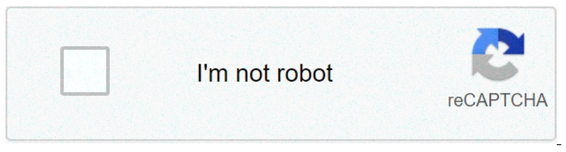

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Ped in medical terms

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Aspes Issue Brief May 2005 Friendly version for printers in PDF format This bulletin is available on the Internet at the following address: http: //aspe.hhhs.gov/health/MedicalExpenditurses/ Content since the US population etÃ, consumes More health care. Elderly people suffer from disease and other medical problems to a greater extent than younger people. And with health care prices that continue to increase much more quickly than other goods and services, the use and social health care is expected to go up in the future. Since public programs finance much of advanced health care, over time there will be increasing pressure on federal and state budgets, and long-term voltages on public funds will put pressure upwards on tax rates. Which, in turn, could cause legislators to review the coverage commitments that have done through federal programs and state health care. Whatever the outcome of these competing pressures, the steps to moderate the growth of health prices and increase the efficiency and effectiveness of health delivery are essential to moderate the economic burden that future health costs are likely to impose. National healthcare of historical perspective 1960 1985 2003 (in billions of current dollars) aggregation fees 27 427 1,679 per capita 143 1,765 5,670 (in billion dollars constant 2003) * aggregate spends 166 730 1,679 per capita 891 3,019 5,670 pil share 5.1% 10.1% 15.3% Source: National healthcare costs, Medicare & Medicaid services centers, Actuario Group Office, National Health Statistics; US Department of Trade, Economic Analysis Office; And Census Office * Regulated for changes consumer price index The nations that spend on medical assistance were on an upward route to a certain number of decades. In 1960, aggregate health expenses in the United States amounted to $ 27 billion; In 2003, the figure amounted to almost $ 1.7 billion at 63. On the contrary, the population of the United States has grown only by 51 percent. The per capita healthcare costs (or per person) increased from $ 143 in 1960 to 5,670 dollars in 2003. General inflation has increased the prices of goods and services in the economy of 5 times. On the contrary, the recorded increase in prices for medical assistance was 12 times, guided mainly by increases in hospital expenses and doctors. [1] The global economic dimensions of growth were equally impressive, with the share of the economy dedicated to health trebling in the period, which goes from about 5 percent of the gross domestic product (GDP) in 1960 to over 15 percent In 2003. Inflation and laughed in Health Care Price 1960-2003 1990-2003 price percentage) 515% 41% General medical assistance 1,232% 82% Medical care services 1,469% 88% Source: Consumer price index for all-Urban consumers, cit. The consumption of health care by the elderly is larger than for the rest of the population. In 1999 expenditure on health care per capitaThe population of the United States as a whole was $3,834. For the population under 65, it was $2,793. For the age of the population 65 years or more, it was $11,089, or almost four times higher. Also within the aged population, divergence was significant. For those ages from 65 to 74, it was only $8,167 compared to $20,001 for those people aged 85 or more. The members of Medicare, 87 per cent of which were 65 or older, comprised 14,5 per cent of the total population of that year, but represented 37 per cent of the personal health expenses of the nations. [2] For two million people living in full-time care homes (three quarters of which were 75 and older), per capita costs were $44,520. Among the recipients of age 85 and older, 22 percent stayed in nursing homes. [3] People aged 85 and older included 1.6% of the population in 1999, but accounted for more than 8 percent of the nation's personal health expenses. Per-Capita Health Care Spending from Aged Compared to the rest of the population, 1999 Age grouping Per Capita Personal Health Care Spending All ages $3,834 Under 65 2,793 65 and older 11,089 19-44 2,706 45-54 3,713 55-64 5.590 65-74 8,167 75-84 12,244 85 and older 20,001 Source: Age estimate in national health accounts, Sean P. Keehan, Helen C. Lazenby, Mark A. Zezza and Aaron C. Catlin, Health Care Financing Review, 2 December 2004. Health care expenditure for medical population Age 65 or above, at cost level, 1999 Share of health expenses supported by: 1 percent of users Top 5 percent of users Top 10 percent of users 12.8% 35.9% 53.8% Source: Medicare Current Beneficiary Survey, loc. cit. While average expenditure per age group illustrates the effects of higher age on health care consumption, they do not show the concentration of use of health care within the elderly. In each year, most medical care expenses tend to be supported by a relatively small group of people. In 1999, 1 per cent of Medicare enrolled age 65 or older has sustained 13 per cent of that health care group. 