

III. FUTURE BUDGET PRESSURES ARISING FROM SPENDING ON HEALTH AND LONG-TERM CARE

Public spending on health and long-term care is likely to put considerable pressure on government budgets in the future. Such spending has already risen over the past three decades, accelerating since the turn of the century to reach almost 7% of GDP for OECD countries on average in 2005.¹ OECD projections suggest that in the absence of policy action, the average spending share could almost double by 2050, albeit with considerable variation across individual countries. This chapter presents the projections, highlighting the many uncertainties – related both to policy and to the underlying drivers of spending – but also what seems like more robust conclusions.

Public health and long-term care spending is set to rise...

Spending pressures arise from a number of different factors. Population ageing is one of these, but it may not contribute as much as sometimes thought. Higher incomes will also boost the demand for quality care but, again, perhaps less than sometimes argued. An important factor boosting demand will be the discovery of new medical techniques and treatments. In some countries, female labour-force participation is likely to rise significantly, reducing the scope for informal care and boosting demand for public provision. Finally, and notwithstanding efficiency gains due to better technology, it is likely that prices of health and long-term care will rise faster than the general price level.

... driven by a multitude of different factors...

The OECD projections embody assumptions in all these fields. Two main scenarios are distinguished (Table III.1):

... and with an important role for policies

- In the absence of policy action to break with past trends, average public health and long term care spending could reach almost 13% of GDP by 2050 (the “cost pressure” scenario).
- In a “cost containment” scenario, that embodies the assumed effects of policies curbing expenditure growth, average spending would still increase by 3½ percentage points to reach some 10% of GDP by 2050.

Striking differences emerge across OECD countries (Figure III.1). In the cost-containment scenario, a group of countries stands out with increases of health and long-term care spending at or above 4% of GDP, over the period 2005-50. It includes countries (namely Korea, Mexico, Ireland, Italy, Japan, Slovak Republic and Spain) that combine rapid ageing with strong projected growth of some non-demographic factors, such as a substantial shift from family-provided (informal) to publicly-provided (formal) long-term care. In contrast, Sweden is in the lowest range, with an increase below 2% of GDP. This country is in a mature phase of its ageing process and already spends a relatively high share of GDP on health and long-term care.

Cross-country differences in spending increases are large

1. This chapter deals with public spending only. Private spending added another 2% of GDP on average to expenditure on health and long-term care in 2005.

Table III.1. Summary projections of public health and long-term care spending

In % of GDP

	Health care			Long term care			Total		
	2005 ¹	2050		2005 ¹	2050		2005 ¹	2050	
		Cost- pressure	Cost- containment		Cost- pressure	Cost- containment		Cost- pressure	Cost- containment
Australia	5.6	9.7	7.9	0.9	2.9	2.0	6.5	12.6	9.9
Austria	3.8	7.6	5.7	1.3	3.3	2.5	5.1	10.9	8.2
Belgium	5.7	9.0	7.2	1.5	3.4	2.6	7.2	12.4	9.8
Canada	6.2	10.2	8.4	1.2	3.2	2.4	7.3	13.5	10.8
Czech Republic	7.0	11.2	9.4	0.4	2.0	1.3	7.4	13.2	10.7
Denmark	5.3	8.8	7.0	2.6	4.1	3.3	7.9	12.9	10.3
Finland	3.4	7.0	5.2	2.9	5.2	4.2	6.2	12.2	9.3
France	7.0	10.6	8.7	1.1	2.8	2.0	8.1	13.4	10.8
Germany	7.8	11.4	9.6	1.0	2.9	2.2	8.8	14.3	11.8
Greece	4.9	8.7	6.9	0.2	2.8	2.0	5.0	11.6	8.9
Hungary	6.7	10.3	8.5	0.3	2.4	1.0	7.0	12.6	9.5
Iceland	6.8	10.7	8.9	2.9	4.4	3.4	9.6	15.2	12.3
Ireland	5.9	10.0	8.2	0.7	4.6	3.2	6.7	14.5	11.3
Italy	6.0	9.7	7.9	0.6	3.5	2.8	6.6	13.2	10.7
Japan	6.0	10.3	8.5	0.9	3.1	2.4	6.9	13.4	10.9
Korea	3.0	7.8	6.0	0.3	4.1	3.1	3.3	11.9	9.1
Luxembourg	6.1	9.9	8.0	0.7	3.8	2.6	6.8	13.7	10.6
Mexico	3.0	7.5	5.7	0.1	4.2	3.0	3.1	11.7	8.7
Netherlands	5.1	8.9	7.0	1.7	3.7	2.9	6.8	12.5	9.9
New Zealand	6.0	10.1	8.3	0.5	2.4	1.7	6.4	12.6	10.0
Norway	7.3	10.7	8.9	2.6	4.3	3.5	9.9	15.0	12.4
Poland	4.4	8.5	6.7	0.5	3.7	1.8	4.9	12.2	8.5
Portugal	6.7	10.9	9.1	0.2	2.2	1.3	6.9	13.1	10.4
Slovak Republic	5.1	9.7	7.9	0.3	2.6	1.5	5.4	12.3	9.4
Spain	5.5	9.6	7.8	0.2	2.6	1.9	5.6	12.1	9.6
Sweden	5.3	8.5	6.7	3.3	4.3	3.4	8.6	12.9	10.1
Switzerland	6.2	9.6	7.8	1.2	2.6	1.9	7.4	12.3	9.7
Turkey	5.9	9.9	8.1	0.1	1.8	0.8	6.0	11.7	8.9
United Kingdom	6.1	9.7	7.9	1.1	3.0	2.1	7.2	12.7	10.0
United States	6.3	9.7	7.9	0.9	2.7	1.8	7.2	12.4	9.7
OECD average²	5.7	9.6	7.7	1.1	3.3	2.4	6.7	12.8	10.1

