Health Economics Information Resources: A Self-Study Course

Module 2 - Sources and Characteristics of Information Relating to Health Care Financing in the US

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Module 2: Learning objectives

By the end of this module, readers will

- be able to describe the significant trends in spending, outcomes, and access within the U.S. health care system; and
- know where to go to find the main sources of literature and data relating to health care financing in the U.S.

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The U.S. health care financing system

In this section we will be looking at a **snapshot** of the current health care situation. We will ask whether the **U. S. health care system is really a system** and will investigate **how the money is spent**, what are the **health outcomes** and how individuals **access** the system.

A snapshot

In the U.S. health care is financed, or paid for, in a variety of ways. Individuals may pay directly for services received. Others may have health **insurance** coverage as a tax free benefit from their employment. Military personnel and their dependents, as well as veterans, are provided health care coverage through the federal government. Older Americans depend upon **Medicare** and low income mothers and children, as well as some disabled persons in the U.S., receive health care assistance through **Medicaid**. Children who might not otherwise receive medical attention may do so through the **State Children's Health Insurance Program** (SCHIP).

Many of the employed are covered by employer provided health care insurance… traditional **indemnity insurance** or a **managed care** plan, such as a **Health Maintenance Organization** **(HMO)**, **Preferred Provider Organization**, (PPO) or **Point of Service Plan** **(POS)** – which employers purchase as a group. Employees may or

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may not have had some input into the choice of that plan. Those with employer provided insurance are in good company, as the vast majority of Americans are covered by employment-based private insurance plans, **64%** of the U.S. population, for example, in 2000.

An additional **24%** of our population in the same year was covered by **some type of government plan**. The breakdown is as follows: **Medicare, 13%**; **Medicaid, 10%**, **Military Health Insurance, 3%**.

Many Americans are **covered** by **more than one health insurance plan**, and coverage between plans often overlaps. Among plans and programs there are **many differences** in the range of services covered, procedures followed, and payment provided. For our purposes today, it is probably not so important that we know all of these details, and you will find additional information on various types of insurance plans in the glossary.

From this brief description, however, one point is very clear. The health care financing system is **not** so much a system as it is a **crazy-quilt of programs** that, when pieced together, **cover to some degree**, the majority--but clearly not all—of the American people.

Because there is such a wide variety of public and private insurance programs in the US, there is also great opportunity for researchers to study the tradeoffs between key issues. Most notable are issues related to spending, outcomes, and access.

The next section deals with health care spending.

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Spending

Spending on **health care services and products** reached **$1.3 trillion in 2000**, which **was up 6.9%** from the previous year. This $1.3 trillion figure represents **13.2% of the U.S. Gross Domestic Product (GDP)**, or the total value of goods and services produced that year in the U.S.

Looking at this amount in the very broadest context over **13%** of the total amount that was spent for all goods and services, or about **1 dollar in every 7**, was allocated for health care purchases in 2000.

The $1.3 trillion also means that individuals spent **$4,637.00 per capita in 2000** in their quest for "health". This is **well above** what other industrialized nations spend. The U.S. **ranking for per capita health expenditures consistently exceeds** that of other OECD nations, and **the rate of increase** in per capita health expenditures is **relatively high** as well.

What are some **factors** that contribute to the **rapidly escalating health expenditures**?

Throughout the literature, several determinants are cited repeatedly: an **aging population**, an increased **demand for and use of advanced technology**, a **decline in enrollment** in restrictive, cost-containing health care plans, and **rapid spending growth on prescription drugs**.

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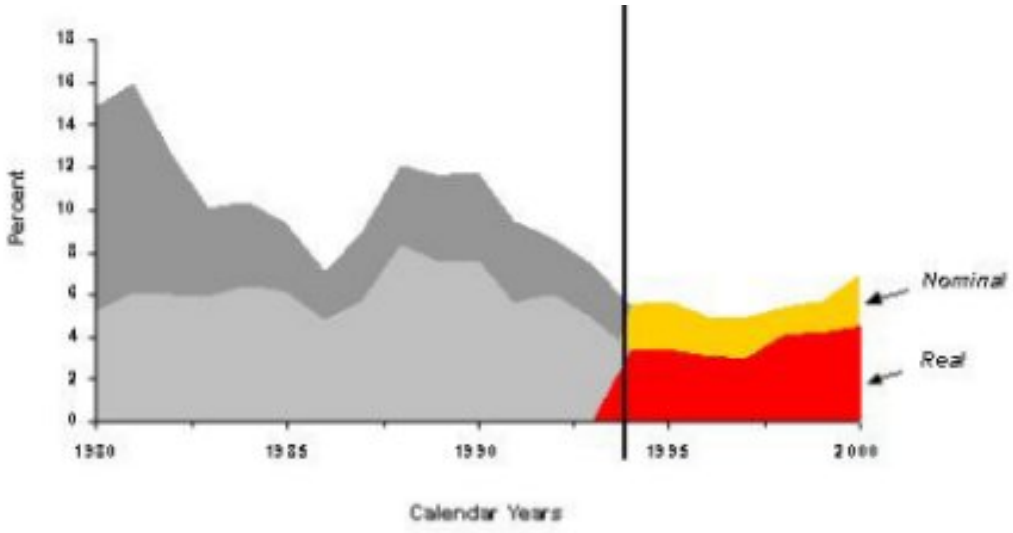
Growth in national health expenditures



Source: CMS, Office of the Actuary, National Health Statistics Group

Note: Deflated using the GDP chain weighted price index.
Nominal: values expressed in current dollar terms (not adjusted for inflation).
Real: values adjusted for economy-wide inflation.

Health spending growth **slowed** between 1993 and 2000 to an

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average increase of **5.6** percent, about half the rate of increase between 1980 and 1993.

