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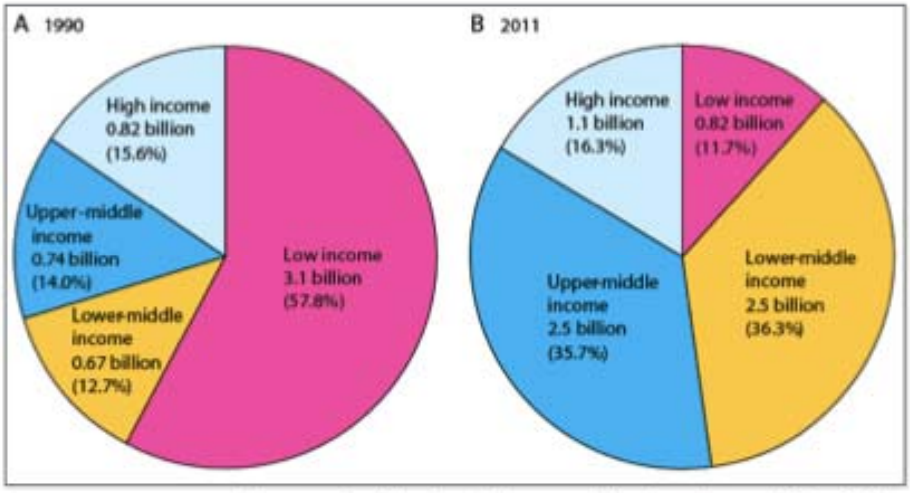
Alexander S. Preker

HIF New York

1993-2013: Extraordinary Health & Economic Progress



Movement of populations from low income to higher income between 1990 and 2011

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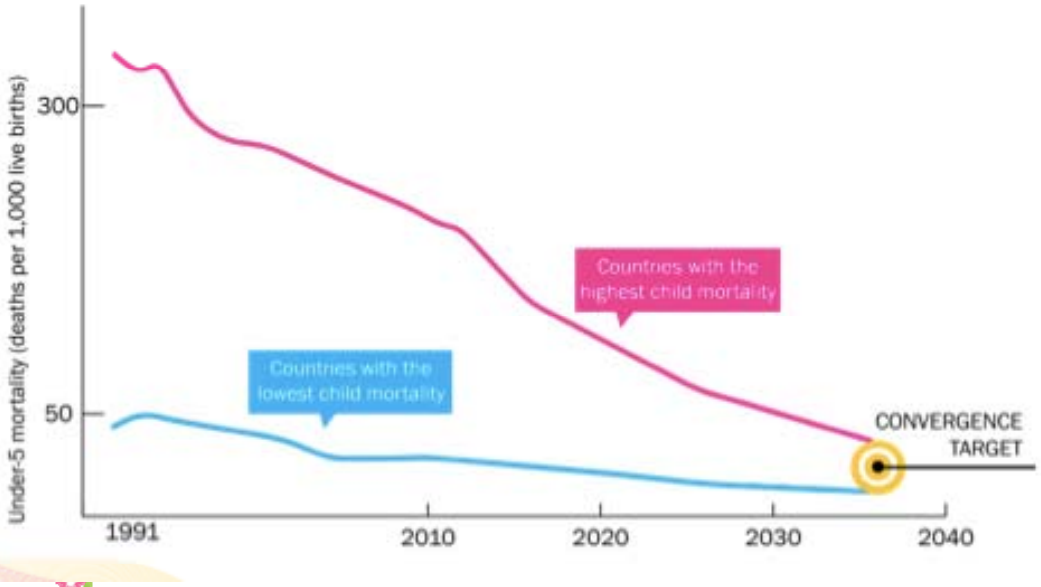
Now on the Cusp of a Historic Achievement: *Nearly All Countries* Could Converge by 2035