10 percent higher with higher expenses supported 54 percent. The meaning of this concentration is not only that the health costs of nations will increase as the elderly grow in number, such costs will be amplified as those of the population with the highest incidence of health expenses grow as a part of the population. In the only period of 8 years, 1992-2000, the percent of the Medicare population of people aged 85 and older grew from 9,7 percent to 10,9 percent. [4] [Go to Content] The meaning of public financing of the health of the Nations Infederal and state public funding sources and local governments joined directly at almost half of the nation's health expenses. This includes personal health care, research, construction, supplies and other related costs. They covered 44 percent of the expense made for personal health carecare for active military and veterans. In the last half a century, government entities have played an increasingly important role in meeting the health care needs of nations. In 1960, they financed 25% of the aggregated national energy costs. With the advent of Medicare and Medicaid in 1965, the governmental share rose rapidly to 38% in 1970 and continued to rise later, reaching 46% in 2003. Amended by the public (federal and state) and private financing of national health expenses 1960 1970 1980 1990 2003 — (percentage) Public funds 25 38 43 41 46 Private departments 75 62 57 59 54 Source: national health expenses, cit. The broadest source of funding for personal health care today comes from private insurance, which provided 36 percent of the funding for such expenditure in 2003. The out-of-pocket expenditure represented for 16%, making the next largest private source. Medicare and the federal share of Medicaid include most federal government support. The share of Medicaid States is the largest component furnished by state and local governments. Sources of financing of personal health care, 1960 and 2003 Â 1960 2003 © Provided by: Private insurance 21 36 Out of pocket 55 16 Medicare --- 19 Medicaid * --- 17 Other Private 2 4 Other Federal 9 4 Other State and Local 13 3 Source: national health expenses, loc. cit * consists of federal and state funding. Among the sources, the federal component has become most of the last four decades, rising from 9 percent of personal health care spending in 1960 to 33% in 2003. Although the emergency of Medicaids in 1966 significantly raised federal governments by spending medical care for the poor, the share of personal health care spending on medical care for bad funding by state and local governments (which includes their corresponding funds for Medicaid) effectively broke a little further than four decades, with their share that will fall from 1.3% in 1960 to 11 percent in 2002. Financing of the Federal and Federal Government of expenditure on personal health care, 1960 and 2003 1960 2003 â per cent financed by: federal government 9 33 state and local governments 13 11 source: national health expenses, loc. cit. It is important to note that while private sources still seem to finance most of the nation's health expenses at 54% in 2003, the figure masks indirect support that federal and state governments and local government provide tax preferences for health care. More than $100 billion in so-called health care tax expenses were supported by the federal government alone in 2003. Tax expenditure is taxable on income which is expected because employers and individuals are authorizedExclude from the taxable income that the portion of their income used health insurance premiums and / or related expenses. If those earlier tax revenues are considered, most of the healthcare of nations nations 60% has been financed directly by federal, state and local governments in 2003 or indirectly supported through tax provisions. With the growth of public and private insurance programs over the last forty years, the role of direct payments between individuals and health care providers has changed substantially. In 1960, individuals have paid directly for more than half of all their personal health needs by paying 55% of their out-of-pocket medical costs. In 2003, only 16% of