International Report

Outpatient Pharmaceuticals And The Elderly: Policies In Seven Nations

These nations appear to be using the same mix of policy tools, but with very different results.

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Prescription drug coverage for the elderly—here defined as persons over age sixty-five—is a pressing issue for health care managers and politicians throughout the developed world. Two key sources of pressure are well known: the growing number of elderly persons, who are the highest per capita users of medicines; and the introduction of new, often more expensive medicines. Despite variations in health care financing mechanisms among nations, a common dilemma is the balancing of two often conflicting policy goals: providing the elderly with equitable access to needed pharmaceuticals while controlling costs.

In this paper we compare and contrast prescription drug policies for the elderly in seven Organization for Economic Cooperation and Development (OECD) nations: Australia, Canada, Germany, Japan, New Zealand, the United Kingdom, and the United States. Focusing on access to drug insurance, extent of insurance benefits coverage, and costs, we review the strategies these nations use to ensure access while controlling costs. We conclude with a discussion of potential implications for drug coverage reform in the United States. Our data come from an extensive literature review and from interviews with key informants administered by telephone or as part of in-country visits.

Coverage In The Seven Nations

All seven nations but the United States have made a national commitment to universal access to medically necessary hospital and physician services.[1] All but Canada and the United States include access to prescription medications in their national plans.[2]

■ **Australia.** Australia guarantees universal access to health care regardless of ability to pay. The national government funds most nonhospital medical services and pharmaceuticals. More than 90 percent of persons age sixty-five and older have some private insurance, chiefly for hospital care. Australia's Pharmaceutical Benefits Scheme (PBS) provides access to essential drugs for all Austra-

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lian residents. The PBS was introduced in 1953 and now includes a cost-effectiveness criterion. Australia uses a "positive" list, which describes the drugs that a resident can expect to have publicly covered. A combination of generic substitution and reference-based pricing is used to control costs.

■ **Canada.** Since 1965 Canada has had a single-payer health insurance system with universal access. Provinces and territories are the sole payers for all services deemed "medically necessary," the definition of which varies within each province. Canada does not have a national pharmaceutical program. Each of the ten provinces and three territories sets policy for access, coverage, and cost sharing. Thus, copayments are highly variable. Four provinces have universal coverage for drugs, and more than 60 percent of all Canadians have some sort of private drug coverage plan. One province has adopted reference-based pricing.

■ **Germany.** The national Medicare system is operated by the Statutory Health Insurance Organization (GKV), in which 88 percent of the population is enrolled. Individuals receive this medical coverage by belonging to one of the 482 sickness funds, and 9 percent of the population has private insurance. The sickness funds negotiate with providers and collect payments from individuals. Sickness funds contracted with the GKV pay for all physician-prescribed drugs, except those on the negative list, which was implemented in 1983.

■ **Japan.** Japan's universal-access health insurance system is a mixture of private, employer-based insurance and government programs for employees of small firms, the self-employed, pensioners, the unemployed, and the poor. One hundred percent of all citizens have health care coverage, which includes a drug benefit. Including government-mandated transfer payments, about half of all health care costs are borne by the government. All citizens over age seventy, and over age sixty-five if bedridden, are covered by Health Services for the Elderly. Health care, including a drug benefit, is free to those patients. For those in the other public programs, premiums vary depending on income, assets, and household size, and with income and demographics of place of residence—a community-rated system based on municipality.

■ **New Zealand.** A single health funding authority (HFA) funds health services, contracting with both public and private providers. More than 40 percent of the population has private, non-tax-deductible health insurance. Private insurance accounts for only 7.1 percent of total health expenditures and very little for pharmaceuticals. The Pharmaceutical Management Agency (PHARMAC) is a nonprofit company owned by the HFA, which was created in 1993 to manage the national pharmaceutical schedule (positive list). The positive list describes the subsidy for each drug listed and how it will be reimbursed from public funds.

■ **United Kingdom.** The National Health Service (NHS), introduced in 1948, provides universal access to health services for all citizens. Public and private providers "compete" for contracts with the 100 district health authorities. Only about 10 percent of the population has private insurance, which is used mostly for supplementary coverage. All prescribed pharmaceuticals are reimbursed by the NHS, except for those on the selected list scheme (negative list). All elderly persons are exempt from copayments. Recently promulgated clinical standards are meant to provide guidelines for the appropriate use of pharmaceuticals.

