Gaviria *et al* (2006) reveal that the target of the Sisben is very imperfect: 50% of the levels 1 and 2 do not benefit from the coverage offered by the subsidised regime whereas 20% of the level 3 are beneficiaries. Moreover, one of the objectives of the *Law 100* was to rationalize the budget of public hospitals through the competitive pressure between EPSs. These authors show that the managed care approach has not succeeded in this objective, the expenditures of public hospitals being still out of control.

Finally, the perspective of the Colombian health system—with the *Law 1122*, adopted in 2007—has deeply changed. Indeed, this law limits the vertical integration of the EPSs and more generally the role of the EPSs in health risk management. It is worth then asking about the usefulness of the competitive framework if the managed care orientation is limited.

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## IV. INVITED ARTICLE III

### The Interaction of Public and Private Systems in Healthcare Provision: The Italian Case of *Intramoenia*

By Giuseppe Turchetti\*

#### Introduction

Over the years, there has been a progressive introduction of market elements in public healthcare systems. An important test case of an attempt to join public and private is the Italian case of *intramoenia care*, private provision of health services within the public healthcare system, which is one of the possible ways of creating public-private interaction and coexistence in the organisation, delivery and funding of healthcare.

In the case of *intramoenia care*, public medical and healthcare staff, individually or in teams, exercise outside the normal hours of service, in ambulatory, day hospital or day surgery where they carry out diagnostics, laboratory analysis and hospitalisation, as requested by and based on the free choice of the patient. The choice for *intramoenia care* means that either the patient, his/her insurance company, or his/her integrative healthcare fund pays for the service.

Therefore, *intramoenia care* forms a context where the relationships between actors in the health sector (health workers, hospitals, third payers and patients) is extremely complex. Within public institutions, in fact, regulated and characterised by public mechanisms, services regulated by contracts of a private nature are carried out by the same actors.

*Intramoenia care* was introduced by law in 1996, after which it was subject to various changes and has developed and disseminated in an uneven way in the whole of Italy. Later in 2007 a new law corrected delays and distortions originating from the implementation of the *intramoenia* regime, and introduced various organisational-managerial and structural correction mechanisms. From an organisational-managerial point of view the law favours the establishment of a pricelist which covers the costs of the *intramoenia* regime; the monitoring of the waiting lists for people not using *intramoenia care* and the adoption of mechanisms to reduce the average length of waiting lists; assuring limited differences in waiting time between the regular public waiting list and the *intramoenia* regime; the clarification by the hospitals of their intentions of how to distribute the two modes of healthcare delivery. From a structural point of view, according to the law the healthcare supplier can use for the *intramoenia* regime the spaces available for the institutional activities, but it has to guarantee the separate management of the two types of healthcare delivery in particular with regard to the timetable, the booking, and the payment (which needs to be entrusted to the personnel but in a different location and at different times compared to the institutional activity). Therefore, as *intramoenia care* needs to take place within and under particular conditions, it is necessary to carry out restructuring tasks.

#### Advantages of the *intramoenia* regime

The characteristics of the services provided through *intramoenia care* and the mechanisms that regulate its functioning show numerous advantages for the various interrelated actors in the healthcare system.

Furthermore, *intramoenia* can be used as an instrument to increase the efficient use (technical, economic, and logistic) of resources acquired by the hospital, allowing for a shorter amortization of expensive medical equipment through increased use, and leading to a faster introduction of process and product innovations.

The advantages for the patient are mainly: the possibility to choose one's own doctor; the shorter waiting lists; the possibility to choose the day and time of the doctor's appointment (mode of access); and higher quality accommodation. The fact that this form of private care is highly regulated and made transparent by the fact that it is anyway part of the National Healthcare

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System, is another positive aspect for the patient when compared to private alternatives which are not part of the *intramoenia* regime.

A parliamentary inquest has shown that among the positive aspects of the *intramoenia* regime for the various actors there is the advantage that the hospital can render fee-for-service care; the patients can receive complete packages of diagnostic and therapeutic services (promoting the continuity of care); the personnel directly and indirectly involved in *intramoenia* care can receive financial incentives; highly specialised and distinguished doctors operating in the *intramoenia* regime can, because of their reputation, become the best sponsors for their hospital attracting patients also for the institutional public activity.

In the larger hospitals the *intramoenia* regime is an interesting leverage for extra revenues and an effective tool for increasing the professional and economic motivation of the doctors. The *intramoenia* regime is, as a matter of fact, an alternative way for the Public Healthcare System to financially reward the doctor (who, in Italy, compared with other European countries, receives lower salaries), which is useful to reinforce loyalty to the hospital to which he or she is officially linked.

