



Global Highlights

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Health

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Is health spending too low, too high, or about right?

➤ The [OECD Health Data 2008](#) shows that the average **health expenditure share of GDP across OECD** countries remained unchanged in 2006 compared with 2005, at 8.9 per cent. A combination of slower growth in spending (basically due to a deceleration of pharmaceutical costs), and expanding economies explain this evolution. On average, two thirds are public expenditure, and one third private. The US is the outlier, devoting 15.3 p.p. of GDP (more than half of it being private). France and Germany, the biggest European spenders, devoted around 11 p.p. of GDP (less than one quarter privately funded). So, even if private health is dominant, despite conventional wisdom public health spending in the US is significantly higher than the OECD average, and similar to the EU15. Actually, public spending on prescription drugs in the US soared in 2006, due to the introduction of the new Medicare drug program for elderly and disabled. But, more generally, **are these figures ok, too high or too low?**

➤ To address this question, the empirical literature suggests comparing observed figures with some kind of “**per capita international pattern**”. The level of social expenditure depends on income, so, to begin with, per capita spending is a superior measure for comparisons. Besides, spending is also influenced by socio-economic and demographic factors, such as the ratio of population over 65, the ratio of population under 15, and participation and unemployment rate. This approach allows a comparison after controlling for all those factors. The Spanish Economic Bureau of the President has estimated a “European pattern of social expenditure” ([Economic Report of the President 2008](#), chapter 5, in Spanish) for the main social expenditure categories in the 18 richest European economies. Focusing on health spending, France and Germany would be expending well above their pattern, while Italy and Spain would be significantly under spending.

➤ However, in order to advice cuts/increases in expenditure, it is also necessary to compute **the impact of health spending on health status**, that is, a ‘value for money’ equation. This is a growing field for research, both for medical professionals and economists. The [OECD Health Care Quality Indicators project](#) will soon provide measures of health improvement attributable to medical care. Meanwhile, the US is leading this field of research. The [Agency for Healthcare Research and Quality](#) publishes dozens of indicators of health care quality for every State, distinguishing by type (such as preventive, acute or chronic care) and setting (such as nursing homes or hospitals). The statistics show that no State does well or poorly in all areas. Texas, for example, overall ranks in the lowest 25th (among the worse 10th on vaccinating older people against pneumonia), but exhibits some of the best nursing home indicators.

➤ More important, a [CBO paper](#) argues that geographic variation in health care spending (a variation that is not explained by the health status of the populations, neither by income or preferences) does not appear to improve significantly those quality indicators. For instance, Minnesota, the State that exhibits the best overall health care quality indicator, a 35 percent better than the median, spends just a 3 percent more than the US average.

➤ The availability of datasets and tools to evaluate the level and effectiveness of health spending should be a priority for policy makers. The preliminary results for the US highlight large differences in spending for the care of similar patients that do not improve proportionally their health condition. If correctly identified, it suggests potential efficiency gains, that is, **health improvements at almost zero cost**. Since free lunches are not the rule in the world today, we should make the effort.