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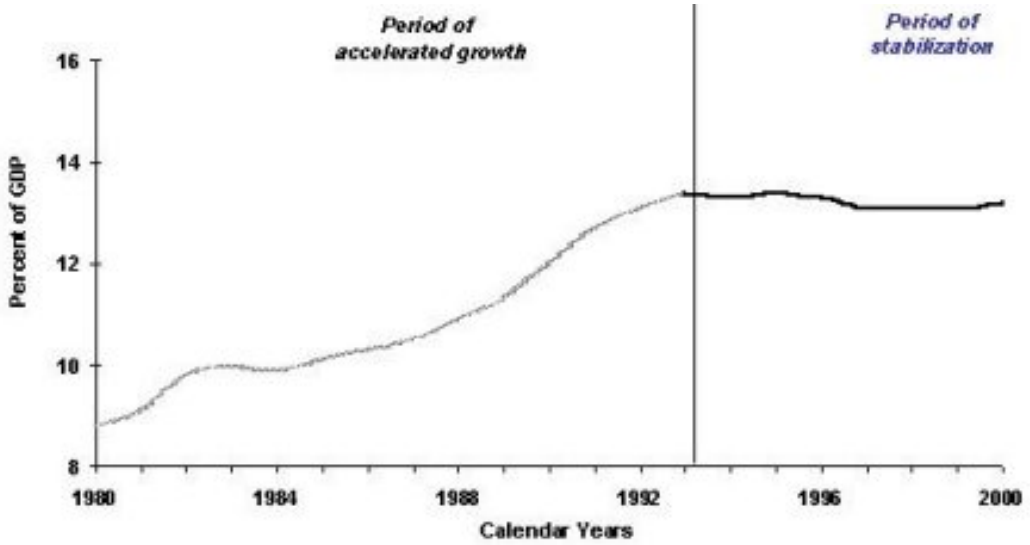
Health care expenditures as percentage of GDP



Source: CMS. Office of the Actuary, National Health Statistics Group.

Rapid growth in the health spending share of GDP **stabilized** beginning in **1993**. Note the sharp upward curve between 1980 and 1992.

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OECD Health Data 2001

When you **compare the U.S. health care system** to that of other industrialized nations, you will see startling results not only in **expenditures** but also in **outcomes**. Data from *OECD Health Data 2001* gives us comparative **health status** information on its 30 member countries.

Characteristic	US	OECD
Health Expenditure per capita, 1998, $US PPP	$4,165	$1700
Life expectancy at birth	Male: 73.9 Female: 79.4	Male: 73.7 Female: 79.8
Infant mortality	7.2 per 1,000 live births	6.7 per 1,000 live births

These data show that, **in spite of ranking at the top of the list for health expenditures**, the **U.S. falls into the mid-ranges** for some broad measures, such as **life expectancy** and **infant mortality**.

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World Health Organization Report, 2000

Member State	Health expenditure per capita in International dollars (Ranking)	Overall health system performance
Chile	44	33
Costa Rica	50	36
Cyprus	39	24
Oman	62	8
United States of America	1	37

Source: Annex Tables 5-10
World Health Report 2000, WHO

What does this table tell you?

See if you can select the correct answer before reading on

This table tells me that:

A. Oman spends more on health care than the United States per capita
B. The US spends more on health care per capita but ranks very low with respect to overall health system performance
C. Costa Rica has a worse overall health system performance than Chile
D. The World Health Organization doesn't keep very good records of health expenditures and overall health system performance

The correct answer is **B**. The U.S. **spends more on health care per**

capita - it is number 1 in spending - but **ranks very low** (37th) with respect to **overall health system performance**.

Current Population Reports

A Current Population Reports Special Study says it in a nutshell:

> "**...the United States outspends the world on medical care, but three-fourths of developed countries have better health measures**".

Source of Quotation: *Population Profile of the United States 1999*, Current Population Reports Special Study, March 2000.

It is important to remember that **medical care is just one factor that determines health**. Some of the others, such as **heredity, lifestyle, and preferences** - diet, exercise, use of tobacco and alcohol, to name a few - **must also be taken into account**.

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Access to health care

The final problem area that should be mentioned is that of **access**. In the U.S. health care system, millions of Americans slip between the cracks and have **no health care coverage** at all. The chance of being **uninsured varies by race and ethnicity, age and employment status**.

Number of uninsured over time

This table shows the number of **uninsured** Americans (in millions) between 1995 and 2001.

Year	Number
1995	40.6
1996	41.7
1997	43.4
1998	44.3
1999	39.3
2000	38.7
2001	41.2

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Those who had no **health insurance** in 2000 accounted for **38.7** million people total in 2000.

Although the number of uninsured dropped from 1998 to 2000, that number has risen again with the downturn in the economy to **41.2** million.

12% of all **children** in U.S. under age 18 – 9.2 million children – had **no health insurance in 2000-2001**.

Health care reform

Nevertheless, **health care reform** is, and has been, a hot issue for some time and is likely to remain so until there has been additional progress in resolving some of the basic issues that have been mentioned. Americans are conscious of, and troubled by, the flaws with the system of providing health care and health care reform is often on the minds of those who work in health care and for the government.

It is likely that health care researchers, policy makers, decision makers, as well as the general public – who are taxpayers and consumers - will continue to **seek improvements** in health care and that, in doing so, they may approach you for assistance in identifying and retrieving health care expenditure and related data. To that end it is important to take a closer look at **major funders** of the health care system and at some of the data available.

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Sources of Health Care Funds

This section will cover who pays and who are the major funders. It will also explore how the system works and possible future trends. Before looking at sources of U.S. health care dollars, it is important to keep in mind the following quote on the subject of health care costs and spending. Jonas and Kovner's book, *Health Care Delivery in the United States*, states:

> "Ultimately, the people pay all health care costs. Thus, when we say health care monies come from different sources, we really mean that **dollars take different routes on the way from consumers to providers** through government (taxes), private insurance companies (premiums), and independent plans, in addition to out-of-pocket payments."