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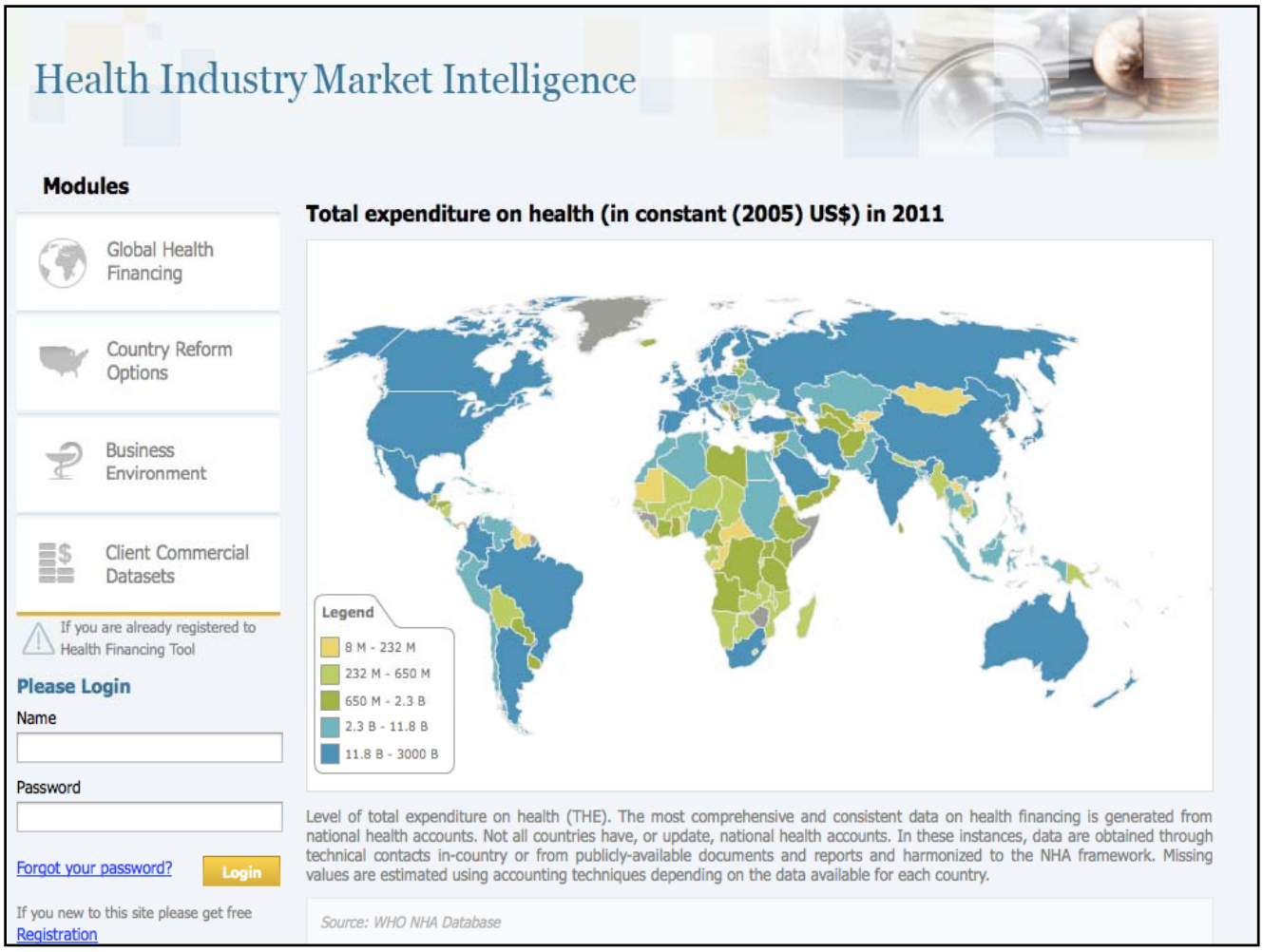
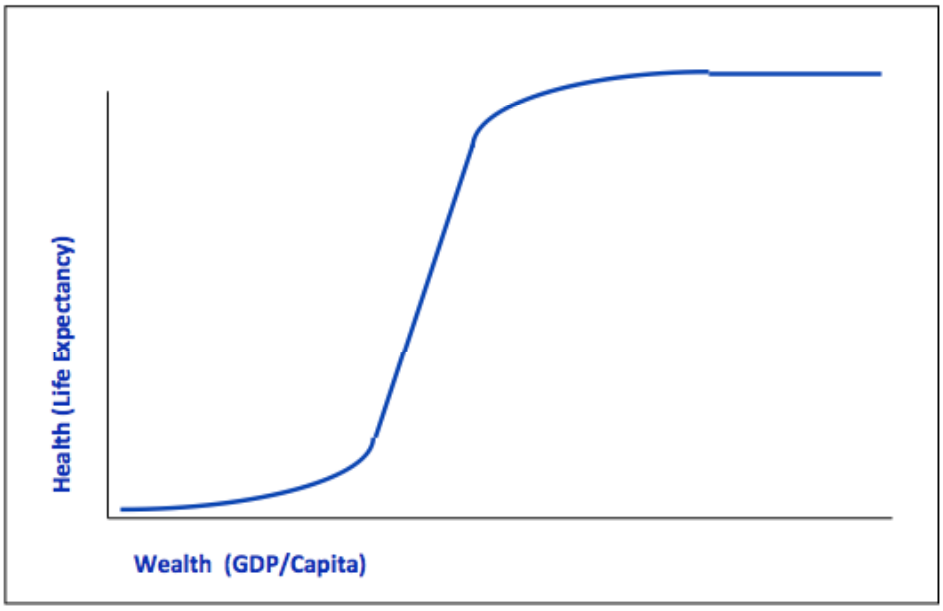

Health Industry Market Intelligence
Modules
Global Health Financing
Country Reform Options
Business Environment
Client Commercial Datasets
If you are already registered to Health Financing Tool
Please Login
Name
Password
Forgot your password?
Login
If you new to this site please get free Registration
Total expenditure on health (in constant (2005) US$) in 2011
Legend
8 M - 232 M
232 M - 650 M
650 M - 2.3 B
2.3 B - 11.8 B
11.8 B - 3000 B
Level of total expenditure on health (THE). The most comprehensive and consistent data on health financing is generated from national health accounts. Not all countries have, or update, national health accounts. In these instances, data are obtained through technical contacts in-country or from publicly-available documents and reports and harmonized to the NHA framework. Missing values are estimated using accounting techniques depending on the data available for each country.
Source: WHO NHA Database

Key Determinants of Good Health

H = Fn(I, E, N, F, Emp, Env)

I	= Income
E	= Education
N	= Nutrition
F	= Fertility
Emp	= Empowerment (women)
Env	= Environmental factors
HC	= Health Care

Impact of Wealth (GDP/capita) on Health



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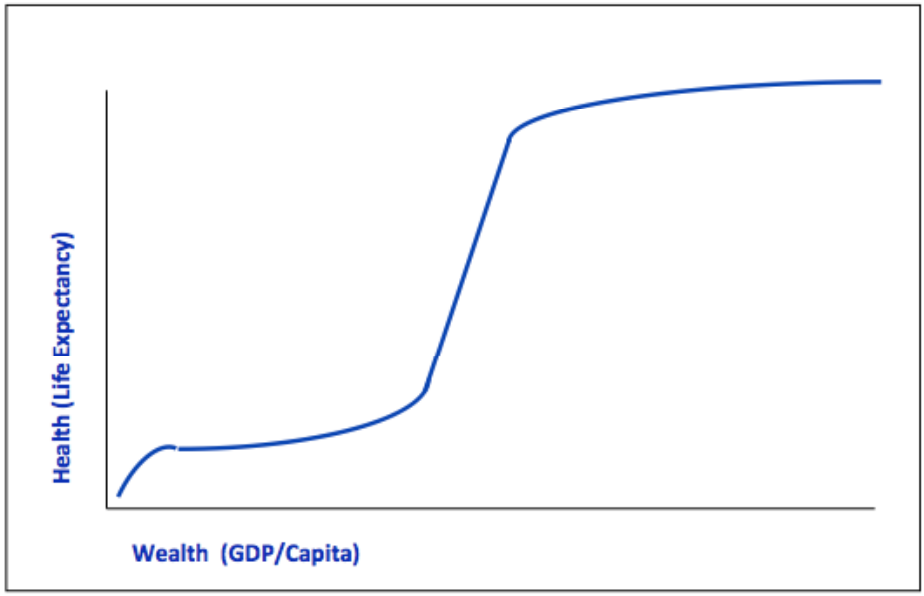
Key Determinants of Wealth

$$W = Fn(C, TL, NR, HC, HE)$$

C	= Competitiveness
TL	= Trade liberalization
NR	= Natural resources
HC	= Human capital
HE	= Higher Education
HE	= Health

