Funding of health and demographic change

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Key Points

- Health as a social good
- The funding of health is a shared responsibility
- Huge pressure on resources
- We are looking at one narrow aspect…
- Welcome your feedback, suggestions and questions

Funding of health – the international evidence

- The composition of funding in Europe varies from country to country.

- Can broadly characterise countries according to the relative contribution of social insurance.

→ "Beveridge" vs "Bismark" models

→ General Taxation vs Payroll contributions

- Average total healthcare expenditure (Public and Private) was 10% GDP in EU-15 (World Bank), while public spending was 7.2% GDP (Eurostat) in 2013.

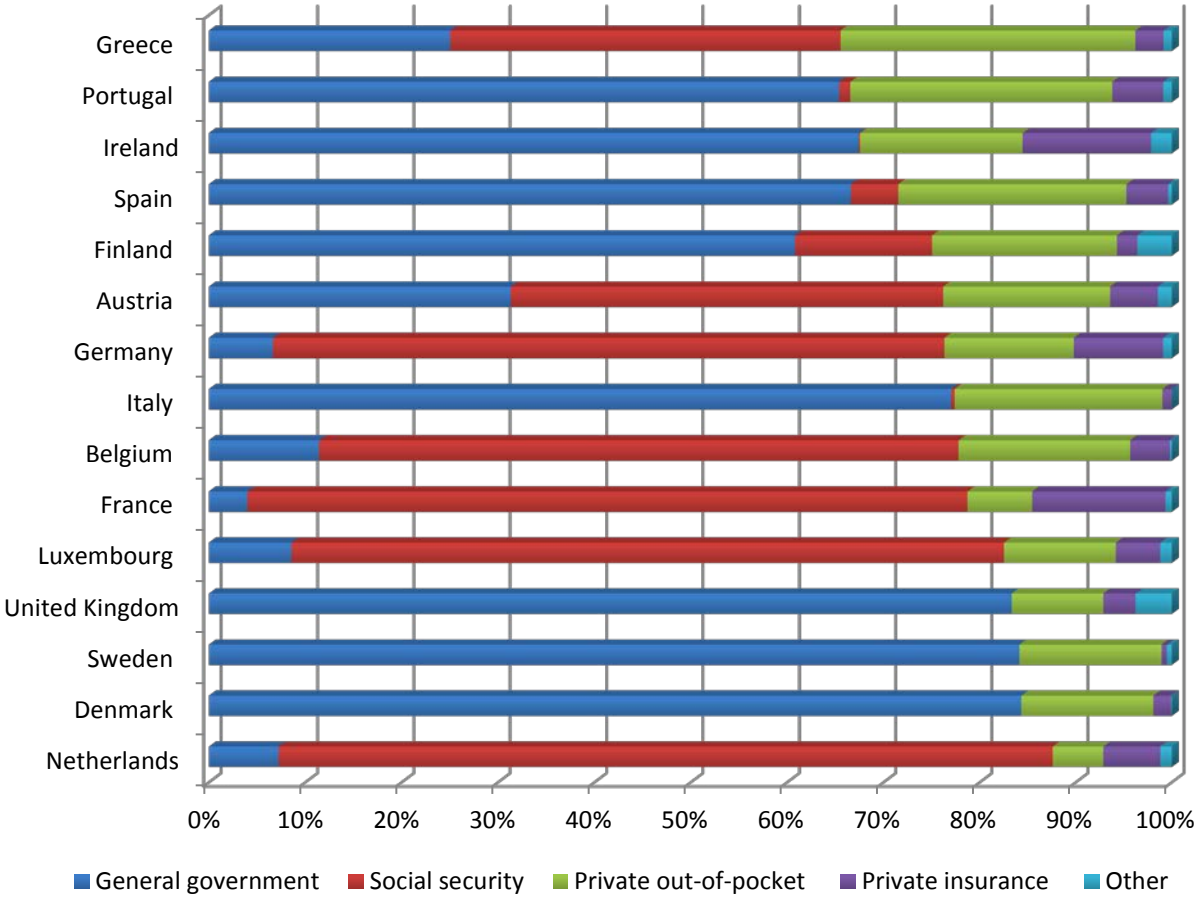
- Northern and Southern Europe funded general taxation, "Continental" Europe payroll contributions.