personal health expenditure was covered with their own pocket, making third parties the predominant medium of medical assistance financing in the United States. Although it is considered that a large number of factors has contributed to the escalation of health costs, the expansion of external taxpayers (government or private) may have decreased incentives for individuals to be aware of the costs of their medical services consumption [5]. Go to the Index] The importance of government sources in the financing of medical assistance for elderly sources of personal health care financing for medical and non-medical populations, 2000 ã, medical population Non-Medicare population, funded percentage From: Medicare 52.3 --- Medicaid 12.2 19.2 12.2 47.7 19.4 15.8 3.9 17.3 s Source: Medicare Current Beneficiary Survey, loc. cit. * It consists of a mix of governmental and private sources, the comparisons of funding sources for the medical assistance of medicare and non-medicare populations reflect the importance of public funding for the elderly. The public funds have directly financed less than half of the health expenses of the nations in 2000, but they were the elderly to receive most of this support. About two-thirds of their health costs have been financed by public programs, and more than half came to Medicare. The dependence of the elderly from public health programs has changed very substantially in the last half century, especially because Medicare coverage did not exist before 1966. But even after the advent of Medicare, the public role grew up. As described by the main actuary medicare programs, Â «for the age of the population 65 or above, Medicare paid for about 42% of total personal health expenses in the fiscal year 1968. By the 1997 calendar year, this year Percentage had risen to 55%, with most of the balance covered by Medicaid, private health insurance, and its own beneficiaries out-of-pocket payments â € œThe increase in the share of Medicare is partly attributable to the deductible part B, That was $ 50 in 1968 and was only increased three times since then, to $ 100 currently. Since covered costs have grown much rapidly, a greater share of the covered costs exceeds the deductible and is therefore refundable from Medicare. In 1968, only 38% of the beneficiaries had part B costs to the deductible, but by 1997, that percentage had climbed to 87% of Medicare's growing share also reflected a rapid rise in prices, usage, and the intensity of that services such as doctor, qualified nurse and home health care. On the other hand, in some years, some uncovered costs, such as prescription drugs and long-term home care, have risen faster than overall health care costs, adding to the share funded by non-Medicare sources. Overall, the trend has been toward a larger Medicare share of total personal health care costs for seniors" The lead actuary also noted "the relatively small decline in Medicaid expenditures as a percentage of total personal health care expenditures for recipients over the age of 65. The proportion of older people with incomes below the poverty line (who are more likely to benefit from Medicaid) fell from about 16% in 1966 to 11% in 1997. Medicare Income Beneficiaries (SLMB). (Medicaid pays the Medicare premiums on behalf of QMB and SLMB and also the cost-sharing charges incurred by beneficiaries for QMB.) Also, during this period, Medicaid absorbed a substantial portion of the rapidly rising home care expenses. The proportion of health care costs paid directly by beneficiaries has fallen significantly since the start of the programme, from about 28% in 1968 to 20% today. This change is mainly attributable to the increase in the rates covered by Medicare and private health insurance". [6] Sources of funding for personal health care expenses for people aged 65 and over, 1968 and 1997 Ã Fiscal Year 1968 Fiscal Year 1997 Ã Percentage from: 42% 55% 14% 11% 11% 3% 28% 20% 5% 11% Source: Trends State Medical and Financial Expenditures, 1966-2000, Richard S. Foster, Health Care Financing Review, Autumn 2000. In 2003, the Congressional Budget Office reported that growth in national health spending over the period 1970-2001 exceeded gross domestic product growth by 2.5 percentage points per year. Medicare, however, grew at a rate that was 3 percentage points higher over a roughly comparable period. Medicaid grew at a rate of 2.7 percentage points higher. [7]On an annual basis, these differences may seem small, but when added up over the decades, they help explain how the combined share of Medicares and Medicaids increased from 19% in 1970 to 37% in 2002. In