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THE CENTRE FOR INDEPENDENT STUDIES

The Coming Crisis of Medicare:

What the Intergenerational Reports should say, but don't, about health and ageing

Jeremy Sammut

Papers in Health and Ageing (2)

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Foreword

This is the second in a new series of papers published by the Centre for Independent Studies on issues of health and ageing. One of the main reasons CIS has launched this series is that health costs are set to spiral in the next few decades, but politicians show little sign of responding seriously to the problems this is going to cause. In this paper, Jeremy Sammut explains why the current system of providing health care in Australia is not going to cope unless it is substantially reformed.

To its credit, the federal Treasury produced an Intergenerational Report in 2002, which it updated in 2007. These two reports try to estimate the level of government receipts, and the demands on government spending, as the population ages over the next forty years. The 2002 report was a wake-up call, particularly as regards spending on the Pharmaceutical Benefits Scheme and other aspects of health care, but the follow-up was less alarming. Basically, the message from the federal government is that health spending is going to rise significantly, both as a result of ageing and of the rising cost of new medical technologies, but that Australia is much better placed to cope than many other OECD countries. Provided private health insurance holds up, taxpayers of the future should be able to pay for most of what the government needs to spend.

Sammut shows in this paper that some of the government's critics think even this fairly optimistic message is too alarmist. The critics maintain that the economy will continue to grow and that this will take care of the rising level of demand and expectation for health treatment as the population ages. Against this, however, Sammut cites Productivity Commission research indicating that the Treasury's analysis may be under-estimating the problem. This is because new medical technologies will combine with ageing to push total costs higher than the Intergenerational Reports predict.

If the Productivity Commission has this right, we are facing a real problem, and the government and its critics are both being too complacent. Economic growth is not going to generate the revenue we need to provide the health care our children will expect, and the next generation of taxpayers is going to get a nasty shock unless something is done now to change the way health care gets funded.

Forecasting forty years into the future is an inexact science, but Sammut's painstaking analysis in this paper suggests we would be wise to set more store by the Productivity Commission's analysis than to rely on the Intergenerational reports' more optimistic forecasts. The technology of health care is going to be revolutionised in the next forty years, and many of the ailments that plague the elderly today will be treatable in the future. People will live longer and the elderly will demand more than they have done in the past. The only way to meet these expectations is to get more of us today to set money aside for our likely needs in the future.

Sammut points out that our current health care system – the public hospitals providing treatment free at the point of demand, our subsidised PBS system and our Medicare-based funding of primary health care – is based on demographic and technological assumptions that are now unraveling. This twentieth century system was not designed for twenty-first century conditions. Either we start to look at serious reform now, or we shall encounter growing queues, shortages and breakdowns of delivery in the decades ahead.

Peter Saunders
Social Research Director

The Centre for Independent Studies

Executive Summary

- The Federal government's Intergenerational Reports (IGRs) show that as the Australian population ages over the next 40 years, demographic change will render current government policies fiscally unsustainable, mainly due to the rising cost of health care.
- The IGRs have been criticised by academics and commentators who dismiss a looming health and ageing 'crisis' as a myth. Because the Reports predict that ageing alone will be responsible for 'only' one quarter of the projected increase in government health expenditure, the critics say that the impact of ageing on government budgets will be 'manageable'.
- Both the IGRs and the critics understate the significance of ageing. Work by the Productivity Commission estimates that providing health care to the larger elderly population of tomorrow will increase government health expenditure as a proportion of GDP per capita by one half.
- The Intergenerational Reports also underestimate the scale of the coming crisis Medicare faces. The medical revolution will expand the range of high-tech and high-cost medicine available. The increased supply of therapies and procedures—which will particularly deliver new treatments for chronic diseases linked to old age—is set to increase demand for health care in older age groups far more than anticipated by the IGRs. Ageing will compound the impact of new technology and amplify the cost pressures on Medicare.
- Neither economic growth nor 'moderate' tax rises can be relied upon to solve the health and ageing challenges of the future.
- 'Free and universal', pay-as-you-go, taxpayer-funded health systems are a twentieth-century social policy designed to provide relatively cheap and basic healthcare to much younger and healthier populations. The demographic and medical realities of the twenty-first century imply that Medicare will not provide every citizen with 'free' access to all the new medicine.
- This suggests that Australians need to think seriously about Medicare reform and explore new ideas about how to self-fund their healthcare in the future.

Population ageing and why Medicare should be reformed

Over the last eleven years, the instinct of the Howard government has been to pursue health reforms which shift the balance in our 'mixed' health system from public to private financing. The private health insurance reforms of the late 1990s—the introduction of a 30 per cent private health-insurance premium rebate, and the new 'Lifetime Cover' community-rating system—have increased the percentage of the population with private health insurance coverage from a historic low of thirty per cent to over forty.

The most notable 'reform' of the Howard era, however, is the 'Medicare Plus' package of 2004. It introduced the Extended Medicare Safety Net, which commits the Federal government to pay 80 cents in every dollar of out-of-pocket, out-of-hospital medical expenses incurred by all individuals and families in excess of $1000 annually. In a step away from the reform agenda which has dominated the public policy debate in Australia for almost a generation, Medicare Plus has reinforced the principle that government should be responsible for financing the healthcare of the Australian community. A new entitlement has been added to the Medicare system at a time when many Western countries are reassessing their commitment to 'free and universal' medicine. The cost pressures associated with the ageing of their populations are expected to render this kind of health system unsustainable by the middle of this century. Yet the Howard government has preferred (as the slogan goes) to be 'the best friend Medicare has ever had'.

The significantly higher life expectancies and the significantly lower fertility rates of the last 30 years mean that the population of Australia is ageing, and will continue to age at an accelerating rate as the baby-boomer demographic 'bulge' reaches retirement age. By the mid 2020s, there will be 2 million more people aged over 65; by the 2040s, the elderly proportion of the population will have doubled from 12 to around 25 per cent.

Demographic change will begin to have an impact in the near future. In 2012, the 'boomers' born at the peak of the post-war baby boom in 1947 turn 65—the age when health problems and demand for healthcare increases.

The 2007 Intergenerational Report[2] (IGR2) predicts that over the next 40 years, population ageing will decrease labor force participation, halve the 'aged dependency ratio' (or the ratio of traditional working-age people to people aged over 65) to under 2.5, slow economic growth per person, and significantly increase government expenditure beyond anticipated growth in national income. As the baby boomers grow grey, the most important source of 'fiscal pressure'—of expenditure outstripping revenue—will be federal spending in the ageing-sensitive area of health.

The projected doubling in federal health spending from 3.8 per cent of GDP in 2006–07 to 7.3 per cent forty years later—due to the combined impact of ageing, new medical technology, and rising overall demand—is expected to contribute 3.5 percentage points of the 4.75 per cent rise in total Federal government spending. Health will contribute the most by far to the anticipated 'fiscal gap'—the 3.5 per cent of GDP by which Federal government spending will exceed revenue in the absence of policy adjustments. *In other words, based on current trends, the current policies of the Federal government, especially Medicare, are fiscally unsustainable in the long term.* In 2021, in the absence of policy changes, the Commonwealth budget will go into deficit, and net Commonwealth debt will re-emerge in the mid-2030s and rise rapidly to around 30 per cent of GDP by 2046–47.[3]

As the baby boomers retire, stop paying tax and start to draw heavily on government services, the proportionally smaller number of taxpayers of tomorrow face having to pay considerably higher taxes to fund the healthcare of the Australian community. The Minister in the Howard Government who has been the most vocal about the unfair intergenerational implications of the looming 'ageing crisis', and the need to ensure that 'future generations of taxpayers do not face an unmanageable bill for government services provided to the current generations', is the Treasurer.[4]

Peter Costello has acknowledged that the 'long-term structural challenge for Australia' is to ensure that the health system is sustainable into the twenty-first century.[5] Yet, arguably, not even the Treasurer has completely acknowledged just how unmanageable the ageing bill in health is likely

to be. Given the limits to future tax receipts, moreover, and the potentially limitless demand for sophisticated and expensive medical treatments, the unprecedented ageing phenomenon is not the sole concern. The additional concern is the impact of the medical revolution that is under way, and the effect new high-tech and high-cost medical technology will have on healthcare supply and demand, *in combination with ageing*. The new medicines and procedures in development to treat diseases and conditions associated with old age have the potential to increase health expenditure far more than anticipated by the IGRs. The threat this poses to the future of Medicare should not be underestimated.

