

Health Care Expenditures in a Global Context

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Global health care costs are rising unabatedly – almost everywhere, health care inflation is increasing faster than the consumer price index (CPI) and, in many countries, the growth rate of government expenditures on health is exceeding the economic growth rate. The forecasts for the not-too-distant future are troubling. Some analysts project that global health care spending could triple in the next 15 years. In the United States, some large employers could be spending as much on health care benefits as they earn in profits. In Europe, Latin America, and Asia, governments could begin privatizing at least some, if not all, elements of health care delivery in order to relieve the pressure that growing costs are placing on the national budget.

Two self-evident truths have emerged globally, regardless of the structure of an individual country's health care system. First, while total health care expenditures may be artificially controlled for a short period of time, they cannot be contained or reduced. Second, a new equilibrium for cost sharing must be reached: employers and employees will have to negotiate with the government and with each other what their respective burdens will be. In this article, we review recent global health care expenditures – their dimensions and contributing factors – and the actions employers should be taking to manage their global health risks.

GLOBAL HEALTH EXPENDITURES Dimensions of Expenditures

With few exceptions, per capita spending on health care increased steadily during the period 1998-2002 (see TABLE 1 overleaf for average expenditures during this period in 21 countries). US expenditures exceeded spending elsewhere, although other advanced industrial

economies are moving in a similar direction. Average Swiss expenditures on health care were approximately 84% of US expenditures, while total expenditures in Germany and Japan were 56% and 55%, respectively, of US expenditures.

The factor that best accounts for increases in total health care expenditures is the ability to pay, as measured by GDP* per capita. Simply stated, governments, employers, and employees in countries with a high GDP per capita are better able to purchase more and higher quality health care services than in other countries. The difference in spending among advanced industrial nations appears to be linked to the nature of the health care system. The highly fragmented nature of purchasing care in the United States tends to give providers more power to establish their prices. When health care is financed at the national – or provincial – level, health care providers have less market power.

A review of government expenditures on health care relative to general inflation in a sample of countries in the Americas, Asia, and Europe shows that government spending tends to decline precipitously in periods of economic crisis (see FIGURE 1 overleaf). In Argentina, per capita government expenditures on health fell from US\$364 in 2001 to US\$120 in 2002, the year the government was forced to end the peso's peg to the US dollar with a dual exchange rate and allowed the currency to float freely. The decrease was due to currency volatility and a freeze on government spending. Similarly, government spending on health

* gross domestic product

TABLE 1 Total Expenditure on Health per Capita at Average Exchange Rate (1998-2002)

Country	Average expenditure
	US\$
Argentina	595
Australia	1,854
Austria	1,937
Belgium	2,068
Canada	2,033
Chile	280
China	48
France	2,220
Germany	2,589
India	27
Indonesia	19
Italy	1,600
Japan	2,537
Mexico	314
Netherlands	2,015
Philippines	32
Singapore	857
Spain	1,107
Switzerland	3,871
United Kingdom	1,824
United States	4,616

NOTE: Comprehensive and comparable data for both advanced and emerging economies is available only up to 2002.

Source: WHO

care contracted in Singapore during the period 1998-2002, as the government struggled to pull the economy out of the recession caused by the Asian financial crisis. In addition to health care cuts, the government reduced contribution rates to the retirement provident funds and asked employers to freeze wages. In the Philippines also, the government was forced to reduce public spending across the board to deal with the impact of the regional financial crisis; however, the government's

response was delayed slightly by political instability and the impeachment of the President.