The nation's health dollar comes from the taxes and **insurance premiums** we pay, as well as from our **co-payments** and **out-of-pocket expenditures**. And perhaps this is one of the most compelling reasons that health care reform is of such vital interest to researchers and the general public alike.

Let us continue and look at routes those health care dollars taken from consumers to providers. As we do so, we will address three basic questions:

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1. What **funders** are included in this category?
2. How does this **funding scenario work**?
3. What are the **trends**?

The Nation's Health Dollar: 2000

What Funders are Included?

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group

What is the largest slice of the health care dollar pie? It is clear from this slide that **monies from private insurance** comprised the **largest category** of funds in 2000 - 34%.

Think about Medicaid and Medicare costs at 33%. Who pays for those receiving health care through those programs? All of us do through the taxes we pay. This is **indirect out-of-pocket expenditures**.

Where does the 15% out-of-pocket costs come from? Again, the money comes **directly** from our checkbooks or pockets. Out-of-pocket costs include paying for services **not covered** by your health plan or insurer. Examples include paying for services from a chiropractor not on the approved provider list of your health plan and co-payments.

In fact, **60% of the total health care dollar** comes directly or indirectly from our pockets, directly from our pockets or indirectly paid for through taxes.

How does this scenario work?

Insurance is like a club.

This is the analogy Sherman Folland uses in his book *The Economics of Health and Health Care*:

> "Consider a club with **100 members**. The members are about the **same age** and they have the **same lifestyle**. It seems that about **once a year one of the 100 members gets sick** and incurs **health care costs of $2,000.00** The incidence of illness seems to be random, not necessarily striking men, women, the elderly or the young in any systematic fashion. The club members, worried about potential losses due to illness, decide to collect **$20.00** from each member and put the **$2,000.00** in the bank for safe keeping and to earn a little interest. If a member becomes ill, the fund is used to pay for the treatment. This in a nutshell, is insurance. **The members have paid $20.00 to avoid the risk or uncertainty**, however small, **of having to pay $2,000.00**. The 'firm' collects the money, tries to maintain and/or increase its value through investment and pays claims when asked."

From the inception of health insurance (in 1847, when the first commercial plan was organized) to the 1930's, the purpose of such insurance was to offset income losses resulting from disability, usually due to accidents. Since that time, however, health insurance has evolved greatly and is now a **mechanism** for **defraying costs of illness**, not just accidents, and for **financing routine and preventative health care**.

Whether private insurance is an **employee compensatory benefit** and thus purchased for individuals by companies and organizations or purchased directly by the individual, it operates in similar fashion. A premium is paid by employers or individuals to an insurance company, which pays the doctors, hospitals and other health care providers for care and services administered to the eligible patient.

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Private funds

Funds in this category of "private insurers" include **premiums** paid to commercial carriers, Blue Cross/Blue Shield and managed care plans, as well as self-insured employers.

Other private funding sources include, among other things, privately funded construction, and additional non-patient revenues, including philanthropy. Out-of-pocket expenditures come from private sources in that they include **direct spending by consumers** for all health care goods and services, such as co-insurance, deductibles, and any amounts not covered by insurance.

As we have seen in the pie chart in the previous section, private insurance accounts for **34%** of the funds while out-of-pocket accounts for **15%** and "other" private accounts for **6%**.

Table: National health expenditures aggregate, per-capita, percent distribution

National Health Expenditures Aggregate, Per Capita, Percent Distribution

Item	2000	1990	1960
Amount in Billions			

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National Health Expenditures	$1,299.50	$696.00	$26.70
Private	712.30	413.50	20.10
Public	587.20	282.50	6.60
Federal	411.50	192.70	2.89
State and local	175.80	89.80	3.80
Per Capita Amount			
National Health Expenditures	$4,637	$2,738	$143
Private	2,542	1,627	108
Public	2,096	1,111	36
Federal	1,468	758	15
State and local	627	353	20

Percent Distribution			
National Health Expenditures	100	100	100
Private	54.8	59.4	75.2
Public	45.2	40.6	24.8
Federal	31.7	27.7	10.6
State and local	13.5	12.9	14.2
National Health Expenditures as a Percent of GDP	13.2	12	5.1

Source: Centers for Medicaid and Medicare Services, Office of the Actuary

So what has the **trend** been with private insurance?

Taking a long term view, that is, over the past 50 years, we can say that we have come to **depend less on funds from private sources**, especially with the inception and implementation of Medicare, in the 60's – as this table shows.

Note that in **1960, 75.2%** of total health expenditures were funded from **private sources**, whereas, in **2000**, the percentage of privately funded health expenditures is at **54.8%**.

Over the shorter term, the past 10 years, there has been a **decrease** from nearly **60%** in 1990 to the **54.8%** level in 2000.

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Public funding

Turning our attention to public funding – we can see that the breakdown of expenditures from public sources for the year 2000 is as follows: Medicare **17%**; Medicaid and State Children's Health Program **16%**; Other Public **12%**.

Medicare

Medicare is one of the more familiar programs to Americans. This federal program provides a **range of medical care benefits** for **persons aged 65 and over, disabled persons and their dependents and those suffering from chronic kidney disease**. Medicare covers about **95% of our nation's aged population**, approximately **39 million** in 2000. Traditionally, there have been 2 parts to the program.

Part A is financed by **payroll taxes** collected under the Social Security System and provides **hospital care**, **extended facility care**, and some **home care**.

Part B is a **voluntary supplemental program** that covers physician's expenses and is supported by **general tax revenue** and a **small premium from enrollees**. Nearly all Medicare beneficiaries automatically covered by Part A join Part B as well.