Note: For a description of the scenarios see text.

1. OECD estimates.

2. Unweighted average.

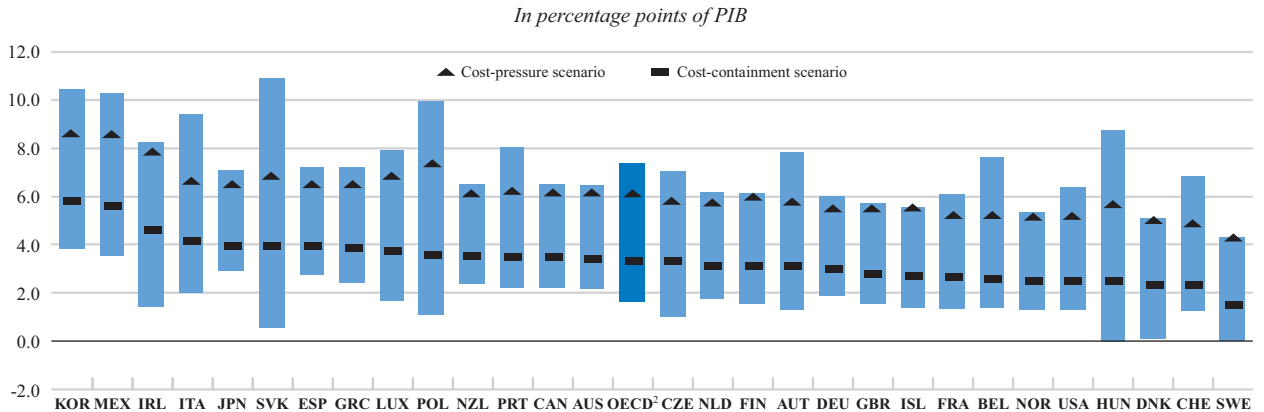
Source: OECD calculations.

StatLink: <http://dx.doi.org/10.1787/111672745588>

The projections appear to be relatively robust

The hierarchy of spending increases across countries stays broadly unchanged through a series of sensitivity tests concerning the main drivers mentioned above (Figure III.1). Furthermore, for virtually all countries and alternative scenarios spending outcomes lie within a range that is only slightly wider than the range between the two main scenarios described above. This suggests a certain degree of robustness of the results. The remainder of the text discusses the projections in greater detail, with an emphasis on the role that the various assumptions play in gen-

Figure III.1. Total increase in health and long-term care spending by country, 2005-2050¹



1. The vertical bars correspond to the range of the alternative scenarios, including sensitivity analysis. Countries are ranked by the increase of expenditures between 2005 and 2050 in the cost-containment scenario. Turkey was not included because data limitations made it impossible to calculate one of the scenarios.

2. OECD average excluding Turkey.

Source: OECD calculations.