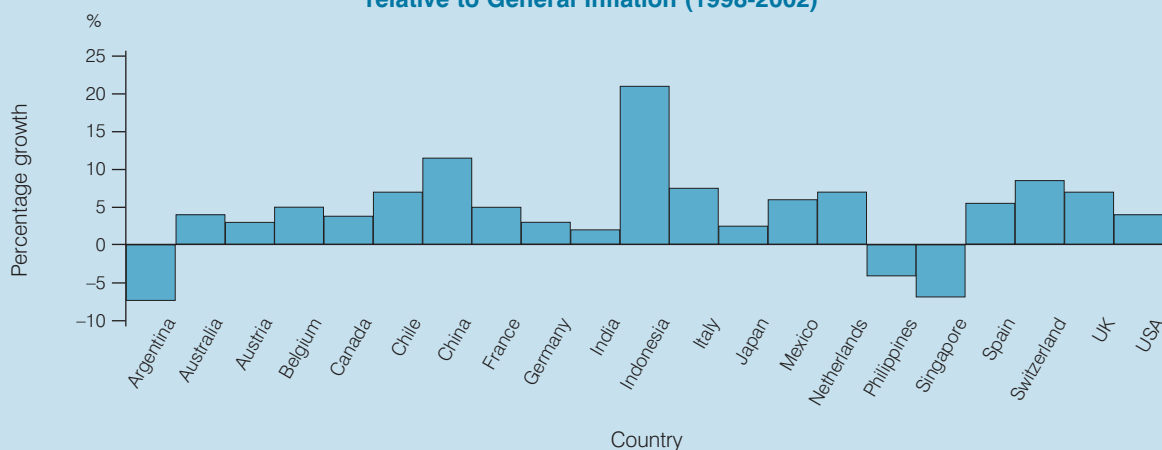
By contrast, government spending on health care increased dramatically in Indonesia and China during 1998-2002. Indonesia recovered more rapidly from the regional economic crisis, due, in part, to oil revenues and the return of foreign investors after the resignation of General Suharto as President. Moreover, the new government increased public spending on welfare and education to quell popular protest. The Chinese government was reasonably successful in insulating the economy from instability and, thus, was able to maintain public spending on health care. Expenditures, however, are grossly deficient when compared with demand – health care is unavailable in rural regions and the public health system does not adequately cover the costs incurred by participants.

In addition, total private expenditures (employer and individual) for health care relative to general inflation rose steadily from 1998-2002 with few exceptions (see FIGURE 2 opposite). Given the magnitude of the economic crisis in Argentina at the time, it is not surprising that private expenditures fell – with real wages dropping to their lowest levels in 50 years individuals had less to spend on health care. Likewise, in Chile, individuals reduced their spending on health care. As the Chilean economy was hit by the contagion effect of the Argentine crisis, wages stagnated and unemployment rose.

In Asia, private expenditures declined in the Philippines as individuals did not have the level of savings needed to sustain prior levels of health care consumption. Conversely, private savings and an increase in company expenditures for health care offset the decline in government spending in Singapore.

Companies – notably, multinationals – typically provide supplemental health care coverage or share in its cost (see FIGURE 3 opposite). Absolute company spending on health care is the highest in the United States. While company expenditures on supplemental health care coverage elsewhere are considerably lower, the rate at which they are increasing is frequently higher as

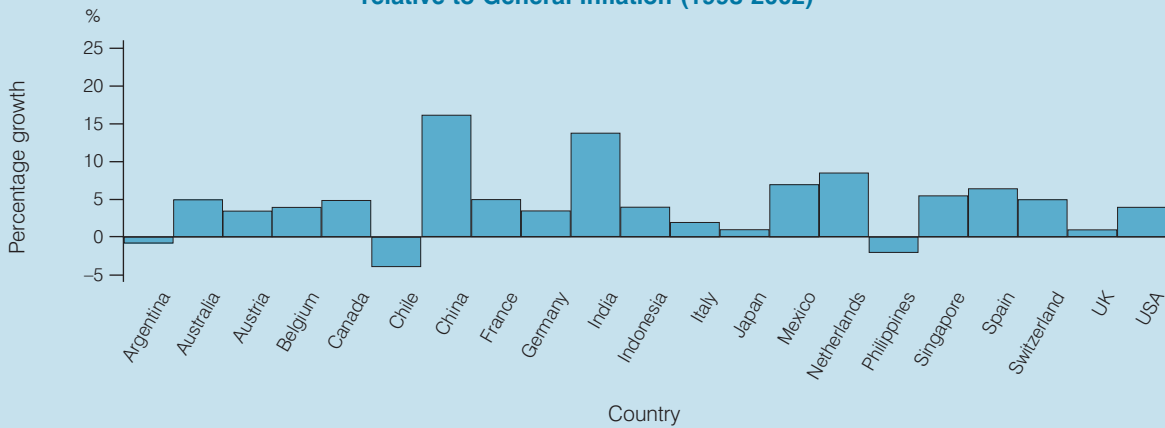
FIGURE 1 Annual Growth of Government Expenditure on Health Care relative to General Inflation (1998-2002)