There is a newer, third part of Medicare – sometimes known as **Part**

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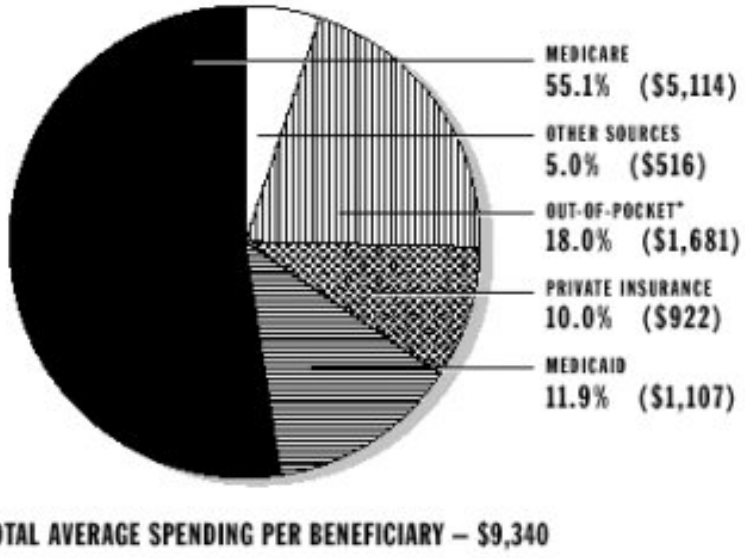
C, established in 1997. It has an expanded set of options for the **delivery of health care** under Medicare, allowing beneficiaries to participate in eligible **HMOs, PSOs, PPOs** and other coordinated care plans.

Sources of payment for Medicare...



Medicare pays **more than half** the total cost of beneficiaries' medical care.

However, Medicare is **not comprehensive**; there are **deductibles, co-insurance fees, and serious gaps in coverage**.

Seniors with Medicare coverage are still responsible for many out-of-pocket expenses – most notably, and most currently newsworthy, **prescription drugs** and **long-term care**. They are the ones we have been hearing the most about in recent years.

Medicaid and SCHIP

Medicaid is a program funded jointly by federal and state governments and, in reality, encompasses 50 different state programs grouped together under this common name and bound together by some general requirements. Medicaid helps **low income persons** and covers about 36 million individuals. Eligibility for Medicaid is determined by the states themselves within federal guidelines, which include major types of care required to be covered.

Created by the Balanced Budget Act of 1997, the **State Children's Health Insurance Program** (SCHIP) is a largely federally funded Medicaid program **designed to help states expand health insurance to children** whose families earn too much for traditional Medicaid but not enough to afford private health insurance. In 2000, **3.3 million** of the nation's approximately 11 million otherwise uninsured children were covered by SCHIP. Due primarily to increased

flexibility and expanded marketing, that amount was increased by **38%** in 2001, resulting in 4.6 million children covered.

Other Public

"Other Public" includes programs such as workers compensation, public health activity, **Department of Defense**, **Department of Veterans Affairs**, **Indian Health Service** and **State and local government** hospital subsidy and school health. These programs provided **12%** of the total health dollars for the nation in 2000.

Public funding has generally **increased** over the long term from roughly 25% in 1960 to **45.2%** in 2000. This increase, especially since 1965, is largely a result of **greater federal expenditures** and much significant rise in federal spending is accounted for by the **Medicare** and **Medicaid Programs**.

The trend here is the **reverse** of that for private funding.

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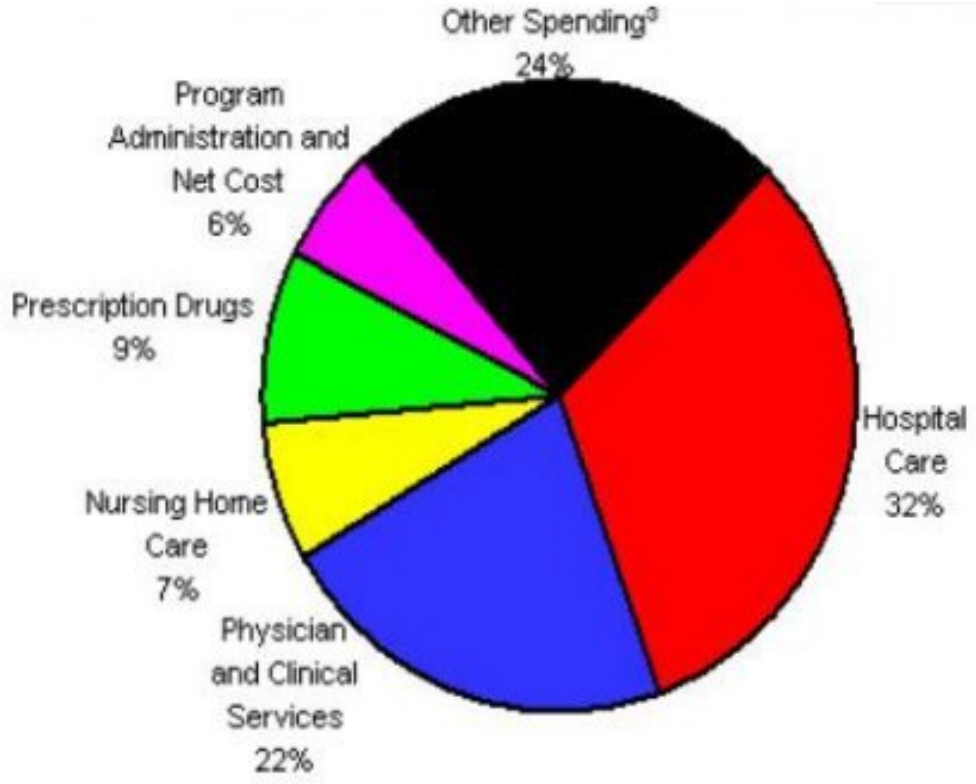
Spending: Where it went – 2000



And where did that money go in 2000?