Comparison of Public Health Funding Systems EU-15

National Health Insurance	Social Insurance
UK	Austria
Denmark	Belgium
Italy	France
Greece	Germany
Portugal	Netherlands
Spain	Luxembourg
Sweden	

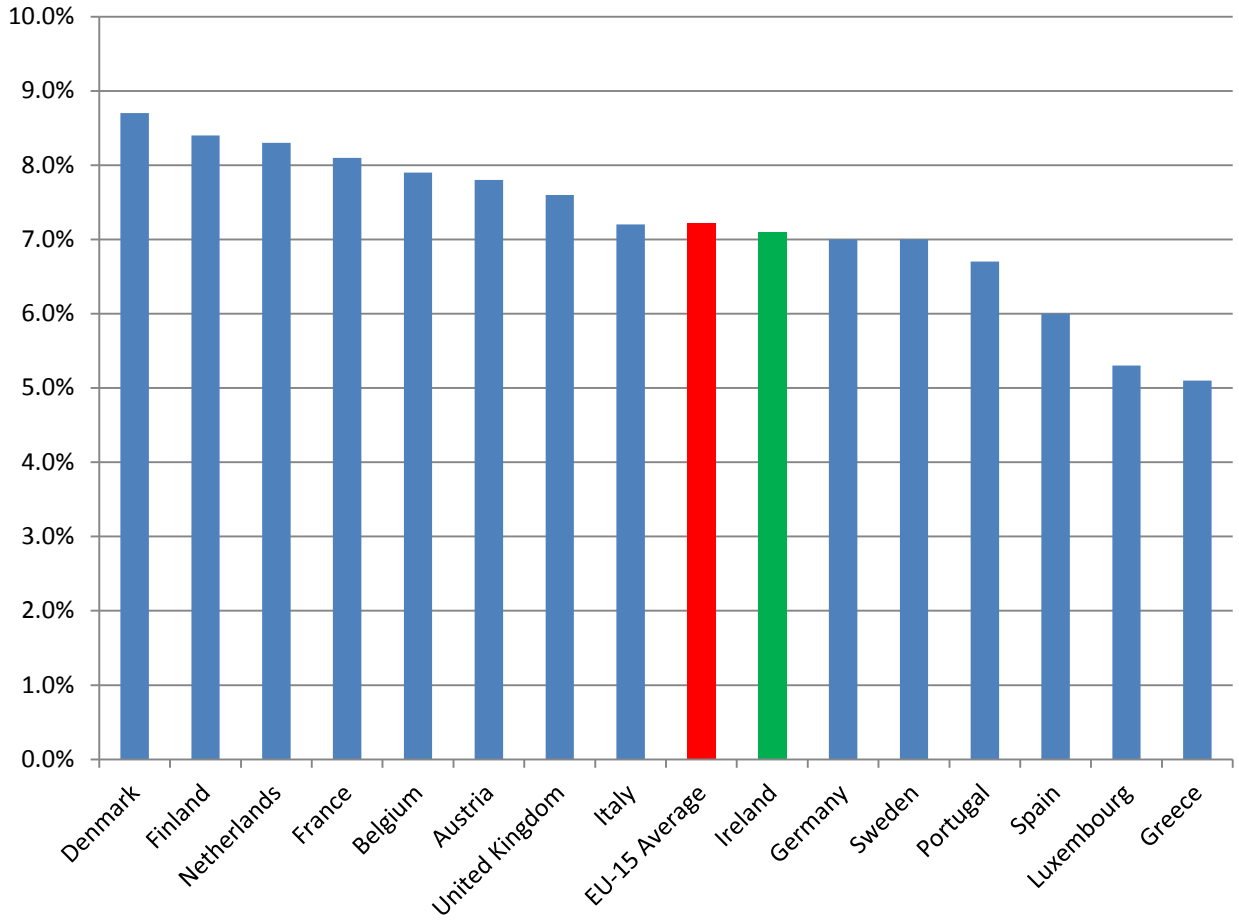
Kulesher and Forrestal (2014)