■ **United States.** Health care in the United States is funded through a combination of public and private sources. Eighty-five percent of Americans have private and/or public health insurance. Around 10 percent of the population, generally low-income persons, are covered by Medicaid, and 15 percent of the population has no health insurance. All Americans age sixty-five and older are eligible for Medicare, which covers inpatient and outpatient acute care and inpatient pharmaceuticals. Approximately 65 percent of elderly Americans have some type of prescription drug coverage. Medicare does not cover outpatient drugs, although some elderly persons receive drug benefits through Medicare health maintenance organizations (HMOs).

■ **Demographics.** The demographic picture adds to these nations' burden of pharma-

ceutical spending for the elderly. Although the nations vary greatly in the percentages of their populations over age sixty-five, all are rapidly aging.[3] The problem is exacerbated by the upward shift in the dependency ratio—the ratio of elderly persons to the working population. The combination of present drug spending levels and future demographic profiles will be a potent force for increased drug spending in the coming years.

■ **Public programs.** Exhibit 1 summarizes publicly provided access to and coverage of pharmaceuticals for the elderly populations in the seven countries we studied. All seven provide essentially universal access to inpatient prescription drugs for the elderly. In Canada and the United States the situation regarding the elderly's access to prescription drug insurance is more complicated and requires further elaboration.

In Canada all elderly citizens with financial need have at least some insurance coverage for outpatient prescription drugs through provincial drug programs. Two of Canada's ten provinces restrict public drug coverage to low-income elderly persons. One of these, though, subsidizes the elderly's purchase of private insurance. Three provinces provide the same levels of coverage to all elderly residents, regardless of income; the remainder have coverage for all elderly but means-based variation in cost sharing. Twenty-two percent of elderly Canadians have some form of private drug insurance as well, usually as retiree benefits from a former employer.[4]

In the United States the terrain is considerably more uneven, with excellent coverage in some instances and no coverage, regardless of financial need, in others. Essentially all elderly persons have inpatient drug coverage through Medicare. Slightly more than one-third of all elderly U.S. residents have no coverage whatsoever for outpatient drugs; the others have varying levels of coverage through employer-sponsored retiree plans, privately purchased "Medigap" plans, the means-tested national Medicaid and veterans' benefit programs, connection with the Defense Department, participation in a Medicare managed care program, and state and even municipal drug access programs, many of which are means-tested. Fewer than half of the low-income elderly, however, live in states with state-level assistance programs.[5] Elderly Americans can, and do, participate in more than one of these options, and thus obtaining relative enrollment numbers is problematic.[6]

Funding, Costs, And Cost Containment

The seven nations vary widely in how they pay for pharmaceuticals for the elderly, but

EXHIBIT 1
Publicly Provided Access To, Coverage Of, And Cost Policies Toward Pharmaceuticals For The Elderly In Seven Nations

Country	Proportion of elderly covered for drugs	Annual premiums for drugs	Deductible for drugs	Cost sharing for drugs	Out-of-pocket annual maximum for drugs	Reductions for low income, chronic disease
Australia	100%	None	None	Fixed amount; pensioners pay U.S.$1.94 per prescription (receive pharmaceutical allowance in pension to defray some of the cost)	Once total drug expenditures exceed U.S.$100.90 for seniors in a year, all prescriptions are free	None
Canada	98%	Varies by province, U.S.$0–$146	Varies by province and circumstance, U.S.$0–$1,160	Combination of fixed indemnity payment and coinsurance	Half of provinces have maximum, some fixed, some income-based	Low income

EXHIBIT 1
Publicly Provided Access To, Coverage Of, And Cost Policies Toward Pharmaceuticals For The Elderly In Seven Nations (cont.)