This slide shows the various categories of expenditures and the percentages of total dollars spent for each. **Hospital care** accounted for 32% of the health care dollar. **Physician and Clinical Services**

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accounted for 22%. **Other Spending** - which includes dentist services, other professional services, home health, durable medical products, over-the-counter medicines and sundries, public health, research and construction - accounted for a hefty 24% with **prescription drugs** at 9%, **nursing home care** at 7%, and **program administration** at 6% of the total spending.

The next section looks at the main sources of literature and data relating to health care financing in the United States.

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Major statistical sources

In this section we will answer the following questions:

1) Where is the data?

2) What does the data mean?

3) What are we measuring?

National Health Accounts (U.S.)

The National Health Accounts series, which the U.S. Department of Health and Human Services has published since 1964, aims to "identify all goods and services that can be characterized as relating to health care in the nation, and (to) determine the amount of money used for the purchase of these goods and services"

The Accounts are available for **downloading** in **spreadsheet** compatible format from the URL at the Centers for Medicare and & Medicaid Services Web site.

The NHA consists of a **matrix of categories** which classify and define the sources of health care dollars and the services purchased with these funds. They are based on a vast array of information collected

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by public agencies and private organizations.

It is, in terms of scope, the most **comprehensive source** to consult for **health care expenditure data**.

The series has many important characteristics: The unified structure of the NHA enables researchers to **make comparisons** of categories over time because it **applies a common set of definitions to variables**. The NHA aims to be **comprehensive** because they contain **all** of the main **components** of the health care system, including not only personal health care expenditure data, but also that pertaining to medical research, construction of medical facilities, program administration, etc. and, they are multi-dimensional in that the data are further broken down by geography and age-levels of subjects.

In addition, the NHA represents the health care sector of the economy and, as such, show several important relationships:

1. **Percentage of Gross Domestic Product (GDP)**. As previously mentioned, this figure reveals the amount the nation decides to allocate to health care – relative to it's productive capacity. It quantifies a national choice and, thus - provides a numeric basis for discussion.
2. **Expenditures by source of funds and changes over time in those sources**. Important for policy makers, insurers, voters.
3. **Projection of future expenditures**. Created from historical trends, these projections alert public and private sectors to possible future outcomes.

NHA/ NHE Documentation

Given this enormous and rich body of information on U.S. health care expenditures, what should we remember when referring users to this source?

As is the case whenever consulting statistical information, users need to be aware of the **limitations** of the data. It is critical that users familiarize themselves with the **definitions, sources, and methodologies** used in creating the NHA in order to grasp what is being measured and how that measurement is being accomplished.

For the NHA, one needs just to consult the **Centers for Medicare and Medicaid Services (CMS)**, formerly Health Care Financing Administration, homepage to find definitions of each category of medical service and source of funding, scope of the program, methodology of program, and source materials from which the NHA are developed. Find information at the CMS Web site.

This information can also be found in the annual review article on NHA in the journal *Health Care Financing Review* and in *Health Affairs*.

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U.S. Bureau of Labor Statistics

In this section we will examine the **Consumer Price Index**.

Aside from total expenditure figures, researchers often require data on the components that make up expenditure, and a key component of health care expenditure is price information The most common measure of prices is the Consumer Price Index. The CPI measures the **average change over time in a fixed "market basket" of goods and services purchased by consumers** and is generally used as a **measure of inflation**. Some version of the CPI has been published by the Bureau of Labor Statistics since the early 1900s.

To produce the index, BLS regularly collects data from over **50,000 housing units** and **23,000 business establishments** in **87 areas across the country**. The CPI is based on **detailed expenditure information** provided by families and individuals on what they have **actually purchased for daily living** over a given period of time. It currently includes price information on food, clothing, shelter, fuels, transportation, health care services, and drugs.

The CPI and the medical prices indexes within it enables us to **compare consumer costs over time** and to **measure the rate of change in prices for various goods and services**. Rate of change in price for medical goods, for instance, can be compared to the rate of change for all consumer goods. We can then address the question: are health care prices escalating faster than the other prices are? Likewise,

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rate of change in prices among categories of medical care can be compared; hospitalization vs. physicians' services, for example.

An annotated listing of many of these key sources is included in the Web Site section of this course (provided as a link from the Menu under Related Content).

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Health Economics Information Resources: A Self-Study Course

Module 2 - Sources and Characteristics of Information Relating to Health Care Financing in the US

Alerting Users to Data Source Issues

Whenever directing users to data sources, however, be sure to alert them to the relevant documentation for an **explanation of scope of study**, **definitions of populations and variables**, and **details of data collection methodology**.

As we consider what care **we must take when using data sources**, we can multiply the level of complexity very quickly when we turn our attention to international statistical information.

International Data Providers

Earlier, I made reference to Organization for Economic Co-Operation and Development (OECD) and World Health Organization (WHO) reports that compare and even rank the health care systems of various countries. Certainly OECD and WHO are respected data providers.