Decomposition of Funding Sources in 2013



Source: OECD: *Health at a Glance 2015*

EU-15 Public Health Spending as a % of GDP 2013



Source: Eurostat Database COFOG

Structure of spending on Health in Ireland

- Majority of Irish health funding from general exchequer ("Beveridge").

- In 2013, Public spending made up over two thirds of health spending (67.4%, OECD 2015).

- Public Spending increased prior to 2008/2009, declined thereafter. Private Spending increased throughout.

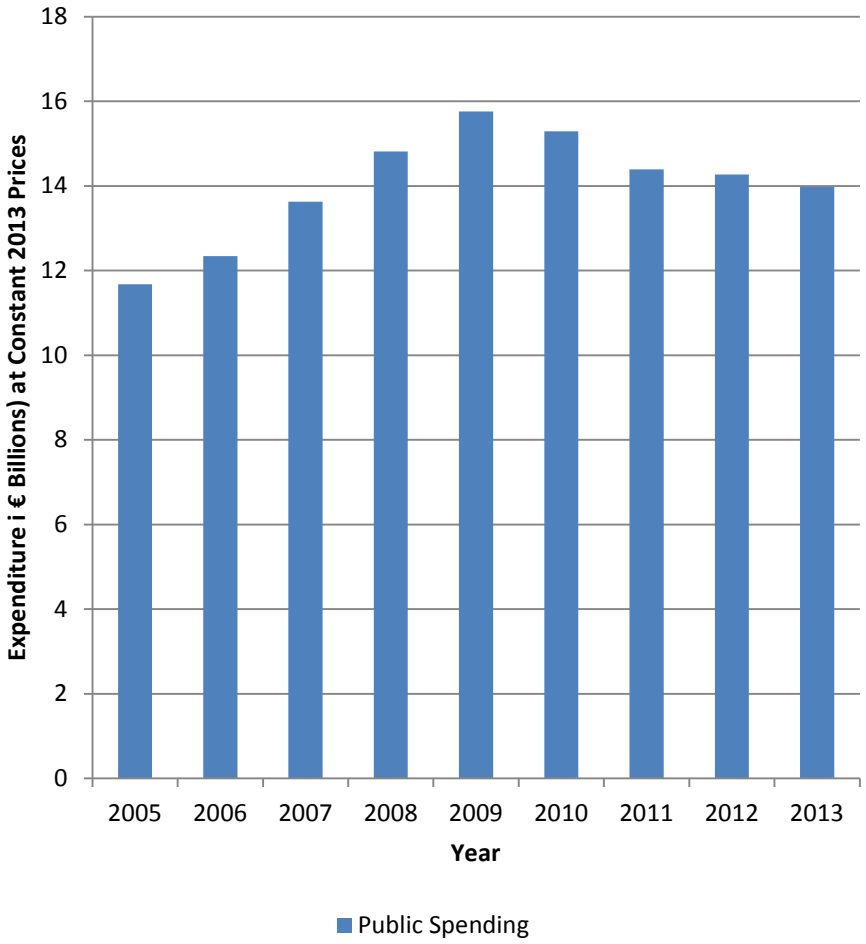
→ €11.7 billion to €15.5 billion 2005-2009 (nominal)