StatLink: <http://dx.doi.org/10.1787/885302076708>

erating the results. The projections for spending on health and long-term care are based on population and economic projections as described in Box III.1 and Table III.2.²

Box III.1. Exogenous assumptions underlying the projections

The projections require a set of exogenous assumptions, as follows (see OECD, 2006 for further details):

- Population projections (*N*). The population projections were gathered by the OECD Directorate on Employment, Labour and Social Affairs, directly from national sources. Projected gains in life expectancy per decade were derived from these national population projections. To derive annual mortality rates, the five-year national projections were linearly interpolated. Using these annual data, the mortality rate by cohort and year was derived (see Gonand, 2005). Given that the underlying assumptions on fertility and life expectancy are not necessarily uniform across countries, a population maquette was used to test the sensitivity of the results to uniform longevity assumptions for a selected group of countries.
- Labour force projections (*L/N*) rely on previous OECD work (Burniaux *et al.*, 2003). These projections are constructed in the basis of a, so-called, cohort approach. They correspond to a baseline scenario, *i.e.* the impact of current policies is assumed to

influence labour participation over the next decades, but no additional assumptions are made concerning future policy changes.

- Labour productivity (*Y/L*) growth is assumed to converge linearly from the initial rate (1995-2003) to 1.75% per year by 2030 in all countries, except former transition countries and Mexico where it converges only by 2050.

The projected GDP per capita is directly derived from the above exogenous variables using the relation: $Y/N = Y/L \times L/N$. This simple framework is not supposed to capture in the best way productivity differentials across countries, but to isolate, as far as possible, the effect of ageing and other demographic factors on the projections.

The results of this calculation are provided in Table III.2. It can be seen that, without substantial increases in labour productivity, ageing will represent a substantial drag on growth, on average a reduction of 1% *per annum* of GDP growth for the period 2025-2050 compared with 2005-2025. For further discussion on the impact of ageing on growth the interested reader can refer to Oliveira Martins *et al.* (2005).

2. For a discussion of the national demographic projections used in this study and their underlying assumptions see Oliveira Martins *et al.* (2005).

Table III.2. Decomposition of projected GDP per capita

Average annual percentage changes

	Labour utilisation ¹	Labour productivity ²	GDP per capita	Memo item : GDP	Labour utilisation ¹	Labour productivity ²	GDP per capita	Memo item : GDP
	2005-2025				2025-2050			
Australia	-0.2	2.2	2.0	2.8	-0.3	1.8	1.4	1.8
Austria	-0.5	2.0	1.6	1.8	-0.4	1.8	1.4	1.2
Belgium	-0.2	1.9	1.6	1.8	-0.2	1.8	1.5	1.6
Canada	-0.3	2.0	1.7	2.3	-0.2	1.8	1.6	1.7
Czech Republic	-0.4	1.5	1.1	1.1	-0.8	1.7	0.9	0.6
Denmark	-0.4	2.0	1.6	1.6	-0.1	1.8	1.6	1.5
Finland	-0.6	2.6	2.0	2.1	-0.1	1.8	1.7	1.4
France	-0.5	1.8	1.3	1.5	-0.3	1.8	1.5	1.5
Germany	-0.2	1.5	1.3	1.2	-0.2	1.8	1.5	1.1
Greece	0.3	2.0	2.3	2.1	-0.5	1.8	1.3	0.9
Hungary	-0.6	2.9	2.3	2.3	-0.7	2.1	1.4	1.0
Iceland	0.0	2.5	2.5	3.1	-0.2	1.8	1.6	1.8
Ireland	0.2	3.5	3.7	4.4	-0.2	1.8	1.5	1.8
Italy	-0.1	1.5	1.4	1.3	-0.5	1.8	1.2	0.7
Japan	-0.3	1.5	1.1	0.9	-0.3	1.8	1.4	0.7
Korea	-0.6	2.4	1.7	1.9	-0.4	1.8	1.3	0.6
Luxembourg	-0.1	3.2	3.0	4.2	-0.3	1.8	1.4	2.3
Mexico	0.8	2.6	3.5	4.5	0.1	2.0	2.1	2.4
Netherlands	-0.2	1.8	1.6	1.9	0.0	1.8	1.7	1.7
New Zealand	-0.3	1.8	1.5	2.1	-0.3	1.8	1.4	1.6
Norway	-0.1	1.9	1.8	2.3	-0.1	1.8	1.6	2.0
Poland	-0.4	3.7	3.4	3.2	-0.8	2.4	1.6	0.7
Portugal	-0.1	2.2	2.1	2.1	-0.5	1.8	1.3	0.9
Slovak Republic	-0.6	2.4	1.8	1.9	-1.0	1.9	0.9	0.5
Spain	-0.2	1.6	1.4	1.7	-0.4	1.8	1.3	1.1
Sweden	-0.6	2.3	1.7	2.2	0.0	1.8	1.7	2.0
Switzerland	-0.1	1.7	1.5	1.6	-0.2	1.8	1.6	1.4
Turkey	-0.3	2.4	2.0	3.0	-0.4	1.8	1.3	1.7
United Kingdom	-0.3	2.1	1.8	2.1	-0.1	1.8	1.6	1.7
United States	-0.3	2.1	1.7	2.6	-0.1	1.8	1.7	2.4
Average	-0.2	2.2	1.9	2.3	-0.3	1.8	1.5	1.4

