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Health Care for the Aging Baby Boom: Lessons from Abroad

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Economic and technical progress in most parts of the world has vastly enhanced both standards of living and the clinical effectiveness of health care. These trends have combined to extend average life expectancy. At the same time, general economic progress has depressed reproduction rates throughout the industrialized world. Consequently, the elderly have come to represent an ever-larger proportion of the population in these nations. In the two decades ahead, that trend that will accelerate. Increasingly, these fruits of economic and medical progress are being discussed as a mixed blessing. In the United States, for example, the impending retirement of the baby boom generation sometime after the year 2010 is now being viewed with the apprehension normally reserved for an impending hurricane.

The economic, social and political challenges posed by the aging of the population are real in many nations, under virtually any set of assumptions about the future. However, cross-national data on health spending on the elderly, to be presented in the following section, suggest that in health care this challenge appears to be manageable, as long as the nation's health system is being managed smartly. Unfortunately, Americans tend to be unimpressed by cross-national comparisons of health systems, apparently on the axiom that American health care is so vastly superior to that anywhere else on the globe as to render any cross-national comparison irrelevant for American health policy. In deference to that sentiment, the cross-national data presented here are supplemented with data on intra-U.S. variation in health spending on the elderly. Jointly, these cross-national and intra-national data suggest that, in the United States, the economic burden of providing

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Table 1
Percentage of the Population Age 65 or Older

Country	*2000*	*2020*
Japan	17.1	26.2
Germany	16.4	21.6
United Kingdom	16.0	19.8
France	15.9	20.1
Canada	12.8	18.2
United States	12.5	16.6
Australia	12.1	16.8

Source: Anderson and Hussey (1999), Chart II-1.

health care for the aging baby boom generation is amplified by a poorly managed and needlessly expensive health system.

Before contemplating the cross-national data, it may be noted that by international standards, the Medicare program for elderly Americans is anything but generous. Elderly Americans at or below the poverty level, for example, spend about 34 percent of their family income on health care (Moon, 1996, Table 1.3). For elderly between 100 and 200 percent of the poverty level, the comparable number is 26 percent. No other industrialized nation now visits that high degree of cost-sharing on its low-income elderly.

Cross-National Data on Health Spending

In their angst over the impending baby boom tsunami, Americans seem unaware that the United States is now among the relatively youngest nations in the industrialized world, and will long remain that way. Only after the year 2020 will the United States attain the current age structure of most European nations and Japan, as shown in Table 1. In 1994, for example, 4 percent of Germany's population was aged 80 or older. In the United States, that ratio is projected to be reached only in the year 2023 (Anderson and Hussey, 1999, p. 8).

Table 2 presents cross-national data on health spending, both per capita and as a percentage of GDP, based on recent data from the Organization of Economic Cooperation and Development (OECD). For convenience, the table also includes data on the percent of the population that is aged 65 and over and on the implied ratio of per capita spending on the elderly to per capita health spending on persons under aged 65. All of the spending data are expressed in U.S. dollars and adjusted for purchasing power parities.

Within any nation, a plot of per capita health spending by age tends to trace out a U-shaped pattern. For example, per capita spending on children in their first year of life is about 2.5 times per capita spending for persons aged 35 to 44; for persons aged 65 to 74, the comparable ratio was 3.5; for persons aged 85 and over,

Table 2
Health Spending and Demographic Structure in Selected Countries, 1997

	—*Per Capita Health Spending*—			*Health Spending as a Percentage of GDP*		
	On all Persons	*On the Elderly*	*Ratio Aged 65+/Age 0–64*	*On all Persons*	*On the Elderly*	*Percent of Population Aged 65+*
United States	$3,925	$12,090	4.4	13.5%	5.0%	12.5%
Germany	$2,339	$4,993	2.8	10.4%	3.5%	16.8%
Canada	$2,095	$6,764	4.8	9.3%	3.6%	12.9%
France	$2,051	$4,717	3.0	9.6%	3.4%	16.0%
Australia	$1,805	$5,348	4.1	8.3%	3.0%	12.2%
Japan	$1,741	$5,258	5.3	7.3%	3.4%	17.5%
United Kingdom	$1,347	$3,612	4.0	6.7%	2.8%	16.1%