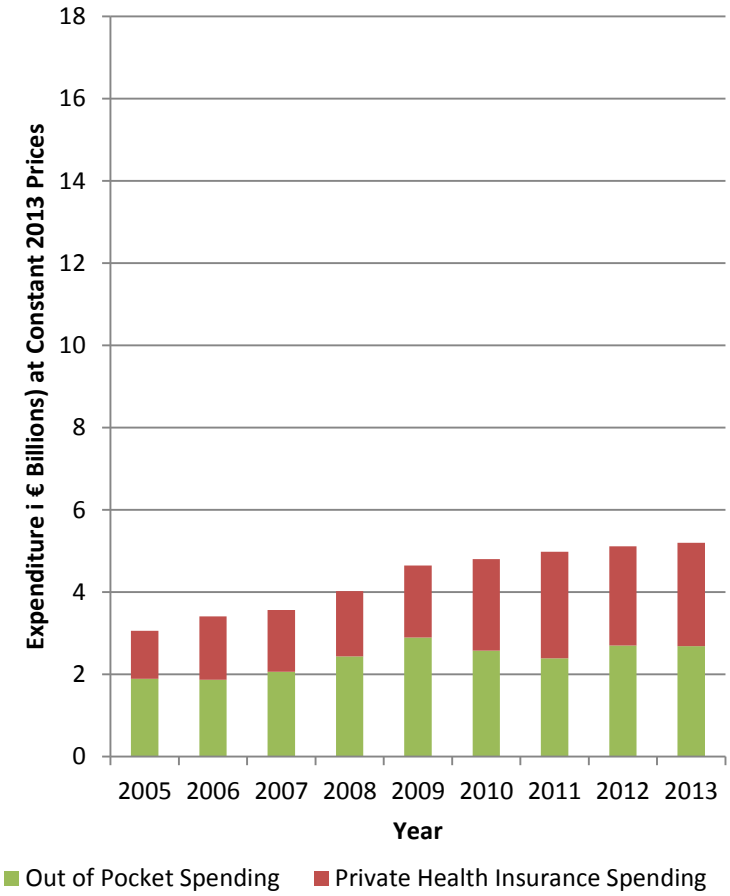
→ Approximately €13.7 billion 2014 (nominal), real decline 18% 2009-2014

→ Nominal private spending increased by €630 million from approximately €4.5 billion to €5.2 billion between 2009-2013.

- Ireland retains a complex "duplicate" system of Public and Private provision. Boundaries between sectors poorly defined.

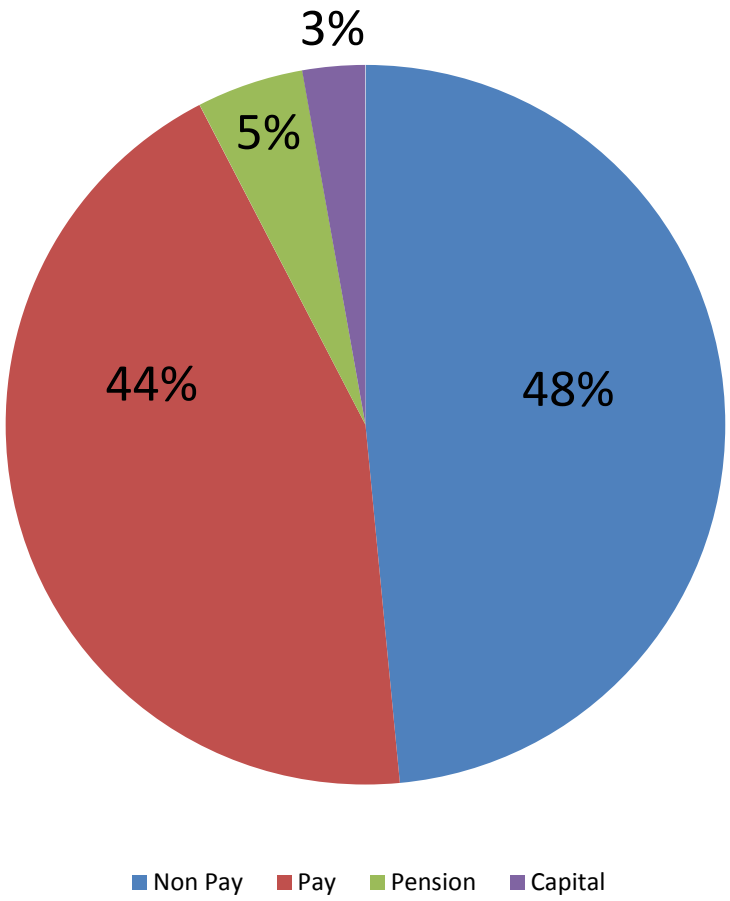
Real Irish Health Spending Public and Private 2005-2013