1. Ratio of labour force to total population.

2. Labour productivity growth converges to 1.75% per year by 2030 except for former transition countries and Mexico which are assumed to converge by 2050.

Source: OECD calculations.

StatLink: <http://dx.doi.org/10.1787/627145782418>

Ageing gives a boost to spending

The effects of ageing on health care costs are cushioned by offsetting factors...

Ageing is associated with a rising share of older age groups in the population which will tend to put upward pressure on spending because health costs rise with age. However, the average cost per individual in older age groups could also fall over time for two reasons:

- Longevity gains could be translated into additional years of good health (“healthy ageing”). This is the assumption adopted in the present projections.

It may be seen as a compromise between two opposed views. On the one hand, rising longevity could imply that individuals spend a longer period in ill health towards the end of their lives, kept alive by (expensive) medical treatment. On the other hand, general improvements in health status could increasingly keep people in good health right until the later and later time of death. Current observations in a number of OECD countries are consistent with the “healthy ageing” hypothesis.

- Major health costs come at the end of life (“death related” costs). Insofar as rising longevity means more people leaving an age group not by dying but by living into the next age group, the average costs of the age group in question would fall. This assumption is also built into the current set of projections. In these, age-specific health spending is adjusted to take into account the distinction between health-care spending on those who survive into a higher age group and on those who die.

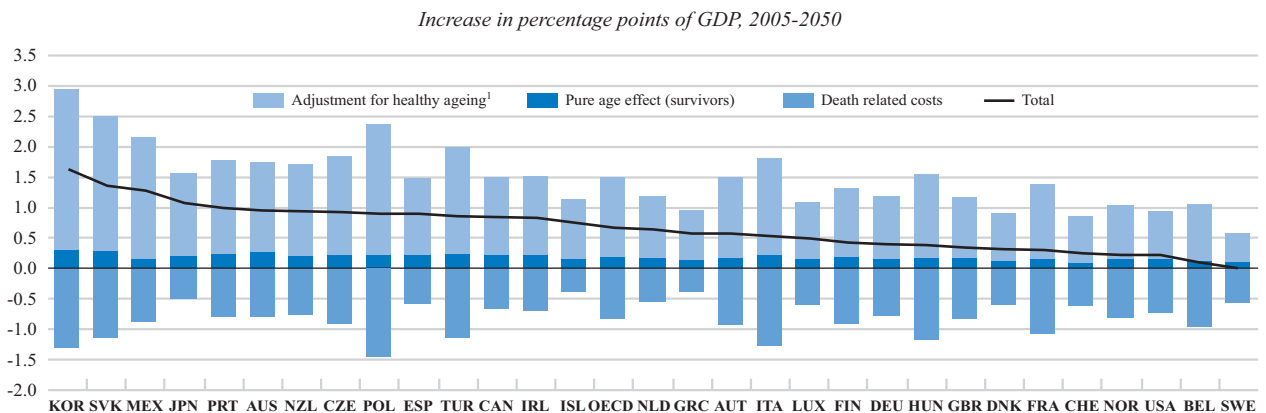
Accounting for these offsetting effects, the net impact of demographic change on health care spending is limited; on average for OECD countries it corresponds to an increase of 0.7% of GDP over the period 2005-50 (Figure III.2). While each individual effect goes in the same direction across all countries, their magnitudes differ significantly. Countries where demographic change is expected to be particularly dramatic, such as Korea, the Slovak Republic and Poland, would have particularly large direct effects of ageing but also very large offsetting influences.