Practicing and certified nurses per 1,000 population, late 1990s

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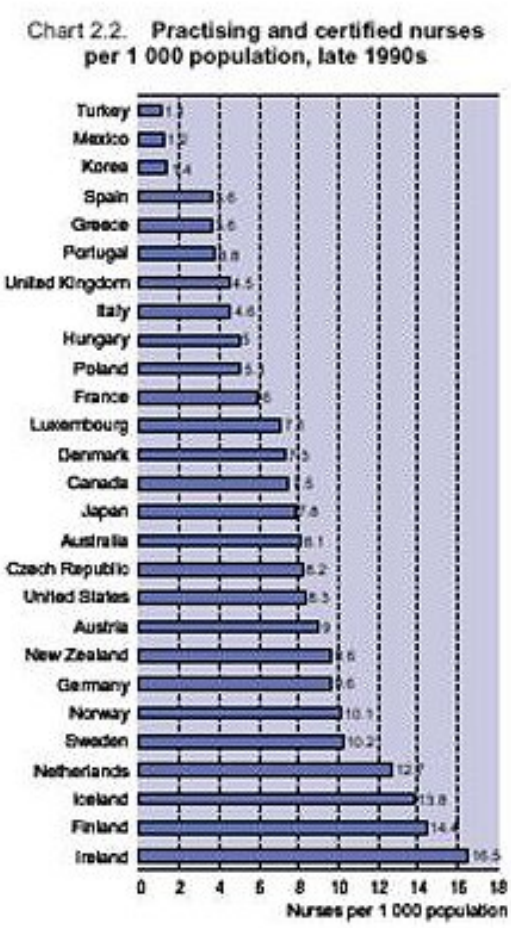

Let us look now a little more closely, however, at an OECD report . Here is a chart entitled "Practicing and Certified Nurses per 1,000 population, late 1990's" from *Health At a Glance, 2001, OECD* – from Source OECD, accessed March 12, 2002. Does it appear from this chart, dated in the late 1990s, that Finland had approximately three times as many nurses per 1,000 as did the United Kingdom? You might think so, too – unless you look at next chart which tells you something very important.

Practicing physicians per 1 000 population, late 1990s

When you look at this chart "Practicing Physicians per 1,000 population, late 1990s" you will see a footnote that indicates that in Finland the count of physicians includes not only all actively practicing physicians but also **those entitled to practice**. Could this also be true of counting nurses in Finland too? On the previous page of the report is the definition of the variable "practicing nurse". "The numbers of actively practicing certified/registered nurses employed in public and private hospitals, clinics and other health facilities."

It goes on to say, "Nursing assistants (also called licensed practical nurses or enrolled nurses) are not included in nurse numbers in some countries such as Australia, Austria, Canada and the United States.

That **items or people are counted differently in different countries** is something to remember if you are comparing this statistic in the U.S. with the same figure for another country that does include nursing assistants or licensed practical nurses in their count of "practicing nurses."

The definition continues, "Most countries report **head-count numbers**, while the Czech Republic, France, Germany, Hungary and the United Kingdom report **full time equivalents**."

Could this make a difference? Think about what, if any, are the implications of this.

And more-
"The United Kingdom and Spain provide only **publicly employed nurses** (nurses employed in the National Health System). Are there others?

Further on–
"Finland reports all nurses **entitled to practice**."

It is easy to see that in reporting the numbers for one seemingly straight-forward variable, that **countries are**, in fact, **measuring differing populations**. It is easy to imagine now much more complicated defining and measuring variables might be when you move into the realm of health care financing.

When you are dealing with international comparisons in health care financing you need also to consider **differing monetary systems and currencies**. The mechanism for accounting for these differences and thus for rendering comparable statistics for expenditures is called **Purchasing Power Parity**. As the name implies PPP is used as a **conversion factor** so that internationally comparable price and volume figures can be established. To see exactly how this conversion is made, check the glossary.

The main point in this discussion of international health care statistics is **documentation, documentation, documentation**!! It is of the utmost importance that you direct your users to it. A seemingly simple endeavor like counting nurses can be fraught with danger of misunderstanding. A reading of the fine print is in order!

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Recapping Module 2: International comparisons

In summary, the introduction to the OECD, *Health at a Glance 2001* report says it best:

> "It is very important to note that variations in the indicators across countries and through time may reflect variations in the definitions of variables as well as variations in the phenomena being observed. In other words, despite growing agreement about international definitions of health variables, and growing adherence to these definitions among countries when reporting their data, there remain many definitional divergences and changes in what is reported…"

For this reason, care should be exercised before drawing conclusions about variations and trends in the underlying phenomena, especially for comparisons across countries.

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U.S. health care financing finding aids

- Bibliographies
  - bibliographies are often good sources of information. The publications consulted in the development of this module provide some key sources that are published annually and that may be helpful to you in the future. The Bibliography appears on the Menu as a link under Related Content.
- Health Economics Core Library Recommendations, 2003
  - NICHSR has made this list accessible on their Web site for use in creating a core library of health economics resources and for doing research
- Journal articles from these two journals contain exceptionally good health care financing content
  - *Health Affairs*
  - *Health Care Financing Review*
- Statistical Abstract
- Statistical Universe

Conclusions and Summary

The U.S. Health Care Financing System – because of its wide variety of programs – provides a **great opportunity for study, learning and improvement**. **Interest in reform is high**. **Funding routes are shifting from private channels to public channels**, thus involving government to greater degree. And the public is being involved to

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greater degree as consumer and taxpayer

Data sources are rich, varied, and complex. Information can be found on Federal and state government sites, through private organizations and from international government and organization sites.

Our challenges are many. How do we find resources? And, how do we give assistance to our clients in using them?

Quiz

Prepare yourself to take the quiz for this module by reviewing possible questions. Then take the quiz. From the quiz you can apply for the Certificate of Success for Module 2.

Module 2 Quiz 2 [review questions]

If you do not wish to take the quiz for Module 2, move on to Module 3: **Identification and Retrieval of Published Health Economic Evaluation Studies**.

