

Healthcare and demographic decline

Philip Booth, Acton Institute Conference, Rome, December 2010

I have been asked to speak about “Demographic Decline and Healthcare”. As an economist, I shall focus on policy choices that we face in this environment. I will begin by outlining the basic policy choices that face us in the field of healthcare; then I shall discuss the demographic background; finally I shall bring the two issues together and discuss the relevance of demography for political economy.

Policy choices – an important distinction

In thinking about health policy, we can split consideration of who should finance healthcare from consideration of who should provide healthcare. The arguments to justify government financing for healthcare are rather different from the arguments surrounding whether the government should be the provider. Apart from the government and commercial organisations many others can be involved in the delivery of care. This will include family, neighbours, voluntary organisations, and so on. These groups are particularly important in providing personal care where a high degree of medical skill is not required. Such care is labour intensive and costly.

Who should finance healthcare?

But before considering provision, I want to consider finance. I want to ask whether the state should finance healthcare. It is interesting to mention Catholic social teaching on healthcare at this point. The Compendium of the Social Doctrine of the Church, quoting an older version of the Catechism, states: “The demands of the common good...are strictly connected to respect for and the integral promotion of the person and his fundamental rights.” Basic health care is then enumerated among various such rights. As we shall see, there is nothing in Catholic social teaching that suggests that the state should be the *provider* of health care - any more than it is for the state to provide food. But I think most would agree that the state must see to it that all do have access to health care through ensuring that all have the financial resources, *one way or another*. For whom the state finances healthcare is a matter for prudential judgement. Though, as I shall mention later, state *provision* of healthcare meets strong principled objections.

The most common ways of financing healthcare are:

- Government finance through subsidies for private insurance or payments to private hospitals.
- Government finance of a government-provided service.
- Private short-term insurance, with policies being renewed each year. Sometimes this is tied to a workplace to obtain the benefits of group underwriting.
- Insurance where the individual takes out a policy at a fixed premium for a long period of time so that, if health worsens, he is still insured – rather as happens with life insurance.
- Private saving or other private means.

- Charitable provision.

In most Western societies, the government finances much healthcare provision – including in the US. This has not always been the case. Before the National Health Service was formed in Britain in 1947, there was an extraordinary array of forms of finance and provision. Where the government does not finance healthcare, it tends to strongly regulate private finance through insurance.

So, why might the government finance healthcare? Typically, the economic arguments made to justify the government providing finance for health are:

- Healthcare is a “merit good” – it is something that people should have regardless of whether they want to have it. This is essentially a paternalistic argument. Compulsory insurance – as in Switzerland – is an alternative to government finance.
- There are externalities from healthcare – for example a certain level of vaccination is necessary to prevent the spread of disease: this probably only justifies the state being involved in about 10% of healthcare spending.
- There are economies of scale in government finance and individual underwriting of health insurance is difficult.

It has to be said, that it is difficult to use these arguments to justify *substantial* government financing of health care.

When it comes to personal and long-term care for non-medical needs, the issues are more subtle. Much personal care is provided by family, neighbours and friends in what might be called the free economy outside the market economy. It seems that the observation of Pope Benedict XVI in *Deus caritas est* is still taken to heart in that area. He said: “The State which would provide everything, absorbing everything into itself, would ultimately become a mere bureaucracy incapable of guaranteeing the very thing which the suffering person—every person—needs: namely, loving personal concern.” It is really very important that the government does not finance such personal care for the elderly unconditionally because, if it does, it is likely to erode dramatically the extent of care provided by the family. Despite our state health service, you may be surprised to know that when it comes to personal care in Britain 65% of care is provided by families, neighbours or friends.

So, that provides a little bit of insight into the dilemmas we face when thinking about the financing of healthcare. We must be careful not to break down mechanisms where people can meet their own needs very effectively, but there may be situations where the state needs to help people finance healthcare.

Who should provide healthcare?

The arguments for government provision of healthcare are much less compelling than the arguments for government finance – especially to a Catholic audience. The normal arguments for government provision are that:

- All people should be treated equally with regard to health because it is a basic human right.
- There is radical market failure in the provision of health which leads to the market providing very badly or very expensively for people.
- There may be gaps in provision unless the state provides a uniform service.
- There may be economies of scale in health provision.

