

A HIGH-TAX FUTURE FOR GEN X AND Y? MEDICARE AND THE INTERGENERATIONAL CRISIS

Younger generations will have to pay a high price for baby boomers' health care, but private health savings systems could give them a greater ability to cover their own needs, writes **Jeremy Sammut**

As people age, their health problems and need for medical treatment increase, and so, inevitably, do their health-care costs. The two Intergenerational Reports (IGRs), released by the federal Treasury in 2002 and 2007, predict that as the proportion of elderly people more than doubles, from 12% to 25% of the population over the next forty years, growth in federal health spending will create serious budgetary problems. Without policy adjustments or cuts to services, governments will have to force a smaller base of future generations of taxpayers—today's Gen X and Gen Y—to pay considerably higher taxes than current generations, to fund health care for the elderly. At the very least, this raises questions of intergenerational inequity. It could also trigger intergenerational conflict.

In policy circles, many commentators remain sceptical about this scenario. They maintain that the costs of aging have proved affordable in the past, and that future demographic change will not blow out health expenditure beyond the capacity of government budgets.² They point out that the IGRs predict that aging will account for 'only around one quarter of the projected increase in health spending over the next 40 years.'³ The main driver of health costs rising faster than growth in GDP in recent decades has been expensive medical

technology utilised by people of all ages. The high cost of new technology used by all age groups will continue to generate the greatest expenditure pressure in the future.⁴ Since all will benefit from spending on new technology, intergenerational issues are unlikely to be serious.

The problem with the Intergenerational Reports

The IGR projections separate out what is called the 'pure effect' of 'aging alone,' which assumes that health-care costs in the elderly portion of the population will grow at the same rate as in the past. The problem is that aging is only now starting to accelerate, and current cost structures, based on existing medical technologies, are an unreliable guide. They do not foresee the advances in technology that are set to significantly increase the cost of providing health care to the elderly.⁵

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In two research reports published in 2005, the Productivity Commission was quietly critical of the way the IGR, and health economists generally, underestimate the potential impact of aging. The commission found there are strong grounds to expect a rising proportion of people aged over sixty-five. This is the age at which health status begins to decline and health costs rise. Older age groups consume over four times the amount of health care of younger age groups. This will compound the expenditure pressures arising from the ‘staggering fecundity of biomedical research.’⁶

The commission reasoned that an expanding elderly population is likely to lead to significantly higher demand for high-tech health care than past trends suggest. This is because it is the elderly who will most want the revolutionary therapies and procedures—from robotic surgery to genetic testing and gene therapy—that promise to vastly improve the quality and length of their lives.⁷ The prudential warning to policymakers is that the interaction between aging and technology has the potential to create much greater, aging-driven expenditure pressures than are presently projected.⁸

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Will economic growth be the saviour?

An influential school of thought is that economic growth will solve the alleged intergenerational challenges ahead. The claim is that a relatively small increase above the expected level of average productivity growth in coming decades will offset the effects of aging, and even automatically finance fiscal gaps without increasing the tax burden. Even in the absence of supercharged economic growth, simply collecting part of the anticipated doubling of the national income over the next forty years as additional taxation would pay for the increased cost of Medicare, without a deleterious impact on living standards, which will still be much higher. The tax-to-GDP ratio would have to rise only moderately, at about the same rate as has occurred over recent decades.

Because health care is a ‘superior’ good, whose consumption rises disproportionately with income, growth in government spending on technologically advanced medicine will stay roughly in line with economic growth. Since no real financial constraints exist, raising taxes to fund higher health-care costs will be a policy choice and political decision for governments and the electorate to make. The higher tax burden will not be intergenerationally unfair because, going by the IGR projections, all of society will be receiving greatly improved health care.⁹

This is a highly optimistic and rather complacent account of our transition to an aging society. As the global financial climate is again making clear, there are also no guarantees of ongoing economic growth. And in a globalised economy, there are limits to how high governments can raise taxes, because of the real implications for work incentives, economic growth, and international competitiveness.¹⁰ In addition, sustained economic growth and productivity rises over the long term are likely to depend in part on continued economic reform. Or, to emphasise the negative, they will depend on the absence of ‘reform fatigue.’

As if determined to illustrate the potential difficulties, as the aging debate has unfolded, supporters of the health policy status quo have latched on to the argument that economic growth will sustain Medicare, to dismiss any need for genuine health reform. Yet they have also dismissed the need for pro-growth, productivity-raising reforms as ‘neoliberal’ rhetoric camouflaging a frontal assault on the welfare state.¹¹ In truth, most members of the social policy establishment look forward to a repeat of the cycle of the past fifty years, and to governments continuing to increase the tax take to pay for a bigger and bigger welfare state.¹²

Unless the economy does grow as fast as health spending, government spending as a proportion of GDP will indeed rise. Estimates based on current trends indicate that by the mid-2040s, services provided to over-sixty-fives will increase from one-third to 57% of total government expenditure. This would lift the percentage of GDP per capita spent by government on health care for the elderly population by half, and account for half the total increase in government health expenditure as a proportion of GDP.

