

Summary of key findings over the period 2002–2051, under ‘central’ assumptions

- % GDP spent on health will increase from 6% to 9%.
- Older people’s share of health expenditure will increase from 40% to 63%, yet the ratio of spending on the average older versus younger person will decrease (by approximately 25%).
- Growth in coverage and prices, not population ageing, will continue to be the key driver of health expenditure.
- However, ageing will increase upward pressure on spending (especially from about 2026), so making it more difficult to constrain spending growth.
- Yet relative compression of morbidity (if it can be achieved) will reduce lifetime healthcare costs and so ease ageing pressure on health spending, constraining total health expenditure growth (by up to 30% of what it would otherwise have been).

Key messages

Policies aiming to maximise the *benefits to society of the ageing population* should focus on interventions to reduce disability rates over time. Reduction in the prevalence of disability (adjusted for severity) will flatten the age–cost curve and so improve intergenerational equity of health expenditure in relative terms. Such interventions are compatible with the Government’s policy of ‘Positive Ageing’.

Improvements in health status will have complex effects on the ageing pressure exerted on health spending, depending in particular on trends in health expectancy relative to life expectancy. Cost-effective interventions that *compress morbidity* relative to mortality have the potential to decrease life-time healthcare costs, and so ease ageing pressure on health expenditure. Investing in such interventions does not necessarily entail a trade-off against life extension—both disability reduction and life extension are desirable and can be achieved, yet it may prove possible to (cost-effectively) accelerate progress in the former relative to the latter.

Policies aiming to reduce the *cost of the public health system* should focus on managing the growth in scope, volume and cost of health and disability support services over time. Coverage and prices are by far the major drivers of health expenditure.

Managing coverage and price growth in future will need to take account of many factors (some of which have been briefly mentioned in this report), and will be made more difficult by the simultaneous increase in ageing pressure. One major factor will be the increasing globalisation of the health workforce, which will put increasing upward pressure on wages and salaries. Greater vigilance will also be necessary in monitoring service coverage and the diffusion of new technologies.

While New Zealand has done well in comparison with other similar countries in controlling capital expenditure and (to a lesser extent) expenditure on pharmaceuticals, we have been less successful in assessing and managing the introduction of other technologies, such as diagnostic tests and surgical procedures. More effort in 'horizon scanning', technology trialling and promotion of evidence-based guidelines for clinical practice may be worthwhile.

Such efforts should aim, wherever possible, at redirecting investment toward cost-effective interventions that will reduce the incidence and improve the management of chronic, disabling diseases and conditions. While population ageing will inevitably make it more difficult to control health expenditure in the future than has been the case in the past; such investment has the potential to constrain spending growth while simultaneously achieving additional population health gains.