The tendency in policy circles and among commentators and academics, however, is to underestimate the significance of ageing and the future pressure that this will place on Medicare.

The tendency in policy circles and among commentators and academics, however, is to underestimate the significance of ageing and the future pressure that this will place on Medicare. Ironically, Peter Costello's Intergenerational Reports have played an important role in encouraging this complacent attitude, because both reports overlook how important is the interaction between ageing and the medical revolution. Instead, they have indicated that ageing is not the main driver of health expenditure growth and have understated ageing's potential impact on health spending. The misleading impression that the IGRs have encouraged is that ageing, *per se*, is not a long-term health and intergenerational problem necessitating urgent health policy reform.

Does ageing increase health costs? The view of the IGRs

> 'Health expenditure is projected to nearly double as a proportion of GDP over the next 40 years. This is partially due to the ageing of the population, although non-demographic factor have an even greater effect'. —*Intergenerational Report Overview 2007*, (Canberra: Commonwealth of Australia, 2007), 12.

> 'The major source of budgetary pressure is health care costs, which are projected to rise by about 4.5 percentage points of GDP by 2044–45, with ageing accounting for nearly one-half of this'. —Productivity Commission, *Economic Implications of an Ageing Australia*, Research Report, (Canberra: Commonwealth of Australia, 2005), xii.

IGR2, released in April this year, states that 'roughly two-thirds of the projected increase in real spending per person is driven by factors other than ageing'. This, it continues, 'is most notable for health spending, where a significant component of the projected increase is driven by non-demographic factors such as the development of new drugs'.[6] IGR2 repeats the conclusions also drawn in IGR1:

> Non-demographic growth rather than population growth or changes in the age structure of the population has been the key driver of real health spending over the past two decades … Non-demographic factors (such as the listing of new medications on the Pharmaceutical Benefits Scheme and greater use of diagnostic procedures) are likely to continue to generate the greatest cost pressure in the future … with ageing contributing only around one quarter of the projected increase in health spending over the next 40 years. Factors other than ageing account for the remaining three-quarters of the projected increase in health spending.[7]

In presenting its findings, the Report separates out the 'pure effect' of 'ageing alone' on health expenditure.[8] The Report's conclusion that ageing will 'have a much smaller effect on spending than the growing cost of new healthcare technology'[9] depends on the assumption that demand for healthcare in the elderly cohort of the population, and thus future ageing-driven health spending, will grow in line with the historic trend. Crucially, this approach[10] to assessing the impact of ageing is valid only 'to the extent that today's costs are a good guide to those that will apply over the long term (in real terms)'.[11] Because it does not 'predict the relative cost changes brought about by changes in medical technology',[12] this approach is prone to understating the

relationship between ageing and rising health expenditure.[13] The 'real issue is not what effect ageing will have on its own, but what effects ageing *and* the other strong drivers…will have *in combination*'.[14]

This is the problem with the Intergenerational Reports: they do not acknowledge the possibility that, or canvass the reasons why, ageing, in interaction with new technology, will lead to much higher than anticipated health spending.

Denial

> 'Contrary to the popular belief that ageing is the primary threat to the health budget over time, population ageing is but one, comparatively small, factor in rising health expenditure'. —Pamela Kinnear, *Population Ageing: Crisis or Transition*, Discussion Paper Number 45 (Canberra: Australia Institute, 2001), 19.

> 'Although it considered ageing to be an important factor, the Treasurer's *Intergenerational Report* concluded that other factors constitute the main drivers'. —Judith Healy, *The Benefits of an Ageing Population*, Discussion Paper Number 63, (Canberra: Australia Institute, 2004), 29.

> 'The Treasurer's next piece of disinformation is his implication the projected hole in his budget—the fiscal gap—is largely the product of ageing: cost of the age pension, aged care and so forth. Not true. Read the report and you find that the greatest single factor by far in the expected growth is federal spending on health. And three-quarters of the projected growth in health spending is 'non-demographic', such as expensive advances in medical technology. Turns out that 'roughly two-thirds of the projected increase in real [government] spending per person is driven by factors other than ageing'. Oh.' —Ross Gittins, 'Report and the Spin – now read on', *Sydney Morning Herald*, 4 April, 2007.

Academics and commentators who deny that ageing will be responsible for 'skyrocketing' health expenditure, have been convinced by the IGRs that ageing is not the 'most important' problem.[15] How can it be said that the health costs of the elderly will inevitably drive up expenditure to unsustainable levels, place enormous pressure on governments, and unfairly overburden taxpayers, when the IGRs state that ageing is 'only' going to increase health expenditure by one quarter?

Seizing on this, the harshest critics have repeatedly zeroed in on the Reports' finding that the effect of population ageing *per se* on health expenditure is relatively small. Based on this finding, critics, who suspect the 'ideological' motives behind the IGRs' intergenerational rhetoric, have dismissed the reports' very premise, on the ground that the alleged ageing problem is actually 'small and manageable'.[16]

The IGRs have become the centrepiece of the counter-argument employed to challenge the idea that Australia faces an 'ageing crisis'. Perversely, therefore, the reports have helped to deflect attention away from the key issue—the long-term unsustainability of Medicare.[17] For example, in response to the release of IGR2 in April this year, Ross Gittins, in his column in the *Sydney Morning Herald*, dismissed what he saw as the Treasurer's exaggerations about the intergenerational impact of ageing. Crucially, the evidence Gittins cited in support of his analysis was the fine print in the government's own Intergenerational Report showing that 'three-quarters of the projected growth in health spending is 'non-demographic', such as expensive advances in medical technology'.[18]

The IGRs have become the centrepiece of the counter-argument employed to challenge the idea that Australia faces an 'ageing crisis'. Perversely, therefore, the reports have helped to deflect attention away from the key issue—the long-term unsustainability of Medicare.

Perhaps this would not matter if the IGR analysis fully examined the health implications of ageing. But there are strong grounds for suggesting it does not. In two reports published in 2005, the Productivity Commission raised serious questions about the approach to health and ageing that IGR2 perpetuates.

The view of the Productivity Commission

In 2004, at the request of the Council of Australian Governments, the Productivity Commission began research into the economic implications of the ageing of the population over the next 40 years. The Commission's report, *Economic Implications of an Ageing Australia*, broadly agreed with the prediction in IGR1 that the proportion of GDP spent by the Federal government on health would double over the next 40 years. Its economic modeling also confirmed that the change in the age structure—the additional numbers of elderly people as their proportion of the population doubles to 25 per cent—would mean that the effect of ageing alone would increase real government health spending by 25 per cent. But the Productivity Commission found that ageing was likely to have a much bigger impact on health spending than the IGR had suggested.

The Commission also conducted a rigorous review of the local and international research and took issue with the claim that ageing will continue to be only a minor factor in rising health expenditure.