Note: Expenditures expressed in U.S. dollars, adjusted for purchasing power parities.
Source: Adapted from Anderson and Poullier (1999), Exhibit 1, and Anderson and Hussey (1999), charts III-1 and III-2.

it was in excess of 5.0 (Cutler and Meara, 1997). As is shown in Table 2, in 1997 the ratio of average per capita health spending for all American elderly to the average per capita health spending for all non-elderly Americans was 4.4. The comparable ratio was higher in Japan and in Canada. It was much lower in Germany and in France.

The observed cross-country differences in the ratio of health spending per elderly to per capita health spending on the young remains if the category of elderly is defined more narrowly as "persons aged 75 and over." For example, in 1993 that category represented roughly the same percentage of the population (slightly over 6.5 percent) in Germany, Switzerland and the United Kingdom. Yet the percentages of these nations' total health spending devoted to persons aged 75 and over were 16, 26 and 27 percent, respectively (Reinhardt, 1997, Figure 9).

While differences in the age distributions within these broader age categories may explain part of the observed variation in the claim of the elderly on total national health spending, another part is likely to be driven by differences in practice styles. Unfortunately, the data available to the author at this time cannot shed light on this issue, which warrants further inquiry.

Casual inspection of the Table 2 suggests that neither the percentage of the GDP that a nation spends on health care on all of its people, nor the percentage of its GDP devoted to health care strictly for the elderly, seem to be driven by the percentage of the population that is aged. In their cross-national study of the effect of aging on social spending, Gruber and Wise (1999, Table 3) similarly do not find any statistically significant relationship between the percentage of a nation's population that is aged 65 or over and total health spending as a percentage of GDP. Although demography matters within nations, by itself it is not a powerful determinant of national health spending.

Whatever marginal impact the observed, cross-national differentials in per

capita health spending may have on health status and longevity, they are not apparent in aggregate measures such as longevity or infant mortality (Anderson and Pouillier, 1998). In spite of the much lower per capita health spending in Canada, for example, Canada's age-specific life expectancy for 65 year-old men and women (16.3 and 20.2, respectively) exceeds the comparable U.S. figures (15.7 and 18.9), as do those for New Zealand, Australia, France and Japan (Anderson and Hussey, 1999, Chart II-3). Nor do American consumers express relatively high satisfaction with their costly health system. As a series of cross-national surveys on consumer satisfaction have shown, a substantially higher proportion of American respondents to such surveys tend to express extreme dissatisfaction with their health system than do other nationals (for example, Blendon et al., 1995). To be sure, these crude indicators of health status and consumer satisfaction are driven by so many factors that correlating them with health spending alone is highly problematic. It should merely be noted that the United States has never ranked high on any of these crude indicators in cross-national comparisons, leaving open the question just what Americans are actually buying with their much higher spending on health care.

One should think that a nation daunted by the task of having to care for its aging baby boom might have at least some interest in exploring how, for example, France and Germany with their already much older populations manage to spend so much less on health care than does the United States, both per capita and as a percentage of GDP. Even more intriguing is the question why neighboring Canada, with a demographic structure similar to that of the United States, spends so much less on health care for all Canadians in general and for elderly Canadians in particular. If it were known that other nations produce jumbo jets or automobiles at vastly lower costs than does the United States, American manufacturers would eagerly search for the factors that could explain these differences. Remarkably, while Europeans and Asians routinely search the globe for health care innovations that might be imported from other nations, the glaring cross-national differences in per capita health spending shown in Table 2 have never triggered much curiosity in the United States.