Source: WHO

FIGURE 2

Annual Growth of Private Expenditure on Health Care relative to General Inflation (1998-2002)



Source: WHO

governments shift the cost burden for health care to the private sector and employers continue to struggle with the changing demographic and health risk profile of their workforce and with distinguishing themselves as an employer of choice. Despite the high level of company expenditures on health care in the USA, currently, on average, company spending outside of the USA still represents a significant cost of employment, generally 2-3% of payroll. For three specific country examples (China, Brazil, and the Netherlands) providing details of health care expenditures as they affect employers and employees, please see page 5.

Factors Contributing to the Rise in Health Costs

There is a myriad of factors contributing to the increase in health care costs globally and increased employment costs related to health. We will consider the most important of these factors in turn.

Improvements in Medical Technology

Advances in medical technology used to diagnose and treat illnesses and injuries have contributed to the rise in health care costs. During the next three to five years, we can expect the introduction or expansion of information technology, designed to integrate care, to increase costs even further. The introduction of new technologies tends to have a disproportionate impact

on costs in emerging economies, particularly for the middle class. In many Asian and Latin American countries, doctors' fees and other costs for the same treatment rise exponentially with the "class" of hospital room and the "class" of patient. The Chinese government recently issued a ruling placing a 10% limit on the number of "luxury" beds at public hospitals.

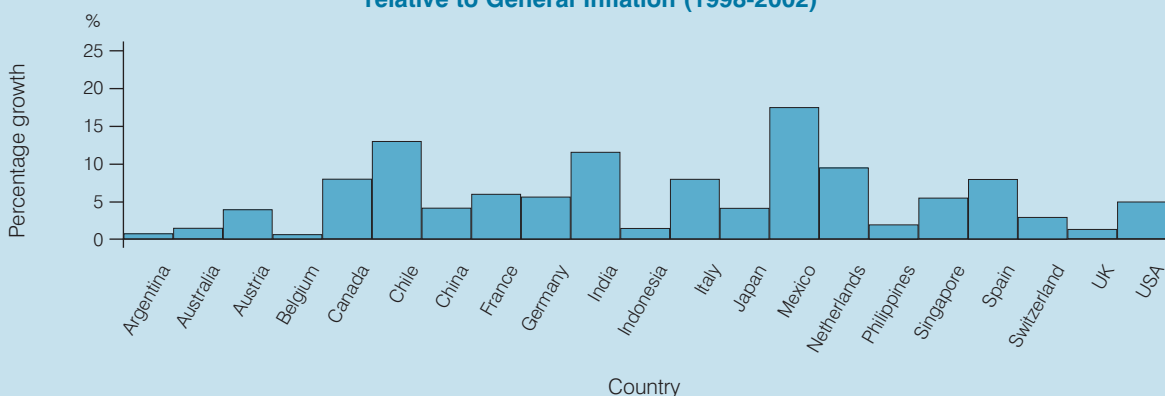
On a related note, the rate of spending for pharmaceutical drugs has been surpassing the rate of total health spending in many countries. The Organisation for Economic Co-operation and Development (OECD) estimates that pharmaceutical expenditures have grown at two times the rate of total health expenditures in the United States and Australia.

Specific Risk Factors

The constellation of health risks is changing as individuals continue to engage in poor health habits. Through government campaigns and employer wellness initiatives, the consumption of tobacco and its associated illnesses have been reduced in some countries. Nonetheless, approximately 4.9 million people die each year worldwide as a result of tobacco use; in China alone, an estimated 300 million individuals continue to smoke.

FIGURE 3

Annual Growth of Company Expenditure on Health Care relative to General Inflation (1998-2002)



Source: WHO

In recent years, there has also been a considerable jump in the rates of obesity and diabetes. The OECD estimates that more than 50% of adults are defined as overweight or obese in 10 countries – Australia, the Czech Republic, Greece, Hungary, Luxembourg, Mexico, New Zealand, the Slovak Republic, the United Kingdom, and the United States. It reports that 31% of US adults are obese. While other countries have not reached this level, the rise in obesity is alarming. In the United Kingdom, 14% of adults were considered obese in 1990; by 2003, that figure had grown to 23%. Moreover, childhood obesity is a growing global problem, and reports of type 2 diabetes in children and adolescents have begun to mount worldwide. In the USA, the health care industry estimates that the cost of services for an obese person is 36% higher than for people of a normal weight.