The Commission made two points. It took issue with the (falsely) reassuring way IGR1 presented the 'smaller effect' of ageing, and found that ageing cannot be underestimated as a source of health-related fiscal pressure, because of the impact that ageing also has on economic growth. The Commission also conducted a rigorous review of the local and international research and took issue with the claim that ageing will continue to be only a minor factor in rising health expenditure. The prudential warning issued to policy-makers was that it is reasonable to assume that the interaction between ageing and technology is likely to lead to considerable increases in health care demand in the elderly cohort, and hence to substantially 'bigger pressures on the health system than … projected'.[19]

The ageing effect

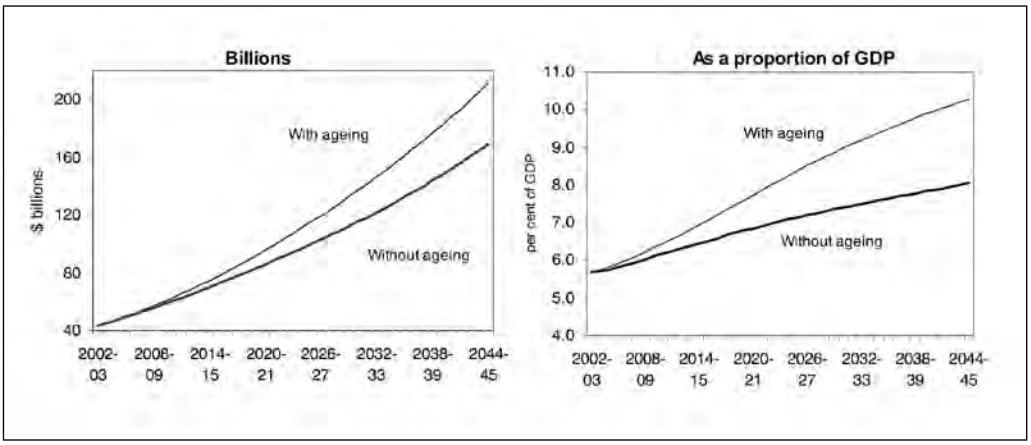
The Commission found that:

> 'In 2002–03, one third of total government expenditure was accounted for by services to the over 65 group. By 2044–45, this proportion is projected to increase to 57 per cent.
>
> 'Another measure of the impact of ageing is the difference in projected expenditure with and without ageing. In this case, the without-ageing scenario assumes that population growth and non-demographic growth both occur as projected, but that the age structure of the population (the shares of population of each age) remains at current levels. If there were no ageing, expenditure is projected to reach $169 billion in 2044–45, whereas with expected demographic change it is projected to be 25 per cent higher at $211 billion. Relative to GDP, ageing also increases expenditure just over 25 per cent (8.1 per cent of GDP without ageing compared with 10.3 per cent with ageing). However, this is more significant than it first appears. *Ageing contributes around 2.2 percentage points (or one-half) of the 4.5 percentage points increase in government health expenditure as a proportion of GDP*'.[20]

It is important to emphasise the point that the Productivity Commission was making. 'When expressed as a share of GDP, fiscal pressure can be overwhelmingly attributed to ageing'. This is because of the way population ageing slows the growth rate of the economy while increasing real health spending faster than growth in GDP per capita. The relative burden on future taxpayers will therefore rise.[21]

The 'ageing effect' (Figure 1) is therefore far more significant as a source of fiscal pressure than appears from the one-quarter increase in expenditure. When future economic growth and health spending was assessed with ageing and without ageing and the effect expressed as a proportion of GDP, ageing actually accounted for *one half* of the additional GDP spent on health.[22] By comparison, IGR1 and IGR2 analyse only total real expenditure rather than real expenditure per capita as the Productivity Commission did.[23] On this basis, the Commission reached an unequivocal conclusion about the relationship between health and ageing: 'The clear message that emerges is that, whatever measure is used, ageing is likely to have a significant impact on health expenditure'.[24]

Figure 1: Projected government health expenditure with and without ageing, 2002–03 to 2044–45



Source: Productivity Commission, *Economic Implications of an Ageing Australia*, 173.

Will 'healthy ageing' lower health costs?

The consensus among many health economists, however, is that 'an ageing *population* will not incur significant health costs', and will have only a minor effect on health expenditure, because older people make big demands on the health system only in their final years of life. In other words, people will stay fit and healthy for longer and will then consume the same amount of healthcare at the end of their lives as they do at the moment.

The Productivity Commission report disputed this claim. It found 'no evidence that the rising age-cost profile is generated solely by costs at the end of life'. To the contrary, it found that the 'limited data available in Australia … support the view that costs rise with age rather than arising predominantly at the end of life'.[25]

What the evidence showed was that health expenditure per person is significantly higher for older than for younger people because the incidence of sickness and disability rises with age, and so does demand for healthcare in all developed countries. The ongoing cost of providing healthcare to elderly people who are not close to death accounts for the bulk of the health spending on the elderly. If, as is likely, this continues to be the case, the 'strong age-related spending patterns' combined with 'rapidly increasing numbers of older people' led the Commission to conclude 'that, all things being equal, ageing will increase health expenditure significantly'.[26]

The Productivity Commission emphasised that while non-demographic rather than demographic factors had been the main source of growth in real health expenditure over the last twenty years, this pattern will change in the future as the rate of ageing begins to accelerate. The sheer number of elderly people will have a big impact on healthcare expenditure by increasing the volume of demand and the proportionate cost of providing healthcare to the elderly. 'Health costs will inevitably rise', the Productivity Commission asserted, because although older people may live longer and live healthy lives, 'in many cases better health is a result of ongoing (and costly) treatment'.[27]

Will prevention lower health costs?

The Commission also considered another argument that health economists and health industry representatives have used to minimise the cost ramifications of ageing, which is that new diagnostic methods, procedures, and medicines will prevent costly episodes of ill health. Because the larger number of elderly will be healthier in the future—assuming that the benefits of new medicine result in a decline in the prevalence of chronic conditions and acute episodes—the argument goes that health costs will not significantly increase, as there will be offsetting expenditure savings across the whole health sector, such as reduced hospital admissions.[28]

There are good reasons to think that the arguments of the self-proclaimed 'ageing realists' are overly optimistic. The recent worldwide trend has seen shifts away from medical services to more

complex and costly medical goods: more advanced equipment, procedures, and pharmaceutical medicines. In Australia, this trend has contributed to health expenditure growing faster than the rest of the economy over the last decade or so, and has encompassed a doubling in the cost to the Federal government of the PBS, with an important driver of cost growth being new and very expensive so-called 'blockbuster' drugs, such as Celebrex for treating arthritis.[29]

The Productivity Commission found that the 'weight of evidence appears to support the view that better health among older people is *not* going to reduce health expenditure'.[30] The evidence indicated that at present demand pressures associated with new technology 'are acting to slightly increase—or at least maintain—the current age profile of expenditure across different components of health care'. And there are good grounds to believe that 'the rising share of older people in the future will compound the underlying growth in health expenditure arising from demand and technology'.[31] In a wealthy country, the growing proportion of the population aged over 65 will have rather more political muscle, will expect governments to satisfy their expanding healthcare needs and wants, and will expect the public system to provide them with the health benefits offered by the latest medical technologies, almost as soon as they are available in the private system.

The rising prevalence of obesity, the resultant increase in the disease burden, and the expected continual decline in health status according to age, will mean that the elderly will demand more and more costly ongoing care and recurring treatment, particularly to manage lifestyle-related chronic conditions.

This was the most critical aspect of the Productivity Commission's report: the idea that ageing will have only a minor impact on rising health expenditure is open to question, it found, because it is more reasonable to expect that 'in combination with demand and technology, ageing *will* place significant additional pressure on future health expenditure'.[32] The Commission reasoned that the demand for healthcare in older age groups could grow into the middle of the century at considerably higher rates than in the past. As the population ages, there will be larger numbers of elderly people who will consume more high-cost healthcare, because they will demand more and more high tech procedures (such as pacemakers, cochlear implants and hip replacements). The rising prevalence of obesity, the resultant increase in the disease burden, and the expected continual decline in health status according to age, will mean that the elderly will demand more and more costly ongoing care and recurring treatment, particularly to manage lifestyle-related chronic conditions. Reduced disability and improved quality and quantity of life for the elderly due to the better healthcare available will therefore not mean lower health costs, but will amplify demand for new, sophisticated, and expensive treatments, and mean that ageing will exacerbate the pressure associated with new technology.[33]