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"Test Yourself" Review Question

Ex. 1 **The US health care system is a crazy-quilt of programs, that, when pieced together, cover to some degree, the majority - but not all — of the American people. True | False?**

Ex. 2 **Children with no insurance receive health care through a program called what?**
A. Medicare B. Social Security Program C. Maternal and Child Health Bureau D. State Children's Health Insurance Program (SCHIP)

Ex. 3 **According to the graph titled, "Health Care Expenditures as a percentage of GDP", growth in the health spending share of GDP accelerated | stabilized | slowed beginning in 1993.**
A. accelerated B. stabilized C. slowed

Ex. 4 **People in OECD countries pay less for health per capita than people in the United States. True | False?**

Ex. 5 **The year with the most number of uninsured Americans (in millions) was:**
A. 1995 B. 1996 C. 1997 D. 1998 E. 1999 F. 2000

Ex. 6 **What percentage of the Nation's health care is paid out-of-pocket? Consider both direct and indirect costs when you answer.**
A. 17% B. 13% C. 33% D. 60% E. 34%

Ex. 7 **In the year 2000, the percentage of *privately funded health expenditures* was higher | lower than in 1960?**

Ex. 8 **Medicare covers *what percentage* of *which population*?**
A. 95% of the elderly B. 20% of mothers and children C. 87% of adolescents D. 55% of the elderly E. 49% of children

"Test Yourself" Review Question

Ex. 9 **When we look at the various categories of expenditures (health care dollars) and the percentages of total dollars spent for each in the year 2000, program Administration and Net Cost consumes which *percentage* of the spending on health care?**
A. 22% B. 9% C. 32% D. 6% E. 19%

Ex. 10 **The National Health Accounts are associated with which agency?**
A. Agency for Health Care Policy and Research B. Centers for Medicare and Medicaid Services (CMS) C. NICHSR D. Centers for Disease Control and Prevention E. NIOSH

Health Economics Information Resources: A Self-Study Course

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Review Questions for Module 2 Quiz

This page links to the review questions that will be used in the Module 2 quiz for you to take to test your knowledge of the content you have just been studying. It also links to the **interactive quiz**.

Quiz 2 **(Module 2)**

The US health care system is a crazy-quilt of programs, that, when pieced together, cover to some degree, the majority--but not all—of the American people. **True** | False?

Explanation

The U.S. Health care system is a crazy-quilt of programs that covers some, but not all of the American people.

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Children with no insurance receive health care through a program called **what**?

A. Medicare
B. Social Security Program
C. Maternal and Child Health Bureau
D. State Children's Health Insurance Program (SCHIP)

Explanation

Children who might not otherwise receive medical attention may do so through the **State Children's Health Insurance Program** (SCHIP).

In the year 2000, spending on health care services and products represented **what percentage** of the U.S. Gross Domestic Product?

A. 13.2%
B. 6.9%
C. 10.3%
D. 7.9%

Explanation

Spending on **health care services and products** reached **$1.3 trillion in 2000**, which **was up 6.9 percent** from the previous year. This $1.3 trillion figure represents **13.2 percent of the U.S. Gross Domestic Product (GDP)**, or the total value of goods and services produced that year in the U.S.

According to the graph titled, "Health Care Expenditures as a percentage of GDP", growth in the health spending share of GDP **accelerated | stabilized | slowed** beginning in **1993**.

A. accelerated
B. stabilized
C. slowed

Explanation

Rapid growth in the health spending share of GDP **stabilized** beginning in **1993**.

People in OECD countries pay less for health per capita than people in the United States. **True** | False?

Explanation

The U.S. **spends more on health care per capita** but **ranks very low** with respect to **overall health system performance**.

Medical care is only one factor of many that **directly** determines health. Which item in the list is **not** a direct factor?

A. diet
B. exercise
C. information technology
D. age
E. alcohol consumption
F. tobacco use

Explanation

We need to remember, however, that **medical care is just one factor that determines health**. Some of the others, such as **heredity**, **lifestyle**, and **preferences** - diet, exercise, use of tobacco and alcohol, to name a few - must be accounted for.

The year with the **most** number of **uninsured** Americans (in millions) was:

A. 1995
B. 1996
C. 1997
D. 1998
E. 1999
F. 2000

Explanation

Those who had no health insurance in 1998 accounted for **44.3** million people total in the United States.

What percentage of the Nation's health care dollar is paid **out-of-pocket**? Consider both direct and indirect costs when you answer.

A. 17%
B. 13%
C. 33%
D. 60%
E. 34%

Explanation

Sixty percent of the Nation's health care dollar is either paid directly out-of-pocket or indirectly through the taxes we pay.

The nation's health care dollar comes from four main sources. Which source does **not** belong here?

A. insurance premiums
B. health care reform
C. co-payments
D. out-of-pocket expenditures
E. taxes

Explanation

The nation’s health dollar comes from the taxes and **insurance premiums** we pay, as well as from our **co-payments** and **out-of-pocket expenditures**. And perhaps this is one of the most compelling reasons that health care reform is of such vital

interest to researchers and the general public alike.

In the year 2000, the percentage of privately funded health expenditures was **higher | lower** than in 1960?

A. Higher
B. Lower

Explanation

Taking a long term view, that is, over the past 50 years, we can say that we have come to **depend less on funds from private sources**, especially with the inception and implementation of Medicare, in the 60's – as this table shows.

Note that in **1960, 75.2%** of total health expenditures were funded from **private sources**, whereas, in **2000**, the percentage of privately funded health expenditures is at **54.8%**.

Over the shorter term, the past 10 years, there has been a **decrease** from nearly **60%** in 1990 to the **54.8%** level in 2000.

Medicare covers **what percentage** of **which population**?

A. **95% of the elderly**
B. 20% of mothers and children
C. 87% of adolescents
D. 55% of the elderly
E. 49% of children

Explanation

We're probably all most familiar with Medicare. This federal program provides a range of medical care benefits for persons aged 65 and over, disabled persons and their dependents and those suffering from chronic kidney disease. Medicare covers about **95% of our nation's aged population**, approximately **39 million** in 2000.