Country	Proportion of elderly covered for drugs	Annual premiums for drugs	Deductible for drugs	Cost sharing for drugs	Out-of-pocket annual maximum for drugs	Reductions for low income, chronic disease
Germany	100%	Yes, based on ability to pay	None	Fixed amounts, based on pack size	Copayments must not be more than 2% of patient income	Those with chronic disease must not pay more than 1% of total income; welfare recipients and those with incomes below a specified amount pay nothing
Japan	100% (employer-mandated system)	Employer and individual premiums and tax revenue for general health insurance	None	None if over age 70 (or over age 65 if bedridden); approximately 10 percent for others	Drug benefits are free if over age 70 (or over age 65 if bedridden); otherwise depends on income, assets, household size, demographics of city, etc., and also varies with type of care	Low income, chronically ill, and seniors over age 70
New Zealand	100%	Yes, part of expenditure on premiums is reimbursed	Not applicable	Fixed amount, U.S.$7.30 per prescription	High use (20 or more listed pharmaceuticals) in one year	None
United Kingdom	100%	None	None	Seniors are exempt from copays	None	None
United States	25% have coverage through Medicare managed care and Medicaid; 40%, through other sources	Varies by plan	Varies by plan and drug	Varies by plan and drug	Varies by plan; most have a maximum benefit and individuals cover cost over this amount	Varies by state residence, income status, and type of plan

SOURCES: Australia: Australian Bureau of Statistics, *Australia Now: A Statistical Profile of Health* (Canberra, 1999). Germany: L. Brown and A. Volker, "Manacled Competition: Market Reforms in German Health Care," *Health Affairs* (May/June 1999): 76–91; A. Evers, "The New Long-Term Care Insurance Program in Germany," *Journal of Aging Social Policy* 10, no. 1 (1998): 77–98; D.T. Mahkorn, "New President of the German Medical Council May Back Reform," *British Medical Journal* 318, no. 7198 (1999): 1576; and I. Rosian, C. Habl, and S. Volger, *Pharmaceuticals: Market Control in Nine European Countries* (Vienna, Austria: Federal Ministry of Labour, Health, and Social Affairs, 1998). Japan: L.A. Graig, *Health of Nations,* 3d ed. (Washington: Congressional Quarterly Press, 1999); N. Ikegami and J.C. Campbell, "Health Care Reform in Japan: The Virtues of Muddling Through," *Health Affairs* (May/June 1999): 56–75; and A. Oliver et al., "Japan's Aging Population: Implications for Healthcare," *Pharmacoeconomics* 11, no. 4 (1997): 306–318. New Zealand: Health Funding Authority's Funding Agreement with Minister of Health: Service Coverage Document (14 April 1999); *Health Expenditure Trends in New Zealand: 1980–1998* (Wellington: Ministry of Health, August 1999); and Pharmaceutical Management Agency Ltd., *Annual Review for the Year Ended June 30, 1998* (Wellington: PHARMAC, 1999). United Kingdom: Rosian et al., *Pharmaceuticals: Market Control in Nine European Countries*. United States: Health Care Financing Administration, *Medicare Chart Book, 1998* (Washington: U.S. Department of Health and Human Services, 1999); and Pharmaceutical Research and Manufacturers of America, *1999 Pharmaceutical Industry Profile* (Washington: PhRMA, 1999).

most use some combination of public sources and individual out-of-pocket sources; in Canada and the United States there is a heavy reliance on private third-party insurance as well. Because the funding mechanisms of different countries are complicated, it is difficult to know precisely what the overall distributions of individual expenditures in each nation are. However, it is likely that the more uniform, national, and public the funding effort is, the more consistent and more progressive the overall funding burden will be. This suggests that nations such as the United Kingdom, Japan, Australia, and New Zealand have the most progressively funded systems, and the United States, the most regressive.[7]

Several strategies have been used to manage escalating costs, including restrictions on drug coverage (through positive and negative lists), practice guidelines, generic substitution, reference-based pricing, user cost sharing, and physician-directed financial incentives.

■ **Positive and negative lists.** A hallmark of publicly funded pharmacare programs has been the use of positive and negative drug lists. These have also been extensively used by U.S. HMOs. All countries but the United Kingdom and Germany use positive lists, often referred to as formularies, which describe drugs that will be subsidized by the insurer. The United Kingdom and Germany use negative lists (that is, lists of drugs that will not be paid for by the insurer, fundholder, or health system). The default assumption is that should a drug receive approval for marketing in the country, the public insurer will subsidize that product unless an exception is made. Functionally, the result of positive and negative lists is the same for consumers. Thus, virtually no elderly persons in the nations studied have access to all licensed and approved drugs. In Germany recent attempts to introduce a positive list of drugs have been blocked by the pharmaceutical industry, as have attempts to greatly expand the negative list.[8] In Australia and New Zealand considerable attention is given to cost-effectiveness evaluation.