Why ageing combined with new technology will significantly increase health costs

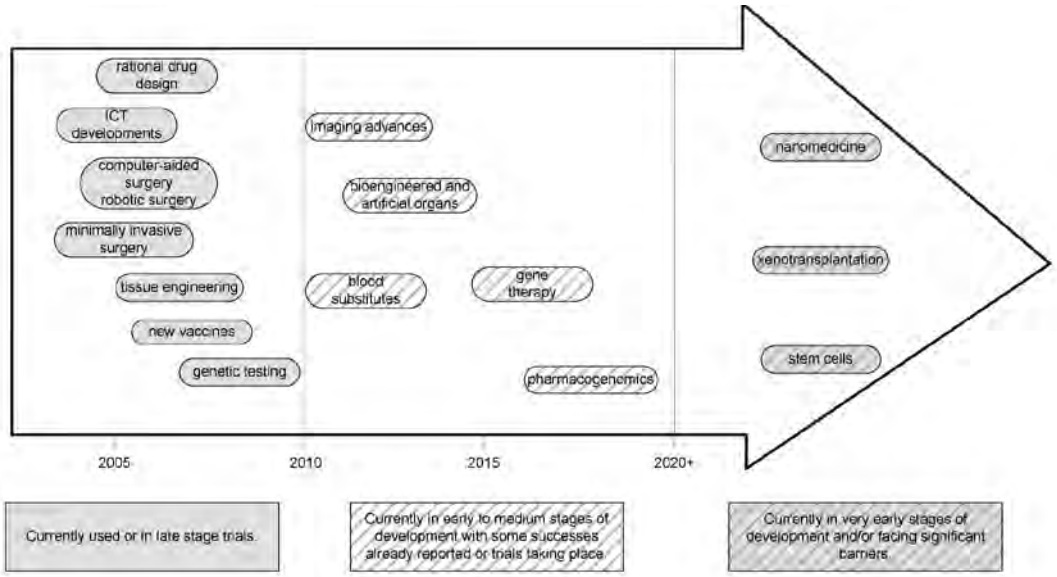
In a follow-up report in 2005, which examined the past and future impacts of medical technology on health expenditure, the Productivity Commission found further evidence that in the future ageing and new technology will prove a 'potent mix' as a key driver of health expenditure. The report confirmed that while there may be some offsetting savings—such as lower aged-care costs, if, say, a treatment for Alzheimer's emerges—new technology would be unlikely to reduce costs across the whole sector because anticipated savings are often outweighed by the high cost of new drugs and expensive procedures.[34] Nor will costs simply be offset by substituting old for new treatments, because new treatments often complement rather replace existing ones. Medical innovations also tend to increase applications and utilisations. Innovations (such as advances in diagnostic imaging technologies) tend to increase the number of diagnoses and to generate new ranges of medicines and procedures to treat previously untreatable diseases.[35] And not only does new technology increase volumes by expanding the age-range of people who can undergo operations; it can also lead to greater ongoing volumes and costs associated with treating the chronic conditions of people who, as a result of treatment, live longer.[36]

The Productivity Commission found that the revolutionary advances in medical technology that are on the horizon—nano-technology, nano-medicine, genetic testing, gene therapy, pharmacogenomics, rational drug design, xenotransplants and bioengineered organ, joint, or

tissue replacement, minimally-invasive surgery, robotics and virtual surgery—are likely to prove both blessing and curse. Balancing out the enormous health benefits will be the expenditure effects of medical advances that make it possible 'to do more for each patient and intervene with more patients'.

What the Productivity Commission highlighted were the heralded advances in medical technology which are likely to have a significant clinical application in the near- to medium-term, and which are therefore likely to create significant expenditure pressures. (Figure 2.)

Figure 2: Medical Advances—What does the future hold?



Source: Productivity Commission, *Impacts of Advances in Medical Technology in Australia*, Research Report, (Melbourne: Commonwealth of Australia, 2005), L.

Ageing, through its role in determining the future disease burden, is fundamental to this. Of the new technologies already appearing in the marketplace—such as robotic surgery for prostate and heart surgery—and the new compounds in the pipeline expected to become mainstream high-cost treatments, the Commission found what was to be expected. Medical research and investment has focused on areas with the greatest potential growth in demand. Many of the medicines already in development are the result of R&D specifically undertaken to discover treatments for the major chronic diseases associated with ageing and poor lifestyle, which will impose the greatest disease burdens in Western countries as the population ages: cancer, heart disease, diabetes 2, kidney disease, blindness, dementia, and arthritis.[37] (Figure 3.)

Figure 3: Pharmaceuticals in the international 'pipeline', by condition, November 2004

Condition	*Clinical trials*			*FDA application*	*Other*	*Total*
	Phase I	*Phase II*	*Phase III*			
Cancer	56	122	62	4	1	245
Arthritis	24	27	17	9	4	81
Cardiovascular	18	35	20	0	2	75
Diabetes	18	20	9	6	3	56
Mental health	9	16	12	6	3	46
Asthma	8	20	4	5	1	38
Injury prevention	1	0	3	0	0	4
Total	134	240	127	30	14	545

Source: Productivity Commission, *Impacts of Advances in Medical Technology*, 274.

Rather than rely on uncertain modelling assumptions and projections, the Productivity Commission provided a reasoned, evidence-based interpretation of why population ageing will

amplify the medical revolution's inflationary effect on health costs. In line with an emerging academic consensus about the impact of ageing,[38] the Commission's research confirmed the reasons why we cannot afford to be complacent about ageing, given the capacity for new technology to intensify the demand-side expenditure pressure on the health system, predominantly in older age groups.[39]

However, as IGR2[40] and the response to its release demonstrates, the full implications of the Productivity Commission's warning about the 'potent cocktail' of ageing and the medical revolution have yet to be incorporated into the debate about health and ageing.[41]

Will economic growth solve the problem?

Some commentators remain unconvinced. Earlier this year, Ross Gittins saw little reason to be as worried about the projected fiscal gap as the Treasurer maintained we should be. Like other self-styled 'ageing sceptics', he argued that the problems posed by ageing are slight, given the expected growth in national income.[42]

Gittins pointed out that the IGRs assume that living standards will be almost twice as high in 40 years time as now. Only a small part of this increase in national income would have to be used to pay for the increased cost of healthcare, so future generations will easily be able to afford additional health expenditure. The argument is that to provide for the needs of an ageing population, taxes would have to rise only gradually (but not onerously) at the same rate as has occurred over the last 40 years.[43] In short, 'our children and grandchildren have little to worry about'. What is intergenerationally unfair about paying moderately higher taxes so that the entire population can receive 'better health care'?[44]

But given the potent cocktail of ageing and new technology, it is imprudent to believe that by boosting economic growth we will be able to afford the increased cost of Medicare.

Gittins stressed that higher health spending through general taxation was no cause for alarm. His surmise was that 'as we get richer over the years' we have always wanted and will always want to devote a higher proportion of national income to spending on a 'superior good' like health because increasingly wealthy communities expect and demand better quality and quantity of care.[45]

Against this, the 'Treasury view' is that we cannot be sanguine about population ageing when this is inevitably bound to impose exaggerated tax burdens on future generations.[46] Why will future generations be willing to accept higher taxes, asked the Secretary to the Treasury, Ken Henry in 2004, when 'our children will experience a slower rate of GDP per capita growth than we have enjoyed, yet our generation has shown considerable resistance to increasing tax burdens? Why should our children be any different?'[47] 'If we are not careful, there is a potential for conflict between generations', warned the then Governor of the Reserve Bank, Ian Macfarlane, in 2003. 'The young may resent the tax burden imposed on them to pay for pension and health spending on the old', particularly 'if they see the old as owning most the community's assets'—a reference to the housing boom which has enriched baby-boomers while increasing the barriers to home ownership for young generations.[48]

The 'Treasury view' also questions whether the 'tax and spend' solution is realistic in the context of the globalised economy and a fluid international labor market. Higher future tax rates will have real implications for national competitiveness. Australia will be competing with neighbouring Asian countries that do not face the same demographic and fiscal challenges, and against other countries—particularly the United States—to retain and attract skilled workers.[49] If policy action is taken today to prevent substantial future tax increases tomorrow, Australia could gain a considerable advantage over other OECD countries condemned by their demography to endure higher taxes, lower economic growth, and the expenditure burdens that previous governments lacked the courage to tackle.[50]

Treasury Secretary Henry, Treasurer Costello, and Governor Macfarlane have all highlighted policies which encourage higher economic growth as the best way of avoiding either higher taxes or slashing public spending. All have called for a renewed round of economic reform to increase productivity and participation as the least painful way of offsetting the effects of ageing.[51] But given the potent cocktail of ageing and new technology, it is imprudent to believe that by boosting economic growth we will be able to afford the increased cost of Medicare.[52]

Why the IGRs can't say what they should say

> 'The forces that have driven up health costs over the long haul are, if anything, intensifying. The staggering fecundity of biomedical research is increasing, not diminishing. Rapid scientific advance always raises expenditure, even as it lowers prices'. —Henry Aaron, 'The Unsurprising Surprise Of Renewed Health Care Cost Inflation,' *Health Affairs*, 'Cost Containment: Commentary Web Exclusive', 23 January 2002: http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.85v1/DC1

> '… the overriding pressures on future costs will be due to the demand side of the health care market. Undoubtedly, supply factors also play a role … But the major drivers of increased future costs are very likely to be the ability of medical care to improve health, coupled with rising consumer expectations that these treatments should be made available'. —Thomas Rice, 'Addressing cost pressures in health care systems', Productivity Commission, *Health Roundtable,* Conference Proceedings, (Canberra: AusInfo, 2002), 68–69.