Impact of Health on Wealth (GDP/capita)



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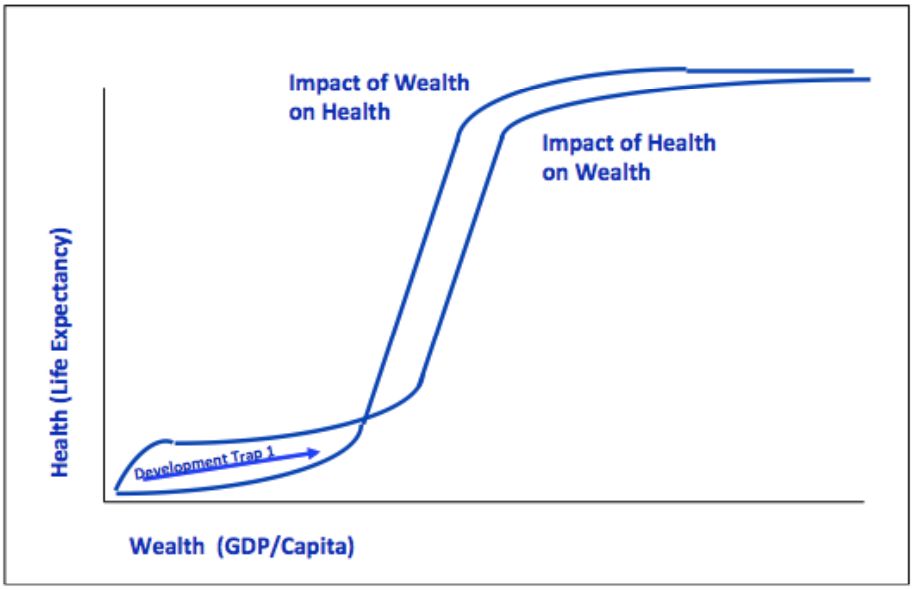
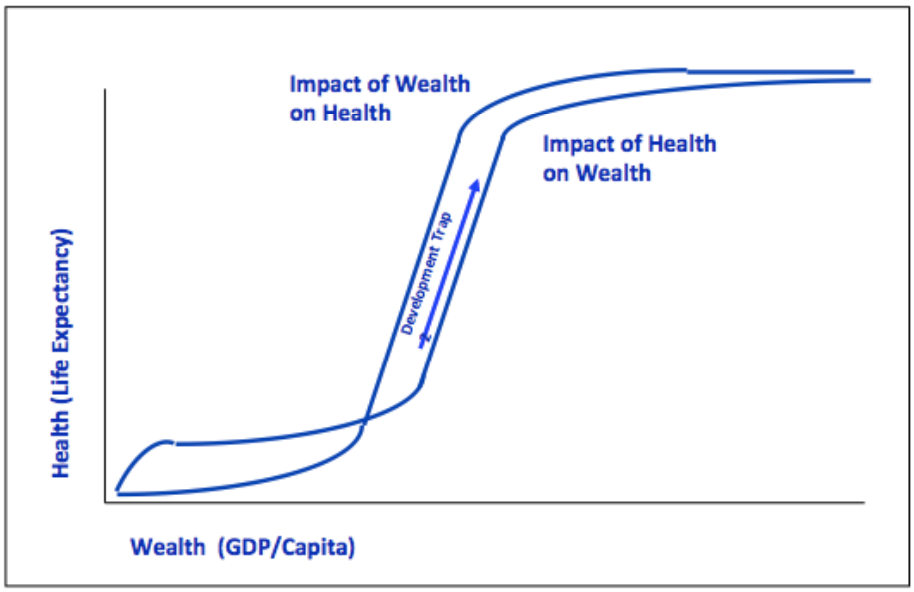
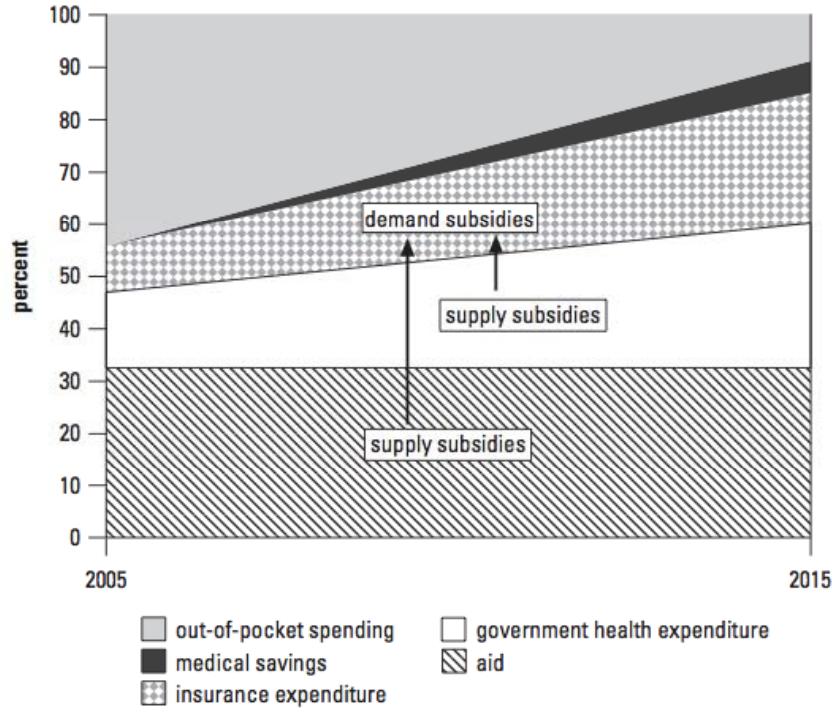
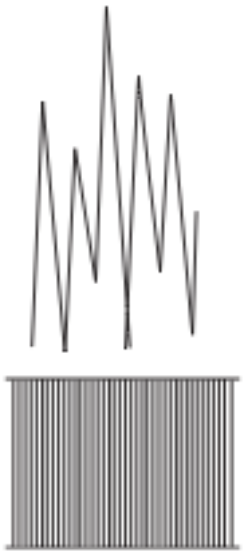
Low-Income Development Trap 1



