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Ageing population not draining health budget but reforms needed

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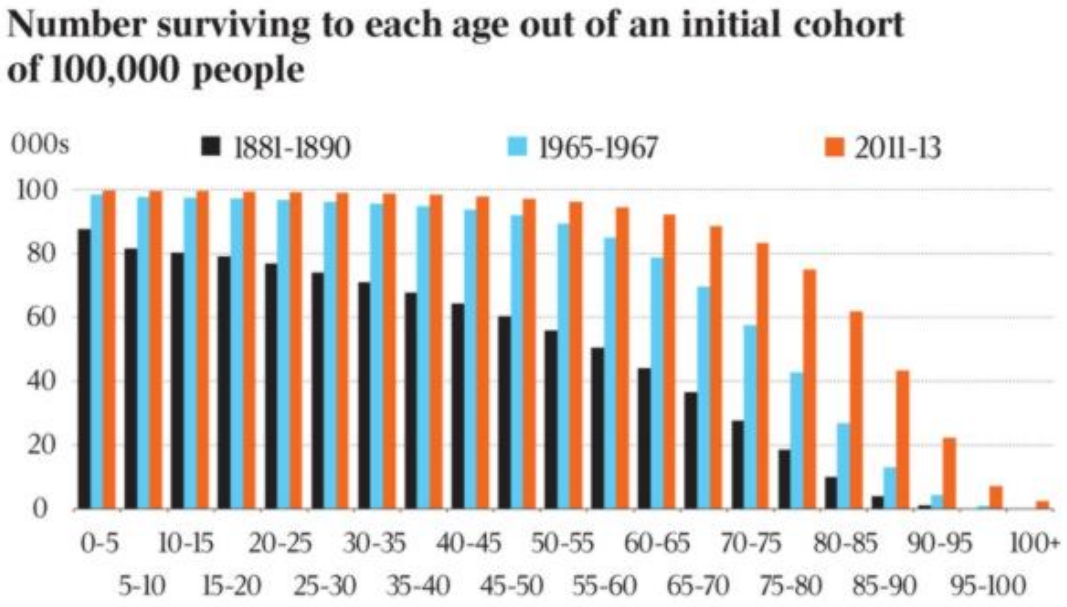

Source: TheAustralian

When Ovid, in the Metamorphoses, made the first recorded use of the term "reformare", it meant the sudden rejuvenation of an old man — but for one day only.

How fitting then that the premiers, hiding under the banner of reform, have simply sought to keep "business as usual" going that little bit longer, instead of placing their health services on an efficient basis.

That the states have been roused into action is hardly surprising. In its first budget, the Abbott government turned the tap off on the hospital and schools agreements Kevin Rudd and Julia Gillard had signed but never funded. With public hospitals due to get some $50 billion of the $80bn that was withdrawn, the states were finally forced to face a hard budget constraint.

It may have been too much to expect them to respond through an outburst of innovation. But before seeking to slug taxpayers for the shortfall, surely they could have provided an even vaguely plausible justification.

Instead, imitating the medieval cartographers whose maps contained wildly imagined illustrations of uncharted territories inscribed with the warning "Here be Monsters!", the best the premiers could do was point to population ageing as the Bermuda triangle swallowing up our health dollars.

However, modelling by David Cullen, chief economist of the commonwealth Department of Health, shows that changes in age structure have only made a small contribution to the recent growth in health expenditure. From 1995 to 2010, 17 per cent of the rise in per capita health expenditure was due to the increased share of the population aged 65, while the fall in the share of the 0 to 14 age group reduced it by 8 per cent.

As a result, less than 10 per cent of the net increment in per capita health spending could be explained by demography.

What is true is that demographic trends could have a greater impact going forward. Indeed, the modelling suggests that were the health system to stay as it is, population ageing would account for a third of the overall growth in per capita health spending over the next 15 years. Already now, a 75-year-old costs the commonwealth, in outlays on the pharmaceutical and medical benefits schemes alone, some $500 more each year than a 70-year-old does; as 70 to 80 per cent of each cohort survive beyond age 80 (as compared to barely 40 per cent in the mid-1960s), the challenge to future budgets seems obvious.

But there are some crucial caveats. While a growing proportion of the population will live to very high ages, there is much less certainty about how that translates into the hospital costs the premiers complain about.

For example, in France, which has some of the best data on health outlays, recent analyses suggest rising longevity has either not materially increased costs or may actually have reduced them. That is mainly because it has postponed both the years of severe illness and the very costly period leading up to death. And with growing numbers coming to the end of life at very high ages, patients, families and physicians are more likely to opt for palliative care than insist on expensive interventions that prolong life but destroy its quality.

Also, whatever population ageing's effect under the "business as usual" scenario, there is great scope for our health system to do better, in the process reducing the growth in hospital costs.

The fundamental issue here is not, as often claimed, cost shifting between jurisdictions; it is the fact that no one bears overall responsibility for managing consumers' interactions with the health system and ensuring the best use of its resources. Rather, key decisions are thrust on to individual patients and health practitioners, who lack both the incentives and the capacity to seek value for money.

That approach may have coped in the past; but as the Rudd government's National Health and Hospitals Reform Commission concluded, it will become ever more inadequate as the burden of chronic conditions rises. It would, instead, be better to empower competing health insurers to act as comprehensive care managers and take overall responsibility for costs, much as Obamacare, whatever its flaws, aims to do.

Sure, such a change would face many difficulties; but the risk, if our system remains unchanged, is that any additional spending will quickly be dissipated in excess costs.

Queensland's experience shows just how great that danger is. During the mining boom, Queensland's health spending more than doubled; with outlays on wages rising by 8 per cent

annually, the bulk of that spending was captured by well organised input suppliers, including doctors and nurses, with few gains in outcomes for consumers. Rather, the steepest improvements came under the LNP, which froze overall spending while using private hospitals to clear waiting lists. Now, as Premier Annastacia Palaszczuk reverses the LNP's changes, cost escalation is set to return: and the more money she has, the greater the waste will be.

Were each state merely increasing its own taxes, it would be up to its voters, and its voters alone, to prevent public funds being squandered. But the states want to spread the blame for the tax slug, including to the Abbott government. Before it lets them get away with that, it should require credible commitments to lift productivity, including by using private hospitals where they are cost-effective.

After all, while the Rudd-Gillard agreements promised rivers of cash, they demanded serious changes in return; it would be absurd to restore the flood with no assurance of real reform.

The alternative, of course, is for "reform" in Australia to revert to its meaning in Ovid's time: not an improvement but a miraculous step backward. Then again, perhaps it already has.