■ **Practice guidelines.** Because of their higher prices, new drugs present a challenge to pharmaceutical budgets and to the formulary system. Although the entry prices of new drugs are much greater than those of the older generation of drugs with which they compete, they often possess a clinical advantage that may justify their use in limited circumstances. An increasingly popular mechanism for dealing with such discretionary use is the use of practice guidelines. These are, in essence, authoritative statements of best practice in the management of specific medical conditions. Whereas formularies manage budgets through inclusion or exclusion of specific products, practice guidelines allow for greater discretion on the part of the prescriber while still restricting use.

Guidelines also are used in Australia, New Zealand, and the United Kingdom to set reimbursement policies for expensive new medications. They are being used increasingly in Canada by provincial governments and are commonly used in the United States by managed care organizations.

In the past it was common to develop guidelines through consensus conferences of leading physician specialists. Now guidelines often are developed with explicit reference to the "best evidence" on effectiveness and efficiency, incorporating input from epidemiologists, statisticians, and economists. The incorporation of formal economic analysis techniques was pioneered in Australia and Canada and was adopted much more recently in New Zealand.[9] It will likely play an important role in the United Kingdom, through the new National Institute for Clinical Excellence (NICE).

■ **Generic prescribing and reference pricing.** Generic drugs are chemically identical "copies" of pharmaceuticals with expired patents. In most countries physicians must prescribe by generic name for the generic product to be dispensed. Generic prescribing is promoted by most public insurers studied.

Reference-based pricing carries substitution a step further by declaring drugs in particular therapeutic classes as equivalent and setting reimbursement at either the lowest price or the average among therapeutically equivalent products, whether or not the prod-

ucts are generic. Some form of reference-based pricing is used in Australia, New Zealand, and Germany. One province in Canada has introduced it, and it is used in the United States by some pharmacy benefit managers (PBMs). However, policies vary greatly across the nations in terms of therapeutic categories of drugs selected, inclusion of patented medicines, and the selection of the reference price. For example, New Zealand makes no distinction between drugs that are on or off patent. Because the reference price is the lowest-price product (often a generic), generic prescribing is not heavily promoted.[10] By contrast, in Germany patented products are not referenced with off-patent drugs, and median prices are set as the reference.[11]

"U.S. policymakers' choice of policy levers will be dependent upon the political will to introduce explicit rationing criteria."

■ **Cost sharing.** While the above methods of cost containment have focused on supply-side measures, considerable effort has gone into demand-side management and cost control through deductibles, copayments, and coinsurance (applied to the drug ingredient cost alone, the dispensing fee, or both). In terms of elderly persons' spending on pharmaceuticals, because most of the nations employ last-dollar rather than first-dollar coverage, the out-of-pocket costs for prescription drugs can be considerable, even with universal coverage. Japan and the United Kingdom are the exceptions here. In the United Kingdom the elderly are exempt from copayments, and in Japan those over age seventy face extremely small copays and no premiums. Among Medicare beneficiaries in the United States, where there is no universal drug coverage and where the elderly consume one-third of all prescription drugs, the estimates for average, individual yearly out-of-pocket drug spending range from $300 to almost $600.[12]

All but the United Kingdom employ some cost sharing, but there is considerable variation across nations in how this is done (Exhibit 1). There also is large variation in cost-sharing provisions among Canada's provinces and U.S. states.[13] In all countries cost sharing in general has increased in the past decade. Australia, Japan, and several provinces in Canada provide the elderly with some relief from cost sharing; 80 percent of the British population, including all of the elderly, are exempt from drug cost sharing entirely. In New Zealand reductions in cost sharing are based on high use of chronic medications, many of which are used largely by the elderly.

■ **Physician-directed financial incentives.** Physicians in the United Kingdom, Germany, and New Zealand have prescribing budgets. In the United Kingdom, with the internal-market reforms of the early 1990s, some larger physician practices managed true fixed budgets for pharmaceuticals, while smaller practices held notional (nonbinding) budgets, with no tangible consequence if surpassed. With the recent conversion to primary care groups (and eventually primary care trusts), physicians collectively hold "hard" budgets for pharmaceuticals that are unified with budgets for other services.[14] A similar attempt in Germany to hold physicians financially accountable for prescribing budgets in the early 1990s was reversed within two years of its introduction, and physicians are resisting recent attempts to reintroduce strict budgets.[15]

In New Zealand, primary care organizations have taken on prescribing budgets.[16] In most cases, these have been notional budgets, and savings have been split between the primary care organization and the government. Because drug budgets were established based on relatively high historical rates of prescribing, drug budgets supply a large income for primary care organizations.