fact, over a period of 32 years, these two major public programmes have almost doubled their role in financing nations' health expenditures. [Go to Index] Future Prospects The Trustees of Social Security and Medicare predict a sharp increase in the proportion of seniors in the population in the coming decades. If today people aged 65 and over account for 12% of the total population, in 2025 they will account for 18%. In addition, It is not just the result of the second post-war post-war period the boom generation reaching its advanced years. Significant improvements in longevity and a decline in the birth rate over the past 30 years are expected to lead to a further increase in the proportion of older people in the population after the death of the baby boomer. Anticipated Increase in Older Population 2005 2025 2045 2065 2080 Number of Older Persons 37 million 62 million 79 million 89 million 96 million Total Population Share 12% 18% 21% 22% 23% Source:The 2005 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, Washington, D.C., March 23, 2005 For Medicare, these demographics incite Increasing numbers mean that an increasing number of people will become eligible for filling each year and each successive group of new subscribers will receive benefits for a longer period of their lives. For Medicaid, they mean that an increasing number of people will need and become eligible for the nursing home and its institutional care. For both programs and the federal government in general, they mean a decreasing percentage of the population will be in the primary working age range between 20 and 65, from which much of the government's tax base comes. Growth due to demographic trends is compounded by uncertainty, but still resilient, rising prices and use of health care. It is unclear to what extent they can continue to grow at these rates. Decrease in birth rates and increase in life expectancy, 1965-2080 (current and projected) E Ã Ã Ã Ã Ã Ã Ã Ã Ã Ã Ã Ã Ã Comparison of Medicare Pro-Person Growth, Medicaid and Gross Domestic Product, 1970-2003 Average Annual Pro-Person Growth as Percentage of GDP Medicare Medicaid 1970-2003 6.3 9.4 8.8* 1980-2003 5.0 7.4 5.0 7.4 7.1 1990-2003 3.8 5.6 6.0 The Long Term Budget Outlook, CBO, loc cit. *For the period 1975-2003. The higher per capita growth in national health care and Medicare and Medicaid spending slowed in the latter part of the 1970-2003 period (Medicaid minus Medicare), but it grew much faster than the overall economy. Recognizing this trend, Medicare trustees in their central long-term forecasts, the so-called intermediate projections, have assumed that written costs for Medicare will grow at a final rate of 1 percentage point faster than gross domestic product.[8] This is lower than the 1990-2003 figure, but it is still less than the 1990-2003 figure. is still higher than in the economy as a whole. Reducing the difference between the growth of national health expenditure and the growth of gross domestic product is the amount by which national health expenditure exceeds the growth of the (in Percentage) 1960-2001 2,1970-2001 2,3 1980-2001 2,3 1990-2001 1.5 cast iron: The Long-Term Budget Outlook, CBO, place. CIT. CIT. prospects, the project of Medicare trustees that the expenses of Medicare could rise from 2.7% of the gross domestic product today to 9,6 percent in 2050 and reach 13,9 percent in 2080. In a scenario with similar assumptions, the Congressional Budget Office projects that Medicare and Medicaid combined could increase to 11.5 percent of gross domestic product in 2050. [9] Expenditure in this capacity is now more than half of the entire federal budget. While recognizing the great uncertainty surrounding their forecasts, the Medicare trustees say that their projections "continue to demonstrate the need for timely and effective action to address the financial challenges of Medicares is the long-range financial imbalance facing the HI Trust Fund [Hospital Insurance] and the increased problem of rapid expenditure growth. First the solutions are emanated, more flexible and gradual can be"[10] What can be said about future private expenditure is uncertain but equally problematic. Health insurance premiums are growing rapidly. With a report, health insurance premiums increased at an eight-time rate faster than general inflation in 2002; experimenting with the greatest increase of a year of prizes in more than a decade. [11] A survey of the Kaiser Family Foundation found that "work-based health insurance premiums increased by 11.2 percent in 2003, surpassing previous growth rates. All types of health plans, including HMO, PPO