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Citation
Singapore Management University. Nursing homes: Insure to ensure quality care. (2013).
Available at: https://ink.library.smu.edu.sg/pers/282

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NURSING HOMES: INSURE TO ENSURE QUALITY CARE

Published:

24 Jul 2013

Women are more likely to need nursing care, but few – men or women – can afford it in old age

In 2009, the United Nations estimated that the world's population aged 80 and above would nearly triple* in just over 40 years. From 101.9 million in 2009, the elderly population worldwide would balloon to 394.7 million in 2050. It is a testament to human development, but longevity brings with it its own set of problems.

"Partly because of the success of modern medicine, we've been able to keep people alive longer and longer," says **Olivia Mitchell**, International Foundation of Employee Benefit Plans Professor at the Wharton School of the University of Pennsylvania. "However, it's expensive to keep people alive and when they are old, they fall prey to many diseases which cost money to cure or at least to treat. In the U.S., we're spending a lot of effort trying to figure out how to pay for nursing home care for those that need it."

Nursing home care is certainly not cheap. Speaking to *Perspectives@SMU* at a recent SKBI conference, *Retirement Readiness: Income adequacy, long-term care and social well-being*, Mitchell delivered the bombshell: Nursing home care in the U.S. can cost up to US$100,000 a year.

ADL: ACTIVITIES OF DAILY LIVING…OR A DREADED LIST

While that fearsome figure is particular to America, the path to a nursing home starts the same way everywhere in the world: the inability to perform tasks of Activities of Daily Living, or ADLs. There are six basic ADLs:

- Bathing
- Dressing
- Toileting

- Transferring (switching from lying to sitting/standing position)
- Walking
- Feeding

If one is unable to perform these activities that healthy people take for granted, nursing homes become a necessity. To deal with that nightmarish US$100,000 per year price tag, insurance companies offer Long-Term Care (LTC) policies whereby payouts are triggered when patients are assessed by doctors as being unable to perform two – sometimes three – of the six basic ADLs.

All well and good, but pricing these policies can be difficult.

“The more restrictions one requires, the cheaper the policy gets,” Mitchell explains. “What we found was that the difference between men and women’s frailty was such that if you used a criterion of two ADLs, women would be more expensive to take care of because they are more likely to hit that two ADL threshold.”

Mitchell quotes the findings of the U.S. Health and Retirement Study (HRS), a panel study of over 26,000 Americans aged 50 or older. Besides showing a strong correlation between health and education level, a main finding was that men were less likely than women to have problems with performing ADLs at advanced ages.

For example, between ages of 65-74, ten percent of men had problems with at least one ADL, while the figure for women was 16 percent. By the age of 85 or older, just over 30 percent of men fall under this category, but for women it is 50 percent. On top of that, American women outlive their male counterparts, and consequently consume more nursing care services. The bottom line: women are more costly to insure.

THE PRICE IS WRONG

“It’s typically the case that men are less likely to need nursing home care because unfortunately they have a shorter life expectancy,” says Mitchell. “The ultimate goal is trying to look at the consequences of our work for insurance pricing. If nursing home private insurance were to become more popular – it’s not that popular right now in the U.S. – but if it were to become more popular, the question arises ‘how do we price it?’.”

Money, as it is in most cases, is the big question. Mitchell describes how LTC policies are not popular in the U.S. because many elderly either expect or believe Medicaid will take care of that. In reality, Medicaid reimburses only 35 percent of LTC expenditures for all elderly. However, that translates to US$106 billion dollars in 2008, and that figure is projected to increase at 7.5 percent a year.

“I think this is probably the biggest question that aging societies have to deal with,” Mitchell argues. “The problem with the government stepping in is that it has a ‘crowd out effect’. If you know the government will take care of you when you become frail, you will tend not to save, you will tend not to insure. You will probably tend to spend your money so that when the time comes, you become a ward of the state.”

SINGAPORE AS A CASE STUDY

Mitchell describes Singapore’s government-run ElderShield scheme as a point of research interest. ElderShield, as described on Singapore’s Ministry of Health website, is “an affordable severe disability insurance scheme which provides basic financial protection to those who need long-term care, especially during old age.” From age 40, Singaporeans men pay about S$175 monthly and women about S$218 for 25 years. The scheme pays out S$300 a month for up to

five years if individuals are assessed to have disability in performing at least three ADLs. An enhanced version of the scheme that pays out S$400 monthly for up to six years is available for a higher price.

It may not sound like a lot of money for someone needing LTC, but multiply it by an increasingly aging population needing expensive nursing care, and the numbers can be daunting. And even then, there will probably be a shortfall, though not nearly as bad as that in the U.S.

So how do you pay for all that nursing care?

“We are trying to learn more about financing of age care around the Asia Pacific region and, in particular, Singapore,” says Mitchell. “Singapore and Japan are the two most rapidly aging countries on earth. So the rest of us look eagerly to them to try out some new approaches, because heaven knows we need to have some good examples.”

* http://www.un.org/esa/population/publications/WPA2009/WPA2009_WorkingPaper.pdf