I want to test one or two of these arguments, though there is not time for a full discussion.

The UK is probably the best-known example of government provision and finance. Canada is another example. I want to test this model at its strongest point – the supposed equality of outcome that it produces. The original document that established Britain's state health system said: "Poverty must be no bar to health...There should be no lower limit of income...for access to the benefits of the entire services."

Despite this aim, health inequalities are very marked in the UK. The gap between life expectancy for men in the highest social class and that in the lowest social class has widened from about five years to about seven years between 1972 and 2002. Infant mortality was 17% higher in the lowest social class than in the highest social class in 2006 and this gap has increased from a level of 13% in 2000. This is despite huge per capita budgets that are 42% higher in areas containing the poorest 10% of people than in areas containing the richest 10% of people.

These health inequalities are not, of course, completely explained by the model of state health provision. However, the very model that is supposed to eliminate health inequalities does not do so. The articulate and the better off are probably better at exploiting a system where priorities are determined by bureaucratic discretion. Bureaucracies are also not effective at dealing with the very personal and particular needs of the poor.

The UK system is also very bureaucratic. A 2003 survey calculated that there were eight support staff for every ten nurses: in a typical private sector hospital the ratio was 1.8 to ten. When healthcare is provided by the state, the state is also apt to determine priorities. In a 2003 survey, 60% of doctors said that they had direct experience of politically-motivated goals distorting clinical priorities. This is worrying in the context of a deeply secular country where one sixth of all conceptions end in abortion.

There is a similar experience with the Canadian system. This is organised along the same lines as that in the UK except that in many provinces, private insurance is actually illegal. Perhaps the final indictment of this model of health provision came when the government was taken to the provincial court in Quebec because waiting times for operations were so long that they were

regarded as violating an individual's right to preserve their own health. In other words, the one system that is designed to provide healthcare equally for all was regarded by the country's own courts as preventing its citizens from accessing their basic human rights to healthcare.

There has been an extraordinary increase in spending on healthcare in the UK too. Spending after inflation more than doubled between 2000 and 2010 to almost 10% of national income. At this point it is interesting to mention a passage in the papal encyclical *Centesimus annus*. Pope John Paul said:

"In recent years the range of such intervention has vastly expanded, to the point of creating a new type of State, the so-called "Welfare State"...However, excesses and abuses, especially in recent years, have provoked very harsh criticisms of the Welfare State, dubbed the "Social Assistance State"...By intervening directly and depriving society of its responsibility, the Social Assistance State leads to a loss of human energies and an inordinate increase of public agencies, which are dominated more by bureaucratic ways of thinking...accompanied by an enormous increase in spending."

This passage could have been written to describe the National Health Service in Britain. It is very perceptive. We have had an inordinate increase in resources and we have public agencies dominated by bureaucratic ways of thinking. And, the model has certainly not achieved equality.

Demographic decline and health costs

I now want to come to the main focus of this discussion, demographic decline. The precise pattern of demographic decline is different in different countries. Italy is at one end of the spectrum. At current birth rates, ignoring increased longevity and migration, by the year 2500 – in 500 years time – there will only be 16 Italian people left. Things are not so bad in the United States and New Zealand. Britain is a median case, so I am going to illustrate things with the British example.

The changing demographic profile of the UK can be summarised by the following statistics:

- The percentage of older people (aged 65 and over) increased from 13 per cent in 1971 to 16 per cent in 2003 and is projected to rise to 23 per cent in 2031
- The number of people over age 85 is likely to rise from 2.8 million to 4.5 million in the next 15 years.
- There will only be 2.5 people aged between 20 and 64 for every person over 65 by 2030 – the current ratio is 3.7.
- Ageing could cause the number of healthy adults per unhealthy adult to fall from 5.1 to 4.3 in the next 15 years.
- Research by a UK charity Help the Aged suggests that, over the next ten years, there could be nearly 7 million older people who cannot walk up one flight of stairs without resting and over 4 million older people with major hearing problems.

