COMMENTS ON SESSION 3
HEALTH CARE AND LONG-TERM CARE

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I would like to start by thanking the organisation for the opportunity to participate as a discussant in this workshop. According to the allocation of work, I will comment the papers by Przywara and Costello (hereafter PC) and Follette and Sheiner (hereafter FS). I would also like to refer that this discussion is based on the draft versions of the papers presented at the workshop and some of the points raised may no longer be valid for the published versions.

In my opinion, both papers are well structured and have some value added to the health expenditure projections debate. As such, in my discussion I will not focus the results, but instead I will compare the two papers in order to identify some features that might prove useful in further work to be carried out by the authors.

The paper by PC presents the projections for health expenditure in the European Union, elaborated in the context of the Ageing Working Group (AWG). FS, in order to assess the latest government health spending projections for the US, examine past behaviour of health expenditure (in particular excess growth of per capita health spending relative to per capita income), simulate aggregate consumption (both health and non-health) and, at a micro level, analyse current and future prospects for the provision and financing of health care.

Table 1 shows a comparison of the two papers by some relevant characteristics. Concerning the number of countries used in the analysis, the PC paper is a cross-country study. This feature is for sure very useful in the policy debate, but implies the introduction of some simplifying assumptions for the sake of comparability (namely due to data unavailability). To some extent country-specific details are taken into account but a very detailed analysis is not possible. Indeed, the latter would only be possible in a single-country analysis, as in the paper by FS.

Concerning the type of model, using the PC terminology, both papers include 'macro-simulation models' as projections are made on the basis of disaggregating overall population into a number of groups having a set of common features. Given the complexity and interrelations between drivers of health expenditure, extrapolating into the future the trends observed in the past through the use of time-series models does not seem very helpful. Micro-simulation models could be used in a single-country analysis but they are very demanding in terms of the data they require.

As far as sensitivity analysis and use of alternative scenarios is concerned, I would like to highlight that the PC paper constructs several scenarios. Contrary to what happened in the 2006 AWG Report, no central scenario is indicated in the paper. The authors, nevertheless, refer that it might be useful to attach probabilities to the shocks introduced in each scenario. In the FS paper, sensitivity analysis is quite limited, focusing on excess growth of per capita health expenditure relative to per capita income. This option is, however, mostly related with the purpose of the study.

The two papers can also be compared regarding the issue of introducing demand side drivers in the analysis. Please note that I will be using the terminology adopted by PC in their paper. Size and structure of population and income elasticity are taken into account in both studies. However, the health status of the population (in particular relative to assumptions on morbidity, *i.e.* the

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number of years lived in relatively bad health) and death-related costs appear not to be considered by FS. The introduction of these two drivers in the analysis might prove useful.

Supply side drivers explaining health expenditure are very hard to introduce in the elaboration of this type of projections. Perhaps the impact of relative costs in the health sector could be considered in the FS paper. Concerning technology, some literature points to a very significant impact of this factor on health expenditure developments in the past. Their past and future magnitude is, nevertheless, very uncertain. It should be recalled that technology could either increase or decrease overall spending on health care depending on whether the savings from more effective medical treatment and lower unit costs offset the additional spending resulting from the introduction of new and more affordable services. In this context, I believe that the OECD approach of assuming that technology corresponds to the residual growth observed in the past after excluding the impact of demographics and income is not accurate. Indeed, this residual reflects also other factors like, for example, changes in the institutional settings and the impact of discretionary measures.

Concerning other features of the analysis, it should be noted that the PC paper, contrary to the FS paper, focus only public health expenditure. This is linked to another very important issue, which is the cross-checking of "closure-conditions" in partial equilibrium analysis. I found very interesting the exercise carried out by FS in order to confirm that the trends projected for health consumption and public health expenditure do not lead to unfeasible estimates for non-health consumption and private health expenditure, respectively. It could be very useful to consider this type of analysis in the PC paper.

Finally, a comparison with other available projections might prove useful. FS take the official projections as a benchmark, following the purpose of the paper. Perhaps the PC paper could also introduce a comparison with, for example, the health expenditure projections presented by Oliveira Martins and others from the OECD in Perugia two years ago.

In the case of Portugal, the projected change in health expenditure in the 2005-50 period is slightly negative in the pure ageing plus constant health scenario, according to the PC paper. The equivalent figure in terms of the assumptions undertaken in the projections is an increase by 1.0 percentual points of GDP in Martins *et al.* (2006). These results become even more questionable if it is taken into account the fact that Portugal recorded a very high increase in health expenditure in the past: 7.4 percentual points of GDP in total health spending between 1970 and 2004.

After pensions, health is the second most important factor of age-related expenditure growth. As mentioned previously, health spending projections based on a simplified approach may miss some crucial country specific features. As such, calculations based on national models, as it is the case of pension projections, could be a big step forward in the next round of the AWG projections. If that would be the case, nevertheless, they should be fully transparent and carefully assessed through a strict process of peer-reviewing.

As a final remark, I would like to highlight the following points:

- Health expenditure is very difficult to project (much more than pension expenditure, for example). A careful analysis of past developments is in itself a complicated task and may prove to be not very useful in forecasting future trends.
- As a consequence, results are very sensitive to the assumptions considered. In this context, the construction of alternative scenarios is advisable.
- The projections of health expenditure for a group of countries, although very useful in the policy debate, may become less accurate as some simplifying assumptions have usually to be

Table 1

Comparison of the Two Papers in Terms of Main Features

	Przywara and Costello	*Follette and Sheiner*
Number of countries	Projections for a set of countries (European Union)	Single-country analysis (US)
Type of model	"Macro-simulation model"	"Macro-simulation model"
Sensitivity analysis and use of alternative scenarios	Several scenarios are constructed but no central scenario is indicated	Quite limited (mostly in terms of excess growth of per capita health expenditure)
Demand side factors:		
Size and structure of population	Yes	Yes
Health status of the population (morbidity)	Yes	No
Death-related costs	Yes	No
Income elasticity	Yes	Yes
Convergence in living standards	Yes	Not applicable (single country: US)
Individuals' expectations	No	No
Supply side factors:		
Relative costs in the health care sector	Yes	No
Technology	No	No
Resource inputs, both human and capital	No	No
Government policy (incl. financing) and institutional settings	No	Partly (the budgetary impact of two policies is examined)
Use of information on private health expenditure	No	Yes
Cross-checking of "closure-conditions"	No	Yes (both in terms of consumption health/non-health and private/public health expenditure)
Comparison with other available projections	No	Yes (review of CBO's projections)

introduced for the sake of comparability (in particular, due to data availability issues). In this context, is there an advantage in introducing "national ownership"?

- Most health expenditure projections are partial equilibrium exercises. The checking of some "closure conditions" may be a second-best solution relative to general equilibrium approaches.
- Abstracting from these caveats, both projections point to the need of a public intervention to ensure sustainability of health expenditure. However, the policy challenges should also be viewed in terms of general welfare and not only on the basis of budgetary considerations. In addition, improvements in efficiency of expenditure are warranted.