insurance and private insurance. In recent years, personal payment and the welfare program defrayed between 70 to 80 percent of the total long-term care expenditures for those aged 65 and older, with Medicare, a social insurance program[3], and private insurance playing a minor role. This system may be likened to a two-legged stool, which is unlikely to be stable and reliable. Heavy reliance on personal payment and public welfare has spawned many calls for reform.

There have been many reform proposals over the past two decades. Some have suggested a new social insurance program. But new taxes have not been found. Others have promoted private long-term care insurance. But relatively few people buy this type of insurance; despite tax deductibility for the premiums of such policies being used as an incentive under the federal and (some) state tax laws. Many have come to the realization that neither social insurance nor private insurance will solve the problem. There is in existence a public-private partnership program, but its operation is limited to four states and any expansion of it into other states will require Congressional approval. A new funding model is needed.

The most promising approach to financing long-term care appears to be a new system that combines personal savings, private insurance, and social insurance. The government could create a social insurance plan to cover basic long-term care, to be supplemented by private insurance and personal payments. I call it a "three-legged- stool" approach[4] . When these three sources fail to provide for some individuals, a welfare program would cover the cost.

Where would the new system obtain its funding if public dollars are not available and private dollars are also scarce? It may be necessary to consider merging the resources we already have in order to increase our ability to meet more expenses. To combine resources, it is necessary to create linkages in both public and private sectors. Therefore, I suggest use of the trade-off principle—trading one purpose for another purpose—as a means to link resources.

The trade-off principle can be applied in both the public and private sectors. Applying it in the public sector, one could fund a social insurance program for providing basic (floor-of-protection type of) coverage for long-term care by requiring Social Security beneficiaries to divert a small portion, such as 5%, of their benefits for this purpose. I call it a "Social Security/Long-Term Care (SS/LTC) Plan." This plan would cover low-income Social Security beneficiaries but exempt them from the trade-off. Actuarial estimates suggest that the SS/LTC plan funded by transferring 5% of Social Security benefits could be expected to cover one year of nursing home stay or two years of home care.

In the private sector, we could apply the trade-off principle to enhance the ability and willingness of individuals to purchase long-term care insurance by linking it to:

- life insurance products (such as whole life, paid-up life, universal life, group life, or annuity policies)

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vernacular sense ("something to fall back on"), rather than in its actuarial sense, in terms of risk pooling among a large number of persons exposed to the same type of risk.

[3] Medicare is a federal health insurance program for people who are age 65 or older and for some younger persons with disabilities. Medicare has two parts. Medicare Part A helps pay for hospital stays, skilled nursing facility stays, home healthcare, and hospice care. Medicare Part B helps pay for doctor's bill, home healthcare, medical equipment, and preventive services. Medicare does not pay for long-term care in a nursing home or in one's own home, nor routine medical checkup. Medicare is regarded as a social insurance program. Part A is financed by payroll taxes paid by employees, employers, and the self-employed. Part B of Medicare is paid for by premium payments from enrollees with subsidies from general revenues.

[4] The "three-legged stool approach" is patterned after the way, as a model or as an ideal; we provide retirement income and acute health care for the older population. Retirement income is provided using Social Security for a floor of protection, with employment-based (occupational) pensions and personal savings supplying supplemental income. When these three sources fail to provide for some individuals, public welfare (Supplemental Security Income) serves as a safety net. Similarly, acute health care for the elderly is provided by Medicare, supplemented by employer-provided health benefits for retirees and by individual payments for non-covered expenses in some cases through Medicare Supplemental (Medigap) policies. When a person's health care needs cannot be met by these sources, public welfare (Medicaid) acts as a safety net.

- individual retirement accounts or other employed-based saving vehicles such as 401(k) plans, occupational pensions from employers, or government employee retirement programs at federal, state, and local levels, or medical saving accounts;
- home equity conversion (reverse mortgage) plans under which an homeowner may purchase life insurance policy with a rider for long-term care benefits.

Linking long-term care benefit to life insurance or annuity products already exists in the market, combining long-term care protection with income protection through life insurance or annuity. For example, with a rider for long-term care, a life insurance policy pre-pays the death benefit for long-term care expenses. If the insured does not need long-term care, then the funds in the insurance policy (such as universal life or variable universal life) continue to grow. Stated differently, unused long-term care benefits will pass to the beneficiaries of the policy. Under this arrangement, in essence, the policyholder trades off some or all of the death benefit for long-term care.

A word about use of home equity is in order. Empirical evidence suggests that few older homeowners have converted their home equity into spendable cash to augment their retirement income. In recent years, there have been suggestions that older homeowners pay for their long-term care expenses with money received from home equity conversion plans such as reverse mortgages. It would be more financially sensible, however, if older homeowners were to use money generated by reverse mortgages to pay the premiums for private long-term care insurance policies, rather than to pay for long-term care expenses per se.

In conclusion, to cope with anticipated high costs of long-term care, this editorial suggests a "three-legged-stool" funding model that represents contributions from government, employer, and individual, plus a safety net. It believes that such a funding approach is a viable strategy to allocate responsibility for a major cost such as long-term care between public and private sectors through a mixture of social insurance, private insurance, and personal savings. The three-legged-stool funding model may be regarded as a policy approach that would foster self-reliance (by means of private insurance and personal savings) and solidarity (with social insurance) simultaneously.

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II. ARTICLE I

Long-Term care insurance of Japan: How it has changed the way we take care of the elderly

By Seiritsu Ogura[*], *Wataru Suzuki*[+] *and Yanfei Zhou*[δ]

1. Introduction

The long-term care insurance (LTCI) of Japan was introduced in the year 2000. Many features of the Japanese LTCI have been taken from those of Germany and the Netherlands, but there are some important differences between them (Table 1). First of all, in the German or the Dutch systems, everyone is insured, and no one is excluded from its benefits, including the young and the handicapped. In contrast, the Japanese system covers only those at or above age 40, and only those at or above age 65 are entitled for to benefits. Those under the age 65 but over the age 40 are obligated to pay the premiums but are not entitled to benefits except for 15 specified "age-related" diseases (such as Alzheimer's, cerebro-vascular conditions, Parkinson's, etc). For the handicapped or disabled, Japan has a separate welfare program financed by the general tax-revenue. Secondly, in Germany, there are only three grades of care levels, and those who are certified as "support required" (Level 1) in our system would not qualify for benefits. In this sense, the Japanese system is more generous than the German system. Thirdly, in Germany or in Netherlands, in addition to at-home care benefits and institutional care benefits, cash benefits are paid to family care-givers. Cash payments have been excluded from the home-care menu in Japanese LTCI.

Table 1. Comparison of the Long-term Care Insurance System in Japan, Germany and Netherlands

	Germany	Netherland	Japan
Name of the system	Pflegeversicherung	Algemene WetBijzonder	Long-term care insurance
Insurants	Medizinischer Dienst der Kassen	Central government	Municipalities
Budget	Premium	Premium+ Copayment	Premium+ Tax+ Copayment
The insured	Almost all citizens	All citizens	· Citizens aged 40~ 60(Type 2 insured) · Citizens aged over 65(Type 1 insured)
Young & disabled	Eligible for payment	Eligible for payment	Not eligible for payment
Care level	3 levels	No care level defined	6 levels
Cash payment	Yes	Yes	No

Source: HLWM (2004) "Comparison of Long-term Care Insurance System Between Japan and Other Countries", Information released at the 12th Social Security Council.

