Informal Discussion Transcript

Session 5A - Aging and Changes in Health Status

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TOM SHELBY: First of all, I want to thank Tom Getzen for the presentation. I have looked everywhere for that kind of data. I finally, out of necessity, sat down and tried to perform the same calculation and amazingly I came up with the three-year lag, so I'm confirmed about that, I thank you for it. The other thing that I had was that my projection, which has been somewhat criticized by other actuaries as being too low, but my long-range projection ran to I think about 40 percent. Recently in one of the papers here that was given, the maximum level that was given is 34 percent, I'm talking about percentage of GDP. And I think you came out at 26 percent. Basically that is based on how you treat the improvements. I think it was a very interesting paper and I welcome it.

TOM GETZEN: Whether it's 26 or 40 percent depends a lot on whether this "surge" in costs continues. Health spending as a share of GDP was very flat through the '50s. There's been this giant surge that appears to be coming back down. The question is do we keep it coming down. It's hard to know with this Congress or any Congress. When the economy recovers, will they still be able to keep their belts tight, which is essentially a question that we're asking. I'm going to just take half a second to respond to Eric's comment. One of the disadvantages to a bottom-up analysis

is the inability to get to the budget constraint. The advantage of a top down is the budget constraint. They both have advantages and disadvantages. Right now, one of the big problems that some congressmen worry about is the budget constraint. When I started out in 1975, there was a consensus that health expenditures would never exceed 10 percent of GDP. All I know is every time I tweak my model and try to apply my judgment instead of what the data say, I tend to be more wrong rather than more right, so I'm just waiting for the data to let me know.

MATT MALKUS: Hi, Matt Malkus, Institutional Life Services. My question was for Stephen. I found it interesting most of the factors you found to be significant related to health declines are also experienced in mortality rates but one that was not was the fact that females, younger females, experience greater health declines but they don't experience greater mortality rates. I'm wondering if you know, have some explanation for that or if you believe that's a function of self-selection or self-reporting of that data.

STEVE PRUS: I haven't looked at the mortality comparison but you know I'll take your word for it. Just to go with what you were saying, of course there's a flip when we measure health using mortality relative to self-rated health and the answer might be right in there, the fact

that this is self-reported health and mortality is a much more concrete measure of health.

That being said, it's interesting because when I used the health utility index, another widely used measure of health, which measures functional health, it ranges on a scale from 1 to about 0, where 0 would indicate death and 1 perfect functional health or physical health. The results are almost identical to this, so they hold up even when using a concrete measure, so you know that's a really good point, I'd have to see, you know, or I could make some suggestions why. Both are self-report, the health utility index and self-reported health, so it simply could be a subjective difference whereas life expectancy, of course, is concrete. But that's a good point because there appears to be a paradox here in the data, but something I'll give some more thought to. Thank you.

MICHEL POULAIN: Michel Poulain, Tallinn University, Estonia. I just want to stay on the slide and just to look two slides later when you talk about the 65 plus. What we see on this slide is that for the 65 plus, the difference seems to be less than for the other one and you see that women are under, you see the women are under. That means that their health decline seems to be less important than for men. How can you reconciliate this with the fact that when you look at both 65, the self-rate health of women is

going worse and worse and the worse situation is when they are 90 plus. In 90 plus, you have a huge difference between men and women in favor of men; men are really more healthy in terms of self-rated health's, so that's the question. I have just a suggestion. Do you have in your survey any question about happiness or optimism, because that could be fully related with the perception of health and it could be also related with the alcohol consumption. I think that's a good way to try to solve the problem.

STEVE PRUS: Thank you and you know I'll answer the second question first. There isn't a measure of happiness or quality of life in the National Population Health Survey. There are measures of psychological well-being such as stress but that's the extent, but you know certainly that could play an important factor in explaining some of the results.

In addressing your first question, these tables are quite interesting and I was at first reluctant to put them in because I thought they're going to generate a lot of questions, and you know simply because we do see this change. So I was reluctant because I haven't, you know, this would require a lot more analysis to, you know, indicate why it is that this gap exists and why it reverses. There's certainly a gap as I said in younger ages where males advantaged, then females become advantaged, in

terms of healthy aging. Again, it wasn't the focus of the paper, but it's background information. But it appears that a lot of you have really good questions about it, you know why it exists and it's something I'll certainly want to look at further.

MICHEL POULAIN: Just a suggestion to cut your last age group in two, 65-76 and 75 plus, and to see if there's a difference.

STEVE PRUS: Yeah, I could certainly, you know, I wouldn't be able to do a complex multivaried analysis breaking it down by age groups, because the data simply wouldn't be large enough, the sample size, especially at the old ages, but it would be interesting to see if I continue to breakdown the 65 plus further into age groups, you know, whether or not it bends again or the gap changes. Why these gaps? I think your first question, it could be some type of selection process, you know, certain men drop out of the study, certain women drop out of the study and it would leave more robust populations and again I wouldn't be able to tease that out with the data, but that's all good. Thank you.

ROB BROWN: I wanted to just make a comment on some data that came out of Tom Getzen's study. Tom mentioned that the U.S. is spending about 18 percent of gross national product on health care and 46 percent of that is administered by

the "government." In Canada, 70 percent of the system is "government" so we quite often hear the categorization then that Canada has a government health care system and the U.S. is a private system, or at least it is 54 percent private and 46 percent public. Let me just restate the data though and let you go away and think about it: 46 percent of the U.S. system is administered by the government and the U.S. consumes 18 percent of gross national product on health care. That means the U.S. government is allocating 8.3 percent of gross national product and controlling it for health care. In Canada, 70 percent is government administered but we're spending 11 percent of gross national product on health care. So, in Canada, the government is taking, allocating and controlling 7.7 percent of gross national product for health care. So it may cause you to re-evaluate your single word descriptors—private versus public.

TOM GETZEN: I think you are speaking to the choir. I mean what you express is correct, and it's been known for quite a while by those who are well informed. Twenty years ago I remember talking to a reporter and she said, "What do you mean the United States doesn't have the best health care system in the world?" I said, "Well, are the Washington Wizards the best basketball team in the United States? Their record is not that great." Same with health care, it

is the record that counts rather than rhetoric. As we all know, there's been a ton of work both by demographers like recent National Academy press report by Crimmins and Preston. Many research examine the sociology and demography of aging, looking at how the United States, the health of people at age 65 and their health progression, stacks up against a series of other countries. Crimmins and Preston is really an excellent publication. The U.S. is at the middle or even toward the bottom. Costs are way high, quality and life expectancy is down, but you still have some people who don't want to deal with reality—and there are people in Canada who don't want to deal with reality too. If you're from Toronto, I can talk to your mayor.