Population Aging and Long-Term Health Care in the People's Republic of China

中国人口老龄化和长期老龄护理
Observations & Suggestions

Abstract

The rapid aging of the population of the People’s Republic of China (PRC) is exerting financial pressure on the provision of health care services and, in particular, long-term health care. The elderly poor are particularly vulnerable.

Although the PRC has recently made significant progress in extending health insurance coverage, out-of-pocket payments still account for about 45-50% of total health expenditure, exacerbating the vulnerability of the elderly in rural areas. In order to minimize financial barriers, it is recommended to further expand health insurance coverage, reduce co-insurance rates, introduce ceilings on maximum out-of-pocket payments, and regulate the provision of health care services.

Changes in cultural norms of filial piety and the one-child policy make it difficult to rely on children to provide care to their parents. It is recommended that the long-term care delivery system be expanded by constructing more long-term care facilities and by training sufficient long-term care personnel.

There are various options to address the financing of long-term care. One approach would be to target beneficiaries and prioritize assistance for the elderly poor and for individuals with severe functional dependencies, instead of opting for a universal program, which is more costly. In a later stage, the government could gradually increase the coverage based on different eligibility criteria, including capacity to pay and the degree of functional dependency.

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I. CHALLENGES IN AN AGING SOCIETY. IMPLICATIONS FOR HEALTH AND LONG-TERM HEALTH CARE IN PRC

1. Rapid demographic change. The population in the PRC is aging rapidly. The proportion of people aged 60 years and above over the total population is expected to increase from 11% in 2005 to 33% in 2050, turning the PRC as aged as Denmark, and older than the US (26%). This trend results from the combined effect of increasing average life expectancy levels and falling fertility rates due the one-child policy. Given the insufficient development of safety nets and, in particular, low health spending, rapid aging will exert financial pressure on the provision of health care services, in particular long-term care.

2. Limited public support to the elderly. Public safety nets for the elderly are limited, and the development of long-term care services and institutions lags behind desirable standards. Moreover, there is a wide gap in pension coverage and health care programs between urban and rural areas. In rural areas, most caregivers are the spouse (39.7%), son (26.1%) and daughter-in-law (18.1%), suggesting that family members remain the primary source of support. However, the family-support mechanism is endangered by the socioeconomic changes deriving from economic development and modern lifestyles.

3. The vulnerability of the elderly. It is estimated that in the PRC more than 55% of the elderly depend entirely on family support for a living, and due to the limited coverage of pensions, most of pensioners partially depend on relatives. As a result, the majority of the elderly are economically vulnerable, and often forced to continue working in spite of old age and illness. Hence, the participation of the elderly in the labor force in the PRC at 19.7% is about 20% higher than in developed countries. The situation is particularly acute in rural areas, where young people tend to migrate to cities leaving the elderly without family support and relying on farming for subsistence.

4. Population aging and health care. Population aging is one of the major causes of chronic diseases, such as cardiovascular problems and diabetes. In the PRC, chronic, non-communicable diseases account for an estimated 80% of total deaths. The aging population is predicted to result in a 200% increase in deaths from cardiovascular diseases in the PRC between 2000 and 2040. Health standards are substantially better in urban than in rural areas, where health care is often unaffordable. Evidence shows that the use of inpatient care is significantly lower for those with lower education, lower household per capita income, and those without health insurance coverage.

1. Social security spending in PRC stands at 2.2% of GDP compared to 16.1% of GDP average spending in OECD countries.

2. At present total health care expenditure stands at 0.9% of GDP, below average OECD health spending levels (6.3% of GDP).
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5. Population aging and long-term care. The elderly have greater need for long-term care assistance. It has been estimated that the demand for beds in nursing homes in the PRC will increase from 325,000 in 2006 to 1.68-4.2 million in 2030, depending on different scenarios. Studies suggest that long term care expenditure only might reach 3% of GDP by 2036.