We should also note here that together with the LTCI, "market principle" was introduced into the service market for the first time. Under the welfare system for the elderly that had preceded the LTCI, the suppliers of LTC services were limited to either the public sectors or "social welfare corporations" closely regulated by MHW. Furthermore, the elderly themselves or their families had been given no voice in the selection of their suppliers. With the introduction of LTCI, however, not

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only a wide range of new suppliers, from NPO to for-profit corporations, were admitted to provide the home-care services, but also the reimbursement rates for home-care services had been set significantly above the supply costs, in an attempt to induce a large number of new suppliers into the market. As in any other market, these suppliers are chosen directly by the consumers, rather than by the government.

2. Changes in the LTC Market

After the introduction of LTCI, the expansion of LTC market has been very impressive. Looking at the expansion from the demand side (see Table 2) the number of individuals with certified Care Levels has increased from 2.56 million in 2000 to 4.16 million in 2004. The number of individuals who actually utilized LTC services have increased from 1.68 million to 3.16 million. During this period, therefore, the number of the elderly who received LTCI benefits has increased by more than 10% per year. In comparison, the number of the elderly has increased at the rate of 3% per year.

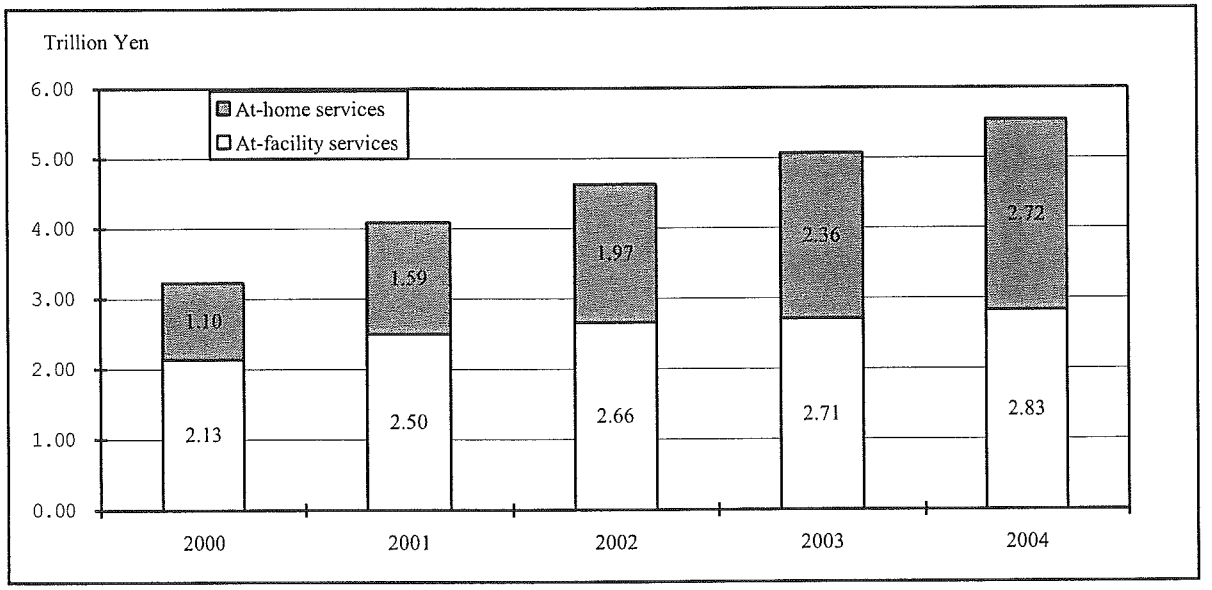
Table 2. Number of Certified Elderly and Users (in thousand persons)

	2000	2001	2002	2003	2004
Number of certificated elderly	2'562	2'983	3'445	3'839	4'162
		16.4%	15.5%	11.4%	8.4%
Number of long-term care service users	1'687	2'175	2'540	2'868	3'156
		28.9%	16.7%	12.9%	10.0%
Number of at-home service users	1'134	1'520	1'840	2'136	2'393
		34.1%	21.0%	16.1%	12.0%
Number of at-facility service users	554	655	700	732	763
		18.3%	6.8%	4.6%	4.2%
(Reference) Population over 65	22'422	23'168	23'934	24'494	25'229
		3.3%	3.3%	2.3%	3.0%

Notes: (1) Growth rate in the second line, (2) Predicted values for year 2004.

As a result, the benefits of LTCI increased from 3.24 billion yen from FY 2000 to 5.73 billion in FY 2004. As is shown in Figure 1, most of the growth in the expenditures for LTC comes from the home-care sector, even though the expenditures on institutional care have been growing steadily.

Figure 1. Cost of Long-Term Care Insurance Benefits (in trillion yen)



Source: Announcement of HLWM.
Notes: (1) Predicted values for year 2004.

Looking at the expansion from the supply side, not only the number of suppliers has jumped, but also the total number of employees in the LTC service sector has increased from 720,000 in 2000

to almost 1,000,000 in 2004, a 38% increase in the period. It is not surprising that most of the increase came from the home-care service sector that has added more than 200,000 employees, with institutional care sector adding only 70,000 employees.

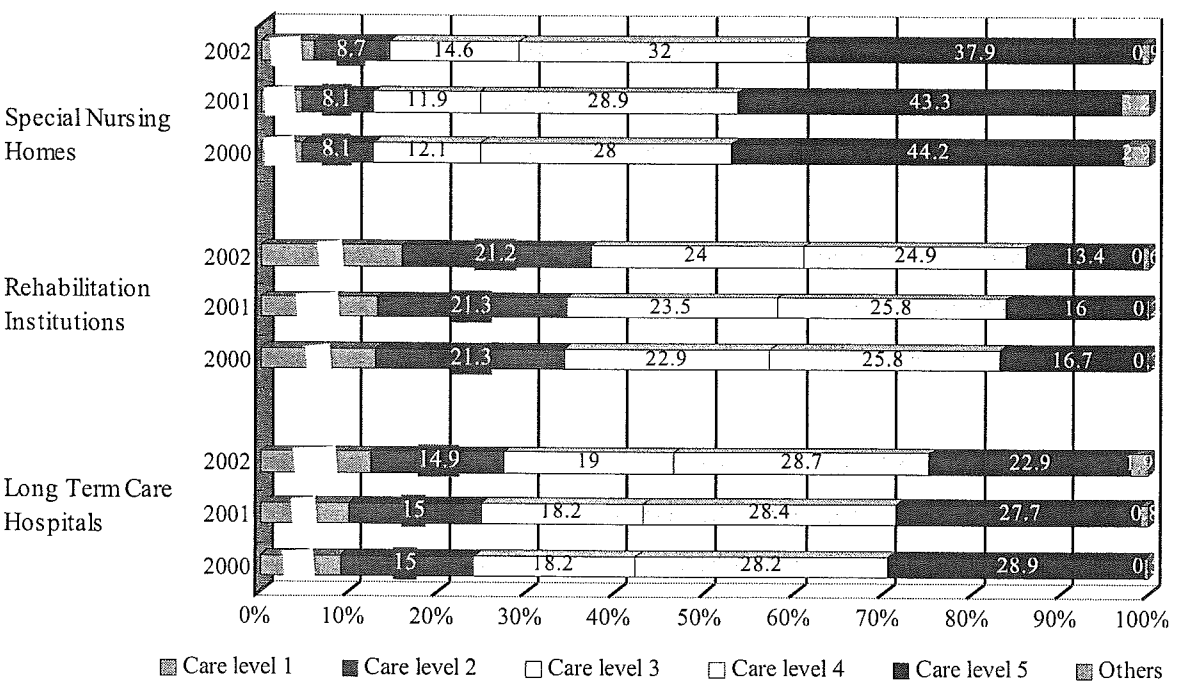
The cause of the differential growth rates seems to be in the very design of LTCI. While the restrictions on the entry of the home-care suppliers have been removed, the supply of institutional care services is still limited to social welfare corporations, medical corporations, and municipal government agents. In contrast to the surge in the demand for institutional care, following the introduction of LTCI, only limited increases in the supply capacity have taken place. This has resulted in overwhelming excess-demand and long waiting-lists for admission.