> 'Medical technology developments occur in response to anticipated demand, which in turn largely reflects the projected disease burden. The anticipated accelerated ageing of the population is expected to be the major driver of the projected disease burden over the next few decades. Thus technological advances affecting diseases of ageing could be expected to have the greatest impact on healthcare expenditure in Australia in the next five to ten years'. —Productivity Commission, *Impacts of Advances in Medical Technology*, 276.

While the Treasurer has insisted that the intergenerational effects of ageing need to be on the national agenda, the Federal government has let the critics of the IGRs enjoy an almost uncontested victory in the debate about the significance of ageing.

In the lead-up to the release of IGR2, there was some anticipation that the 'surging cost of medical technology and rising demand from the ageing population [would] be a centrepiece of the second intergenerational report'.[53] The expectation was that IGR2 would pick up the themes of the 2005 Productivity Commission report on the impact of medical technology.

But IGR2 did not even mention the work of the Productivity Commission on the potential growth in health costs due to ageing and the medical revolution. The explanation for this is probably political. The Productivity Commission reports show that ageing is a policy problem because the elderly are going to increase demand for better healthcare in the future. The implication is that demand-side reforms (sometimes called demand-side conservatism) are the appropriate policy response—for instance, using more price signals such as user charges or some other form of self-financing to limit government expenditure. But to canvass such policy alternatives is to challenge the bipartisan commitment to the 'free and universal' principles of the Medicare system. The politics of Medicare—a determination to avoid political backlash and not to set the political hares running by casting even the slightest of electorally-damaging shadows over the future of Medicare—probably explain why the Intergenerational Reports present the challenges ahead as predominantly supply-side issues and downplay ageing.[54]

While the Treasurer has insisted that the intergenerational effects of ageing need to be on the national agenda, the Federal government has conspicuously refused to use the Intergenerational Reports to set that agenda in health. Instead, IGR2 reiterates the relatively reassuring message that the government's marginal supply-side reforms—higher PBS co-payments and changes to generic drug pricing—are controlling the growth in costs, improving the 'sustainability' of Medicare, and even creating the 'headroom' needed to allow new drugs to be listed on the PBS.[55] In addition, by continuing to endorse in the IGRs the idea that ageing will increase spending by 'only' one quarter—without providing the qualifications that are readily to hand—the government has let the critics of the IGRs enjoy an almost uncontested victory in the debate about the significance of ageing.

What the IGRs should say is that:

- the projected one-quarter increase in health expenditure due to ageing is only a conservative estimate;
- the effect of ageing, measured by growth in GDP devoted to health spending, is double this;
- the elderly are going to consume over half of what governments spend on health in the future; and
- the interaction between ageing, technology, and cultural factors has the potential to ratchet up ageing-driven health spending.

What IGR1 said about the relationship between health and ageing, IGR2 should have expanded by incorporating the measures and scenarios canvassed by the Productivity Commission.

The 2007 Report would thereby have laid out the reasons why ageing is a far more significant intergenerational issue than projections of the 'pure' effect of ageing make it appear. It should have explained why the prudent course would be to pursue health reform and create as cost-effective and sustainable a health system as possible. What it should have made clear is why we cannot afford to be complacent about ageing, the medical revolution, and the future of Medicare.

Why ageing means a crisis for Medicare

> 'The available evidence indicates that population ageing will only have a limited effect on healthcare costs, and there is no evidence that population ageing will cause chaos for our health system. Policy making in Australia would be improved if this was more widely acknowledged'.— Michael D Coory, 'Ageing and Health Care Costs in Australia: a case of policy-based evidence?' *Medical Journal of Australia*, 180:11, 2004, 581–583, 583.

Figure 4: 'Small and manageable'? Why ageing and new technology will have a substantial effect on expenditure—estimated net expenditure impacts of selected advances in medical technology

Technology	*Disease category*	*Per patient costs*			*Volume*	*Net expenditure impact*
		Unit cost	Substitute/ complement/ add on	Costs elsewhere		
Insulin sensitisation drugs for prevention of type 2 DM	Diabetes	↑	Partial substitute	↓	↑	↑
IADs for control of AF and stroke prevention	Cardiovascular disease	↑	Substitute/ add on	↓	↑	↑
Robotic-assisted surgery for prostate cancer	Cancer	↑	Substitute	↓	↑	↑
Vaccine for treatment of established Alzheimer's disease	Neurological disease	↑	Substitute	na	↑	↑

Source: Productivity Commission, *Impacts of Advances in Medical Technology,* 307.

Future Australian governments are being counted on to supply an expanded range of expensive, state-of-the-art medical treatments, while maintaining 'equity' and therefore only minimal restraints on demand, at a much greater—indeed, unknown and potentially limitless—cost to the taxpayer. The taxpayers of the future are being counted on to fund at least half of the additional percentage of GDP spent on health (and probably much more) to provide superior healthcare to a much larger and much older, and very fortunate, generation of elderly people.

The question, however, is whether Australian governments are going to be able to continue to provide on a 'free and universal' basis the sophisticated care that people, the elderly especially, are going to want? Will future generations of taxpayers be prepared to bear the significant health costs of the unprecedented ageing phenomenon and accompanying medical revolution, and is it fair to expect them to do so?

As governments find that health expenditure is continuing to grow faster than the economy and revenue, politicians will increasingly have to resort to tighter expenditure controls to limit the cost of a 'free and universal' public system. In practice, this will mean more rationing and longer waiting lists. Governments might also slow the take-up of new medicine, which will mean that a technology gap will open which will deny Australians access to the latest advances. It is not feasible, in a globalised economy and with a smaller base of taxpayers, that governments will able to derive sufficient funds through the taxation system to sustain the present pay-as-you-go basis of financing Medicare. If our current arrangements for healthcare financing remain unaltered, an unsustainable and overburdened Medicare system is likely to deliver lower-standard care and even more strictly rationed technology and treatment, and will probably still break down under the strain.

Expecting the public health system to deliver higher volumes of advanced treatments will starkly expose the tension between the bottomless pit of community demand and expectation, and the limitations of government budgets. Medicare enjoys a high level of community support because people are reassured by the promise of universal entitlement to taxpayer-funded health care when illness strikes. But when the prospect of ageing and new medical technology are thrown into the governmental equation, it is highly unlikely that ensuring 'free' healthcare for all Australians is going to come out on top of the list of governmental priorities.

The 'free and universal' health systems of the twentieth century were created in an age when medicine was relatively rudimentary and inexpensive, when the old died relatively young, and when doctors mainly saved people from misadventure rather than from the consequences of their lifestyle choices.

Defenders of the status quo maintain that any move to limit the social entitlements of the elderly will be intolerable because this will break the social contract at the heart of the welfare state. Current social policy settings should not change, so the argument runs, because retirees who paid taxes throughout their working life to support the elderly should receive the same intergenerational transfers in retirement, lest younger generations perpetrate a gross intergenerational injustice on the elderly.[56]

What those who make this case ignore is the way population ageing in the twenty-first century will itself rewrite the generational social contract. Far from being cheated, as it presently stands, the baby-boomers are set to expect future generations of taxpayers to pay for an expanded range, level, and quality of life-enhancing and life-prolonging medical treatments that they did not have to pay tax to provide for the present generation of elderly. As Governor Macfarlane warned, the emergence of a generational wealth divide over the last 15 years has set the stage for real intergenerational conflict, if a rising tax burden reduces the ability of Gen X and Gen Y to accumulate wealth.[57]

The 'free and universal' health systems of the twentieth century were created in an age when medicine was relatively rudimentary and inexpensive, when the old died relatively young, and when doctors mainly saved people from misadventure rather than from the consequences of their lifestyle choices. It is intergenerationally unfair to insist that younger taxpayers preserve in aspic, to the considerable benefit of ageing baby-boomers, a health system intended to provide cheap,

basic healthcare to a far younger and healthier population. This is not going to be the case in an ageing Australia, given the medical realities of this new century. Accessing the high-tech care will substantially enhance and prolong the lives of the elderly—and save more people from the disease consequences of their lifestyle.[58] A more hardheaded approach to the intergenerational politics of Medicare is required.