... and therefore give only a modest boost to spending...

For long-term care, there may be less of an offset to the direct ageing effect than for health care. The limited available evidence suggests that the prevalence of dependency (*i.e.* the inability to perform one or several activities of daily living) rises exponentially with age, reaching very high levels for people at a high age.³ In these conditions it might not be realistic to expect the prevalence of dependency to shift

... while the effect is stronger for long-term care

Figure III.2. Demography effects on health care spending



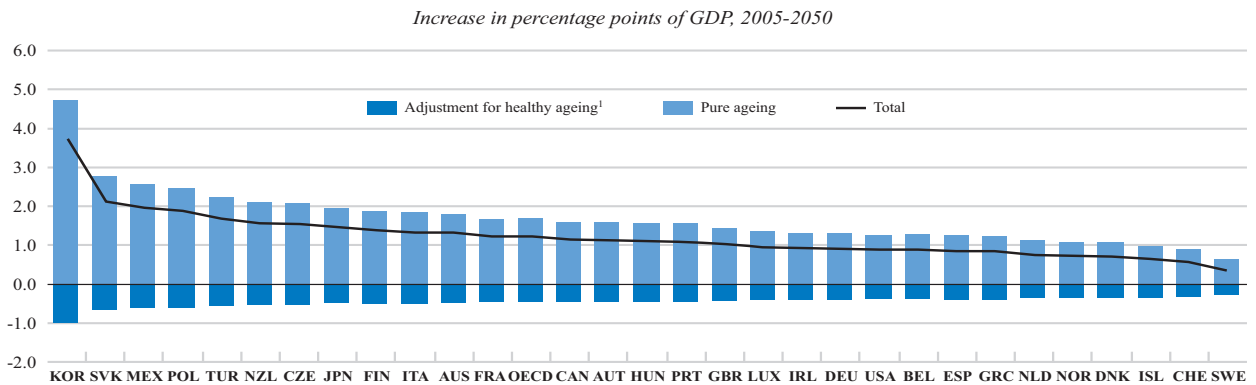
1. This adjustment implies that longevity gains are translated into additional years in good health.

Source: OECD calculations.

StatLink: <http://dx.doi.org/10.1787/223562801633>

3. Scattered evidence from four OECD countries (Comas-Herrera and Wittenberg, 2003) suggests that in the 85-89-year old age group, around 30% of persons could be in need of long-term care. This dependency ratio goes up to nearly 70% for those above 95.

Figure III.3. Demography effects on long-term care spending



1. For long-term care, the “healthy ageing” adjustment corresponds to only half of the longevity gains.

Source: OECD calculations.

StatLink: <http://dx.doi.org/10.1787/405572135327>

pari passu with increasing longevity. Hence, the projections embody the less sanguine (but ultimately arbitrary) assumption that only half of the longevity gains translate into a reduction in dependency. On this assumption, the net demographic effect on long-term care spending over the period 2005-50 is an average increase of 1.2% of GDP – both in absolute and relative terms much larger than for health care (Figure III.3).

Less informal care may push up demand for formal care

Higher female participation could reduce informal care...

In countries with low female labour force participation, women often provide informal care within families. Increased female labour force participation, spurred by improved education levels and policy reforms to overcome obstacles to female participation, can therefore reduce the supply of informal care and increase demand for institutionalised provision of care. Indeed, econometric estimates suggest that public spending per dependent person is significantly associated with labour force participation among persons in the age group 50-64 years.

... leading to more pressure for public spending

Based on these estimates, and the trends in participation rates that lie behind the GDP projections (see Box III.1 above), the effects of reduced provision of informal care on public spending are included in the spending projections.⁴ The increased demand for formal care could push up public spending on long-term care by close to or above 1% of GDP over the period 2005-2050 in some countries (Ireland, Greece, and Mexico). In an alternative scenario, where participation rates in the 50-64 years age group increases to at least 70% in all countries, the corresponding average spending increase over the 2005-50 period is 1.7% of GDP.⁵ Other factors potentially boosting the demand for formal care – such as the reduced size of households – are not taken into account in the scenarios.