Currently, the number of individuals on the waiting-list are estimated to be between 300,000 to 400,000, which translates to an average waiting period of 5 to 7 years before admission. Reflecting this severe constraint on the supply of institutional care, the fastest growth in LTCI benefits is currently observed in such quasi-institutional services as group homes or care-houses, which are relatively its close substitutes in the home-care menu.

3. Changes in Care Levels in LTC Institutions

Prior to the LTCI, understaffed public LTC institutions had been notorious for low quality care service and they had been practicing cream-skimming, taking in patients with least care needs. Following the introduction of LTCI, however, there seems to be an improvement in these institutions as well. In Figure 2, the care level distributions of patients in each type of LTC institution are shown: the average care level has increased by 0.2 in the last three years in each type of institutions. Part of this increase may reflect the natural progression of care levels in institutionalized patients. From the figure, however, the increases in the share of high care level patients, particularly those of level 5, are taking place at the expense of those of low care level patients. This probably reflects the changes in the admission policies under LTCI: among the patients in the waiting list for admission, in some municipalities, priorities in admission are now determined in the order of applicants' care levels, rather than the calendar dates of their applications.

Figure 2. Distribution of Care Levels of Patients at LTC Facilities



Source: HLWM" Survey of Long-term Care Service Facilities"(2000-2002)

4. Economic Incentives and Changes in Care levels

From the viewpoint of the cared individuals, the changes in the quality of life are the most important consequences of LTCI. Unfortunately, there are few studies yet on this subject. Some even argued, on a limited evidence they have, that the care given to the institutionalized individuals has

deteriorated due to LTCI, since the insurance failed to provide financial incentives to prevent the deterioration or to reverse the care levels.

It is, however, much too early to make any definitive statements about the causal relationship between the observed changes in care levels and LTCI. On this point, Kawagoe[5] complied a panel data of all the individuals receiving LTC in one small prefecture and computed the complete transition matrix of individuals' care levels in 2000 and 2002 (Table 3). An individual's care level tends to increase over time, and the trend is particularly clear for levels 4 and 5. But for someone with a lower care level, the level remains the same for many, and some actually succeed in reversing the trend. For those with care level 2 in 2000, the results indicate that compared with individuals receiving home-care, those in LTC institutions had significantly lower proportions of improvements, and, more proportions of deteriorations. It is interesting to note that compared with home-care, individuals receiving quasi-institutional care (care-houses and group-homes) have experienced significantly more improvements.

Table 3. Changes in Care Level from 2000 to 2002 (%)

		Care level in year 2002							
		Support required	Care level 1	Care level 2	Care level 3	Care level 4	Care level 5	Dead or discharged	Total
Care level in year 2000	Support required	**32.4**	**34.8**	**8.4**	**2.9**	**1.7**	**1.1**	**18.7**	**100.0**
	Care level 1	**5.9**	**39.8**	**18.5**	**8.4**	**5.5**	**2.4**	**19.5**	**100.0**
	Care level 2	**0.5**	**11.6**	**31.8**	**17.9**	**10.2**	**4.1**	**23.9**	**100.0**
	Care level 3	**0.3**	**2.6**	**9.8**	**27.8**	**22.9**	**10.3**	**26.4**	**100.0**
	Care level 4	**0.1**	**0.7**	**1.4**	**7.1**	**29.9**	**25.66**	**35.3**	**100.0**
	Care level 5	**0**	**0.1**	**0.2**	**0.8**	**5.2**	**20.2**	**43.5**	**100.0**
	Total	**5.6**	**16.7**	**12.8**	**10.9**	**12.1**	**14.6**	**27.3**	**100.0**

Source: Kawagoe (2003).

5. Conclusions

LTCI, just four years after its introduction, has changed significantly how we take care of the elderly not only at home, but in institutions as well. The first stage of the new insurance has been a solid success: all available indices of LTC market outputs have literally doubled. At the least, a substantial portion of the family burden has been replaced by LTCI benefits, and the LTC institutions are admitting high care level individuals. This success in the first stage, however, immediately creates a far more difficult problem for the second stage: namely, how can we control the costs and make the system sustainable in the long-run?

The insurance program is scheduled for periodical review once every five years, and, at this moment, the administration's LTCI reform bill is in the final stage before becoming a law. The bill adds preventive care services to its at-home care menu, and starts charging housing and food costs to the individuals in LTC institutions. The preventive care services are introduced to prevent the deterioration of the disabilities, and the new out-of-pocket costs for institutional care are introduced to reduce the huge excess-demand for the service. Additional changes in its financing mechanism are in the wings for FY 2006 as well: the inclusion of 20 to 39 years old, who are currently excluded from the insurance, and integration of LTCI with the cash-stripped welfare system for the handicapped are some examples.

[5] Kawagoe (2003), "Evaluation on the Efficiencies of Long-term Care Services – Current Circumstances and Future Style of Care Management", *A Report of Nichii Soken*.

III. INVITED ARTICLE II

Do workplace factors influence health? Cross-country findings

By Nabanita Datta Gupta[*] and Nicolai Kristensen[#]

Introduction

Uncovering the precise impacts of work on health becomes especially salient as the workforce ages, and as physical job demands and stress have been found to be important predictors of early retirement (Johnson, 2002). In fact, concerned that increasing job demands and changing skill requirements may be forcing older workers into retirement, the recent Barcelona target urges EU countries to find ways to retain their older workers on at the job (EU Commission, 2003). Among prime-aged workers as well, health deterioration due to work-related illness/injury or mental health problems resulting from job strain and stress leads to an annual sickness benefit expenditure of almost 2-3% of GDP in certain European welfare states (Askildsen *et al.* 2000). For the purpose of formulating appropriate workplace health policy therefore, it becomes imperative to know the channels through which work affects health.