There is some evidence that drug budgets in the United Kingdom increase the prescribing of generic drugs and slow the increase in drug costs; however, the long-term cost-effectiveness of this strategy has not yet been evaluated.[17] Concern has been voiced recently that budgets may be resulting in regional inequities in access to more-expensive drugs.[18]

Common Problems And Converging Policies?

Faced with the common problem of balancing access to medicines while controlling costs, the nations we studied appear to be using the same mix of policy tools but to differing degrees. The convergence is particularly apparent in approaches to containing the costs of drug benefits for the elderly. Japan is an outlier in that it has not attempted to restrict the consumption of pharmaceuticals and has maintained its primary reliance on a strict pricing-regulation scheme to control costs.

Another common theme is the move toward universal or near-universal access to coverage for inpatient prescription drugs and last-dollar coverage for outpatient prescription drugs. None of the countries guarantees access to or subsidization of all outpatient drugs that are approved for marketing. The United States is an outlier in that it provides much less overall coverage for outpatient drugs through public sources and does not guarantee access to insurance for any outpatient drugs.

We were motivated to undertake this international review by the current U.S. debate over the adoption of universal outpatient drug coverage for the elderly. Are there lessons for the United States from the international experience? Although common policy tools are being used across nations, their application and the emphasis on one approach or another are largely governed by historical, contextual, and political factors. Whether implicitly or explicitly, each nation has defined certain values that place it on a different point on the spectrum between access and cost containment. Therefore, the scope of inferences that U.S. policymakers need to make regarding the choice of policy levers is dependent on more than technical approaches. Choices will be dependent upon the political will to introduce explicit rationing criteria for efficiency and cost containment. If explicit rationing using the policy mechanisms we have outlined is deemed unacceptable, then granting universal access will be very costly. However, the current absence of universal coverage involves a great degree of implicit rationing through the marketplace and consumers' ability to pay. In addition, U.S. HMOs already apply rationing tools.

We also caution the reader regarding the complexity of policy effect. When the elderly's access, coverage, and costs are assessed from an international perspective, the final result for any citizen is the product of several different policies that are simultaneously in force. Policies about out-of-pocket maximums, first-dollar versus last-dollar coverage, copayments, coinsurance, the use of positive and negative formulary lists, and so on form a complicated web; as each policy varies, it can have profound effects on the impact of another (and may also depend on policies toward hospitals, physicians, and other sectors).[19]

If the U.S. governing process decides to publicly guarantee meaningful access to outpatient prescription drugs for the elderly—an idea that the public apparently supports—then the nation presumably will be pushed toward adopting cost containment policies similar to those we have described. The choice of policy options should be anchored first by a consideration of where on the spectrum between access and cost containment the United States now lies.