Medicare pays **more than half** the total cost of beneficiaries' medical care. **True** | False?

Explanation

Medicare pays **more than half** the total cost of beneficiaries' medical care.

However, Medicare is **not comprehensive**; there are **deductibles, co-insurance fees, and serious gaps in coverage**.

Seniors with Medicare coverage are still responsible for many out-of-pocket expenses – most notably, and most currently newsworthy, **prescription drugs** and **long-term care**. They are the ones we have been hearing the most about in recent years.

Federal expenditures have decreased | increased between 1960 and 2000?

A. decreased
B. **increased**

Explanation

Public funding has generally **increased** over the long term from roughly 25% in 1960 to 45.2% in 2000. This increase, especially since 1965, is largely a result of greater federal expenditures and much significant rise in federal spending is accounted for by the Medicare and Medicaid Programs.

The trend here is the reverse of that for private funding.

When we look at the various categories of expenditures (health care dollars) and the percentages of total dollars spent for each in the year 2000, program Administration and Net Cost consumes which **percentage** of the spending on health care?

A. 22%
B. 9%
C. 32%
D. **6%**
E. 19%

Explanation

The pie chart that was used to characterize where the money went shows the various categories of expenditures and the percentages of total dollars spent for each. **Hospital care** accounted for 32% of the health care dollar. **Physician and Clinical**

Services accounted for 22%. **Other Spending** - which includes dentist services, other professional services, home health, durable medical products, over-the-counter medicines and sundries, public health, research and construction - accounted for a hefty 24% with **prescription drugs** at 9%, **nursing home care** at 7%, and **program administration at 6%** of the total spending.

The National Health Accounts series has many important characteristics and aims to be comprehensive because it contains some | most | all of the main **components** of the health care system.

A. some
B. most
C. all

Explanation

The National Health Accounts series has many important characteristics and aims to be comprehensive because it contains all of the main **components** of the health care system.

The National Health Accounts are associated with which agency?

A. Agency for Health Care Policy and Research
B. Centers for Medicare and Medicaid Services (CMS)
C. NICHSR
D. Centers for Disease Control and Prevention

E. NIOSH

Explanation

For the NHA, one needs just to consult the Centers for Medicare and Medicaid Services (CMS), formerly Health Care Financing Administration, homepage to find definitions of each category of medical service and source of funding, scope of the program, methodology of program, and source materials from which the NHA are developed. The Web site is located at http://www.hcfa.gov/stats.nhe-oact/lessons.

In order to be comprehensive, the NHA contains the following types of data: (Select the **best** answer)

A. personal health care expenditure data
B. personal health care expenditure data and medical research, construction of medical facilities, program administration
C. multi-dimensional personal health care, medical research, construction of medical facilities, and program administration expenditure data
D. personal health care expenditure data and geographical and age-specific data

Explanation

The NHA, includes not only personal health care expenditure data, but also that pertaining to medical research, construction of medical facilities, program administration, etc. and, they are multi-dimensional in that the data are further broken down by geography and age-levels of subjects.

When referring users to the NHA/NHE there are a number of limitations we should remember to tell them. Which item listed below is **not** a limitation?

A. limitations of the data
B. use of Web site
C. data definitions
D. source materials
E. methodologies used

Explanation

As is the case whenever consulting statistical information, users need to be aware of the **limitations** of the data. It is critical that users familiarize themselves with the **definitions, sources, and methodologies** used in creating the NHA in order to grasp what is being measured and how that measurement is being accomplished.

Ready to take the quiz for module 2? When you successfully complete the quiz you can apply for the Certificate of Success for this module.

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Quiz for Health Economics Module 2

Module 2 was intended to provide viewers with information on sources of information relating to health care financing in the United States. Upon successful completion of this quiz you may request a **Certificate of Success** by clicking on the **button** located at the **bottom of the answer page**.

1. The National Health Accounts are associated with which agency?

○ A. Agency for Health Care Policy and Research ○ B. Centers for Medicare and Medicaid Services (CMS) ○ C. NICHSR ○ D. Centers for Disease Control and Prevention ○ E. NIOSH

2. Children with no insurance receive health care through a program called what?

○ A. Medicare ○ B. Social Security Program ○ C. Maternal and Child Health Bureau ○ D. State Children's Health Insurance Program (SCHIP)

3. When referring users to the NHA/NHE there are a number of limitations we should remember to tell them. Which item listed below is *not* a limitation?

○ A. limitations of the data ○ B. use of Website ○ C. data definitions ○ D. source materials ○ E. methodologies used

4. Medicare covers *what percentage* of *which population*?

○ A. 95% of the elderly ○ B. 20% of mothers and children ○ C. 87% of adolescents ○ D. 55% of the elderly ○ E. 49% of children

5. The National Health Accounts series has many important characteristics and aims to be comprehensive because it contains some | most | all of the main components of the health care system.

○ A. some ○ B. most ○ C. all

6. Federal expenditures have decreased | increased between 1960 and 2000?

○ decreased ○ increased

7. In the year 2000, spending on health care services and products represented what percentage of the U.S. Gross Domestic Product?

○ A. 13.2 percent ○ B. 6.9 percent ○ C. 10.3 percent ○ D. 7.9 percent

8. People in OECD countries pay less for health per capita than people in the United States. True | False?

○ True ○ False

9. When we look at the various categories of expenditures (health care dollars) and the percentages of total dollars spent for each in the year 2000, program Administration and Net Cost consumes which *percentage* of the spending on health care?

○ A. 22% ○ B. 9% ○ C. 32% ○ D. 6% ○ E. 19%

10. The year with the most number of uninsured Americans (in millions) was:

○ A. 1995 ○ B. 1996 ○ C. 1997 ○ D. 1998 ○ E. 1999 ○ F. 2000

Submit your answers Back

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