We present cross-country evidence on the impact of workplace factors on health within subgroups of workers in the labour market by estimating separate dynamic panel models for Denmark, France and Spain, three countries with different economic structures, labour market institutions and health-care systems.

Data

Data from 3 countries in the European Community Household Panel (ECHP), Denmark, France and Spain, are utilized for each year in the period 1994-2001. Only full-time employed respondents (30+ weekly hours) between 18 and 65 are selected, resulting in panel samples of about 13,000 observations in Denmark and around 23,000 observations in France and Spain. The ECHP household data file contains demographic information and detailed household and labour market income components.

An objective measure of health is employed i.e. the presence of an Activity of Daily Living (ADL) disability. This is based on the question "Are you hampered in your daily activities by any physical or mental health problem, illness or disability?" with values 1=yes, severely, 2=to some extent, 3=no, and transformed to a 0/1 binary variable in the empirical analysis.[6]

Workplace factors are measured as satisfaction with various job domains at the present job including job security, type of work, number of working hours, working time (shift) and working conditions. Broadly speaking, we can distinguish between health effects of *extrinsic* job characteristics, which have to do with financial rewards such as job security, number of working hours, working time and *intrinsic* job factors such as the type of work and work environment. All measures are subjective and record the individual's satisfaction level with the relevant job domain, on a scale of 1 to 6. The subjective work environment variable captures both physical exposures at

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[6] An objective health measure does not suffer from the problem of non-comparability across individuals inherent in subjective self-assessed health mapped to a categorically defined measure, for example (Kerkhofs and Lindeboom, 1995, Groot 2000). On the other hand, an objective measure could be only weakly correlated with actual work incapacity.

the workplace (noise, tobacco smoke etc.) as well as psychological aspects such as relations with co-workers, conflict resolution, discretion over work etc.

Results

Table 1 presents marginal effects of job factors on health, derived from panel estimations of a health model in each of the 3 country samples for blue and white collar workers as well as workers aged 50 years or more, separately.[7] The parameter estimates of the additional controls are not reported here but generally concord to a priori expectations. The most striking finding from the estimations is that the effect of a (good) work environment is highly significant and promotes health in all three countries, cf. Table 1 overleaf.

Focusing first on blue-collar and white-collar workers, the results show that a good working environment is the factor most strongly associated with good health for both blue-collar and white-collar workers in all 3 countries, the only exception being white-collar workers in Spain, for whom the effect is on the margin of being significant (t=1.36). The marginal effect of (good) work environment decreases the probability of ADL limitation by about 1% for blue-collar workers and about half a percent for white-collar workers in Denmark and France. Apart from work environment, cross-country differences seem to exist in the relative importance of other job factors: In France, satisfaction with job security is important for good health of white-collar workers and in Denmark, both satisfaction with job security and working time are important.

Table 1 Marginal effects of satisfaction with workplace factors on health (ADL), by country and type of worker

	Denmark			France			Spain		
	Blue collar m.e.	White collar m.e.	Aged 50+ m.e.	Blue collar m.e.	White collar m.e.	Aged 50+ m.e.	Blue collar m.e.	White collar m.e.	Aged 50+ m.e.
job security	-0.003	-0.003 **	-0.003	-0.007 ***	-0.004 ***	-0.015 **	-0.001	0.000	-0.002
type of work	-0.004	-0.001	-0.004	-0.008 ***	-0.003 ***	-0.010 *	-0.001 *	0.000	-0.006 ***
work hours	0.002	-0.002	0.002	-0.006 **	-0.001	0.000	-0.002 ***	0.000 **	-0.007 ***
working time	-0.004	-0.002 *	0.007	-0.006 ***	-0.002	-0.006	-0.001 **	0.000 **	-0.004 *
environment	-0.008 **	-0.004 **	-0.006	-0.012 ***	-0.004 ***	-0.021 ***	-0.002 ***	0.000	-0.009 ***

Note: m.e. = marginal effect. *=significant at 10%, **=significant at 5%, ***=significant at 1%.

Satisfaction with the type of work seems to matter for health of blue-collar workers in both Denmark (only marginally significant, t=1.2) and France, although in the latter, satisfaction with job security and working time also exerts significant effects. In Spain, on the other hand, satisfaction with working hours is important for health of both blue-collar and white-collar workers. Job security on the other hand, does not seem to exert an important effect on health.

Thus, a definite divide seems to exist between Denmark and France compared to Spain with respect to the health effects of working hours and job security. A possible explanation for this difference could be stricter working hour regulation and lower employment protection in Northern

[7] Additional controls in the models include lagged health, demographics, SES (log income, education and home-ownership), occupation, industry and firm related variables as well as year dummies to capture any annual shocks to health due to business cycles or epidemics etc. This health equation is re-estimated separately for each of the workplace factors (domain satisfaction): work environment, working hours, working time, type of work and job security. See our companion paper for further details on the methodology (Datta Gupta and Kristensen, 2005).

and Continental Europe as opposed to Southern Europe. Time-sharing "work less, work all" policies adopted in previously high-unemployment economies such as Denmark and France ensures that the length of the working day is kept relatively shorter. This seems to have a beneficial effect on worker health. On the other hand, northern and continental labour markets are more flexible with easier employer recourse to firing of workers. As unemployment is one of the major causes of depression and mental ill health (Clark (2003), Clark et al. (2001), Clark et al. (2004), Winkelmann and Winkelmann (1997), Theodossiou (1998)), it may be the case that workers faced with a higher degree of uncertainty about their prospects of continuing on in the job may suffer greater anxiety and psychological stress.

With respect to older workers, since the sample only covers full time workers (30 hours/week or more) selection is present for all three countries. Nonetheless, here too, largest marginal effects obtain for working environment in all three countries.[8] In terms of other factors, job security and type of work is important for older workers in France, while type of work and working hours are significant in addition, in Spain. The lack of significance of other factors in the Danish case most likely just reflects the smaller sample size. Another interpretation may be that health-related exit from the labour market is common particularly among blue-collar workers holding physically demanding career jobs so that older workers who remain on the labour market in Denmark are in relatively better health and less affected by their working conditions.[9]

Conclusion

We investigate whether workplace factors are important for health by estimating a reduced-form dynamic panel model of health on 3 separate ECHP country samples over the period 1994-2001. Results show that job factors, both extrinsic and intrinsic, do impact employee health significantly even after accounting for unobserved heterogeneity and minimizing concerns of reverse causality. Further, despite wide differences in economic structure, labour market institutions and health-care systems, one regularity emerges in all 3 countries and across all worker types (blue-collar/white-collar/older): satisfaction with work environment is most strongly related to good health.

