Is There No Prescription to Decrease Health Care Outlays in the Face of an Aging Population?

The world population is aging. As a result, health care spending will increase, because the elderly are sicker and use more drugs. This seems to be the common conception, assumption, and guiding principle. Is it really that simple? Are there actions that can be taken to mitigate the inevitable?

■ The Trends

The aging of the population is clearly a major trend, perhaps the major trend, driving social, political, and economic forces on all continents except Africa. Aging by itself is a biological imperative, but its impact on social welfare systems is not. Governments are already discussing the impact of aging on their social systems. For example, in the United States, the Old Age, Survivors', and Disability Insurance program of the Social Security system came into existence in 1935, when the average life expectancy was 61 years and the retirement age was set at 65. By 1965 life expectancy averaged 70 years, or five years after retirement.¹ (See Table 1, above.)

As the average life expectancy increases while the retirement age is fixed at 65, the growing number of retirees become a greater burden on the system. As the ratio of workers to retirees continues to fall, there is less taxable income to support the social welfare system. Clearly, programs that increase the worker/retiree ratio and increase the retirement age can help balance the impact of aging on health care outlays.

■ How Governments Respond

Countries support their economies and social welfare systems by taxing the working segment of the population. The balance between the working and retired segments is a critical indicator of the vibrancy of an economy. As populations age governments look to balance the increased impact of retirees by changing immigration policies: By increasing immigration they can increase the number of workers supporting retirees. Governments must also make dif-

TABLE 1 Worker: Retiree Ratios

Year	Ratio of Workers: Retirees	Average Life Expectancy
1935	25:1	61 years
1950	16:1	68 years
2000	3.3:1	76 years
2025-2030	<2:1	≥ 78 years

Sources: Shipman WG. *Social Security privatization*. Cato Institute, August 14, 1995; and Marron D. *Not privatizing Social Security is the biggest risk of all*. Wall Street Journal, May 18, 2000, A26.

ficult decisions about reforming their welfare systems and the level of programs offered to the aged population.

As life expectancy rises the age of retirement becomes an important driver of the worker/retiree ratio. For example, in the United States the life expectancy has been rising while the age of retirement has remained at 65. Health care spending for those over age 65 is 4.4 times that for the younger population and the inflation rate is 3 times that of the under-65 population. Since Medicare is a pay-as-you go program (i.e., there are no savings; expenses are paid as they are incurred) there is an almost unlimited cost potential for this aging population. Government response to this is typically to ration or to reform welfare benefits. All of this assumes that the number of workers is not reduced; however, when the number of workers is reduced by retirement or other means, governments are consumed with debates over reforms of tax, immigration, and social welfare programs. The familiar debates over whether to increase taxes and decrease incentives are compounded when health care costs rise and worker/retiree ratios fall.

Another option to increase the workforce is to stimulate welfare reform by offering income supplements to drive people off welfare rolls into the labor market. These programs also improve the worker/retiree ratio. Minnesota offered such a supplement starting in 1998 (the Minnesota Family Investment Program) and

Canada is in the midst of a similar experiment (Canadian "Making Work Pay" Program).² While many countries are considering these programs, the challenge is to ensure that the short-term successes influence longer-lasting results.

Demand for health care services increases naturally with increasing age. Demand also increases with low coinsurance rates. As life expectancy increases toward 80 years, retirement at age 65 is a hardship on the system. As a result, policymakers are considering increasing the retirement age; however, large increases are not politically acceptable, and they are an immediate burden on the retired population. As a result, incremental increases (e.g., six months per year) are a favored option.

Of course the state of the economy is an important factor. When the U.S. economy has a budget surplus, new entitlements are popular, which increases health care spending. Paying for entitlements may take the form of drug subsidies or price controls, which do not decrease drug spending but rather shift the payor source.

■ Lessons from Other Countries

Aging baby boomers will test the limits of the health care system globally. However, Uwe Reinhardt, a Princeton University economist, has suggested that health care costs are manageable if the United States will test its assumption that its health care system is so superior that it has nothing to learn from other countries.³ A critical evalu-

TABLE 2 Health Spending for Seniors, 1999

Country	Percentage of Population Over Age 65	Health Care Outlays on Elderly	
		Share of GDP (%)	Per Capita (\$)
United States	12.5	5.0	12,090
Canada	12.9	3.6	6,764
France	16.0	3.4	4,717
Great Britain	16.1	2.8	3,612
Germany	16.8	3.5	4,993
Japan	17.5	3.4	5,258

Source: Information please almanac. Boston: Information please L.L.C., 2000, 899.

ation of variations in medical costs both within the United States and internationally indicates that spending on health care is manageable. An evaluation of Table 2, above, demonstrates that nations with a high percentage of elderly (greater than 16%, a percentage the United States will likely reach by the year 2020) have significantly lower health care outlays than the United States. For example, the life expectancy for 65-year-olds in Japan and several European countries is higher than in the United States, even though many believe that America gets more for its money. A poor elderly American typically spends one-third of his or her income on health care, more than peers in any other industrialized nation, but is less satisfied.

Reinhardt suggests that a major difference between Europeans and Asians and Americans is that the Europeans and Asians critically review their own systems and "search the globe for health care innovations."³

How Does Health Care Respond?

Health care systems respond to aging by

changing utilization incentives. One disincentive is to increase deductibles, possibly by adopting catastrophic insurance or voucher systems. Intermediate options are to increase coinsurance. Other alternatives are based on informing consumers of options, presuming that educated consumers will self-regulate utilization in favor of necessary versus discretionary care.

Another response is to focus elderly health care on prevention rather than treatment. Jeffrey Kang, M.D., chief clinical officer of the Health Care Financing Administration (HCFA), has said that "the challenge for us is how to modernize Medicare from a medical acute care model to a comprehensive health care model emphasizing successful and healthy aging through health promotion and risk factor reduction."⁴ The initiative would improve quality of life and decrease health care spending by compressing periods of severe disability and terminal disease into fewer years. This is known as "compression of morbidity" or "squaring the morbidity curve."

Aging is inevitable, but the ability of

governments, health care systems, and individuals to pay for the diseases of the aged is not without recourse. Politics and the state of the economy certainly influence which course the federal government will take. Health insurance systems are currently taking the recourse of increasing coinsurance. Managed care has a fundamental imperative toward wellness that is clinically acceptable and serves to decrease insurance risk. It will require vision and leadership to achieve fundamental managed care goals in the future. ■

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