II. INTERNATIONAL EXPERIENCE IN LONG-TERM CARE SYSTEMS

6. Long-term care systems in developed countries. Long-term care systems in developed countries, particularly in terms of financing and services delivery, differ significantly depending on the role of the public sector, and the overall structure of the social security system. Western European countries, including Germany, France, and The Netherlands, rely on the social insurance system for long-term care because functional dependency is seen as an area where society must be able to provide a pooling mechanism. In Scandinavian countries, the state plays a key role in the financing and delivery of social services, and long-term care is financed through taxes, and managed by public providers. For example, Sweden and Norway spend 2.9% and 2.15% of GDP respectively on long-term care, with most of the spending coming from public sources. The number of long-term care beds in nursing homes per 1,000 individuals aged 65 and above, varies across OECD countries as indicated in the following examples: Italy (17.4), Spain (21.3), Japan (26.6), USA (43.3), Germany (47.8), and Sweden (86.3).

7. Public financing for health and long-term care. The financing mechanism for health care and for long-term care is closely linked. Germany and Japan, for instance, provide social insurance for health care and long-term care, while Scandinavian countries rely on tax-based financing for both. On the other hand, the US has a tax-based system for both non-elderly health care and long-term care targeted for the poor. The UK has a National Health Service with universal coverage, but its social care system (including long-term care) is based on the ability to pay of the individuals.

8. Although it is difficult to separate medical care from social care in the context of long-term care, most countries have separate schemes for social and health care. Integrating long-term care into the health care system often leads to inefficiencies if long-term care patients are treated in general hospitals at a much higher cost. To minimize inefficiencies, contribution-based social insurance for long-term care, covering all the elderly in need regardless of their income level, was introduced in Germany in 1995, in Japan in 2000, and in the Republic of Korea in 2008. This system allows for cost savings by utilizing the existing administrative structure of the health insurance organization to manage long term care insurance (LTCI). LTCI eligibility is usually determined by assessing physical functions of the patients. In Germany, LTCI provides coverage for all types of long-term care needs regardless of age, and those insured have an option for cash benefits. Japan's LTCI only covers age-related long-term care and does not provide a cash benefits option. From the financial point of view, Germany's
LTCI is solely funded through members' contributions, while in Japan, funding comes from taxes (45%), members' contributions (45%), and co-payment (10%).

III. POLICY RECOMMENDATIONS

A) Strengthening the Health Care System

9. Expanding health insurance coverage. Although the PRC has recently made significant progress in extending health insurance coverage, out-of-pocket payments still account for about 45-50% of total health expenditure, exacerbating the vulnerability of the elderly in rural areas. In order to minimize financial barriers, it is recommended to further expand the health insurance coverage, reduce co-insurance rates, introduce ceilings on maximum out-of-pocket payments, and regulate the provision of health care services. It is also recommended to explore the feasibility and advantages of establishing rural-urban risk pools to increase the purchasing power and the efficiency of health insurance and accelerate health reforms.

10. Prioritizing primary health care and gate-keeping. As the elderly usually need health care for longer periods the efficiency of the provision of these services is important to guarantee its sustainability, in particular in aged societies. In this context, it is suggested that the government, when formulating health policies and its resource allocation, prioritizes the provision of primary health care. For that purpose it is recommended that primary care physicians resort to gate-keeping, as primary health care is usually provided at a lesser cost than in hospitals and it is more efficient. Gate-keeping can be enforced through financial disincentives for those who by-pass primary health care.

11. Provider's payment system. The utilization of unnecessary care increases the financial burden on patients. Hence, it is important to implement payment systems that give health care providers the right incentive to deliver cost-effective health care. The PRC is experimenting with several payment systems to control costs of health care. Key payment methods that are currently explored are: (i) capitation payment, when providers are paid an amount of funds to deliver a defined package of services for each person enrolled with the provider for a fixed period; (ii) case-based payment, a hospital payment method that reimburses hospitals at a predetermined fixed rate for each treated case; and (iii) performance-based budgeting, a system based on the attainment of certain pre-defined performance indicators. More recently, the PRC introduced a system of "separation of revenue and expenditure (SRE)" to reduce the incentives for providers to maximize their income through, among others, increasing the number of tests performed on patients and inflating prescriptions of drugs. A

3. Gate-keeping ensures that patients will consult at primary health care level (e.g. family doctor) prior to seeking care in hospitals.
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through review of various experiences needs to take place and current provider payment systems (mostly based on fee-for-service known for inducing over-utilization and cost escalation) should be reformed.