Country differences exist, however, in the relative importance of other job factors: In Denmark and France, satisfaction with job security is important for good health of white-collar workers and satisfaction with the type of work for health of blue-collar workers. In Spain, on the other hand, satisfaction with working hours is important for health for both blue-collar and white-collar workers. A possible explanation for cross-country differences in the effects of the other workplace factors on employee health could be the health protective effects of stricter working hour regulation in Northern and Continental Europe compared to Southern Europe. At the same time, despite generous unemployment protection of the Northern welfare-state regimes, satisfaction with job security seems to affect health of white-collar workers in Denmark and France but not in Spain. This may reflect the low-level of employment protection in Denmark and France, which is particularly a concern for white-collar workers for whom replacement rates of UIB are typically low. Finally, health-related early exit is more accessible in Denmark than in France and Spain, which may explain why older workers who remain in a full-time job in Denmark do not suffer health consequences of workplace factors.

Thus, welfare-state policies, labour market institutions and government regulation play an important role in generating health differences across countries. But, across countries, satisfaction with work environment is found to be the most important workplace factor affecting health. Accordingly, our conclusion is that employers and policy makers alike should explore ways in which to design or improve workplaces so as to create a working environment that reduces sickness absence and turnover, increases productivity and enables workers to stay on longer at the job.

[8] The estimated coefficient is not significant in Denmark, but this is likely due to the small sample size, given that the t-ratio is reasonable at 1.48.

[9] In Spain, under certain conditions, early retirement is possible at 61. Early exit in France can start in the late 50's for workers with considerable labour market experience. In Denmark, early retirement is widespread among certain groups at ages 60-62 (mainly blue-collar workers coming from physically demanding jobs) through the post-employment wage scheme, *efterløn*, or through disability pension, *førtidspension*. The latter is also accessible to individuals fulfilling certain social criteria and can begin at any age.

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IV. ARTICLE III

Prevention and private health insurance

By Christophe Courbage[*] and Augustin de Coulon[+]

Changes in individual behaviour induced by insurance coverage are one of the main concerns in insurance economics. In particular, the relationship existing between insurance and prevention activities has always been an important issue in the field. In their seminal work, Ehrlich and Becker (1972) looked at the interaction between market insurance and prevention activities. And as economists usually do, they classified prevention activities into two types. The first type, named self-insurance, is an ex ante activity (i.e. before the loss occurs), that reduces the severity of the loss should it occur. The second type, named self-protection, is also an ex ante activity, but one which reduces the probability of the loss. These authors showed that self-insurance and insurance are substitutes, i.e. the purchase of market insurance decreases the demand for self-insurance. Surprisingly, they derived that market insurance and self-protection could be complements.

These results were pioneers in the field of ex ante moral hazard. The ex ante moral hazard problem is defined as the possibility that insurance reduces incentives to prevent the loss occurring (Shavell, 1979). But contrary to Ehrlich and Becker's work, the moral hazard problem ultimately stems from an informational asymmetry, where the insurer cannot observe some of the actions of the insured. If market insurance premiums are actuarially fair and reflect prevention activity, the individual has an incentive to spend on prevention because it lowers the price of insurance. This is no longer the case if the price of market insurance does not reflect the individual's spending on

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prevention, and thus the availability of insurance may cause spending on prevention to fall, creating ex ante moral hazard. The price of insurance reflects individual spending on prevention if insurers are able to observe those activities or if insurers are able to infer the level of prevention from the loss.

This analysis may not fully apply to health insurance. A particularity of health insurance is that it does not insure the health risk directly but only the financial consequences of the illness. In addition, health insurance only reimburses a part of the cost of the treatment. Thus, the extent of moral hazard in terms of actions that affect health may not be that large for health insurance in most instances, since the uncompensated loss of health itself is so consequential. For instance, it would be surprising if people smoked because they knew health insurance would cover the cost of their possible lung cancer.

Ex ante moral hazard has mainly been discussed theoretically and there appear to be few empirical studies on health insurance markets (Zweifel and Manning, 2000). Actually, most of these empirical works look at the influence of cost sharing on the demand for preventive care rather than ex ante moral hazard (the true ex ante moral hazard effect). They mainly show that a higher level of coverage (including both curative care and preventive care) leads to an increase in preventive care. This seems to be the case because more health coverage makes preventive care less costly and not necessarily because health insurance reduces the financial consequences of the health risk. Considering prevention activities that are not insured, such as exercising, dieting or non-smoking behaviour, allows this confusion to be avoided (see Kenkel, 2000).

In a recent work (2004), we tested whether any evidence of ex ante moral hazard can be observed in the British health insurance system. In particular, based on both simple probits and an Instrumental Variable (IV) strategy, we examine whether purchasing private health insurance modifies the probability of exercising and smoking in the U.K.

In the U.K. private health insurance covers approximately 10% of the population. Over half has coverage through schemes provided by their employer, the rest being insured at their own cost or via members of their family. Previous evidence showed that waiting lists are a key determinant of the demand for private health insurance. Contracting private health insurance is a way to supplement the overall level of health insurance coverage that individual receive. Thus investing whether contracting private health insurance modify preventive effort addresses the ex ante moral hazard issue.

Without entering too much into details, it appears that being privately covered causes individuals to produce more non-insured preventive activities like walking, swimming and practicing sport. It may be the case that paying to be insured rather than being insured (through family members) only makes individuals more concerned about the risk they face. This particular issue would however require further investigation. Generally our results suggest that a health care market with widespread insurance coverage may lead to more (rather than less) prevention compared to a market where coverage is low. Such results prove to be a strong argument in favor of the development of private coverage in the health sector, at least on the ground of developing prevention activities. Given the potentially important policy implications of these findings, this calls for a deeper analysis.

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V. OTHER RESEARCH PROGRAMMES - SHARE

Survey of Health, Ageing and Retirement in Europe (SHARE) - New data will help Europe turn the challenges of population ageing into chances

"Northern Europeans are healthier and wealthier but the people in the South live longer," says Professor Axel Börsch-Supan, the coordinator of the Survey of Health, Ageing and Retirement in Europe (or SHARE). "There is a clear North–South gradient in health and income: Older persons in the North are better off financially and are in better health, but this does not translate into corresponding mortality differences."

This is one of many new findings revealed by the survey. Financed by the European Commission's DG Research, the US National Institute on Aging, and several national agencies, SHARE provides data on the life circumstances of about 22,000 persons age 50 and over in 11 European countries, ranging from Scandinavia to the Mediterranean. "Old Europe" has the highest proportion of older citizens of any continent, and the population ageing process will continue for the better part of this century. The data from SHARE, which all researchers have free access to, is a strategically important piece of the European research infrastructure.

"Europe is blessed with large cultural, historical, and political differences—even within small distances," notes Börsch-Supan. "SHARE provides a reliable scientific infrastructure that permits researchers in public health, economics, and the social sciences to use modern quantitative methods that compare countries and regions within Europe. Doing so will help us understand how culture, history and public policy — particularly important in these times of social and economic reform — affects the lives of Europeans over the age of 50."

SHARE, which is unique in its international and interdisciplinary breadth, has already produced a wealth of findings, the first results of which appear in a new book[10], *Health, Ageing and Retirement in Europe*.

On Health:

- *Education keeps us fit*: Within all 11 countries, there is a strong relation between health behaviour and socioeconomic status. For instance, compared to individuals with a higher education, individuals with a low education are 70 percent more likely to be physically inactive and 50 percent more likely to be obese.