Also for a third party payer the advantages of the *intramoenia* regime can be considerable; among others we mention: a) the development of a potentially large and profitable market, b) the possibility to reduce the risk of adverse selection by broadening the patient portfolio, c) the chance to enter into a market where it is possible to become acquainted with the cost of the various healthcare services, allowing for their monitoring, and d) the possibility to use the “diagnostic-therapeutic route” in a cost-effective manner, thereby avoiding redundancies.

### **Disadvantages of intramoenia**

Although there are numerous advantages linked to the *intramoenia* regime, the phenomenon has not spread as much as could be expected. One of the main reasons why a patient requests an appointment with a specialist, paying in full (in particular when this regards a first appointment), is because he or she hopes that this first contact will successively lead to a privileged treatment or will create other advantages when anyway deciding to use the public regime. This type of behaviour, however, distorts the original role and task foreseen for *intermoenia* care and leads to an unfair situation between patients as not all can afford an appointment in the *intramoenia* regime.

The weaknesses which result from the Parliamentary Inquiry mainly regard structural deficits (the lack of appropriate spaces) and organisational-managerial deficits (the lack of a complete regulation of the *intramoenia* regime; lack of a centrally organised system of information, booking and pricing; lack of information about the differences between the access and use of diagnostic and therapeutic paths of the public regime and of the *intramoenia* regime; the possibility of double waiting lists (patients who erroneously register on both lists).

The most important weaknesses, therefore, mainly originate from the difficulties related to the interaction between organisational and managerial mechanisms linked to public and private transactions and the distortions which may spring from these difficulties.

### **Benefits coming from a professional private financing of intramoenia care**

Let us address some thoughts on the introduction of coverage instruments such as healthcare insurance policies and integrative funds which serve to finance the cost of healthcare services provided in an intramoenia regime. This could promote:

- a *better organisation/canalisation of demand* for healthcare services as a consequence of the definition of sets of healthcare services rather than singular services, linked to the concept of therapeutic pathway suggested, for each pathology, by medical science and clinical practice. In consequence, departing from these *ex ante* established sets of treatments related to a certain pathology, non useful and/or redundant exams and/or treatment -*non-appropriateness of the demand for health services*- can be eliminated, thereby reducing also the length of the waiting lists;
- a *more effective and efficient organisation of the supply of healthcare services*. The adoption of the logic of benchmarking and comparison between the different hospitals will facilitate a virtuous mechanism promoting the increase of levels of efficiency of healthcare providers, and effectiveness and quality of the services rendered;
- a *significant reduction of the burden of healthcare expenditure on public finances*, as a result of the progressive contribution of third party payers;
- a *greater equity in the composition of private health expenditure*. Part of this expenditure will no longer be *out-of-pocket* but will become expenditures intermediated by professional third party

payers, able to operate a fairer pooling of risk. Moreover, if a tax relief linked to the level of income were introduced, we could also observe a lower level of regressivity connected to the private payment.

## Conclusion

In the process of the progressive hybridisation of “pure” (public and private) healthcare systems - due to the presence of both failures of market and failures of planning - leading them to intermediate positions, we have to consider the fact that the interaction between public and private mechanisms is often difficult and complex to achieve. The main reason for these difficulties is to be found in the fact that *planning* and *market* are two different systems of organisation and governance of transactions and relationships, following totally diverse types of logics and functioning rules. The Italian case of *intramoenia* regime is an *extreme* case of coexistence of public and private in which all the possible distortions typical of the relationship between different operators (doctor-patient-hospital-payer) are enhanced and strengthened by the fact that they are located in a context characterised by the co-presence of different regulation instruments and operating mechanisms, those of the market and those of the planning.

The introduction of the mechanisms of the market and of the competition cannot be fully realised by integrating instruments typical of the market in a system based on planning, without changing the incentive schemes and the monitoring instruments of the system based on planning. On the contrary, market mechanisms should affect the structure of relationships and roles existing among the different operators involved. This concept requires, in general, the differentiation of sources of financing and, more specifically, the use of private capital.

The entering of private payers, if properly defined, re-designs the modes of measurement/evaluation and the objectives of the production units of healthcare services, by adopting the concept of cost-effectiveness of healthcare services in substitution of the concept of adherence to the reference values of the planning. The adoption of the concept of cost-effectiveness implies the presence of several autonomous units of production competing with each other, and finds its implementation in the rewarding of the ability to interpret and satisfy the value of use requested by the citizens, and in managing efficiently the resources.