4. As an order of magnitude, in 2003 average costs of institutional care per dependent person in the United States ranged between \$40,000 and \$75,000 per year. See Taleysen (2003).

5. However, higher participation rates are likely to have positive effects on public budgets which, depending on how they come about, may more than offset the effect via long-term care spending.

Health care spending will rise with income

Historically, spending on health care has risen faster than GDP and this has been the case even if adjusting for demographic change. There are a number of candidates to explain this development – not least effects of technology and relative prices which are discussed below. Another potential explanation is an increasing preference for health as income rises (*i.e.* health as a “superior” good) but the empirical evidence on this explanation is mixed. Indeed, data for individuals do not point to a strong relationship between income and health expenditure. And a number of methodological objections have been raised against macroeconomic studies suggesting that health is a superior good. Against that background, the current projections are based on the assumption that, everything else unchanged, health spending tends to grow in line with GDP.⁶ This implies that projected health care spending as a share of GDP is independent of economic growth.

Health spending could rise broadly in line with GDP...

Very limited information is available that permits an empirical assessment of the sensitivity of long-term care to income. *A priori*, however, long-term care may be seen more as a necessity than health care and therefore less sensitive to income. Based on this argument, and in the absence of empirical information on the sensitivity, the current projections embody the assumption that long-term care spending does not depend on income levels and therefore tends to fall as a share of GDP as economies grow. Under the growth assumptions presented in Box 1, this effect amounts to an average reduction in spending by about 0.6% of GDP over the period 2005-50. This assumption probably leads to a bias in the projections in the direction of underestimating spending pressures.

... whereas higher growth could reduce spending on long-term care as a share of GDP

Technology, rising prices and the role of policies

Technological developments and relative price changes are inter-linked and could be major drivers of health and long-term care spending going forward.⁷ The contribution of technology is a net effect of different influences. The advent of new treatments may increase demand for health care. Indeed, “healthy ageing” does not arise only from improvements in lifestyle, but also from advances in medical treatment/technology.⁸ At the same time, some technological developments may be cost-saving and can lead to lower prices of particular treatments. The extent to which that will be reflected in lower spending depends, however, on the extent to which demand responds positively to lower prices; little information is available on this.

Technological developments could boost spending...

While technological developments may lower prices of some health products and services, prices of health and long-term care as traditionally measured have generally tended to increase relative to the general price level.⁹ This is because a large

... as could rising relative prices...

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6. Pooled cross-country/time-series econometric evidence at the macroeconomic level suggests that the addition of time-trends to estimations of health spending on GDP/capita leads to elasticity estimates at or below unity (see OECD (2006), Annex 2B for details). Assuming a one-to-one relation between health expenditure growth and income growth is also consistent with the fact that, over the long run, the share of health expenditure in GDP cannot grow without limit.
 7. See early work by Fuchs (1972) and Mushkin and Landefeld (1979). More recently, there has been a renewal of interest in the effect of technology and prices, see Newhouse (1992), KPMG Consulting (2001), Wanless (2001) and Productivity Commission (2005a and b).
 8. See Sheehan (2002) and Cutler (2001) on improvements in lifestyle, and Jacobzone (2003) on the impact of technology.
 9. If prices of health care were appropriately adjusted for quality improvements, this might not be true. The counterpart to a falling relative price would in that case have been a much faster rise in the volume of health services.

part of the output produced in these sectors consists of personal services with only limited scope for productivity growth in line with that in the rest of the economy. If wages in these sectors rise in line with wages elsewhere, their relative prices will then rise faster. This tendency for rising relative prices, often referred to as the “cost disease”, is probably most acute in long-term care, which consists of particularly labour intensive activities.¹⁰ The effect of relative price changes on overall spending will then depend on the extent to which higher prices lead to lower demand. To the extent long-term care is seen as a necessity, as argued earlier, the price sensitivity may be correspondingly low.

... and these effects are built into the “cost pressure” scenario...

In practice, little is known about the historical effects of technology and relative prices and, by implication, uncertainty is large as concerns the future impacts. In the projections, these effects were dealt with differently in the cases of health care and long-term care.