- *Education helps prevent Alzheimer's disease*: Similarly, the strong relation between health and socioeconomic status also holds for mental health. For instance, cross-country differences between cognitive impairment rates correspond closely to cross-country differences in education. Depression is more frequent among persons with low income or low wealth, particularly in the northern countries of Europe.

- *Geriatric care needs improvement*: SHARE is the first survey that includes comparable indicators of quality of care for older persons. And most of these indicators suggest that there is much room for improvement. For example, from a preventive perspective, there is a serious lack of geriatric assessments and screening tests.

[10] Börsch-Supan, A. / Brugiavini, A. / Jürges, H. / Mackenbach, J. / Siegrist, J. / Weber, G. (eds.), Health, Ageing and Retirement in Europe – First Results from the Survey of Health, Ageing and Retirement in Europe. Mannheim: MEA, 2005.

On Employment:

- *Incentives to early retirement create early retirement*: Differences in welfare systems clearly affect the distribution and the age pattern of labour market participation and retirement. In countries where early retirement is allowed and/or is generous (typically Southern countries, but also Austria and France), we see a high prevalence of early retirees. As a result, there is a large unused labour capacity in countries such as Austria, Italy, and France, where many healthy individuals are not in the labour force.

- *Uptake of disability insurance is unrelated to health status*: The prevalence of the receipt of disability benefits during early retirement ages between 50 and 64 varies dramatically across the 11 countries, from 16 percent in Denmark to 3 percent in Greece. SHARE, which provides the first data that link these differences to internationally comparable health measures, reveals that the large variation in disability insurance across 11 European countries cannot be caused by differences in health.

- *Agreeable work place conditions support later retirement*: The perceived quality of employment during the pre-retirement years—for example, how much control we have over our work and how much of a match there is between effort and reward—varies considerably across the European countries surveyed, with a clear North–South gradient. Quality of employment is strongly associated with well-being: Lower quality of employment goes hand in hand with poor health and depression.

- *Volunteering is frequent in some countries*: Work for pay is not everything: Overall, 10 percent of the 65–74 age group does volunteer work, and in the Netherlands the percent is even higher—more than 25 percent. Then again, in other countries, like Spain and Greece, less than 4 percent report doing volunteer work in all age groups.

On Family and Social Networks:

- *The family unit has remained strong across generations*: Because the various generations of a family are geographically close, the potential for everyday support is high all across Europe, particularly so in the South. In particular, time spent helping others or looking after grandchildren is substantia l: About a third of the persons age 65 and over reported that they helped others or looked after grandchildren on a daily basis, and they spent on average 4.6 hours per day on such activities.

- *Parents give in the North, while children give in the South*: The SHARE data show that intergenerational money transfers are a major source of household wealth, but there is a clear North–South gradient. In the North, younger individuals receive more from their parents, while in the South, younger individuals frequently provide more for their parents.

On Economic Status, Income and Wealth:

- *Poverty is often alleviated by non-financial resources*: While poverty is still serious in some of the countries surveyed, poverty is limited, especially in the South, when you take into account the value of one's house. Likewise, living close to one's children—in the same household or the same building—remains a very important mechanism of social solidarity that serves an important poverty alleviation role, not only in the South but also in Germany.

- *Consumption inequality is much lower than financial inequality*: The SHARE data on consumption, the first of its kind, has revealed surprising differences across countries. The level of food consumption is much lower in the northern countries (e.g., Sweden and Denmark) than it is elsewhere in the countries surveyed. In all 11 countries, consumption inequality is lower than income inequality, and income inequality is lower than wealth inequality.

For further details, please visit http://www.share-project.org/ Coordinator: Professor Axel Börsch-Supan,Director, Mannheim Research Institute for the Economics of Aging, +49-621-181-1861.

VI. THIRD HEALTH AND AGEING CONFERENCE

Longevity - a Medical and Actuarial Challenge

Munich, 24 November 2005
hosted and co-organised by GE Frankona Rückversicherungs-AG

08.40 Welcome / Opening Remarks

- Patrick Liedtke, Secretary General of The Geneva Association
- Prof. Dr Wolf-Rüdiger Heilmann, GE Frankona Rückversicherungs-AG, Board Life & Health

09.00 – 12.45 Morning sessions
Chair: Prof. Dr Wolf-Rüdiger Heilmann, GE Frankona Rückversicherungs-AG

Session 1: Impact of technological and medical advances on longevity

- **Dr Caspar Sieger**, Head of Medical Department, GE Frankona Rückversicherungs-AG, Munich, "Impact of technological and medical improvements on longevity"
- **Dr Nicola Pangher**, Medical Director IT and R&D, ITAL TBS SpA, Trieste, "Living longer with micro and nano technologies"

Coffee Break

Session 2: Impact of pharmaceuticals advances on longevity

- **Dr Stephan Mumenthaler**, Head Economic Affairs, Novartis International AG, Basel, "Advances in longevity and the role of pharmaceuticals"

Session 3: Impact of social factor and multifactor on longevity

- **Steve Wilson**, Group Chief Actuary of Zurich Financial Services, Zurich, "The impact of multifactor on longevity" (tentative title)
- **Professor Axel Boersch-Supan**, University of Mannheim, "Socio-economic determinants of life expectancy"

12.45 Lunch Break

14.00 –16.40 Afternoon sessions
Chair: Dr Christophe Courbage, Head of Research Programme, The Geneva Association

Session 4: Longevity and insurance

- **Lucie Taleyson**, Head of the International Research and Development Center on Long-term Care Insurance (CIRDAD), SCOR VIE, Paris, "Longevity and long-term care insurance"
- **David Paul**, BUPA Group's Actuary, London, "Longevity and its impact on health systems"

Coffee break

Session 5: Innovative strategy to deal with the longevity challenge

- **Florian Boecker**, Head of the Actuarial Department of L&H, GE Frankona Rückversicherungs-AG, Munich, "Reinsurance of longevity" (tentative title)
- **Barbara Blasel**, Senior Marketer, BNP Paribas, London, "Longevity Protection: The Longevity Bond"

16.40 End of Conference: closing remarks

Should you be interested in participating in this conference, please contact the General Secretariat of The Geneva Association at secretariat@genevaassociation.org

VII. CALL FOR PAPERS

CALL FOR PAPERS

The Geneva Association Health and Ageing Research Program is pleased to announce a

Special issue of
The Geneva Papers on Risk and Insurance – Issues and Practice
on Health Insurance
October 2006

We encourage you to submit contributions related to the following areas:

- The impact of integrating an ageing population in health insurance systems.
- The effect of technology change on health insurance.
- The cost of intervention and technological advances in medicine.
- Development of health care systems and the capitalization debate.
- The interaction of public and private systems in health care provision.
- Long-term health care insurance and long-term health risks.

Suggestions for other topics will be considered by the editors.

The issue will be co-edited by Christophe Courbage (The Geneva Association) and Joan Costa-Font (LSE & University of Barcelona). All contributions will go through a blind refereeing process. Papers should be submitted electronically (word or adobe format only) by **31 January 2006** to Christophe Courbage (christophe_courbage@genevaassociation.org) and Joan Costa-Font (J.Costa-Font@lse.ac.uk).