12. Pharmaceutical policy. Pharmaceutical costs comprise a large part of out-of-pocket expenses in the PRC. As the elderly rely heavily on drugs for treatment, promoting a rational use of drugs and motivating cost-effective prescription practices of physicians is important. The government has made notable reforms in pharmaceutical policy, such as zero mark-ups for essential drugs provided by public health institutions, and the inclusion of essential drugs for reimbursement in medical insurance. There is room for further improvement, in particular to abolish the existing link between drugs prescriptions and hospitals and doctors' income.

13. In sum, improved efficiency in health care delivery as a result of reforms in the payment system and pharmaceutical policy would provide additional fiscal space to extend health insurance coverage as well as to increase the financial protection for the elderly.

B) Extending the Long-term Care System

14. Extending long-term care facilities. Changes in cultural norms of filial piety and the one-child policy make it difficult to rely on children to provide care to their parents. It is recommended that the long-term care delivery system be expanded by constructing more long-term care facilities and by training sufficient long-term care personnel. The lack of long-term care facilities could result in unnecessary admissions in acute care hospitals and, therefore, is a waste of health care resources. Different types of facilities such as nursing homes, assisted residential facilities, and day care centers need to be expanded to match needs. Ambulatory or community-based long-term care should also be developed to avoid the excessive institutionalization of long-term care. In developed countries, caregivers visit and provide personal care to the elderly at home, or provide assistance with housekeeping and other daily routines. Other programs in developed countries include the delivery of meals, transportation services, and day care centers. Community-based care can be less costly and the elderly usually prefer getting home care than staying in long-term care institutions.

15. Providing long-term care assistance in a gradual manner. The government could consider various options to address the financing of long-term care. One approach would be to target beneficiaries and prioritize assistance for the elderly poor and for individuals with severe functional dependencies, instead of opting for a universal program, which is more costly. In a later stage, the government could gradually increase the coverage based on different eligibility criteria, including capacity to pay and the degree of functional dependency. Private insurance and wealth tax are options to complement government assistance to long-term care.
16. **Planning for long-term care financing.** Rapid aging requires substantial increases in the coverage of public assistance programs resulting in much higher costs. Hence, it is important that long-term care public financing reflects accurate financial projections, and an appropriate design of benefits and contributions in relation to long-term care delivery. Coordination between long-term care insurance and the health insurance system should be taken into account to ensure the sustainability of, and to minimize the need for, long-term care. Coordination between long-term care and welfare services, usually provided by local governments, is also important because of its link with other vital social services.
Observations & Suggestions

一、人口老龄化对当前和未来医疗体系的影响

1. 快速的人口结构变化。中国人口正在快速老龄化，预计2050年中国60岁及以上的人口占总人口的比重将从2005年的11%增长到33%，将接近当前日本的水平，而且高于美国的水平（26%）。中国人口老龄化趋势是平均预期寿命提高和计划生育政策下生育率下降的综合结果。由于社会保障尚不健全，特别是公共财政的医疗支出水平依旧较低，人口的快速老龄化使得医疗服务的供给，特别是长期老龄护理服务的供给，面临很大的资金压力。

2. 针对老年人的社会保障不足。目前，中国针对老年人提供的社会保障仍然十分有限，长期老龄护理服务和护理机构的发展较慢。此外，在养老金覆盖面和医疗卫生保障方面，城乡之间存在较大差距。在农村地区，家庭仍然是赡养老人的主体。多数老人由配偶（39.7%）、儿子（26.1%）和儿媳（18.1%）赡养。然而，经济发展和现代生活方式带来的社会经济变化，将会威胁到传统的家庭赡养机制的有效性。

3. 老年人的脆弱性。据估计，中国城乡有超过55%的老人完全依靠家庭赡养，由于养老金覆盖面有限，即使有养老金，大部分老人还是需要亲友提供生活支持。因此，绝大多数的老人在经济上处于弱势地位。为了生活而工作，即使在年老日高或身染疾病的情况下仍不得不继续工作。中国劳动人口中老人比重已经达到19.7%，比发达国家高出20%左右。在农村地区，上述现象更为严重。由于农村中青年大多选择进城打工，老人缺少家庭赡养，只能依靠从事农业劳动维持生计。