Middle-Income Development Trap 2




100
90
80
70
60
50
40
30
20
10
0
percent
2005
2015
demand subsidies
supply subsidies
supply subsidies
out-of-pocket spending
medical savings
insurance expenditure
government health expenditure
aid

Variance	Nature of risk	Instruments
	**Insurable risk** • low frequency • high variance • unpredictable	Reinsurance Insurance
	Noninsurable • high frequency • low variance • predictable	Subsidies Savings

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Mark E. Litow

Independent Consultant

Purpose of Model

I. Represent current system re markets / coverage, expenditures, treatment access, revenues

II. Reflect risk characteristics that are drivers of above

III. Reflect changes with modifications to system design / provisions

Current System Illustration with Risk Characteristics

Illustrative Model United States 2013 Health Care Expenditures, Revenues*

	2013 Start Point	Age / Gender	Income / Subsidy	Benefits	Health Status	Reim-bursement	Availability of Providers, Etc.	Medical Cost Per Person	Population (millions)	Total Medical Cost B
Large Group – Under 65	9500	1.00	1.00	0.94	1.05	0.57	1.00	5345	123	657
Small Group – Under 65	9500	0.99	0.99	0.9	1.16	0.57	1	5541	27	150
Individual – Under 65	9500	0.93	0.96	0.84	1.08	0.57	1	4386	15	66
Medicaid – Under 65	9500	0.9	1	1.6	1.5	0.3	0.83	5109	48	245
Medicaid LTC	9500	4	1	1.2	8	0.3	0.75	82080	2	164
Uninsured	9500	0.93	0.93	0.6	1.12	0.45	0.92	2286	50	114
Medicare	9500	3.2	1	1.3	1.17	0.37	0.95	16253	45	731
Other***	9500	1	1	1.4	1.01	0.4	0.975	5239	10	534
Total									320	2662

** Illustrative Estimates of US Health Care System in 2013 reflecting NHE Expenditure Data, Extrapolation and Projections, and other Data as available*
*** Revenue from specific taxes and premiums. Remainder come from general revenues whether from income taxes or fees or borrowing*
**** Includes prisoners, military, Indians and some other groups. Costs include those for government institutions (i.e., HIH), government research and construction costs, dental, and long term care not included above*

Current System Illustration with Risk Characteristics

Illustrative Model United States 2013 Health Care Expenditures, Revenues*

	Total Medical Cost B	Admin	Cost Sharing	Premium	Health Cost Total	GDP	Gov Tax / Mpremium	Gov Revenue**
Large Group – Under 65	657	12.50%	0.86	646	738		0	0
Small Group – Under 65	150	23.00%	0.78	152	184		0	0
Individual – Under 65	66	30.00%	0.68	63	85		0	0
Medicaid – Under 65	245	7%	1	264	264		264	0
Medicaid LTC	164	7%	1	177	177		177	0
Uninsured	114	0	1	114	114			
Medicare	731	2%	0.74	552	742		552	331
Other***	534	0.00%	1	N/A	534		427	0
Total	2662	118.5	514		2838	16500	1420	331

** Illustrative Estimates of US Health Care System in 2013 reflecting NHE Expenditure Data, Extrapolation and Projections, and other Data as available*
*** Revenue from specific taxes and premiums. Remainder come from general revenues whether from income taxes or fees or borrowing*
**** Includes prisoners, military, Indians and some other groups. Costs include those for government institutions (i.e. HIH), government research and construction costs, dental, and long term care not included above*

Risk Characteristics

- Starting Point: Reflects certain market averages. In U.S. illustration, it is large group market for average labor force population (non-government)with $1,000 total out-of-pocket cost and loosely managed care
- Age / Gender: 3% to 4% on average per age-higher slope for males and less for females
- Utilization by Income: Lower for low income and higher for high incomes, without benefit recognition or subsidies; subsidies to low income can increase utilization; how they are provided makes a difference
- Benefit Level / Managed Care: The more third party payment the higher the utilization; the less coverage the lower the utilization

Risk Characteristics (cont.)

- Health Status: Note relationship to coverage level and access to treatment
- Reimbursement: Amount paid to providers - correlation to utilization and access to treatment important
- Provider Access: What is access to treatment within markets and coverage level
- Cost per person per market is multiplication of all factors; Total market cost is population times cost per person (can add administrative load)
- Premium, if applicable, is cost per person times cost sharing percentage divided by one minus administrative load as a per cent of premium
- Total cost / premiums are the sums across all markets as applicable

Factors to reflect in reform scenario are the impact of:

i. Subsidies and corresponding utilization modifications

ii. Mandates, including utilization and cost implications

iii. Eligibility provisions-impact on participation and utilization

iv. Coverage incentives or limitations (i.e., managed care, deductibles, HSAs, etc.)

v. Rating limitations by age, health status, etc.-can impact on coverage participation and utilization

Factors to reflect in reform scenario are the impact of: (cont.)

vi. Provider restrictions and requirements

vii. Provider reimbursements-impact availability of services, utilization, health status

viii. Limitations on population access to providers / services

ix. Taxes or revenue modifications: Can impact premiums and costs and utilization to

x. The extent services require direct payment

Outcomes

i. Compare status quo and reform scenario re participation, cost and affordability, and access to treatment.

ii. Balance of variables is what is important: A low cost system with modest or little access to treatment may or may not be better than a high cost system with great access to treatment.

iii. Countries with lower costs often have low reimbursements with limited access to treatment. But higher cost countries often have better access to treatment with affordability an issue.

iv. High costs may arguably incent poor behavior re health status just as poor access to treatment may encourage better behavior or lifestyles.

v. Other correlations / controversies - model is a tool to understand outcomes and identify areas for research.