The evaluation of the areas of intervention of private financing in healthcare—integrating public funding—means, in our opinion, that we can analyse the contribution that this funding could offer, in a dynamic perspective, to the increasing of the general performance of the system. In other words, it is a matter of modifying the traditional view of the involvement of the private financing sector in the National Healthcare System that is still linked to a mere financial logic of mitigation of the pressure on public finance. Instead, in this paper, we propose to evaluate the contribution of the private sector in the financing of healthcare as a tool for re-defining the structure of property rights within the system in order to obtain a better organisation of production and provision of healthcare services.

The public Regulator has to indicate the context and under which conditions it could be convenient to put alongside the elements of guarantee and organicity of the planning, the abilities to extract information, to define effective incentive schemes, and to coordinate typical of the market. The area of the services provided in the *intramoenia* regime seems to be, as we hope to have been able to effectively discuss in the present paper, one of the more suitable.

In the *intramoenia* scenario, in fact, we maintain that the role of third party payers, i.e. professional intermediaries, can mitigate potential opportunistic behaviours of the various actors and promote a more effective and positive interaction, coexistence, and integration between *public* and *private*, and benefit from the advantages of both systems of governance of transactions.

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## V. 5<sup>TH</sup> GENEVA ASSOCIATION HEALTH & AGEING CONFERENCE

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Should you be interested in contributing or participating, please contact Christophe Courbage at [christophe\\_courbage@genevaassociation.org](mailto:christophe_courbage@genevaassociation.org)

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## VIII. PUBLICATIONS ON HEALTH ISSUES

**The Effectiveness of Health Impact Assessment. Scope and Limitations of Supporting Decision-making in Europe**, edited by Matthias Wismar, Julia Blau, Kelly Ernst and Josep Figueras, published by the The Cromwell Press for the World Health Organization on behalf of the European Observatory on Health Systems and Policies, 2007, ISBN 978 92 890 7295 3. This book provides a detailed map of the use of health impact assessment (HIA) in the WHO European Region across a large range of sectors, including transport, environment, urban planning and agriculture, and at national, regional and local levels. It also reviews the implementation and institutionalization of HIA with specific focus on governance, financing, resource generation and delivery. Full text available for download at:

[http://www.euro.who.int/observatory/Publications/2007/20071016\\_1](http://www.euro.who.int/observatory/Publications/2007/20071016_1).

**The Ideas and Influence of Alan Williams**, edited by Anne Mason and Adrian Towse published by Radcliffe in association with the Office of Health Economics, 2007, ISBN-1 84619 231 5. Perhaps best known for his work within cost-benefit analysis, Alan Williams was a man of principles who developed guiding values in healthcare economics that embraced and encouraged active intellectual engagement and progression. He was concerned with the philosophical and ethical issues that underpin decision making and his courageous intellectual battles bore new ideas and revised ideology. This compilation of papers and further discussions arising from the Alan Williams tribute conference provides an analysis of the evolution and current status of key concepts in the field. It is highly recommended for health economics professionals and students.

**Fat Economics - Nutrition, Health, and Economic Policy**, by Mario Mazzocchi, W. Bruce Traill and Jason F. Shogren, published by Oxford University Press, 2008, ISBN 978-0-19-921386-3. The obesity epidemic and the growing debate about what, if any, public health policy should be adopted is the subject of endless debates within the media and in governments around the world. Whilst much has been written on the subject, this book takes a unique approach by looking at the obesity epidemic from an economic perspective. Written in a language accessible to non-specialists, the authors provide a timely discussion of evolving nutrition policies in both the developing and developed world, discuss the factors influencing supply and demand of food supply, and review the evidence for various factors which may explain recent trends in diets, weight, and health.

**Better But Not Well: Mental Health Policy in the United States since 1950**, by Richard G. Frank and Sherry A. Glied, published by John Hopkins University Press, ISBN: 0-8018-8443-8. This book examines the well-being of people with mental illness in the United States over the past fifty years, addressing issues such as economics, treatment, standards of living, rights, and stigma. Marshaling a range of new empirical evidence, they first argue that people with mental illness—severe and persistent disorders as well as less serious mental health conditions—are faring better today than in the past. Improvements have come about for unheralded and unexpected reasons. Rather than being a result of more effective mental health treatments, progress has come from the growth of private health insurance and of mainstream social programs—such as Medicaid, Supplemental Security Income, housing vouchers, and food stamps—and the development of new treatments that are easier for patients to tolerate and for physicians to manage.