As opposed to aging ‘only’ increasing total real health expenditure by 25%, the ‘aging effect’ is more significant than it seems in pushing up the tax burden. This is because of the way the increasing dependency ratio of working-age to retired people will slow economic growth while almost certainly increasing real health spending faster than growth in GDP per capita.¹³

If one considers how the interaction between aging and the medical revolution is likely to ratchet up the pressure on health spending—potentially, far beyond existing projections and expected growth in GDP—growth in the aging-driven cost of Medicare will further accentuate the massive shift in health resources from people of working age to the elderly.

The main beneficiaries of the higher taxes and higher health expenditure will not be the proportionately smaller base of taxpayers of tomorrow, but the significantly larger number of retired baby boomers. Demography and technology will change the balance of rights and obligations between the generations in ways that raise real concerns about intergenerational inequity, if not conflict.

Will there be intergenerational conflict?

The higher proportion of the population aged over sixty-five is sure to have significantly greater political muscle in coming decades. The baby boomer generation will expect the public system to satisfy its healthcare needs and wants, and to deliver its members the health benefits offered by the latest medical technologies, in the fashion Australians have become accustomed to. Politicians already pork-barrel the ‘grey vote,’ and the expanding elderly constituency can be expected to vote in favour of tax and health spending policies that extract higher transfers from younger workers.¹⁴

On this reckoning, aging and rising health costs set the stage for intergenerational conflict over the perennial controversy of whether lower taxes or higher government spending is more desirable. Due to Medicare’s open-ended commitment to provide ‘free’ (or nearly free) health care for all Australians, if an aging Australia continues to rely on pay-as-you-go tax contributions to fund the bulk of health spending, the political economy of Medicare could become untenable.

It is unrealistic to assume, as the economic-growth school tends to, that taxpayers will bear this with equanimity because of the expected rise in real national income. Nobody calculates their relative well-being, or how onerous tax rates are, over a forty-year span, and younger generations are just as likely as we are today to resent a rising tax burden. The question is whether younger

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generations, who may have prioritised other needs and wants, will duly bear the additional, indeed potentially limitless, cost of the unprecedented aging phenomena and medical revolution.¹⁵ Instead, they may resist governments siphoning off a considerably larger portion of their earnings as taxes to subsidise the aging-fuelled cost of Medicare.¹⁶

Public support for higher taxes in return for government spending on services, particularly health services, closely tracks the economic cycle. In prosperous times, with incomes rising, opinion-poll evidence suggests that more people say they are prepared to pay higher taxes, because they want to consume better health services. However, support for higher taxes and spending is not open-ended, and tends to be selective: most people will trade tax cuts only for better government health services they expect they or their families will use. In recent years, due to the extraordinary long boom, push has never come to shove. No trade-off has been needed, because growth-driven budget surpluses have financed rising government expenditure without real increases in tax. Most importantly, as economic growth slows, more people tend to prefer tax relief to higher tax and spending.¹⁷

If we presume, all things being equal, that growth in health spending—predominantly on the elderly—will exceed (slowing) economic growth, resistance to higher taxes could well emerge in the younger generations. Factors such as

the emerging pattern of intergenerational wealth disparity, which is strongly linked to strong growth in average housing prices in the last decade, also has the potential to change the character of the intergenerational social contract.¹⁸

The traditional idea of a contract that obliges working-age people to fund the social costs of the elderly may lack resonance when many baby boomers are retired on tax-free superannuation, negative-gear property, and, perhaps increasingly, reverse-mortgaged family homes that would once have formed the bulk of the succeeding generation's inheritances.

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Implications

If resistance to higher taxation emerges, governments may face tough choices. They may resort to tighter expenditure controls to limit costs, which would mean more 'rationing' or longer waiting lists. Or, they might slow the take-up of new medicine, which would see a technology gap open. This implies that Medicare won't provide all Australians with 'free' access to all the new medicine available.

Another scenario is that the response will be mixed: there will be some (constrained) tax rises, more rationing of services and technology, and perhaps some greater reliance on cost-sharing measures, such as higher PBS copayments or the introduction of upfront charges for GP consultations and public hospital treatment. When demographic change bursts the bubble of 'free' health care, more Australians will face paying for a higher-than-expected proportion of their health care out of their own pockets.