and POS, have shown double-digit increase in cost." Kaiser reported that employers' paid premiums for employee family coverage increased from an average of $6,438 in 2000 to $9,086 in 2003, and that the average amount of workers paid to those premiums rose almost 50 percent, from an average of $1,619 in 2003 to $2,412. [12] As an increase in premiums, it is reasonable to assume that employers will try to limit their costs. [13] Workers may be required to pay more medical expenses directly or being required to pay a greater share of employers' premiums or having increased the cost-sharing requirements. Premium excursions for Medicare services (i.e. now necessary for non-hospital services and drug coverage) and health insurance policies that complete Medicare (i.e., Medigap policies) would probably have a similar effect on older people. Large premium increases can cause politicians to impose higher medical deductibles or currency and can cause recipients to seek less expensive additional cover with higher cost breakdown requirements. When such expenses out of stock would have a restrictive impact on medical prices is uncertain. In addition, as they emerge, the responsibleThey could intervene and ask governments to take even greater share of the burden. the tension, however, between a further governmental absorption of out-of-the-bag costs and government budgets will grow only stronger, as the costs already imbedded in public programmes increase. the continuous increase of medical expensespromoted appeals for a radical change of the health systems of nations. Some support more government intervention to control prices and usage directly or indirectly. Others believe that more free competition on the market in ensuring that these costs are the most promising way. Others still believe that medical technology and innovation, a greater promotion of healthier lifestyles, the promotion of case management practices and the application of information technologies to the spread of effective medical advances and the labyrinth of bureaucratic practices for care and services will make the health system significantly less expensive. So far, there seems to be no consensus on what could be the best solution to address the increase in health care prices. Given the uncertainty, it is likely that in the coming years it will evolve and will implement a combination of the various main political prescriptions, as pressure on costs, both public and private, will intensify. [Go to index] [1] As measured by the consumer price index for all urban consumers, Bureau of Statistics, U.S. Labor Department of Labor. [2]Trends in the MCBS, 1992-2000, Center for Medicare and Medicaid Services. [3]See Medicare Current Beneficiary Survey, Center for Medicare and Medicaid Services and Older Americans 2000: Key Indicators of Well-being, Federal Interagency Forum on Aging-Related Statistics. [4]Trends in the MCBS, 1992-2000, loc. cit. [5]The Long Term Budget Outlook, Congressional Budget Office, December 2003. [6]Trends in Medicare Expenditures and Financial Status, loc. cit. Note that the recent legislation has increased the B-part to $110 in 2005, and higher premiums for high income subscribers will be introduced gradually over a five-year period from 2007. [7] The Long Term Budget Outlook, CBO, loc. cit. [8] See the Annual Report 2004 of the Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Washington, D.C., 23 March 2004. [9] The Long-Term Budget Outlook, loc. cit. [10]The 2004 Annual Report of the Federal Hospital Insurance Trust Council and Federal Trust Funds of Complementary Medical Insurance, loc. cit. Hospital insurance (HI) is part A of Medicare; Complementary medical insurance (SMI) consists of the traditional B part and the new part D. [11] Healthcare costs, National Healthcare Coalition, 2004. [12] Cost of sickness insurance, health benefits to the employer: Annual survey 2004, Kaiser Family Foundation. [13] A study by the Washington Business Group on Health, representing about 200 important employers, found that 80% of employers offering insuranceEmployee plans to increase co-payments or cost-sharing in 2003, up from 65% who responded in 2001. In a more recent study, the group found that 57% plan to increase cost-sharing for 2004. (Martinez, With rising health costs, workers have to pay more", more", Street Journal , 16 June 2003.) A New York Times article reported that "after corporate income taxes, employee benefits are the second-largest structural cost for American manufacturers, adding 5.8% to costs." (Daniel Gross, whose problem is Health Care, The New York Times, February 8, 2004.)