**Responding to the Challenge of Cancer in Europe**, edited by Michel P. Coleman, Delia-Marina Alexe, Tit Albreht and Martin McKee, published by the Institute of Public Health of the Republic of Slovenia, ISBN 978-961-6659-20-8, 2008. The book provides an overview of the epidemiology of cancer, including a discussion of the major risk factors. Comprehensive cancer plans are discussed as an approach to cancer control. Contributors examine the current status and plausible future developments for cancer screening in the EU; drug discovery, evaluation and deployment; the role of psychosocial oncology; and the provision of palliative care. Current patterns of cancer survival and the challenges facing cancer researchers in Europe today are examined. Three case-studies are provided. One focuses on changes in the clinical management of cancer, using the example of colorectal cancer in France. Two broader descriptions of cancer control evoke the current situation, recent achievements and continuing challenges in eastern Europe and in Slovenia. Full text available for download at <http://www.euro.who.int/Document/E91137.pdf>.

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- Screening Equilibria in Experimental Markets, *by Lisa L. Posey and Abdullah Yavas*
- On Tail Value-at-Risk for Sums of Non-independent Random Variables with a Generalized Pareto Distribution, *by Antonella Campana*

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- Overconfidence and Trading Volume, *by Markus Glaser and Martin Weber*
- Adverse Selection and the Market for Annuities, *by Oded Palmon and Avia Spivak*
- On the Role of Market Insurance in a Dynamic Model, *by Helge Braun and Winfried Koeniger*
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**No. 343 / April 2008**

8th CEO Insurance Summit in Asia  
Achieving Regional Synergies & Partnerships to Boost Competitiveness  
Jakarta, 30 January – 1 February 2008

**No. 342 / March 2008**

KIDI International Conference 2007  
New Risk Management Environment and Strategy  
Seoul, 6 September 2007  
&  
Montepaschi Vita Annual Forum 2007  
Insurers and Banks: Complementarity and Competition  
Rome, 12 October 2007

**No. 341 / February 2008**

5<sup>th</sup> Chief Communications Officers Meeting of The Geneva Association  
Munich, 13-14 December 2007  
&  
10<sup>th</sup> Meeting of The Geneva Association's Amsterdam Circle of Chief Economists  
Amsterdam, 7-8 February 2008

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4<sup>th</sup> International Insurance and Finance Seminar of The Geneva Association  
London, 6-7 December 2007

**No. 339 / January 2008**

Barriers to Global Insurance Business Operations: The Situation in Brazil, China, India, Mexico and Russia  
Research Report

**No. 338 / January 2008**

3<sup>rd</sup> Chief Risk Officer Assembly  
Key Drivers of a New Risk Culture  
Rüschlikon, 26–27 November 2007  
&  
5<sup>th</sup> Annual Round Table of Chief Risk Officers  
Edinburgh, 21-22 May 2007

## XI. CONFERENCES ORGANISED AND/OR SPONSORED BY THE GENEVA ASSOCIATION

### 2008

#### March

17-20 Dubai **World Insurance Forum**, supported by The Geneva Association

#### April

3-4 Geneva **24<sup>th</sup> PROGRES Seminar** on Insurance Regulation and Supervision

3-4 Hartford **Insurance, Intellectual Property & Innovation**, organised by the Insurance Law Center and the Intellectual Property and Entrepreneurship Law Clinic at the University of Connecticut and The Geneva Association

20-22 Copenhagen **6<sup>th</sup> ART of CROs meeting**, co-organised by Tryg Vesta

#### May

28-31 Hamilton **35<sup>th</sup> General Assembly of The Geneva Association** (members only)

#### June

26-27 Zurich **1<sup>st</sup> Meeting of Chief Investment Officers in Insurance**, hosted by Swiss Re

#### July

13-16 Taiwan **The Geneva Association / IIS Research Awards Partnership**

#### September

15-17 Toulouse **35<sup>th</sup> Seminar of the European Group of Risk and Insurance Economists**

18-19 Munich **M.O.R.E. 22 – Conference on Management of Risks in the Economy**

#### October

8-10 Rome **Montepaschi Vita Annual Forum**, organised by AXA/Montepaschi Vita and The Geneva Association

#### November

6-7 Zurich **5<sup>th</sup> Liability Regimes Conference**, a joint initiative by Swiss Re, Zurich Financial Services and The Geneva Association

6-7 London **5<sup>th</sup> Health & Ageing Conference on Long-Term Care – Risk Profiles, Future Determinants and Financing**, jointly organised with BUPA

20-21 Munich **4<sup>th</sup> CRO Assembly** jointly organised with Munich Re

#### December

*tba* London **5<sup>th</sup> International Insurance and Finance Seminar** of The Geneva Association

11-12 Rome **6<sup>th</sup> Meeting of The Geneva Association's Chief Communications Officers**, hosted by Assicurazioni Generali