One can understand why American health care executives find little of interest in health systems that are able to constrain per capita health spending much below American levels. After all, these executives do not have to compete with lower-cost foreign rivals in the health care market. Furthermore, these executives book "health spending" as "revenue and profit." That circumstance alone makes any allusion to foreign health systems appear to them as a threat to their proverbial bottom line.

It is more difficult to understand why public policymakers show little interest in health policies abroad, unless one assumes that they represent in their policy decisions less the general American taxpayer than the providers of health care who have become major contributors to campaign financing. Truly curious, however, is why American foundations, which annually spend hundreds of millions of dollars on health services research, have never shown much interest in research on the

effect that the observed cross-national spending differentials have on clinical outcomes and the quality of patients' lives. To be sure, a few studies on this question have been published; but they are relatively rare and limited in scope, for want of adequate funding.

After a study tour of European health systems, Donald Berwick (1996, p. 2), an internationally recognized expert on quality control in health care, reminded his fellow Americans of the price they pay for this isolationism thus:

> I visited Haukland Hospital in Bergen, Norway. It is a first-rate, academic, high-tech referral center where the equipment, access, ambiance, and service levels seem at least as good as in any comparable American facility familiar to me. What is unfamiliar is its costs. Although the exact figures are elusive, the Haukland Hospital seems to be operating for 25–40% lower cost per unit of service than a U.S. facility would. . . . So why are teams of American managers and clinicians not crawling all over Haukland Hospital to seek clues to solve their local problem of cost and quality? . . . Caesarean section rates in several European countries are one-third those in the U.S., or even less, with better maternal and fetal outcomes. One might predict a stampede of [American] clinicians and managers to these "benchmark" systems, curious to study, learn and copy better ways, but we see at best a trickle of inquiry . . . We [Americans] stand to harvest lessons of immense value from the serious study of organizations and systems far from our own. . . . When our awareness of our differences impedes our learning [from other nations], we pay a high price in missed opportunity.

Several formal cross-national studies support Berwick's (1996) contention. In their comparative study of spending on hospital care in Canada and the United States, for example, Newhouse, Angerson and Roos (1988) found that Canada spent about 50 percent less per capita on hospital care than did the United States, leaving the authors to wonder "what, if anything, the United States bought for that additional expenditure" (p. 12). In a subsequent comparative study on the use of cardiac procedures and outcomes in elderly patients with myocardial infarction, Tu et al. (1997) found that American patients received far more resource-intensive treatments than Canadian patients. But while the 30-day mortality rate was slightly lower in the United States than it was in Canada (21.4 percent vs. 22.3 percent), the one-year mortality rates were identical. *Business Week* recently reported on the so-called "Eurofetus" study, according to which in the United States only about half the patients at risk are being tested with ultrasound procedures that are being tested in Europe (Freundlich, 1997). Even more disturbing was the finding that the procedure, as it is currently applied, "is three times as accurate in Europe as in the U.S.—at a quarter of the cost." According to the study, the difference in accuracy reflects differences in the locus of the procedure. In Europe, the procedure is done mainly in hospitals, by specially trained and certified technicians. By contrast, in the

United States "any doctor can buy ultrasound equipment and begin scanning without special training" (p. 85).

In a recent report, the management consulting firm McKinsey & Co. sought to explain the observed cross-national health spending per capita of Germany, the United Kingdom and the United States by exploring differences in productivity at the microeconomic level of managing four common diseases (McKinsey Global Institute, 1996). The report was the product of a multiyear study conducted by about 20 of the firm's employees, under the tutelage of an outside advisory board of distinguished clinicians and economists. Table 3, taken from Bailey and Garber (1997), presents the gist of the comparison between Germany and the United States.

According to the McKinsey researchers, per capita health spending in the United States exceeded Germany's by close to $1,000 in purchasing power parity U.S. dollars in 1990.[1] The McKinsey researchers report that Germany's *clinical* productivity is actually lower than that in the United States, which they infer from their observation that German patients received more strictly medical inputs (hospitals days, physician visits, prescription drugs, etc.) per episode of the particular illnesses they studied than did their American counterparts, allegedly without any observable difference in clinical outcomes. According to their calculation, the United States actually received $390 (or 26.5 percent) *less* per capita in strictly medical services than did Germany in that year.