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Al Schmitz

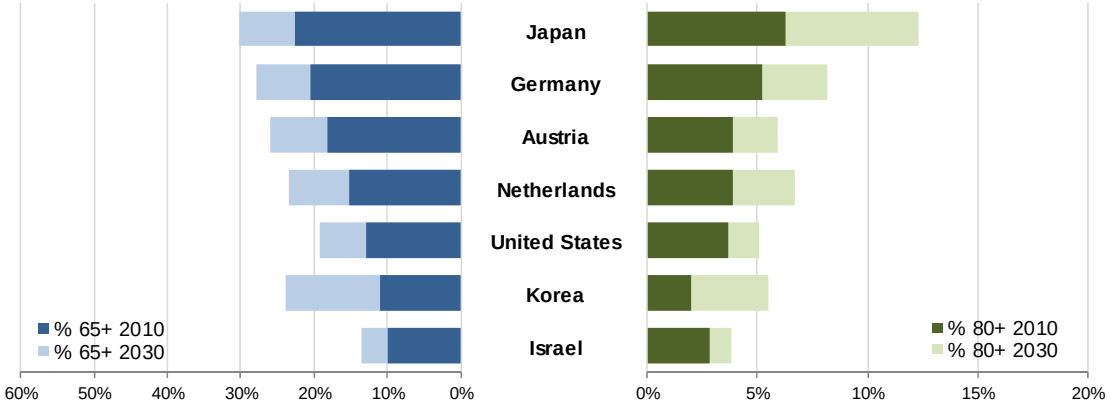
Milliman

LTC – Important Part of Healthcare

- International LTC Picture – Common Themes
  - Demographics
  - Costs
  - Provider Environment
- LTC Systems Around the World – What's Working
  - Public / Private Roles
  - Financing, Benefits, Eligibility, Participation

Aging Populations

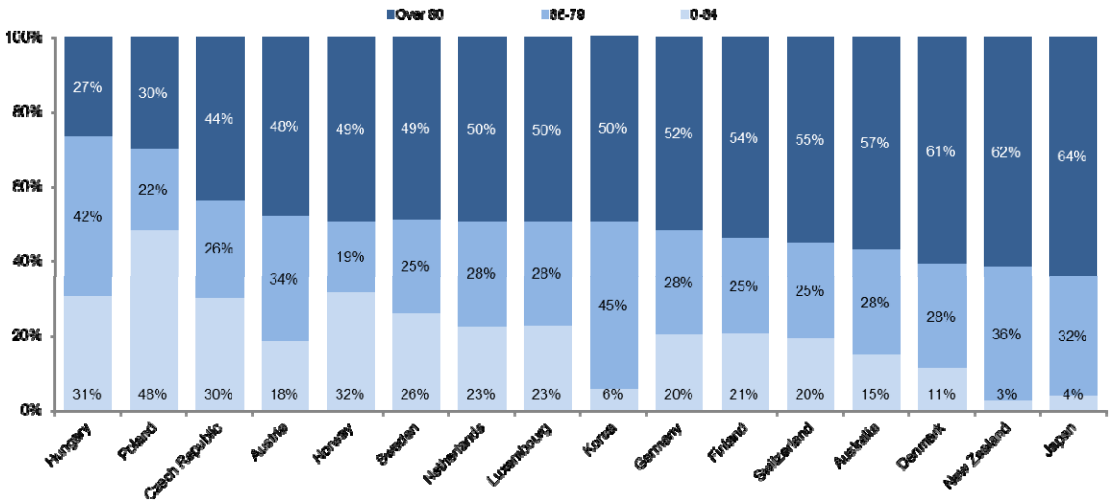
Figure 1: Shares of Population Age 65 and Older and Age 80 and Older



Source: U.S. Census Bureau, International Data Base.

Demand by Age

Approximately half of all LTC users aged over 80 years



Source: OECD Health Data 2010 and additional Australian and Swedish data.

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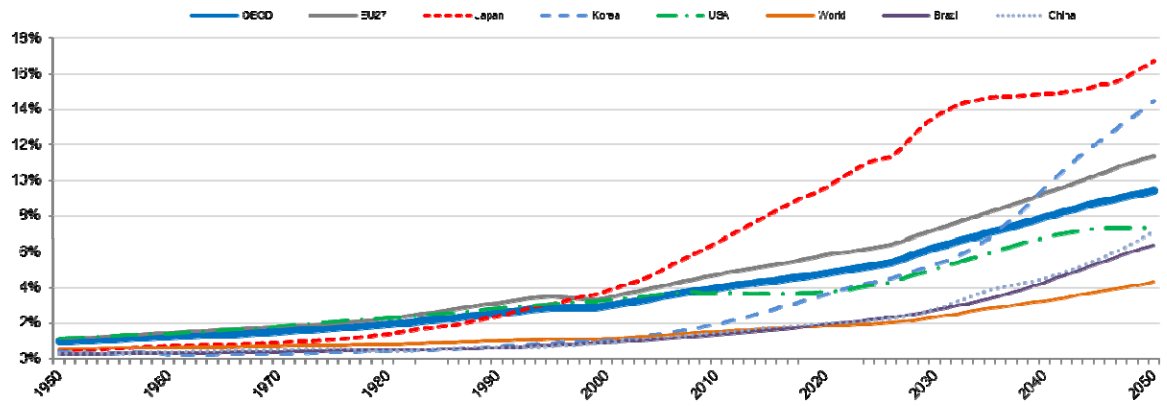
Population Age 80+ Increasing



Source: OECD Labour Force and Demographic Database, 2010.