Without reform, healthcare in the 2040s is likely to be increasingly about rationing. The questions will include whether people who suffer from lifestyle-related diseases should be entitled to receive all available health care, or whether resources should be conserved to do more to help people suffering non-self inflicted conditions. Ageing and the medical revolution also mean that far more people will live beyond 80, when frailty, debilitating illness and demand for greater care dramatically increase. Should the elderly patient nearing death receive the same level of treatment as the young person expected to live a long time? Given increased calls on government to fund a wide range of new treatments and procedures, hard decisions will be called for. Informal practices—the type of rationing that already occurs in public hospitals—and even formal policies may be developed by health authorities to determine the circumstances which justify the withdrawal of intensive 'life-saving' medical intervention from the very sick very old, in favour of giving younger, healthier patients priority of access to scarce beds, theatre slots and other therapies.[59]

Opting out, before Medicare opts out on us

This bleak prospect (referred to as the 'draconian solution' in the ageing literature) is the starting point for the new politics of health. The evidence strongly suggests that there are no guarantees that in the future Medicare will be able to give everyone for 'free' all the life-preserving and life-enhancing procedures and therapies modern medicine makes available. The choice is to opt out of Medicare before Medicare opts out on us—or else the healthcare that people will demand but which government will not be able to provide will be the great controversy of the twenty-first century.

The average citizen looks somewhat apprehensively on proposals to reform Medicare, since people tend to focus only on what they lose—particularly when it comes to protection against the risk of ill health—rather than what they have to gain by a transition out of the old arrangements in favour of becoming more self-reliant. But the health implications of ageing demand a rethink as to whether it is best for governments to retain command or for individuals to take control of the provision of their healthcare. There is good reason to think the already antiquated welfarist politics of Medicare are going to become positively archaic in the next 40 years.

Future papers in the CIS 'Health and Ageing' series will set out what our best options for a sustainable health system may be.

Endnotes

[1] The author gratefully acknowledges the invaluable comments of two anonymous referees. All remaining errors are the responsibility of the author.

[2] The Intergenerational Reports are an initiative established by the Howard government in conjunction with the *Charter of Budget Honesty Act 1998*. Their purpose is to 'assess the long term sustainability of current Government policies over the 40 years following the release of the report, including by taking account of the financial implications of demographic change.' They are prepared by the Federal Treasury, and the Treasurer, Peter Costello, released the first Intergenerational Report in May 2002.

[3] The 2007 bottom line is an improvement on the 5 per cent gap in 2041–42 projected in IGR1. This is partly due to the incorporation of levels of economic growth higher than previously projected. The main reason, however, is lower PBS cost projections—down by 0.9 per cent, from 3.4 to 2.4 per cent of GDP, in 40 years' time. The reduced PBS projections are due in part to new modelling methods but more so to the incorporation of the recent PBS reform that have reduced growth in PBS costs in recent years (the reforms include the introduction of higher patient co-payments, the raising of the PBS safety-net threshold, and changes to the pricing of generic drugs). Also significant is the effect of patent expiry for big-selling PBS medicines. IGR2 has brought the projections into line with the more moderate projections of the Productivity Commission of 2004, which found that Commonwealth government health expenditure would double to around 7.5 per cent of GDP. IGR2, like the Productivity Commission, employs a slowing rate of long-term growth rather than the exponential rate of future growth used in IGR1, which heavily weighed the recent but waning trend of very high rates of growth. The Treasury was lobbied heavily by the pharmacy and pharmaceutical industry to adopt this conservative approach to future PBS costs. Note: the Productivity Commission's estimate of government health expenditure cited on page 2 of this paper is higher than the IGR's because it incorporates State as well has Federal government budgets.

[4] Peter Costello, *Address to the National Press Club*, *Intergenerational Report 2: Frameworks for the Future*, 2 April 2007: http://www.treasurer.gov.au/tsr/content/speeches/2007/003.asp.

[5] Due to the 'much heavier draw-down on services, particularly health services' by the elderly, 'we're going to have this big mismatch between revenue and expenditure', which 'will be either filled by massive increases in taxes or, as I want to do, by putting of expenditures on a sustainable basis'. The Treasurer also warned that 'if we can get the changes going now, you will get those health services in 2045 but if we don't get going now, the options won't be there'; and 'the system will break, standards will fall … you won't get new drugs.' Treasurer, Doorstop Interview, Senate Courtyard Parliament House, Canberra, 12 April 2005: http://www.treasurer.gov.au/tsr/content/transcripts/2005/039.asp.

[6] *Intergenerational Report 2007* (Canberra: Commonwealth of Australia, 2007), xiv.

[7] *Intergenerational Report 2007*, 48 and 51; compare with *Intergenerational Report 2002–03,* 2002–03 Budget Paper No. 5 (Canberra: Commonwealth of Australia, 2002), 35.

[8] See the influential and widely-cited modelling and assessment of the minor effect of 'ageing alone' on health expenditure by Richardson and Robertson. They found that if demand for healthcare followed the historical trend and grew at the same average rate, the more important factors of increased demand across all ages and the cost of new technology, rather than ageing *per se*, would remain the primary cause of rising health expenditure. If ageing alone drove future growth, health spending would not increase above expected growth in real GDP, and health expenditure would actually decline as a percentage of GDP: Jeff Richardson and Iain Robertson, 'Ageing and the cost of health services', in Productivity Commission and Melbourne Institute of Applied Economic and Social Research, *Policy Implications of the Ageing of Australia's Population*, Conference Proceedings, (Canberra: AusInfo, 1999), 329–356.

[9] *Intergenerational Report 2002-03*, 38.

[10] The IGRs employ the approach to assessing the effect of ageing on health expenditure developed for the Federal Department of Health and Aged Care in the late 1990s. This also indicated that 'the increased costs attributable to ageing alone should be manageable' (Clive Cooper and Philip Hagan, *The Ageing Australian Population and future health costs: 1996–2051*, Department of Health and Aged Care Occasional Papers, New Series No. 7 (Canberra: AGPS, 1999), V) and 'sustainable', i.e., below the expected growth in real GDP (Peter Crowley and Greg Cutbush, *Ageing gracefully: an overview of the economic implications of Australia's ageing population* (Canberra: Commonwealth Department of Health and Aged Care, 1999), 20). This also became the premiss of the National Strategy for an Ageing Australia when launched in 1999. As the background paper concluded, 'increasing health and aged care costs are not an unavoidable consequence of population ageing': Department of

Health and Aged Care, *Background Paper: The National Strategy for an Ageing Australia* (Canberra: Commonwealth of Australia, 1999), 20, 16–7. As the discussion paper, *World Class Care*, concluded, 'population ageing is expected to continue to have only a relatively modest impact on growth in health expenditure': Department of Health and Aged Care, *World Class Care, Discussion Paper* (Canberra: Commonwealth of Australia, 2000), 43. From the outset, the National Strategy was dead as a vehicle for ageing-driven health reform. The 'good news', declared the responsible Minister when launching the National Strategy in June 1999, 'is that population ageing contributed less than one-fifth of the annual increase in health outlays over the last 20 years and it is expected to add a similar proportion over the next 20 years.' Bronwyn Bishop, *A national strategy for an ageing Australia*, Speech to National Press Club 8 June 1999: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-mediarel-yr1999-bb-bbsp990608.htm.

11 Cooper and Hagan, *The Ageing Australian Population*, 1.

12 'Health costs are very definitely rising rapidly in older groups, as mankind finds more and more medical things to do to elderly people to make their lives longer and more comfortable': Brent Walker, 'The Consequences of Declining Fertility on Health and Aged Care Policy in Australia' in, Committee for Economic Development of Australia, *Ageing and Health Care Costs—A Real Health Care Crisis in the Making*, Conference Papers edited by Ray Block, September 1996, 25.