For further information on the *Geneva Papers*, visit its web site http://www.palgrave-journals.com/gpp/

VIII. EDUCATION IN HEALTH ECONOMICS

Advanced Methods Of Cost-Effectiveness Analysis: Australian National University & University of Oxford, Health Economics Research Center, Canberra, Australia, 9-11 November 2005

A three-day computer-based course in cost-effectiveness analysis as used in the healthcare sector hosted by Australian National University. The course is for health economists, and health professionals with some experience of health economics, who wish to learn about recent methodological developments in cost-effectiveness analysis and gain practical experience of methods and techniques. For further details, please visit: http://www.herc.ox.ac.uk

Economic Evaluation in Health Care: Health Economics Research Group, Brunel University, Buckinghamshire, UK, 9-11 November 2005

This three day course provides an in-depth introduction to methods, techniques and use of economic evaluation in health care for those with no, or little, previous training in health economics. It draws on the extensive experience of the Health Economics Research Group and the teaching combines formal presentations, group work on case studies and opportunities for one-to-one discussions with the faculty. The aims of the course are to understand, to review and to use published economic evaluation studies; to be familiar with the key issues in setting up an economic evaluation study; to be able to identify the main data requirements for economic assessment of health care technologies. For further details please visit: http://www.brunel.ac.uk/about/acad/herg/courses/.

Master's Degree in Health and Medicine Economics on Line, organised by the University Pompeu Fabra

The degree consists of the postgraduate Programme in Pharmacoeconomics and the postgraduate programme in Health Economics and is adapted to the needs and requirements of professionals who have managerial responsibilities or would like to acquire the necessary skills to undertake them in: hospitals, clinical laboratories and public or private health centres; public administration dealing with the management/financing of medicine and health services; insurance or pharmaceutical companies; medicine and health services management training centres, etc. Fur further information you can consult the programme web page: http://www.idec.upf.edu/mesiol

Advanced Health Leadership Forum, University of California, Berkeley, January 6-13, 2006.

The Advanced Health Leadership Forum is a certificate-based international health program focusing on key health policy and management issues. Participants grapple in a practical manner with the health policy issues and options that have been converging internationally Participants will substantially advance their knowledge of workable solutions, innovations, and how to request and interpret policy analyses. They will also make important contacts with other prominent health care leaders from around the world-both speakers and fellow participants.
For further information, please visit: http://www.ahlf.upf.edu/

York Expert Workshops in the Socio Economic Evaluation of Medicines, St. William's College, York University, June 2006

The 3-day Quality of Life Workshop provides a detailed introduction to the theory and practice of quality of life measurement with particular emphasis on its use in economic evaluation. For further details, including our on-line booking form, go to http://www.york.ac.uk/inst/che/training/expert.htm

IX. HEALTH CONFERENCES

2005

October 20 — **International Forum on Long-term Care,** Washington DC, USA. For further information, please visit http://www.aarp.org/ltcforum

October 21-22 — **European Conference on Long-Term Care**, Mannheim, Germany. For further information, please visit: http://www.zew.de/de/veranstaltungen/details.php?LFDNR=424

October 28-30 — **6th International Conference on Health Policy Research: Methodological Issues in Health Services and Outcomes Research,** Boston, Massachusetts, USA. The conference theme is "Methodological Issues in Health Services and Outcomes Research". For further information, please visit http://www.amstat.org/meetings/ichpr/2005/index.cfm

November 3 — **Scientific Meeting: The UK Society for Behavioural Medicine,** London, UK. Topics will be on on incentivising General Practitioners, behavioural medicine, implementation, treatment adherence and concordance, determinants of behaviour change, and others. For further information, please contact admin.uksbm@iop.kcl.ac.uk

November 6 — **5th Annual Canadian Day on Global Health Research: Your Money or Your Life: Health in the Global Economy,** Ottawa, Canada. For more information, please contact info@ccghr.ca

November 24 — **3rd Health and Ageing conference on Longevity - a Medical and Actuarial Challenge, Munich, Germany.** For more details please contact The Geneva Association.

December 1-3 — **13th International Congress on Occupational Health Services,** Utsunomiya City, Japan. For further information, please visit http://www.dokkyomed.ac.jp/dep-m/pub/ohs2005.html

December 9 — **Agro-food technologies - Opportunities and barriers to improving health: Lipgene Project,** Munich, Germany. Its purpose is to highlight the potential of existing and new technologies in improving the nutritional composition of animal and plant foods to benefit health, particularly in relation to the metabolic syndrome. For details please visit http://www.lipgene.tcd.ie/

2006

January 4-6 — **2nd Franco-British Meeting in Health Economics,** City University, London. For further details, please visit http://www.ces-asso.org/

June 10-14 — **5th International Conference on Health Economics, Management and Policy,** Athens, Greece. For further information, please visit http://www.atiner.gr/

July 6 — **6th European Conference on Health Economics,** Budapest, Hungary. For further information, please visit http://www.eche2006.com/index1.htm

August 23-26 — **4th Congress of the European Union Geriatric Medicine Society**, Geneva, Switzerland. For further information, please visit http://eugms2006.org

X. BOOKS ON HEALTH ISSUES

Long-term Care for Older People, OECD Health Project, OECD publication, 2005, ISBN 92-64-008489-9. This study reports on the latest trends in long-term care policies in nineteen OECD countries. It studies lessons learnt from countries that undertook major reforms in the past decade.

Dilemmas of Care in the Nordic Welfare State – Continuity and change, edited by Hanne Marlene Dahl and Tine Rask Eriksen, Ashgate Publication, 2005, ISBN 0-7546-4266-6. This book provides a comprehensive overview of the complex state of paid work in social care within the Nordic welfare states and of the dilemmas facing state-provided care in the region.

Commercialisation of Health Care - Global and Local Dynamics and Policy Responses, by Maureen Mackintosh and Meri Koivusalo, Palgrave McMillan Publications, 2005, ISBN 1-4039-4349-4. This book analyzes the causes and consequences of the expanding global and local commercialization of health care. It argues for the necessity and possibility of effective policy responses to develop good quality, universally inclusive health systems worldwide.

Long-term Care: Matching Resources and Needs, edited by Martin Knapp, Davis Challis, José-Louis Fernandez and Anne Netten, Ashgate Publications, 2004, ISBN 0-7546-4341-7. This volume honours the outstanding contribution of Bleddyn Davies to the field of long-term care, bringing together contributions from scholars and practitioners from many countries

Economics of Health Care Financing - The Visible Hand, by Cam Donaldson, Karen Gerard, Craig Mitton, Stephen Jan, Virginia Wiseman, Palgrave McMillan Publications, 2004, ISBN 0-3339-8431-5. This book examines the economics of health care systems in a non-technical manner. It is written in a highly accessible manner for economists and non-economists alike. It is very timely and includes the latest evidence of health care reforms and their implications from a number of countries with different systems.