Demographic decline and health policy

We can relate the problem of demographic decline to that of policy choices in health finance and provision. To do this, we need to distinguish between three different processes. We can have an ageing society arising from the fact that fewer new people are being born. Secondly, we can have an ageing population because people are living longer. Thirdly, there is the much more complex issue of whether people have greater healthcare needs because of ageing.

We need to think about this third issue in greater detail. Figures are often given to show the relationship between healthcare spending and age. For example, in the UK, spending per head on those over 65 is three times spending on those aged between 15 and 64. When we look at spending on those aged over 85, we get much bigger numbers. The argument is frequently made that the demographic crisis inevitably leads to a healthcare financing crisis.

This is a fallacy. The point is that proximity to death is the most important factor affecting health care costs. If the population ages due to rising longevity, death will occur later, on average and healthcare costs will therefore be incurred later. That does not automatically make healthcare costs per person higher.

The key issue is the relationship between healthy life expectancy and total life expectancy. If people, on average, live ten years longer and have ten years more healthy life, then demographic decline is not necessarily a problem for healthcare systems.

The data suggest that the number of years of ill health seem to be a relatively stable proportion of the total life span – though the proportion is growing slowly. Due to technology, we are also better able to adapt to ill health. Overall, I do not think there is too much to fear from people living longer and populations shrinking unless – and this is an important caveat – we adopt the wrong policy choices.

If healthcare is financed by people saving throughout their lives for those needs that tend to occur at the end of life, we do not have a great problem. The financing problem arises if no provision for healthcare is made until the time of need so that the healthcare of the elderly has to be financed by the shrinking young population through taxation. This is a very important point. If taxpayers in general are paying for healthcare an increase in the number of old people per taxpayer could lead to a huge increase in costs. If we save to finance healthcare costs, the total cost does not fall but there is a pool of capital to meet those costs. As such, just as we can talk about unfunded pensions, we can talk about unfunded health liabilities. Unfortunately, it is the case that, in nearly all developed countries, the state does pay for healthcare for the old – even if it is provided privately.

Policy response

With regard to the finance of healthcare, we should certainly be sympathetic towards arguments for state support for the poor - though we should not forget charity, of course. The vast majority of people, though, are able to finance their own healthcare – though not necessarily at the time of need. Both saving and insurance are important in meeting health needs in a prosperous society that is in demographic decline.

The link between demography and finance is crucial. *We must not discourage* long-term insurance where level premiums are paid for an increasing risk so that premiums do not increase as people get older. The US system is particularly bad in this respect. *We must not discourage* saving for healthcare costs in the same way as people save for pensions. We also need to ensure that diverse methods of provision and finance *are not discouraged* that can evolve naturally and dynamically to changes in human need and demographic profiles. One particularly effective mixed method of finance and provision, for example, is to have a large group whereby the group as a whole pay directly for health care and share the cost but there is not an insurer underwriting the risk of the group as a whole. This method was used in the UK in the form of Friendly Societies before the nationalisation of provision in the UK and is often used in micro-finance schemes in under-developed countries. It is also a mechanism of health finance that strongly encourages community bonds and health education and prevention.

Indeed, it is worth noting that health education and prevention are important issues in their own right. It is possible to reduce the expected proportion of life spent in ill health through better lifestyle choices. Again, systems of finance and provision that encourage individual responsibility in this respect have a part to play in ensuring adaptability to demographic change.

Family and neighbourly provision of personal care should *never be crowded out by the state*. Families and neighbours provide the majority of personal care for the elderly in the UK and it is easy to undermine this by state subsidisation of formal care provided by professionals. We have seen this happen in child care in continental Europe.

Finally, there is an important role for charity in both finance and provision. Our intimate needs in this area of can sometimes best be met with charitable provision. The hospice movement is a shining example.

The state should do what the great principles of Catholic social teaching suggest. It should provide support for the poor to obtain healthcare. But it should do so in a framework that allows families to pursue their legitimate objectives and not in a way that imposes a model upon the poor. As long as we save to meet the needs of old age and as long as we have strong families, there will not be a serious financial problem from ageing. However, government policy has, for many decades, in most countries, undermined our ability to meet healthcare costs and the burden for the next generation will be enormous.