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Social Policy Highlight 16



Demographic change and social health care systems

This *Social Policy Highlight,* like three other recent issues, stems from the ISSA's Project on Demography and evaluates the impact of demographic change on social health care systems. Addressing the influence of population ageing, changes in family structure, urbanization and migration, a range of possible responses to be made by social health care systems are discussed. To counter the argument that the financial challenges associated with demographic change may restrict the expansion of health care, this *Highlight* concludes that a growing awareness of evolving demographic structures actually offers an opportunity to help promote social health protection coverage.

Hans-Horst Konkolewsky, ISSA Secretary General

Demographic factors

Diverse demographic trends are contributing to demands for increased expenditure on social health care. Commonly, increased expenditure is required for new benefits and services to meet the evolving health risks of ageing populations.

Of course, increases to health care costs are often traceable to non-demographic factors too, such as technological advancement and the inappropriate use of expensive technologies and treatments.

Regardless of the causes, current higher demand is not being matched fully by increasing revenues from the insured population. In many countries, the impact of lower fertility rates has led to a reduction in the number of young people actively contributing to social programmes, including social health care systems. And with a global trend towards increased longevity, more individuals are now seeking health care.

This issue

- Identifies four major demographic trends impacting health care systems globally
- Summarizes the responses of health care systems to demographic change
- Spotlights policy challenges and priorities for improving access to health care

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When addressing questions of social health care provision, population ageing is often seen as the most important among demographic factors. However, other factors to be considered are changes in family structure, urbanization and migration.

Key global statistics

- By 2020, there will be 1 billion aged 60 or older; by 2050, nearly 2 billion. Today, around 90 million are aged 80 or older; by 2050, there will be more than 400 million.
- In 2010, over a quarter of the world population was younger than age 15; by 2050 it will be less than one fifth. This trend affects all regions of the world, including the least developed.
- In 1950, less than 30 per cent of the world population lived in cities; today it is more than 50 per cent.
- In 2010, international migrants represented over 3 per cent of the global population. This figure is expected to increase by nearly half again by 2050.

Ageing populations

Increased life expectancy is a very positive outcome of the prevention and treatment of infectious diseases. In turn, general improvements in living conditions and an appreciation of the value of investing in human capital have been equally important. The development of new medical technologies to detect, treat or delay the progression of chronic diseases, as well as more comprehensive rehabilitation procedures following trauma, have further increased life expectancy.

Early technological developments, which were effective in prolonging and improving quality of life, were relatively inexpensive. More recent developments, however, tend to be more expensive and are usually more widely available. Often, improvements in technology and access to care have not been matched by sufficient knowledge about the appropriate use of these new treatments. Since most chronic diseases occur late in the lifespan, population ageing has become synonymous with higher health care expenditure and with inefficient care provision.

Changing family structures

When infant and child mortality rates were high, large families were considered necessary to ensure adequate family income. However, small families are now desired even in countries where infant and child mortality rates remain relatively high. This tendency to have fewer children may be driven by young parents' perceptions of the costs of child-rearing based on the desire to provide children with consumer goods and opportunities that they did not have. In some countries, such as the People's Republic of China or Singapore, national policy has prescribed limits to family size.

Two other aspects to consider are late marriage and increased requests for in-vitro fertilization (sometimes associated with "late pregnancy"). While the rewards of in-vitro fertilization are well appreciated, the method has high initial costs and is linked to a significant increase in premature and multiple births among older women, which means even higher treatment costs. This change process is now occurring in countries and cultures in which large families and the care of the elderly and disabled family members within the home has remained the norm.

Taken together, these demographic factors lead to more people living alone, most of whom are older persons with growing needs for assistance in daily living as well as for home care by health professionals. In many countries, a trend towards the use of more custodial care is visible, with a growing role for community day care centres for the elderly and disabled persons and, ultimately, permanent residential institutions.

Urbanization

The continuing shift of large populations from rural to urban areas is not always a shift of nuclear families, but of younger members seeking employment or study opportunities. More young people live away from their families, often alone or in hostels, and in environments with new health threats, such as overcrowding and pollution. For many, the new urban environment may also encourage substance abuse, heavy smoking, unbalanced nutrition and sexually transmitted infections, and these are added to the stress of finding jobs and remitting money back to their families. At the same time, urbanization and globalization have increased exposure to knowledge of new medical technologies and access to multiple health care providers, thus heightening demand on social health care systems.

Migration

International migrants now represent over 3 per cent of the global population and their number is projected to increase. In the absence of a national law in the host country for universal social security coverage for all residents, or bilateral agreements between the host and the home country, migrants may not have social security coverage, including for health care. Migrant workers are generally healthy adults, but they are exposed to new risks and have family members in the host and home countries that need health care also.

Responses by social health care systems

Normally, the process of responding to demographic trends has entailed delays in recognizing the need for change and assessing the broader impacts of these trends beyond having to pay more for health care benefits. For instance, in spite of greater awareness of the health care needs of the elderly and of increasing health care costs, there may be less awareness of the need for changes in the health care financing mechanism. Nonetheless, six key health care policy responses are identifiable.