It is also possible that health spending could prove an exceptional case. Irrespective of economic growth, governments might raise taxes high enough to cover the cost of Medicare because younger generations will not want

their parents and grandparents to forgo the revolutionary medical care the future promises. In addition, the intergenerational issues may simply be oblique. Most taxpayers are unlikely to know how many of their tax dollars are going to health care for the elderly. Politicians will be reluctant to highlight the intergenerational issue and risk 'attacking' the elderly.

Age-driven health costs may not end in intergenerational conflict. But what appears certain is that in the absence of extraordinary economic growth, younger generations will inevitably pay higher taxes to fund the better health care of older generations.

The alternative path to avoiding a high-tax future

The alternative path to avoiding a high-tax future is to uncouple future health spending from the PAYG tax system and the economic cycle. When demographic change dictated reform of the old-age pension system, the Keating government introduced the compulsory Superannuation Guarantee in 1992. Having set the international pace and moderated the future cost of the old-age pension, Australia has acquired a long-term advantage compared to other OECD countries. Though current rates of superannuation are generally regarded as too low, the superannuation system offers a precedent for self-provision and for spreading the burden of rising health costs between generations.¹⁹

Outlined below are three potential 'health savings' systems, each of which would entail other reforms to make them possible:

- *The Wenkart Model.* Purchasers of private health insurance would be eligible to contribute part of their income into a tax-advantaged Health Savings Account (HSA) managed by health funds, with accumulated funds (as a means of containing premium rises) earning tax-free 'interest' pegged to the consumer price index (CPI). Savings would be withdrawn to pay for personal and family out-of-pocket medical expenses, insurance 'gaps,' and aged-care needs. Patients with HSAs would lose the right to be treated as a public patient in public hospitals, and would have to be admitted as

private patients. It may also be necessary to means test free public hospital care to encourage or compel health fund members to take up HSAs. Outside of these changes, the Medicare system would remain as is.²⁰

- *The Fitzgerald Model, Marks I and II.* Adapt the existing superannuation model and mandate compulsory employee HSA contributions to a discrete account within existing superannuation accounts. The first option would allow accumulated funds to be accessed only after age sixty-five, to cover old-age health and aged-care expenses. These expenses could include both residential and community nursing aged care, ‘gaps’ and out-of-pocket charges, and the payment of one or both of the Medicare levy and private health insurance premiums. The second option would allow immediate access to HSAs as a potential path to the introduction of upfront charges into the public health system.²¹
- *The CIS Medicare Opt-outs Model.* Adults who voluntarily opt to ‘cash out’ their entitlement to Medicare-funded medical treatment would receive a tax credit to fund a HSA. Those who opt out of Medicare would have to pay for their day-to-day medical expenses, and would be required to take out private health insurance to cover expensive hospital care and treatments.²²

The voluntary opt-out proposal has a number of advantages over the other options. It is clearly the most far-reaching reform. Rather than adding HSAs onto existing arrangements, opt-outs would definitely shift the funding and provision of health care outside of the public system for those who choose to take on financial responsibility for their own health care. Creating a consumer-driven alternative to the public system would allow participants to enjoy the benefits of choice and competition, and demonstrated benefits for those who opt out would encourage others to follow suit. An opt-out system is also designed to be quite clearly a transitional arrangement. The option of sticking with the public system would insulate the elderly and those near retirement age against changes to their current Medicare entitlements. Emphasising the element of voluntary choice would address the greatest political obstacle to substantial health

reform by neutralising the scare campaigns—of the ‘Medicare under threat variety’—that health-care reform invariably generates.

Gen X and Y: Pay now or later, you’ll still pay twice

The time has come to face the problem that bedevils attempts to switch from pay-as-you-go to pre-funded health-care or pension systems: one unlucky generation has to pre-fund their own health or retirement costs while still paying tax to finance the social costs of the elderly. With the bulk of the baby boomers nearing sixty-five, only a minority are likely to join any new health savings system. For this fortunate breed, the free ride in health will simply have to continue.

Gen X and Y are in an invidious position. They face either poorer health services, or a higher tax future, or paying more for their own health care, plus for their superannuation, and for the pensions and health care of the elderly. Undesirable outcomes are dictating the choices that have to be made. However, the benefit of health savings systems over a purely tax-financed system is that health savings would give people greater control over what health care they consume in the future. The alternative path is to continue to depend on the faltering public system, which, as the ‘hospital crisis’ demonstrates, is increasingly unable to provide the community with the medical services it needs.

The longer we continue to delay establishing a national system of health savings, the more Medicare will become a problem.

The need for intergenerational reform will not go away. However tempting, now is not the time for preemptive intergenerational envy, but for some enlightened self-interest and self-sacrifice. This will have to go along with a fatalistic acceptance of the need to pay twice for health care. Otherwise, the longer we continue to delay establishing a national system of health savings, the more Medicare will become a problem.