Sources: Department of Health Statistics
World Bank Data Bank, Adjusted with GDP Deflator

Decomposition of 2014 Gross Public Expenditure on Health



Source: Department of Public Expenditure and Reform DataBank

Demographic change – implications for demand

Demographic changes impact healthcare demand through several pathways.

- **Change in overall population**

→ Variation in fertility ,patterns of migration and cohort sizes

- **Death related costs**

→ Mortality rates, accumulation of costs immediately preceding death

- **Morbidity Compression or Expansion**

→ "Healthy Ageing Hypothesis"

Demographic change – implications for demand

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❑ Population Changes

→ Most intuitive demographic driver of demand increases

→ Increases in population and compositional changes

→ Given high relative cost for certain cohorts (infants, women of child-bearing age, elderly) change in fertility and life expectancy will likely impact healthcare utilisation and cost.

Demographic change – implications for demand

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❑ Death related costs

→ Hypothesis states that relevant factor in cost incidence and care demands is proximity to death rather than age per se.

→ Majority of lifetime healthcare costs accumulate at the end of an individuals life.

→ Death related costs higher for younger patients than old ones. Generally offset by lower mortality rates.

Demographic change – implications for demand

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❑ Morbidity Compression or Expansion

→ Debate as to whether healthcare improvements characterised by expansions or contractions with respect morbidity.

→ Morbidity expansion implies that increases in life expectancy translate into more years spent in ill-health. Chronic illness and disability drives increases.

→ Morbidity compression proponents suggest that number of years spent in good health will increase as life expectancy increases. The relative portion of life spent in ill-health shrinks.

→ Some evidence for morbidity compression outpacing life expectancy gains within "treatment groups"-Hubert and Frees (1994), Chakravarty et al. (2008).

Public Health Expenditure Projections 2014-2035

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- Projections calculated via growth accounting method

→ Health Expenditure growth has demographic, income and residual components.

→ Methodology used by OECD- De la Maisonneuve and Martins (2013). Use CSO population projections.

→ Income component relates to increased healthcare demand with rising income.

→ Residual reflects everything else. Thought to include factors such as institutional arrangement, costs increases due to technology, relative prices etc.

→ Cost-pressure used EU-15 average residual of 1.85%. Cost control has residual decline to zero in 2035.Estimates public expenditure 2015-2035.