Long-term care systems

Long-term care insurance has been introduced in many social health care systems, and is financed usually through a new and mandatory contribution. The Netherlands was the first country to introduce universal mandatory social health insurance covering a broad range of long-term care services provided in a variety of care settings, including the home and hospices for terminal care. The impetus for the 1968 legislation was not only population ageing, but an appreciation of the benefits of rehabilitation, and to realize a more appropriate use of beds in general hospitals. Later reforms have given greater freedom to the care recipient to determine how services will be given and by which

provider, and to enable payments for supervised home care providers and temporary institutionalization to give breaks to carers.

Prevention and promotion

Measures to support prevention and health promotion can help address the rapid rise of non-communicable diseases linked to the ageing of the population. This need has been heightened by rising levels of migrants and greater mobility generally, which have contributed to the spread of new and re-emerging infectious diseases. Most social health care systems now accept that their role must include keeping individuals healthy (see Box), as well as providing protection when individuals are sick. There is an acceptance that patient empowerment, through education and counselling, is key to healthy lifestyles and for seeking appropriate care.

Financing prevention and health promotion

- In the Czech Republic, health promotion and prevention is funded partially by penalties imposed on the late payment of social insurance contributions.
- In the Republic of Korea, a 50 per cent increase in funds available for health promotion has come from revenue sourced from recent increases to tobacco prices.
- In Finland, a fixed proportion of health insurance expenditure is allocated to prevention and rehabilitation, as well as to finance research into these areas.

Regulation

One response to the high costs of care is more regulation. In practice, however, the rationing of demand for new high-cost care may come into conflict with patient preferences and with realizing equity in access to care. Rationing would mean, for example, that social health care systems limit organ transplants to individuals under a defined age or that the number of attempts of in-vitro fertilization would be limited for each candidate. While limitations may be rational from expected quality of life aspects, patients with resources may seek services outside their social security framework and sometimes from unregulated providers, with the follow-up costs borne by the regular social health care system.

A more practical approach would be the application of evidence-based clinical protocols, developed in collaboration with government and academic institutions. One example is the Ottawa Ankle Rules, which offer simple guidelines to help emergency physicians decide when to use radiology for patients with ankle injuries. The application of such protocols serves the social insurance systems well and similar guidelines could be developed for injuries that occur frequently among the elderly.

Linking work permits to insurance coverage

The provision of insurance coverage to all workers with work permits exists in a number of countries with large migrant worker populations. However, the tendency, as in the oil-producing Gulf States, has been to cover this population through commercial rather than social insurance, which means limited benefits are provided only for the duration of work, and without coverage of dependants. A more comprehensive approach is that of the Philippines Social Security System and Philhealth, which now promote coverage for migrant workers and their families, in the host and home country, through the Overseas Workers Welfare Administration.

Negotiations on pharmaceutical pricing

Social health care systems are often the largest purchasers of pharmaceutical products. To achieve more favourable pharmaceutical pricing, negotiated purchasing could be pursued more systematically. For instance, huge reductions in the price of anti-retroviral drugs for the treatment of AIDS were negotiated through the William J. Clinton Foundation. As the elderly population grows, such a concerted approach could be used to a far greater extent for a wide range of currently high-cost drugs for cancers and other chronic diseases.

Steps in this direction have been taken in some countries. In Mexico, where pharmaceutical spending accounts for 24 per cent of total health expenditure, an intergovernmental commission coordinates the purchase and negotiates maximum prices for patented pharmaceuticals registered in the National List of Essential Medicines.

Provider payments

The use of provider payments presents social health care systems with opportunities to control costs, particularly if the payment methods are developed in coordination with the government authorities that regulate and operate health services. The Health Insurance Review and Assessment Service of the Republic of Korea has developed a pay-for-performance scheme. This gives financial incentives to tertiary hospitals for improvements in acute myocardial infarction treatment and for reductions in unnecessary caesarean deliveries, and enforces penalties on bad performers. Such mechanisms could be expanded to the provision of appropriate care of the elderly and other vulnerable groups, based on agreed criteria.

Social health care system priorities

Social health care systems are increasingly aware of the impacts of demographic change. Responding in an appropriate and ongoing manner is crucial as health costs continue to rise. Clearly, the pace and sequencing of the major identified demographic trends will vary among countries and the responses enacted by social security systems will be shaped by national priorities.

Although addressing population ageing might be the priority in a growing number of countries, policy challenges associated with urbanization and migration may be more pressing in others. While the need for adequate long-term care is growing, other equally important priorities lie with improving health promotion and prevention, developing regulations on the appropriate use of all technologies and negotiating favourable prices for access to these, including pharmaceutical products.

The increasingly high costs of health care, and a perception of the inability to control these costs as a result of demographic factors, sometimes serve as a justification for social security systems not to provide health care coverage. Consequently, there are many developing countries where health care has not been added to the range of benefits in social protection systems. To improve access to health care, the development of partnerships with the sharing of knowledge and experience among social security systems, government and health care providers, is

essential. Such developments must also include the coordinated expansion of protocols and indicators and the training of health professionals. In the coming years, the growing awareness of the challenges of demographic change should be used as a means to promote, and not to impede, the extension of social health protection.

Key conclusions

- Current demographic trends (population ageing, changing family structures, urbanization and migration) may affect countries differently. Health system responses must be tailored to national priorities and contexts.
- Social health care systems contribute to improving the health of populations. In turn, healthy populations can make a greater contribution to supporting the financial sustainability of social security systems.
- Demographic change presents important challenges for social security systems, but is also an opportunity to extend access to health care.

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