Global Health Costs

Global health costs are increasing as health risks become greater. These risks include chronic diseases such as heart disease, stroke, cancer, hearing and visual impairment, and genetic disorders, as well as the spread of infectious diseases such as HIV/AIDS*. The World Health Organization (WHO) estimates that 60% of all deaths globally are due to chronic diseases. In 2005, 35 million people were expected to die from chronic diseases; during the next 10 years, 388 million are expected to succumb to them.

Countries are evaluating public policy changes to address this crisis such as China's recent announcement not to allow the construction of any new cigarette factories and eventually seeking to curb cigarette sales through taxes and the elimination of cigarette advertising. In South Africa, Discovery (the largest health insurance company) provides incentives to enrolled members for healthy living such as quitting smoking, exercising, or obtaining an annual Pap smear; and in the USA the government-sponsored health insurance system is conducting health-support pilot programs for managing the care of individuals with multiple chronic conditions. These are just a few examples of efforts targeted at stemming an alarming trend relative to global health risks.

Concerns over a global pandemic of avian influenza cannot be taken too lightly, given the earlier outbreak of Severe Acute Respiratory Syndrome (SARS). Throughout Asia, the frontline of the SARS epidemic, proactive employers are creating policies and guidelines to deal with avian flu. Prevention measures include the implementation of office sterilization programs, travel restrictions, quarantine of employees, stocking and distribution of flu medication, compulsory and voluntary flu vaccination programs, the provision of masks, commuting restrictions, and office closures.

Population Aging

Increasing longevity is contributing to rising health care expenditures. In his article, "The Future Has Already Happened", Peter Drucker states that:

"The dominant factor for business in the next two decades – absent war, pestilence, or collision with a comet – is not going to be economics or technology. It will be demographics. The key factor for business will not be the *overpopulation* of the world, of which we have been warned

these last 40 years. It will be the increasing *underpopulation* of the developed countries [such as] Japan and those in Europe and North America."

In certain countries, the demographic factors are all too real. In Australia, there are currently five working people for each person aged 65 or older; this is expected to change to 2.5 working people for each person aged 65 or older by 2050. A significant demographic shift is forecast to occur there between 2011 and 2021 when the greatest number of baby boomers will be aged 65 or older. Human Resources and Skills Development Canada estimates that 41% of the population will be between the ages of 45 and 64 by 2011, compared with 29% in 1991. In the European Union, according to research conducted for the European Commission, there will be regional imbalances in terms of the location of available jobs and the location of employable labor due to the aging population.

As the population ages, health care consumption and costs will increase. Older individuals generally consume three to five times more health care services per capita than younger individuals. Age is also directly correlated with an increase in the likelihood of disability.

Implications for Employers

These trends do not bode well for employers, who will have to dedicate more time and resources to determine how to manage this growing risk and the associated organizational cost, giving rise to a number of implications.

First, as fewer employees are available to contribute to social security systems, governments will have even more reason to shift the responsibility for health care funding – and possibly for retiree health care – to employers and employees.

Second, supplemental health care premiums will rise due to:

- (i) the increase in the average age of the working population,
- (ii) the greater sophistication and expense of modern equipment and the consequent lengthening in lifespan, and
- (iii) the increase in the size of the middle class in many emerging market economies.

In some developing economies, the increasing size of the middle class means more employees use, or are entitled to use, semi-private rooms versus wards, with all related expenses, including the room, being three to 10 times more expensive than they would have been for a ward.

Third, employers will have to help their employees become better consumers of health care by providing materials and tools that allow them to assess the

* human immunodeficiency virus / acquired immune deficiency syndrome

COUNTRY EXAMPLES

China

In the late 1990s, the health care system in China was decentralized and public hospitals were given a relatively high degree of operational autonomy. This move created two rather intractable problems for public health care provisions:

- health care services are available primarily in large urban areas, and
- public hospitals, in an effort to boost profits, have been moving away from low-tech care and pushing patients into high-tech care (with expensive pharmaceutical drugs) that is not covered by public or private insurance.