13 Cooper and Hagan, *The Ageing Australian Population*, 6, made the vital but under-appreciated point: the least defensible modelling assumption is that average costs will remain the same over time, 'since it ignores prospective changes in the cost of health services due to such things as the increase in the variety and complexity of medical procedures and the cost of the associated technologies. Neither does it consider the trend toward the use of more expensive technologies.' How cautious these two authors were about their assumptions, and how they qualified their conclusions, has been overlooked by those who latched on to the conclusion that the cost of ageing will be 'manageable'. For comparison, consider that Access Economics' projections of future health expenditure prepared for DOHC in 2001 were considerably 'larger than existing official estimates of the fiscal effects of ageing because they add in a cost for the rising quality of health care.': Access Economics, *Population Ageing and the Economy* (Canberra: Commonwealth Department of Health, 2001), 44–46. Other detailed modeling has been performed which has taken both 'optimistic' and more 'pessimistic' approaches to the continued relative growth in healthcare costs compared with the rest of the economy and the impact this will have on health expenditure in the context of an ageing population. When the more 'optimistic' approaches were taken to the rising cost of the PBS, this modelling still showed an increase in the cost to the Federal government of between 3.3 and 3.7 per cent of GDP over 40 years time— consistent with the health expenditure projections in IGR2. When the 'pessimistic' scenario of continued strong growth in the PBS as envisaged in IGR1 was modelled, this produced an increase in health spending of over 5 per cent of GDP—consistent with IGR1: see VW Fitzgerald and W Haebich, *The Future Costs of Health and Aged Care in Australia*, A Health Reform Discussion Group Forum, The Australian Health Care System: Directions for Reform, Melbourne Business School, 19 September 2002, 18–21.

14 Vince Fitzgerald, 'Demography and Growth' in *Reshaping Australia's Economy: Growth with Equity and Sustainability*, ed. John Nieuwenhuysen, Peter Lloyd, and Margaret Mead (Melbourne: Cambridge University Press, 2001), 268-291, at 281. As Fitzgerald has commented, in Productivity Commission and Melbourne Institute of Applied Economic and Social Research, *Health Policy Roundtable*, Conference Proceedings, (Canberra: AusInfo, 2002), 322-23, '… one issue—financing—had received only scattered treatment during the Roundtable. There seems to be a tendency to understate the effects of ageing in this context, and it is likely that health expenditure as a percentage of GDP will rise significantly in the future due to it. However, there are also [other] significant trends… Examples include the trend in disease management to use more costly drugs, such as statins, which people will stay on for long periods of time; advances in molecular medicine and other areas, widening the range of treatments available; and the high costs of intellectual property-intensive new treatments. These factors alone will ensure that the scale of cost increases will be significant, even without ageing. We should not, however, be unduly concerned about upward movements in the cost of health care per se. As our standard of living rises, individuals will want better health care, and this will probably entail increasing costs. Given the scale of the likely increases, however, the political economy of funding growing health expenditures from the tax system must be considered.'

15 Peter Martin, 'Sir Humphrey could not have said it better', *Canberra Times*, 3 April 2007.

16 Michael D. Coory, 'Ageing and healthcare costs in Australia: a case of policy-based evidence?', *Medical Journal of Australia*, 180:11, 2004, 581–583, at 581.

17 Coory, 'Ageing and health care costs', 582; Pamela Kinnear, 'Ageing—will the real culprit please stand up?', *Online Opinion*, 15 June 2002: http://www.onlineopinion.com.au/view.asp?article=1874; Judith

Healy, *The Benefits of an Ageing Population*, Discussion Paper No. 63 March 2004 (Canberra: Australia Institute, 2004), 29; James Doughney and John King, 'Rhetoric and Reality: Neo-liberal ideology and ageing in Australia, 2003–2050', *Journal of Australian Political Economy*, 56, 2006, 25–43, at 27. The politics of the ageing debate, from the perspective of many critics, is that the Howard government has used the IGRs to manufacture a health 'crisis' and justify its 'neo-liberal' policy agenda. Coory, 'Ageing and health care costs', 583; Doughney and King, 'Rhetoric and Reality', 33, 35, 38. See also Kenneth Davidson, 'A con to wind back the public realm', *The Age*, 5 April, 2007.

18 Ross Gittins, 'Report and the spin—now read on', *Sydney Morning Herald*, 4 April, 2007. Gittins' most damning passage, pulling apart the link between ageing and expenditure growth, was reproduced in the 'Country-Wise The Commentators' section of *The Australian*, 7 April, 2007.

19 Productivity Commission, *Economic Implications of an Ageing Australia*, Productivity Commission, Research Report, (Canberra: Commonwealth of Australia, 2005), xxxi.

20 Productivity Commission, *Economic Implications of an Ageing Australia*, 172, my emphasis.

21 Productivity Commission, *Economic Implications of an Ageing Australia*, 314.

22 Productivity Commission, *Economic Implications of an Ageing Australia*, 314–5. The report dramatically illustrated the point at 315: projected fiscal pressure as a share of GDP 'without ageing' is less than 1 per cent of GDP, which 'implies that nearly 90 per cent of the fiscal gap associated with spending can be attributed to ageing alone.'

23 Productivity Commission, *Economic Implications of an Ageing Australia*, 'Technical Paper 6', 12.

24 Productivity Commission, *Economic Implications of an Ageing Australia*, 174.

25 In Australia 'average [Pharmaceutical Benefits Scheme] costs for a male aged 65–74 years are more than 18 times the average costs for a male aged 15–24 years'. Across all areas of Medicare, costs rise with age; and across all health spending, 'expenditure on those aged over 65 is around four times higher than expenditure on those under 65, and rises to between six to nine times higher for the oldest groups': Productivity Commission, *Economic Implications of an Ageing Australia*, 147.

26 Productivity Commission, *Economic Implications of an Ageing Australia*, 147, 160–2.

27 Productivity Commission, *Economic Implications of an Ageing Australia*, 143.

28 Peter Sheehan, *Health Costs, Innovation and Ageing*, Pharmaceutical Industry Project Working Paper Series, Working Paper No. 9 (Melbourne: Centre for Strategic Economic Studies, Victoria University of Technology, 2002); Access Economics, *A review of the 2002 Intergenerational Report*, Report by Access Economics for Medicines Australia, September 2006, 30–1.

29 Access Economics, *A review of the 2002 Intergenerational Report*, 12–14.

30 Productivity Commission, *Economic Implications of an Ageing Australia*, 158–9.

31 Productivity Commission, *Economic Implications of an Ageing Australia*, 157.

32 Productivity Commission, *Economic Implications of an Ageing Australia*, 143.

33 The evidence that the Commission reviewed confirmed that both in Australia and overseas, ageing has already driven up health spending due to technological advances associated with the treatment of conditions associated with old age. The trend is that the number of surgical prostheses procedures for older people (pacemakers, cochlear implants, hip replacements) has substantially increased in a short period of time due to improvements in anaesthesia, while the cost per device and per surgical procedure has also increased due to technological innovations: Productivity Commission, *Economic Implications of an Ageing Australia*, 151–2. So too have treatment costs for prostate cancer and cataract surgery: Productivity Commission, *Impacts of Advances in Medical Technology in Australia*, Research Report, (Melbourne: Commonwealth of Australia, 2005), xxxii.

34 For instance, the number of PBS prescriptions for cholesterol-reducing drugs has grown from 2 million to 15 million annually and has become the largest single PBS expenditure item at around $900 million. This is yet to be offset by significant reductions in hospital costs by reducing heart disease: see Productivity Commission, *Impacts of Advances in Medical Technology*, xxxii, xxxix.

35 Productivity Commission, *Impacts of Advances in Medical Technology,* xxvi–xxviii, xxxvii, xxxix–xl, and 270–271.

36 On the general cost and demand implications of new technology, see Vince Fitzgerald, 'Health reform in the federal context' in Productivity Commission, *Productive Reform in a Federal System*, Round Table Proceedings, (Canberra: Commonwealth of Australia, 2005), 103–132, 107–108.