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NOTES

1. See G.F. Anderson and P.S. Hussey, "Population Aging: A Comparison among Industrialized Countries," *Health Affairs* (May/June 2000): 191–203.
2. In Canada each province has introduced its own eligibility criteria for publicly funded Pharmacare, resulting in a mix of public and private insurance under which approximately 25 percent of citizens and 48 percent of filled prescriptions are covered publicly. Approximately 62 percent of citizens have some form of private drug insurance coverage, and about 11 percent have no coverage. See D. Dingwall, *Drug Costs in Canada* (Ottawa: Industry Canada, 1997).
3. Anderson and Hussey, "Population Aging."
4. D.J. Willison, P.V. Grootendorst, and J. Hurley, "Variation in Pharmacare Coverage across Canada" (Unpublished paper, McMaster University, Hamilton, Ontario, 2000).
5. S.B. Soumerai and D. Ross-Degnan, "Inadequate Prescription-Drug Coverage for Medicare Enrollees—A Call to Action," *New England Journal of Medicine* 340, no. 9 (1999): 722–728; D. Gross and S. Bee, "State Pharmacy Assistance Programs" (Washington: AARP, April 1999); and National Pharmaceutical Council, "Pharmaceutical Benefits under State Medical Assistance Programs" (Reston, Va.: NPC, December 1998).
6. For a recent attempt to place beneficiaries into single primary categories of coverage, see M. Davis et al., "Prescription Drug Coverage, Utilization, and Spending among Medicare Beneficiaries," *Health Affairs* (Jan/Feb 1999): 231–243.
7. For estimates of spending on prescription drugs by income category in the United States, see M.J. Gibson et al., *How Much Are Medicare Beneficiaries Paying Out-of-Pocket for Prescription Drugs?* (Washington: AARP, September 1999); D. Gross, C. Caplan, and M.J. Gibson, "FYI: Estimates of Financial Burden of Prescription Drugs on Beneficiaries in Medicare Fee-for-Service" (Washington: AARP, September 1998); and Davis et al., "Prescription Drug Coverage."
8. A. Tuffs, "Germany Fails to Introduce Drugs 'Blacklist,'" *British Medical Journal* 318, no. 7193 (1999): 1232; and A. Tuffs, "German Doctors Are Unhappy about Drugs Budget," *British Medical Journal* 319, no. 7209 (1999): 536.
9. Canadian Coordinating Office for Health Technology Assessment, *Guidelines for Economic Evaluation of Pharmaceuticals: Canada*, 1st ed. (Ottawa: Canadian Coordinating Office, November 1994); Commonwealth Department of Health, Housing, and Community Services, "Guidelines for the Pharmaceutical Industry on Preparation of Submissions to the Pharmaceutical Benefits Advisory Committee" (Canberra: Australian Government Publishing Service, August 1992); and R. Braae, W. McNee, and D. Moore, "Managing Pharmaceutical Expenditure while Increasing Access: The Pharmaceutical Management Agency (PHARMAC) Experience," *Pharmacoeconomics* 16, no. 6 (1999): 649–660.
10. Braae et al., "Managing Pharmaceutical Expenditure while Increasing Access."
11. See G.W. Selke, "Reference Price Systems in the European Community," in *Cost Containment, Pricing, and Financing of Pharmaceuticals in the European Community: The Policy Makers' View*, ed. E. Mossialos, C. Ranos, and B. Abel-Smith (London: LSE Health, 1994), 150.
12. Soumerai and Ross-Degnan, "Inadequate Prescription-Drug Coverage"; Davis et al., "Prescription Drug Coverage"; J. Rother, "A Drug Benefit: The Necessary Prescription for Medicare," *Health Affairs* (July/Aug 1999): 20–22; and Gibson et al., "How Much Are Medicare Beneficiaries Paying?"
13. Willison et al., "Variation in Pharmacare Coverage across Canada"; and Barents Group, "Analysis of Benefits Offered by Medicare HMOs, 1999: Complexities and Implications" (Washington: Henry J. Kaiser Family Foundation, August 1999).
14. A. Majeed and L. Malcolm, "Unified Budgets for Primary Care Groups," *British Medical Journal* 318, no. 7186 (1999): 772–776.
15. Tuffs, "German Doctors Are Unhappy about Drugs Budget"; A. Tuffs, "German Government Breaks Off Talks with Doctors," *British Medical Journal* 319, no. 7214 (1999): 874c; and R. Busse and C. Howorth, "Fixed Budgets in the Pharmaceutical Sector in Germany: Effects of Costs and Equity," in *Fixing Health Budgets: Experience from Europe*, ed. F.D. Schwartz, H. Glennerster, and R.B. Saltman (London: John Wiley and Sons, 1999), 109–125.
16. L. Malcolm and N. Mays, "New Zealand's Independent Practitioner Associations: A Working Model of Clinical Governance in Primary Care?" *British Medical Journal* 319, no. 7221 (1999): 1340–1342.
17. P. Wilton and R.D. Smith, "Primary Care Reform: A Three-Country Comparison of 'Budget Holding,'" *Health Policy* 44, no. 2 (1998): 149–166.
18. K. Bloor, A. Maynard, and N. Freemantle, "Regulating Industry (Lessons from Internal Experience in Controlling Pharmaceutical Expenditure, Part 3)," *British Medical Journal* 313, no. 7048 (1996): 33; and J.P. Ballantyne et al., "Management of Drug Budgets," *British Medical Journal* 318, no. 7187 (1999): 874.
19. Individual policies can vary further with different segments of the elderly populations, based on income or geographic area, for example. Therefore, we caution the reader not to simply "pick and choose" among the policy options presented here, but to consider their contexts.