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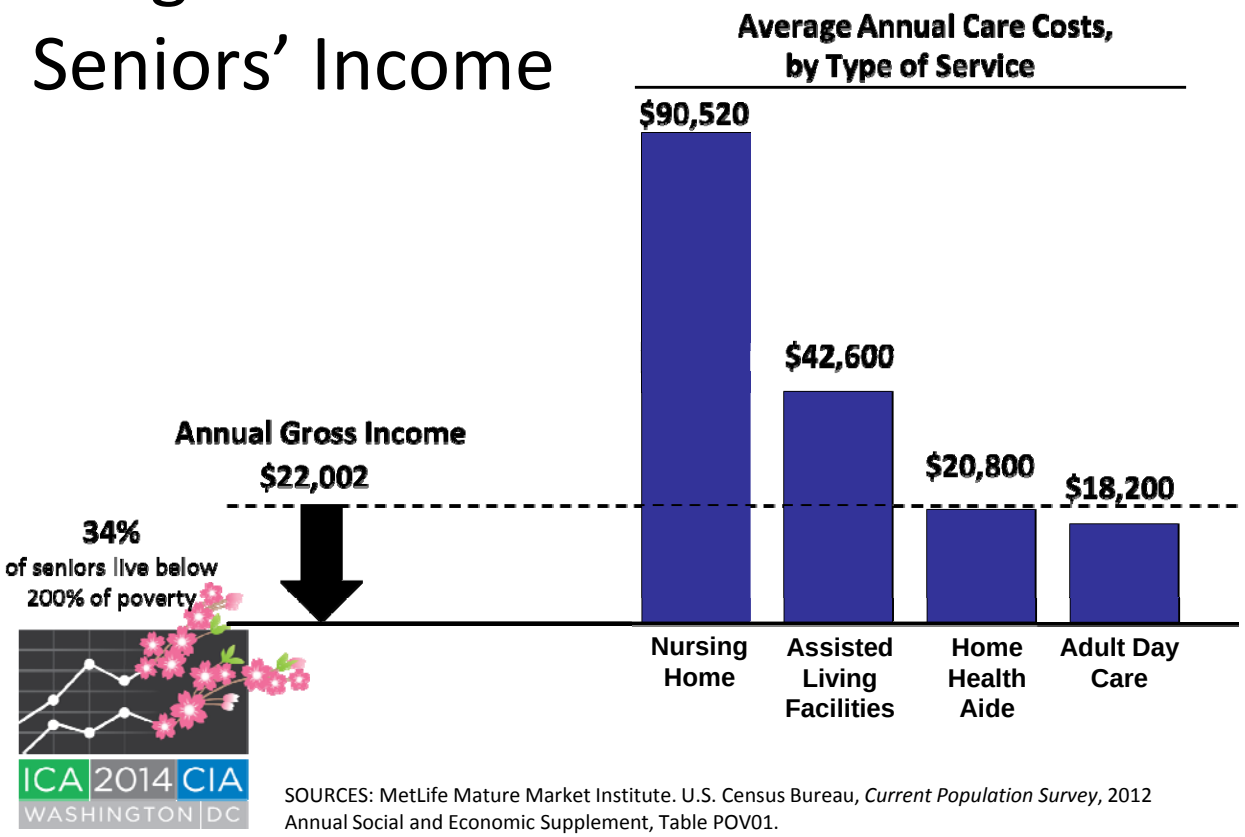
Long-Term Care Costs Can Exceed Seniors' Income



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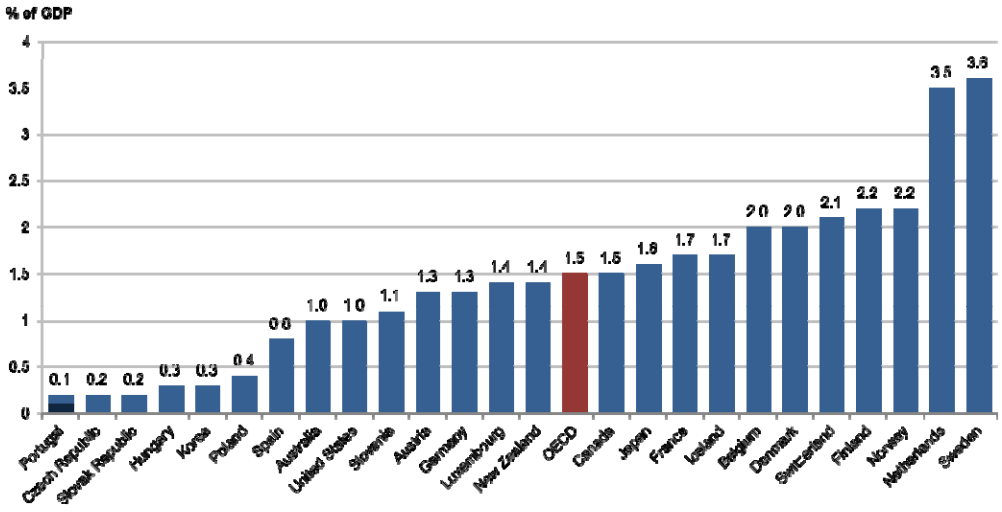
SOURCES: MetLife Mature Market Institute. U.S. Census Bureau, *Current Population Survey*, 2012 Annual Social and Economic Supplement, Table POV01.

LTC Expenditures

Percent of GDP



Source: OECD Health Data 2010.