4. 人口老龄化和医疗护理。人口老龄化是导致心血管疾病、糖尿病等慢性疾病比例上升的主要原因。据估计，在中国，慢性非传染性疾病导致死亡的人数已占到死亡总数的80%。预计在2000—2040年间，中国人口老龄化将使心血管疾病导致的死亡比例上升200%。高价的医疗服务超出多数农民的支付能力。有证据表明，在教育程度、家庭人均收入、医疗保险的覆盖率都较低的地区，病患住院治疗的比列明显下降。

5. 人口老龄化和长期老龄护理。老年人对长期护理的需求十分强烈。据估计，在不同条件下，中国养老院床位的需求量将从2006年的32.5万张增加到2030年168万至420万张。而研究表明，到2036年，中国长期老龄护理支出可能仅占到GDP的3%。

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1 详见2010年1月亚洲开发银行《观察与建议：人口老龄化对中国社会经济的影响》
2 中国社保支出占GDP比重为2.2%，OECD国家的这一比例平均为16.1%。
3 中国医疗卫生支出占GDP比重为0.9%，低于OECD国家6.3%的平均水平。
二、长期老龄护理体系的国际经验

6. 发达国家的长期医疗护理体系。由于公共部门功能用以及社会保障体系结构的差异，在资金来源及服务提供渠道方面，发达国家的长期老龄护理体系差别很大。包括德国、法国、荷兰在内的西欧国家认为社会应该负起责任，因此，主要是依靠社保体系来支付长期老龄护理服务。而在北欧国家，政府直接通过税收筹集长期老龄护理资金。例如，瑞典、挪威长期老龄护理支出占GDP比重分别为2.9%和2.15%，且大部分资金来自公共财政支出。在OECD国家，每千个65岁及以上的老人所拥有的养老院长期护理床位数差异较大，意大利为17.4张，西班牙为21.3张，日本为26.6张，美国为43.3张，德国为47.8张，瑞典为86.3张。

7. 公共资金对医疗和长期护理的支持。医疗和长期老龄护理的融资机制联系紧密。例如，美国则对一般医疗护理和贫困人群的长期老龄护理，建立了专门基于税收的医疗体系。尽管英国拥有覆盖面很广的国民健保制度，然而其护理体系（包括长期老龄护理）却以个人支付能力为基础。

8. 对于老人来说，尽管很难将这两个体系严格区分出来，但大多数国家仍有不同的老龄护理支付体系和医疗保障支付体系，如果享受长期老龄护理的病人花很多费用在医院接受治疗，则将长期老龄护理的费用纳入医疗保障体系中往往会产生问题。为了最大程度地提高效率，德国、日本、韩国分别于1995年、2000年和2008年将长期老龄护理支出纳入了社会保险体系。该体系利用现有医疗卫生保障管理架构，覆盖了所有有需要的老人的长期老龄护理支出。而另一种长期老龄护理保险体系则通常根据对病人身体功能的评估来确定是否有资格享受相应服务。在德国，长期老龄护理保险没有年龄区别，覆盖了长期医疗护理的所有类型，并且被保险人有权提取现金福利的选择权。在日本，长期医疗护理保险仅涉及针对老人的长期护理，并且不提供领取现金的选择权。从资金来源的角度看，德国的长期医疗护理保险的资金来源纯粹是会员的缴款，而日本的长期医疗护理保险的经费中有45%来自税收，45%来自会员缴款，其余10%来自共同支付。