37 Productivity Commission, *Impacts of Advances in Medical Technology*, xlix–lii.

38 P Mohr, et al., *The Impact of Medical Technology on Future Health Care Costs,* Report prepared for Health Insurance Association of America and Blue Cross and Blue Shield Association, Project HOPE, Centre for Health Affairs, Bethesda 2001; DP Goldman, et al., *Health Status and Medical Treatment of the Future Elderly*, Final Report, TR-169-CMS, Prepared for the Centers for Medicare and Medicaid Services, RAND Corporation, Santa Monica, 2004.

[39] 'With continuing improvements in medical technologies designed to further combat the diseases and infirmities of old age, the likely trend is for health care and long-term care costs to gradually become proportionately greater at older age relative to the costs of the working age population.' Brent Walker, 'The Consequences of Declining Fertility on Health and Aged Care Policy in Australia', 23.

[40] In fact, IGR2 makes ageing seem even more insignificant. IGR1, 40, states that 'while population change is expected to be a significant driver of future health spending, new technology and increased use and cost of services are projected to have an even more significant influence.' IGR2, 48, does not even describe ageing as a 'significant driver': non-demographic factors are singled out as the 'key driver' and as 'likely to continue to generate the greatest cost pressure in the future.'

[41] Gary Banks, *An Ageing Australia: small beer or big bucks?,* Presentation to the South Australian Centre for Economic Studies, Economic Briefing, Adelaide, 29 April 2004, 18, http://www.pc.gov.au/speeches/cs20040429/cs20040429.pdf.

[42] In an influential research paper in 2002, Steve Dowrick and Peter McDonald maintained that in 40 years' time, given even modest economic and productivity growth, expected average national income would be considerable higher. The 5 per cent rise in the tax burden would be easily accommodated: it would only mean that real after-tax incomes would be 85 per cent, rather than 100 per cent, higher than today: Steve Dowrick and Peter McDonald, 'Comments on Intergenerational Report, 2002–03', Canberra, June 2002. See also Ross Guest and Ian M McDonald, 'Prospective Demographic Change and Australia's Living Standards in 2050', *People and Place*, 10:2 (2002), 6–15.

[43] Ross Guest, 'Australia's Older and Wealthier Future', *Policy*, 20:2 (Winter 2004), 3–9; Ian McAuley argued that only 11 per cent of the increase in per capita GDP would have to be devoted to higher taxation. The 'modest' 5 per cent average tax rise over the next 40 years would 'put us into the mid league of where other OECD countries are now, and there is a reasonable body of evidence showing that Australians are willing to pay more in taxation to fund health care.': Ian McAuley, 'Death is inevitable, why aren't taxes?—The Commonwealth's *Intergenerational Report', Australian Review of Public Affairs, Symposium: The 2002–03 Federal Budget: Australian Policy Online:* http*://www.australianreview.net/digest/2002/06/mcauley.html.*

[44] Doughney and King, 'Crisis? What Crisis?', *People and Place*, 14:1 (2006), 65–74, at 65, 69, 72–73, 72. Michael Keating has suggested that we close our eyes when taxes inevitably rise and think about how rude our health will be: governments will simply have to raise more revenue to meet the growing demand for a higher quality of healthcare, and the community will have to accept either the cost or increased rationing of services: Michael Keating, *The Case for Increased Taxation*, Policy Paper No. 1, Academy of the Social Sciences in Australia, Canberra , 2004.

[45] Gittins, 'Ageing: sorting the problem from the propaganda', *Sydney Morning Herald*, 29 November 2004. This argument does not look so good if ageing does matter as a source of future fiscal pressure and is going to be responsible for one half of the higher proportion of GDP devoted to health expenditure. It looks even worse if providing healthcare for the older quarter of the population is going to consume over half of the health budget. And if we think about the potential ways in which the interaction of ageing and new technology may ratchet health spending up far higher than expected, and accentuate what is already set to be a massive shift in health resources from the working aged to the elderly, the tax-and-spend 'solution' looks positively intergenerationally unfair.

[46] In response to the sceptic's argument—that 'moderate' tax rises would suffice—those who share the Treasury view pointed out that to balance the budget 'an individual born tomorrow would have to pay 32.2 per cent more in taxes than the present generation.': Gregory Coombs and Brian Dollery, 'An Analysis of the Debate on Intergenerational Equity and Fiscal Sustainability in Australia', *Australian Journal of Social Issues*, 37:4 (November 2002), 363–381, at 368. Or future generations would face an equivalent to 40 per cent increase in income tax: Des Moore, 'Plug the generation gap now', *Australian Financial Review*, 12 June, 2002. Or the GST rate would have to rise to 22.5 per cent to keep the income tax to GDP ratio level: Alan Wood, 'Lower taxes the key to future stability', *The Australian*, 21 May 2002.

[47] Ken Henry, 'The Economic Impact of Australia's Aging Population', *SAIS Review*, 25:2 (Summer-Fall 2004), 81–92, at 87.

[48] Ian Macfarlane, 'Old people, new problems', *The Australian*, 14 November 2003.

[49] *Australia's Demographic Challenges*, (Canberra: Commonwealth of Australia, 2004), 25.

[50] Greg Coombs and Brian Dollery, *The Ageing of Australia: Fiscal Sustainability, Intergenerational Equity and Inter-Temporal Fiscal Balance*, Working Paper Series in Economics No. 2004-1, University of New England School of Economics, 15.

[51] Ken Henry, 'Society faces one of its biggest problems in ages', *The Australian*, 2 July 2003. Work undertaken by Treasury in 2003 demonstrated that if participation rates in Australia rose to match

those at the top of the OECD countries—from 64 to 66 per cent—then GDP could be increased by 9 per cent over 20 years, sufficient to fund all the extra tax otherwise required: D Gruen and M Garbutt, 'Output Implications of Higher Labour Force Participation', Treasury Working Paper 2003-02, October 2003.

52 The real risk is that the 'higher growth we can achieve through productivity and participation will not, by itself, hedge against the fiscal effect of the blow-out in the nation's health costs': 'Report warns, it's the health system, stupid', *The Australian*, 25 November 2004.

53 Mark Metherell, 'Blowout in cost of medical gadgets prompts review', *Sydney Morning Herald*, 20 March 2007. Mark Metherell, reasonably, put two and two together after the Treasurer told him that 'The biggest challenge is going to be to pay for medical services over the next 20 and 30 years, and we've got to make sure that our focus on medical care is for good sustainable state-of-the-art technology, based in a way we can afford into the future.'

54 This would also explain why the Treasurer, in responding to the Productivity Commission report, did not outline, as might have been expected, any specific health reform proposals. Instead, when pressed, he took the easy 'Three P's' and 'pro-growth' way out, suggesting that a 'productive economy is the best way of ensuring that we can sustain these services.': Treasurer, Doorstop Interview, Senate Courtyard Parliament House, Canberra, 12 April 2005: http://www.treasurer.gov.au/tsr/content/transcripts/2005/039.asp. When asked whether the government was willing 'to take tough decisions on health', the half-hearted reply was only that 'we have to get the health care system onto a sustainable basis'. Treasurer, Interview with Stephanie Kennedy, ABC AM, 12 April 2005: http://www.treasurer.gov.au/tsr/content/transcripts/2005/038.asp.

55 *Intergenerational Report 2007,* 6, 51.

56 For a précis of this view, see Myra Hamilton, 'The poorer boomers are not looking forward to retirement', *The Age*, 13 April, 2007.

57 Research conducted by the National Centre for Social and Economic Modelling in 2003 has shown that there has been a huge shift in wealth, driven by housing prices, in favour of boomers, while every age group under 45 has experienced a wealth loss: *Generation Xcluded,* AMP NATSEM Income and Wealth Report Issue 6. November 2003. NATSEM found that the share of total wealth held by 25 to 39 year olds had declined from 27 per cent in 1986 to 19 per cent in 2003, 15.

58 Thomas Rice, 'Addressing Cost Pressures in Health Care Systems', in Productivity Commission, *Health Policy Roundtable*, 68–9.

59 See Ted Waters, 'Funding Options: Who Pays the Piper?', in Committee for Economic Development of Australia, *Ageing and Health Care Costs*, 33, 36, 45.

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