Public Health Expenditure Projections 2014-2035

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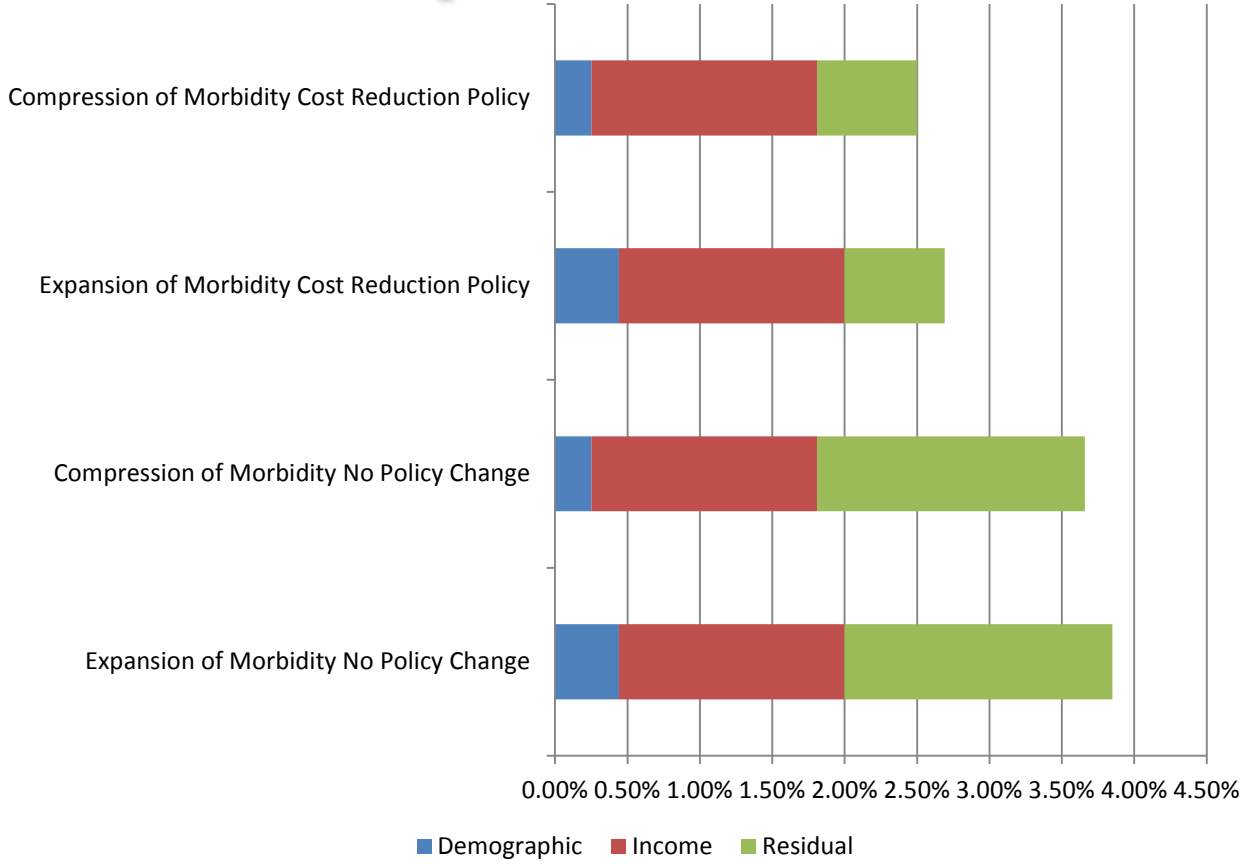
2014 Public Health Spending as a % of GDP	Expansion of Morbidity Public Spend as a % of GDP 2035		Compression of Morbidity Public Spend as a % of GDP 2035	
	No Policy Change	*Cost Reduction Policy*	*No Policy Change*	*Cost Reduction Policy*
7.27%	*10.72%*	*8.80%*	*10.32%*	*8.47%*

Sources: Department of Finance End of December Exchequer Returns 2014, Author's Calculations

Average Annual % Increase in Public Health Expenditure per Capita 2014-2035



Sources: CSO Population projections 2011-2046; Income Growth Calculations from NERI QEO Autumn 2015, Residual from Growth De la Maisonneuve and Martins (2013), Author's own calculations

Public Health Expenditure Projections 2015-2035

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- The above are merely indicative of the *possible* evolution of public expenditure.

→ Projections sensitive to assumptions, such as responsiveness of health demand to increases in income ,the size of the "residual", population developments etc.

→ Changes in health could itself influence economic growth and hence expenditure. Changes occur within a dynamic system.

→ Explosive growth in costs would likely quickly engender responses to contain costs.

→ Degree of judgement required.

Conclusions and questions

- How much will health cost in the future?
- How will it be funded?
- Can the system be made more cost-effective?
- Is there a role for employee-led innovation and, if so, how?

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