According to the Ministry of Health's Third Survey on Health Care Services, which was released at the end of December 2005, 48.9% of Chinese citizens choose not to go to the hospital when ill. Nearly 30% refuse hospitalization due to spiraling medical fees. To address the health care system's inefficiencies, the government is attempting to implement a program, whereby providers are paid a specified sum depending on the diagnosis rather than the care received, and to increase public insurance coverage. In the interim, employers must develop tools and educational programs to help employees better manage their health and their health care choices.

The Basic Medical Social Insurance System in China covers urban employees and is financed through employer and employee contributions. Employees generally contribute 2% of pay and employers contribute between 6% and 12% of pay, both capped at three times the relevant city average wage. Employee contributions are deposited in individual health accounts, which are used primarily for outpatient expenses. Employer contributions are dedicated to pooled accounts that cover critical illnesses and inpatient care, of which a portion is deposited into the employee's individual account, depending on his or her age. Over 90% of multinational employers typically provide all of their employees with supplemental health insurance. In 2005, the government accounted for approximately 15% of total health care expenditures, private insurance accounted for 25%, and individuals accounted for the remaining 60%.

Brazil

Of all South American countries, Brazil has the most developed private health insurance market. Ostensibly, the public health care system, *Sistema Única da Saúde (sus)*, provides universal, comprehensive care. However, the gradual deterioration of the system's infrastructure, poor quality care, and long waiting lists have led employers and individuals to look for private alternatives. Tax incentives, allowing employees to treat employer-provided health care benefits as tax-free income and to deduct health insurance premiums and unreimbursed medical and dental expenses (no limit) incurred in Brazil or overseas, further encouraged this trend.

There are four types of private health care programs:

Group services. A network of clinics and hospitals offers services to individuals on a prepaid basis. Usually, prices are fixed. An individual may choose a provider outside the network and be reimbursed by the plan for these services. Premiums are paid monthly and prorated by age.

Medical cooperatives. Cooperatives are associations of doctors who collectively own the business. In many respects, a cooperative is similar to a group services network, except individuals are limited to doctors within the cooperative (that is, there is no free choice with regard to practitioners).

Health insurance provided by insurance companies. Most insurance plans offer a network of providers and services. Plans are 'free-choice'; individuals choose how comprehensive they wish their coverage to be.

Employer-sponsored plans. Employers may have self-managed plans for employees and their dependents. A preferred provider organization may be contracted to provide services, or services may be contracted through another firm that is responsible for managing services.

The majority of employers in Brazil offer supplemental health plans to their employees; about 25% offer retiree medical care. Nearly 60% of employers do not require employee contributions; when a contribution is required, it is typically 24% of the company cost. Co-payments are common in Brazil; an estimated 70% of plans require a co-payment. To help control health care costs, which are increasing at an average annual rate of 4% (above inflation), employers are turning to health promotion and condition management programs.

Netherlands

To limit rising health care costs by promoting competition within the insurance industry, to preserve individuals' freedom of choice with regard to their health care providers, and to extend and expand the scope and nature of care, the Dutch government passed the Health Insurance Act 2005. This Act abolishes the fragmented system of health care, under which individuals were covered by public or private programs depending on their income, and replaces it with a universal system that requires all individuals who reside in the Netherlands or work outside the country but are subject to Dutch payroll taxes to take out health insurance by January 1, 2006. Individuals retain their ability to choose their insurance provider in the province where they live and/or work.

The new system is financed by employer and employee income-based contributions that are paid into the new Health Insurance Fund, nominal premiums paid by the employee directly to the insurer, and public funds. Employees are subject to an income-based contribution of 6.5% of covered pay up to €30,015. Employers are required to reimburse their employees in full for the contribution, and employees are taxed on the benefit. All insured adults also are required to pay an annual nominal premium of approximately €1,100-1,300. The premium varies only by type of policy and the amount of "personal excess" (deductible); premiums are not allowed to vary according to an individual's risk factors. All insurance policies must provide standardized basic coverage. Supplemental coverage continues to be available on an individual basis or collectively via an employer plan or similar group arrangement. Insurance companies are free to determine the scope of coverage and premium levels for supplemental insurance. As a result of the introduction of the new health care system, employers have the option of continuing, renegotiating, or canceling their current group plan and contracting with another provider. In reviewing their group plan, employers must remember that, since basic insurance coverage is now a universal benefit, employees are not likely to place the same value on the coverage as they did in the past.

advantages and costs of plans (if multiple plans are offered), as well as to assess provider costs and quality.