- For health care, technology and relative prices were seen as the drivers of historical spending growth over and above what can be explained by demographic changes and income. The cost pressure scenario then embodies the assumption that technology and relative prices will continue to act as they did historically. Between 1981 and 2002, public health spending grew in real terms by 3.6% per year on average across OECD countries. With average income growth of 2.3% and an estimated demographic contribution of 0.3 percentage points, the contribution from technology and relative prices is therefore estimated at 1 percentage point per year. Hence, over the projection period health spending in the cost pressure scenario grows 1 percentage point faster than implied by income and demographic influences on account of technology and relative price effects. The impact is to raise spending by 3.2% of GDP over the 2005-50 period.
- For long-term care, the cost pressure scenario embodies the assumption that the relative price of long-term care increases in line with average productivity growth in the economy. This amounts to assuming no productivity growth in the sector and, in the absence of any offsetting demand effect, implies an increase of 1.5% of GDP over the period 2005-50.

... but less so in the “cost containment” scenario

These effects are best viewed as prolonging past trends and the corresponding cost pressure scenario may therefore be interpreted as a business-as-usual scenario, where policies are no more effective in controlling costs than they have been historically. The “cost containment” scenario, by contrast, embodies more effective, but unspecified, policy action that partly checks the above-mentioned tendencies for spending growth. More specifically:

- In the case of health care, the autonomous spending drift associated with technology and relative prices would gradually disappear so that by 2050 growth of health spending is determined only by income and demographic effects. Nonetheless, over the period 2005-50 technology and relative prices would still contribute 1.4 percentage points to the increase in health spending as a share of GDP.

10. See Baumol (1967) and (1993). A “full Baumol effect” would mean that there are no productivity gains in long-term care and wages evolve in line with aggregate labour productivity in the economy (a proxy for future wage increases). Assuming that demand for long-term care is rather insensitive to prices, the share of long-term care expenditures in GDP would then increase steadily over time.

- For long-term care, the relative price is assumed to rise by only half of economy-wide productivity growth. In this case, the effect is to push up spending by 0.6% of GDP over the period 2005-50.

Balance of risks and implications for policy

As mentioned earlier, the projections appear to be relatively robust to changes in individual assumptions. However, combinations of changed assumptions that all go in the same direction could significantly alter the results. It may be easier to see such a confluence of risks materialising in the direction of higher spending. Candidates include an extension of the pre-death period of ill health as longevity increases, increased dependency due to obesity trends, higher than expected costs induced by technical progress in medical treatment and higher demand for long-term care in response to growing incomes, possibly because more people would demand higher quality care.

Even if these upside risks do not materialise, the spending projections point to important policy challenges. These challenges are reinforced by the evidence that macroeconomic cost-containment policies, which had some success in repressing spending trends over the 1980s and 1990s (see appendix), have their limits. For instance, it is difficult to contain wages and, at the same time, attract young and skilled workers into the system. Similarly, controlling prices is not easy when technical progress is permanently creating new products and treatments. As well, price controls may not be desirable insofar as they undermine the development of new and better medical treatments. And overall constraints on supply have resulted in unpopular waiting lists. More generally, it is difficult to determine the appropriate supply of health and long-term care services without market signals – but at the same time, health and long-term care are areas where market failures are rife.

In these circumstances it is difficult to provide policy guidance beyond attempting to remedy market failures and, when this is feasible, allow scope for market mechanisms to work. Indeed, giving policy advice is further complicated by the wide diversity of institutions across countries. Going forward, one of the main spending drivers is likely to remain new and improved health care technology. Indeed, it would be undesirable to choke off technological development that enhances individual welfare – but the balance between costs and benefits of new treatments will need to be considered continuously. Another main driver of spending is demographic change and here there is little that governments can do. By contrast, to the extent that policies can stimulate efficiency in delivering health and long-term care, the tendency for relative prices to rise in this area could be curtailed. This will require policy settings focussed on improved cost efficiency at the microeconomic level. Finally, an element in the policy challenge will be to consider the respective roles of public and private provision and financing. Health and long-term care are likely to remain first-order policy issues for the foreseeable future.

The projections may be optimistic...

... but even if they are not, the policy challenges are big...

... and the answers are only vaguely known

Appendix

Cost containment policies in OECD countries: An overview

Faced with unsustainable growth in health care spending over the 1960s and 1970s, governments initially aimed at containing it through various kinds of macro-economic restrictions. These policies often created allocative problems of their own. Wage and price controls had negative consequences on the supply of health care while top-down spending constraints also discouraged providers to increase output or to enhance productivity.