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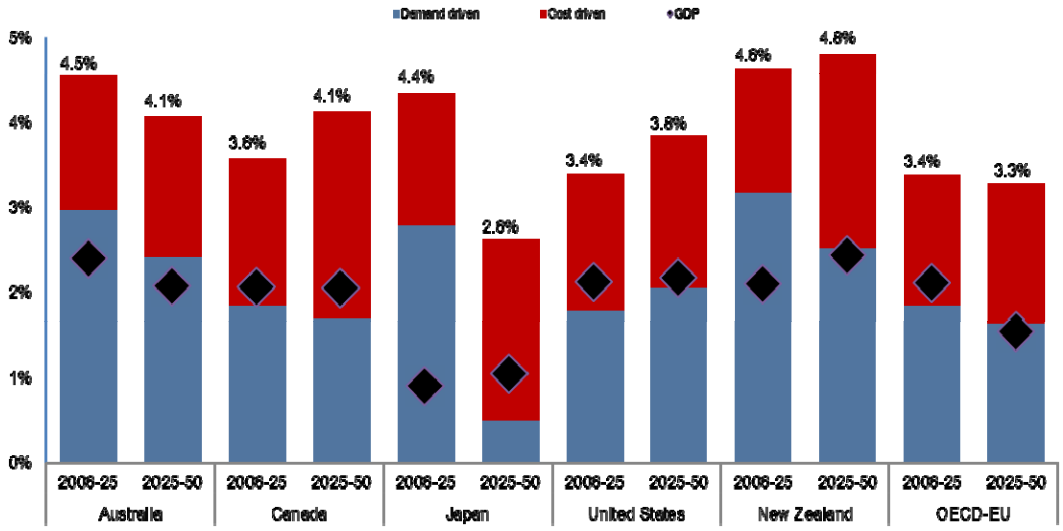
Expected LTC Growth Relative to GDP



Source: OECD calculations based on OECD Health data, EU (2009) Ageing report, OECD Labour force and Demographic database, 2010 and Duval and de la Maisonneuve (2009).

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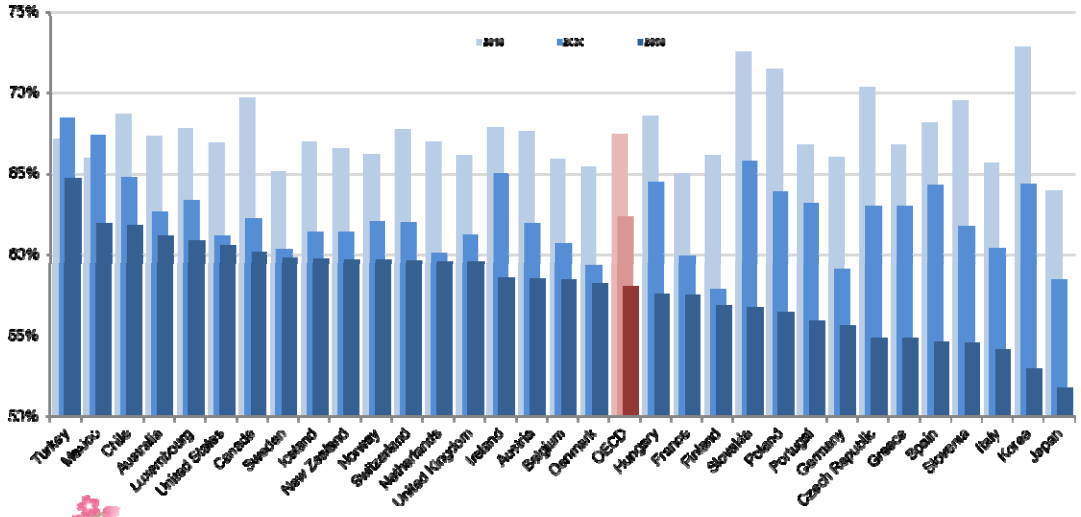
Working Age Populations Decreasing

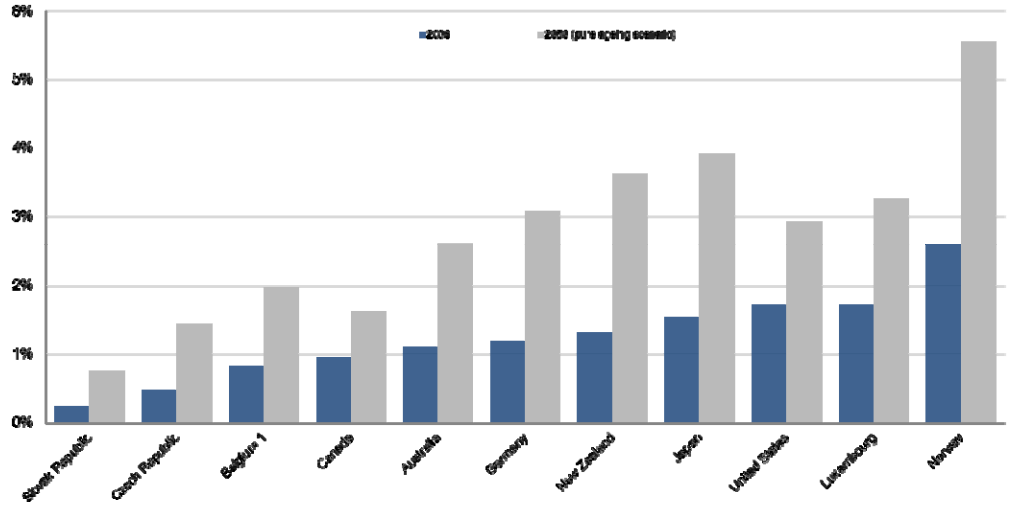
The share of the working-age populations is expected to decrease by 2050
Population aged 15-64



Source: OECD Labour and Demographic Database, 2010.

Demand for LTC Workers will Increase

The demand for LTC workers is expected to at least double by 2050
Percentage of FTE nurses and personal carers to total projected working population



Source: OECD calculations based on OECD Health Data 2010, European Commission (2009), Ageing Report and OECD Labour Force and Demographic database, 2010 and Duval and de la Maisonneuve (2009).