Health Care Policy, Performance and Finance – Strategic Issues in Health Care Management, edited by Huw T.O. Davies and Manouche Tavakoli, Ashgate Publications, 2004, ISBN 0-7546-3865-0. Drawing on experiences from around the world, this essential collection examines the key strategic issues facing health services and analyses the policy implications of leading new research.

Health Insurance for the Poor in Developing Countries, by Johannes P. Jütting, Ashgate Publications, 2005, ISBN 0-7546-4125-2. This book addresses the issue of health insurance for poor people by analysing new and innovative ways of financing health care for these people in developing countries.

International Public Health – Patients' Rights vs the Protection of Patents, by Yves Beigbeder, Ashgate Publications, 2004, ISBN 0-7546-3621-6. This book highlights the need for cooperation between major organisations – intergovernmental, commercial or nongovernmental - to ensure the access of developing countries to affordable medicine and vaccines, in spite of their different mandates and interests.

Providing Integrated Health and Social Services for Older Persons – A European Overview of Issues at Stake, edited by Andy Alaszewski and Kai Leichsenring, Ashgate Publications, 2004, ISBN 0-7546-4196-1. This work presents an overview of European approaches towards the the integrated social and health care services and policies that are required in the face of ageing societies.

Transforming Disability Welfare Policies – Towards Work and Equal Opportunities, edited by Bernd Marin, Christopher Prinz and Monika Queisser, Ashgate Publication, 2004, ISBN 0-7546-4284-4. The contributors address a wide range of issues including what it means by to be disabled, what rights and responsibilities society has for people with disabilities, how disability benefits should be structured, and what role employers should play.

XI. GENEVA ASSOCIATION PUBLICATIONS

The Geneva Papers on Risk and insurance – Issues and Practice

Vol. 30, No 4 / October 2005

Special Issue on the Four Pillars
Editorial, by Geneviève Reday-Mulvey
THE FUTURE OF PENSIONS AND RETIREMENT INCOME
Private Pension Provision: An OECD View, by Juan Yermo
Challenges Posed By Ageing To Financial and Monetary Stability, by E. Philip Davis
Social Security Personal Accounts: Program Interactions and Shifting Risk Burdens, by David P. Richardson and Jason S. Seligman
A Mountain Too Far? The Saga of Social Security Personal Accounts, by Sheila Bair
The Future of Pensions in Taiwan, by Yung-Ming Shiu
WORKING BEYOND 60
Working Beyond 60—Introduction: Key Policy Issues and Recommendations, by Geneviève Reday-Mulvey
The Employment Of Older People: Can We Learn From Japan?, by Casey Bernard
The Fourth Pillar and the UK: Flexibility, Risk and the Deinstitutionalization of the Life Course, by Patrick John Ring
Reversing the Trend from 'Early' to 'Late' Exit: Push, Pull and Jump Revisited in a Danish Context, by Per H. Jensen
Promoting Employment among Ageing Workers : Lessons from Successful Policy Changes in Finland, by Seija Ilmakunnas and Mervi Takkala
The Double Standard in Attitudes toward Retirement – The Case of the Netherlands, by Hendrik P. Van Dalen and Kène Henkens
Labour Force Participation of Elderly Workers in Italy: Trends, Causes and Policy Issues, by Dario Focarelli and Paolo Zanghieri

Vol. 30, No. 3 / July 2005

Special Issue on Corporate Governance and Corporate Social Responsibility
Guest Editor: Norman Baglini Global Brokers, Global Clients: A New Operational and Ethical Context, by James W Hutchin
The Complementarity between Corporate Governance and Corporate Social Responsibility, by Andrea Beltratti
Corporate Social Responsibility: An Economic and Financial Framework, by Geoffrey Heal
The Responsibilities of Accountants, by Ronald F Duska
The Link Between Corporate Governance and Corporate Social Responsibility in Insurance, by Lutgart Van den Berghe & Céline Louche
Towards a Good Governance in Financial and Insurance Services: Transparency in the Life Insurance Industry in Italy, by Giampaolo Galli
Ethical Issues Facing Stock Analysts, by J Paul Newsome
Investor Needs for Transparency and Good Governance, and Insurance Reactions, by Maurizio Lualdi
The Role of Professional Organizations in Boosting Trust in Financial Business, by Brian K Atchinson
Corporate Social Responsibility and Sustainability Challenges for a Bancassurance Company, by Emanuele Marsiglia & Isabella Falautano
Also
Insurers are not Banks: Assessing Liquidity, Efficiency and Solvency Risk Under Alternative Approaches to Capital Adequacy, by Paul Kupiec & David Nickerson
Issues Relating to Collateral Requirements Imposed upon Alien Reinsurers of United States Ceding Insurers, by Ernst Csiszar

The Geneva Risk and Insurance Review

Vol.30, No.1 / June 2005

The Probationary Period as a Screening Device: The Monopolistic Insurer, by Jaap SPREEUW
Assessing the Efficiency of an Insurance Provider—A Measurement Error Approach, by Mario JAMETTI and Thomas VON UNGERN-STERNBERG
A Note on Partial Insurance and the Arrow-Pratt Measure of Risk Aversion, by W. Henry CHIU
Mortality Risk and the Value of a Statistical Life: The Dead-Anyway Effect Revis(it)ed, by Friedrich BREYER and Stefan FELDER
Tax Compliance and Rank Dependent Expected Utility, by Jean-Louis ARCAND and Grégoire ROTA GRAZIOS
Strategic Price Discrimination in Compulsory Insurance Markets, by Luigi BUZZACCHI and Tommaso M. VALLET
The Newsboy Model: Changes in Risk and Price, by Jorge IBARRA-SALAZAR

Recent Working Papers Series "Etudes et Dossiers"

No. 293 / Mars 2005
7th Meeting of The Geneva Association's Amsterdam Circle of Chief Economists, Amsterdam, 10 – 11 February 2005 & Insurance Strategies for China – International Perspectives, Hangzhou, China, 24 – 26 October 2004

No. 294 / April 2005
The 20th PROGRES International Seminar on New Developments in the Regulation and Supervision of Financial Services, Geneva, 4 – 5 November 2004

No. 295 / April 2005
The 27th Liability Regimes Conference on a European Perspective on Global Developments, Zurich, 27 – 29 October 2004

No. 296 / April 2005
Insurance and International Finance Reporting Standards, Milan, 1 December 2004

No. 297 / May 2005
5th Asian CEO Insurance Summit on Creating a World Class Management Culture for Growth and Success in Asia, Taipei, 20 – 22 March 2005

No. 298 / June 2005
The 21st PROGRES International Seminar on the Regulation and Supervision of Financial Services: Challenging Issues, Geneva, 7 – 8 April 2005

No. 299 / July 2005
11th Joint Seminar of the European Association of Law and Economics (EALE) and The Geneva Association, Berlin, 16 – 17 June 2005

No. 300 / August 2005
The Geneva Association's Health and Ageing Research Programme – Contacts and Links

No. 301 / October 2005
The CRO's Spring Workshop 2005 of The Geneva Association, organized with Hannover Re, Hannover, 11 – 12 May 2005