More recently the focus turned to more efficient provision of care. Nonetheless, while spending growth has slowed considerably over the past two decades, studies using statistical tests of the impact of budgetary caps or other policies to limit spending provide little evidence of a strong impact. In some cases, the reduction of health care costs has been achieved by transferring spending to other areas, such as long-term care. Supporting this view is the fact that countries that have been most effective at controlling health care spending are also the ones where long-term care expenditures have increased most rapidly.¹¹

Macroeconomic cost-containment initiatives

Wage controls have been used in public integrated systems in both the hospital and the ambulatory sector where health care personnel are paid on a salary basis (Denmark (hospitals), Finland, Ireland (hospitals), Spain, Sweden and the United Kingdom (hospitals)). Such policies were part of a broader public-sector restraint, rather than specific to the health sector.

Price controls have been widely used, particularly in areas where governments set prices administratively or have oversight on prices agreed between health-care purchasers and providers. A number of countries have set fees directly (*e.g.* Australia, Belgium, France, Japan, Luxembourg and Canada). In others, prices have been automatically adjusted to offset volume overrun so as not to exceed a fixed budget ceiling (*e.g.* Germany (ambulatory care), Austria (hospital care), Hungary (outpatient care), and recent reforms in Belgium). Administrative price-setting has probably been most widespread for pharmaceutical drugs.

Limits in most countries on entry to medical schools are an important factor affecting the growth of the number of medical professionals. The number of new doctors per capita has slowed as a result. There have also been reductions in support staff (Canada, Sweden). Policies to restrain supply have actually led to supply shortages in, for example, Canada, the United Kingdom and Denmark, and waiting lists are a common feature across OECD countries. In countries like Finland, France and Korea, upward pressure on wages has been observed.

Hospital supply policies have encouraged a reduction in the number of beds per capita and concentrated acute care in larger hospital units so as to achieve economies of scale and scope. Nonetheless, the level of acute-care beds per capita remains relatively high in some countries (such as Austria, the Czech Republic, Germany, Hungary and the Slovak Republic).

11. This Appendix is largely based on Docteur and Oxley (2003).

Budgetary caps or controls have been a widely used instrument for controlling expenditure. In general, policies to control and reshape supply and to cap spending in the hospital sector appear to have been more successful at controlling expenditure than for ambulatory care or pharmaceutical drugs. Spending control through budgetary caps also appears to have been most successful in countries such as Denmark, Ireland, New Zealand and the United Kingdom where integrated models of health-care financing and supply are (or were) the rule and in mainly single-payer countries, such as Canada, where health-care budgets are generally explicitly set through the budget process.

Cost sharing has been an increasingly common feature over the 1980s and, particularly, the 1990s. Greater cost-sharing has mainly affected pharmaceuticals, while patient payments for inpatient and doctors visits have been less widespread (Sweden, Italy, France). This is presumably connected to the higher price elasticity for pharmaceutical drugs than for ambulatory and, particularly, for hospital care.

Improving cost efficiency at the micro level

Ambulatory care is of key importance to the overall efficiency and effectiveness of health-care systems. It is usually the place where contact between patient and health-care personnel is first established, and ambulatory care is generally less expensive than hospital care. The gate-keeping role of general practitioners has been encouraged in some countries (United Kingdom, New Zealand, Norway, United States and France). In Eastern European countries, the ambulatory sector has been shifted from the public sector to private practitioners in the course of the 1990s, and, in some cases, they are now paid on a capitation basis.

Hospital-sector reforms concern first and foremost the separation of purchasers and providers within public integrated systems. Purchasers/funders of health care are responsible to the budgetary authorities for cost control and to patients for the quality and accessibility of care. A significant number of countries with integrated systems have now moved in this direction (Australia, United Kingdom, New Zealand, Sweden, Italy, Portugal and, more recently, Greece). More active purchasing has also occurred in countries with public contract models (Germany, Belgium). The role of purchasers has been enhanced in the United States. The contracting out of selected activities has increased, where these can be provided more cheaply externally. Finally, a limited number of countries (the United States, the United Kingdom, Sweden, the Czech Republic and New Zealand) have experimented with greater competition among hospitals as a means of inducing improvement in efficiency, quality and responsiveness.

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