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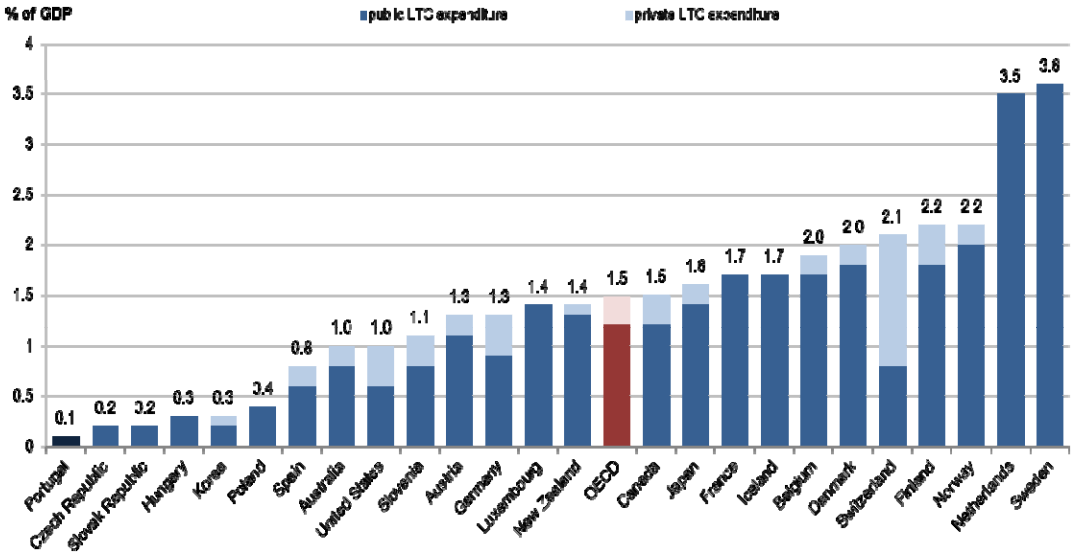
Country Variations

- US, Germany, France, Singapore, Japan, Other
  - Public / Private Roles
  - Framework and Financing
  - Benefits, Eligibility, Participation
  - Varying Measurements of Success

LTC Public and Private Expenditures

Percent of GDP



Source: OECD Health Data 2010.

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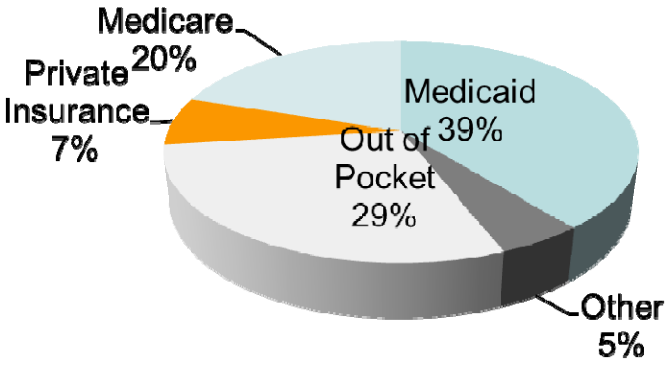
US - Framework & Financing

2008 Sources of Payment for LTC by Payer
Total payments: $264 billion



Source: The SCAN Foundation 2011
NOTE: Numbers do not add up to 100% due to rounding. Private insurance payments include Medigap insurance as well as LTC insurance. Other sources include the Veterans Administration, individual state programs, and private philanthropy.

Important Components of a LTC System

- Financial Soundness
- Affordability
- Enhance Standards of Quality
- Appropriate Incentives
- Encourage Home Care
- Coordinate Health and LTC
- Choice
- Compatibility with Existing Systems

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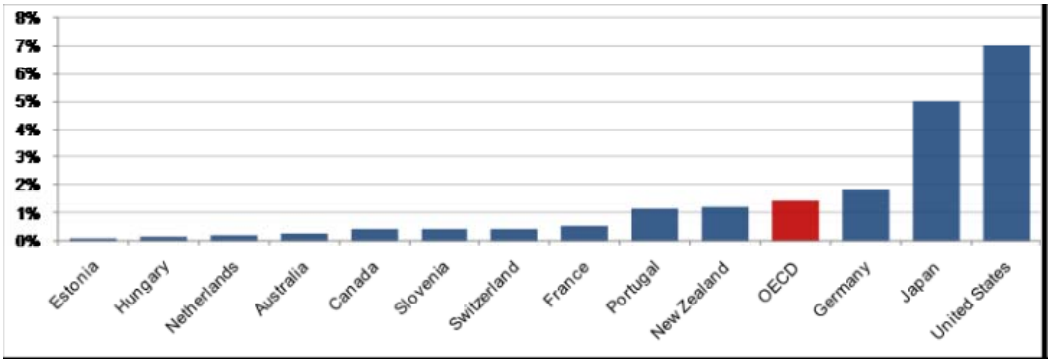
Small Amount of Private LTC

Share of private LTC policies among total LTC spending



- *Source: OECD System of Health Accounts, 2010;* and US Department of Health and Human Services, 2010.

Care Integration Programs

Examples of Care Integration in Selected Postindustrial Countries

Country	National Strategic Framework	Integrated Delivery Structure
Australia	National Strategy for an Aging Australia	Care assessment teams; home- and community-care program
Canada	Collaborative strategy for home and community care (2002); Aging at home (Ontario-2010)	CHOICE (Alberta); SIPA (Montreal); Virtual Ward (Ontario)(interdisciplinary teams providing services when and where needed)
United Kingdom	National service framework for older people (2001)	Care management by local governments; single assessment process
Japan	Gold plan 2 (2000)	Coordination by care managers
United States	Demonstrations	•Social Health Maintenance Organization; PACE (capitation); Medical Home (incentivized care requiring team approach)

Source: “An International Perspective on Long Term Care: Focus on Nursing Homes”, Paul R. Katz, MD, CMD