三、政策建议

（一）加强医疗卫生体系建设

9. 扩大医疗保险的覆盖面。尽管目前中国在扩大医疗保险覆盖率方面已经取得长足进步，但医疗总支出中自费支出的比例仍然高达45%~50%，这使得农村老年人以及城市中的贫困人群更难享受到合适的医疗服务。为了尽可能地减少他们的支付能力不足问题，我们建议在进一步扩大医疗保险的覆盖面的同时，建立一个低成本的简单有效的老龄护理服务体系，对贫困人群降低医保缴费率，设定自费支付最高限额，严格监管医疗服务供给体系。
10. **优先考虑发展社区医疗体系**。由于老人通常需要长期护理及医疗服务，保证低成本高效率对提供这些服务的可持续性至关重要。建议中国政府在制定医疗政策和配置医疗资源时把重点放在由社区医院提供的基本医疗服务上。社区医院提供的服务通常比一般的医院低，因此，相对的效率更高。为此，应该建立一个通过不同的报销比例，鼓励在社区医院看病。

11. **完善医疗服务的收费系统**。一些非必要的医疗服务增加了病人的经济负担。因此，建立合理的医疗服务收费系统十分重要。该系统通过适当激励，鼓励医疗服务提供者提供有成本效益的医疗服务。中国目前正尝试几种支付系统来控制医疗费用，正在探索中的主要支付方式有：(1) 按人头收费，即在固定时期内，医疗机构提供一揽子医疗服务，向每个患者收取一定数量的费用；(2) 按病收费，即对每一种病按照预先规定的价格收费；(3) 按绩效收费，这是一种根据绩效指标付费的支付体系。最近，中国推出了“收支两条线系统”，旨在约束医疗机构通过随意增加病人检测项目和高价药使其来增加收入的行为。目前，有必要对多种方式全面深入的评估，改进当前医院的收费系统（当前多数医院是按所提供的服务收费，这很容易导致医院的过度服务和抬高医疗成本）。

12. **药品政策**。中国的医药费用中，自费开支占有很大比例。由于老年人依赖药物，故而促进合理用药就十分重要。中国政府在医药改革方面已经取得了显著进步，如对于公共医疗机构提供的基本药物实行零加价，将基本药物列入医疗保险报销范围等。但是，医药改革仍有进一步完善的空间，特别是要尽快取消现行的药物处方与医院、医生收入挂钩的做法。

13. 总之，收费体系与药品政策的改革能够提高医疗卫生服务的效率，为扩大医疗保险覆盖范围、增加对老年人的保障拓展了空间。

**（二）长期老龄护理体系**

14. **增加长期老龄护理设施**。由于中国传统孝道观念正在逐步改变，加之计划生育政策的影响，中国社会很难继续完全依靠子女为父母提供养老保障。我们建议中国政府通过建设更多的廉价高效的长期老龄护理设施，培养充足的长期护理人员，建立健康护理服务供给体系。否则，长期老龄护理设施缺乏有可能导致不必要的住院治疗，浪费医疗资源。目前，为了满足不同的需求，需要扩大不同类型的长期护理设施，如养老院、社区救助站、日间护理中心等。为了避免长期护理过度化，还应大力发展门诊或以社区为基础的长期医疗护理。在一些发达国家，医务人员定期上门为老人提供治疗服务，政府还提供家庭及其他日常事务的援助服务，如送饭、到日间护理中心接送服务等。以社区为基础的服务成本更低。相比住院长期护理机构，老人们通常也更愿意在家里接受医疗护理服务。

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5 社区医疗确保病人可以在基层医院就诊前可以在基层卫生保健机构接受咨询（例如家庭医生）。
15. **循序渐进地提供长期老龄护理资助**。中国政府可以考虑多种长期老龄护理资助方案。一种可供选择的方案是，将贫穷的老年人和有严重功能性障碍的人作为优先援助的目标群体。而不要很快地建立对所有老人都享受的普惠性的资助制度。随着社会福利体系的逐步完善，政府可以依据财政支付能力，逐步扩大长期老龄护理资助的覆盖面。商业保险和征收财产税是对政府资助长期老龄护理资金不足的有益补充。

16. **长期医疗护理的融资规划**。随着老龄化进程的加速，公共援助项目的覆盖面会持续扩大，这也意味着成本会大幅上升。因此，要制订详细的财务规划，设计好财政资助与受益者缴费机制。应加强对长期老龄护理保险和医疗保险制度的协调，并且尽量减少不必要的长期护理，以保证长期老龄护理体系的可持续发展。加强长期老龄护理与其他社会服务之间的联系。