Lastly, condition management, employee assistance programs, and health promotion programs should be considered as they all empower individuals to manage their health and minimize the number of acute episodes requiring care. Employers will need to reexamine how to maintain a healthy work environment based on attention to the quality of the workplace, including health and safety, and the balance for employees between work and personal life.

GLOBAL HEALTH RISK MANAGEMENT

Now, more than ever, multinational companies that are expanding or changing their global footprint to meet market demands are facing deeper and broader challenges in the management of their employee benefit programs. In some respects, human resources and finance departments have begun to meet those challenges – companies are building the infrastructure necessary to oversee the financing, administration, and design of global retirement programs. These lessons and practices must also be applied to health care.

Understanding and Awareness

In order to develop a global health risk management strategy, employers must first develop an understanding and awareness of the health care systems in the countries in which they are operating, the local health care markets, and employees' health care needs.

Almost all health care systems, whether they are primarily public or private, are undergoing some restructuring. In both advanced industrial and emerging market economies, there is a reconsideration of the role the government should play in the provision of health care and a consequent shift in the responsibility for health care to employers and individuals. In emerging markets, this trend is more pronounced as governments give individuals the ability to choose between public and private providers for basic health care needs and facilitate the purchasing of supplemental coverage through tax incentives. In Europe, governments are increasing the use and levels of co-payments (for example, in France and Germany). With these changes, employers are being pressured by unions – or other employee representatives – to provide supplemental care or are finding it necessary to add health care to their benefits package in order to remain an employer of choice.

In addition, employers must become familiar with local health care markets, how health care is being delivered in each country, the major vendors, and what efforts are being made to develop relationships with providers. Quality issues should not be overlooked – vendors that delay reimbursements to employees, for example, often make internal administration more difficult. A poor quality service will do little to improve employee absence rates, performance, or productivity.

Lastly, employers need to understand what their employees value with regard to health care and the health risk profile of their population. Surveys of employee preferences and global health risk assessments will most likely give employers the best insight.

Think Global, Act Local

Ownership and accountability are crucial to global health risk management. The oversight of global health must be included in the mandate of the global benefits management team. The team should establish a set of guiding principles; the purpose of the principles is to anchor expectations at corporate headquarters and local offices and between the employer and its employees.

In developing the guiding principles, the global benefits management team must understand any legal issues that would affect changes to existing plans. The team should also seek advice about cultural differences that may influence the approach to health care.

To be implemented effectively, the guiding principles must provide local benefits managers with clarity and specificity. However, principles that are not flexible enough to accommodate local legal and cultural differences are likely to result in a more chaotic and costly health policy.

Governance Framework

A corporate employee benefits philosophy is unenforceable unless it is supported by a governance framework, which is informed by the processes, arrangements, customs, policies, laws, and institutions that affect the way in which corporate health care is directed, administered, and controlled.

The building blocks of the governance framework consist of a global audit, a process for analyzing the health care market in each country, and a decision-making matrix for design and delivery of plans and programs. The development of better and regular communication between corporate headquarters and local offices is crucial to governance success.

The most time consuming and often most frustrating element of the framework is the global audit, since most companies do not have a mechanism for collecting data centrally and monitoring updates. An audit of employee absence and the claims experience of medical and disability insurance programs in each country, along with a detailed understanding of how existing benefit programs fit into the local employment environment and social security system, is key to shaping a global health risk strategy and establishing the guiding principles for local benefit provision.

Getting Started

Some of the most important challenges to the implementation of global health risk management are:

- changing an existing culture of decentralized benefits management;
- recognizing the implications of a lack of strategic review and control; and
- achieving consistency.

Four steps a company needs to take in managing global health risks are, first, to assign corporate accountability; then, establish a global data inventory of current programs and conduct a gap analysis to assess their current status relative to each country's requirements; next, address immediate concerns/gaps; and, finally, define its global guiding principles.

UNDERSTANDING & ADDRESSING KNOWN ISSUES

The time to act is now. Multinational employers must begin the process of understanding and addressing known issues relative to health care globally. It is a cost and productivity concern that cannot be overlooked. Ω

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