On the other hand, the McKinsey team found prices of health services to be much higher in the United States than in Germany. That finding is consistent with Pauly's (1993) earlier study in which he, too, found that physicians, nurses, technologists and other health professionals in other countries of the OECD are paid much less than are their American counterparts. According to the McKinsey study, had the American health system provided on a per capita basis the amount of real care provided in Germany, but at American prices, then the United States would have spent $737 (or 50 percent) more on health care than did Germany. The last two rows show that administrative and "other" costs were also higher in the U.S. health system than in Germany. Overall, the net effect of all differences combined made American per capita health spending in 1990 exceed Germany's by $966 per capita (or 65.6 percent).

The McKinsey team may well have exaggerated the alleged gap in clinical productivity, as David Cutler properly notes in his commentary on the report (Bailey and Garber, 1997). Much of it is inferred from the shorter length of hospital stays in the United States, but the report uses an average cost method to estimate the value of a hospital day, when it is clear that the value of the last days saved in longer German hospital stay are much lower value than the average cost. Be that as

[1] This estimate of the gap may be conservative. The OECD data base reports 1990 per capita in health care spending of $1,320 for Germany and $2,799 for the United States, which implies a difference of $1,479 that is not even adjusted for Germany's much older population (Anderson and Poullier, 1999, Exhibit 1).

Table 3
Decomposition of Differential Per Capita Health Spending Germany and the Unites States, 1990
(U.S. dollars, in purchasing power parity)

Per Capita Spending in Germany	**$1,473**	**100.0%**
Less use of real medical inputs in the U.S.	($390)	−26.5%
Plus higher prices in the U.S.	$737	50.0%
Plus higher administrative costs in the U.S.	$360	24.4%
Plus "other" higher costs in the U.S.	$259	17.6%
Total additional costs per capita in the U.S.	$966	65.6%
Per Capita Spending in the U.S.	**$2,439**	**165.6%**

Source: Bailey and Garber (1997, Figure 10).

it may, even if one takes the McKinsey numbers at face value, one is struck by the fact that more than the entire cost saving attributable to the allegedly superior American *clinical* productivity ($390) is absorbed by the American system's much higher administrative costs ($360) and by whatever items hide in the catch-all category "other" ($259). In the study, the latter category was described as "differences that were unaccounted for by differences in input quantities, input prices and administrative costs" (McKinsey Global Institute, 1996, p. 8–10).

Moreover, the administrative costs estimated by the McKinsey team do not even include the cost of the countless hours American households spend on choosing among health insurance plans and on claims processing. Nor does that cost estimate include the considerable costs employers must absorb to manage their employees' health insurance. According to a recent study by Towers Perrin (1999), that overhead burden amounts to anywhere from 6 to 15 percent of the total premiums employers pay for health insurance, depending upon the type of insurance product. While the premiums do become part of measured total national health spending, the employer's overhead for employee benefit management does not.

Curiously, the McKinsey team saw in its findings reasons to urge upon Germany the type of health reforms that the United States had initiated during the first half of the 1990s (and which that management consulting firm evidently could help Germans initiate). They conclude that the American health system is more "productively efficient" than either Germany's or the United Kingdom's, and thus should be emulated (McKinsey Global Institute, p. 8–10; Bailey and Garber, 1997). The McKinsey team confidently predicted in 1996 that "Germany's productivity gap with the U.S. . . . is widening" (p. 6). If that prediction were on the mark, one should have observed a narrowing of the per capita spending gap between the two countries. However, during the 1990s this spending gap actually widened. According to the most recently published OECD data, by 1997 Germany spent $2,339 per

capita on health care and the United States spent $3,925, or 68 percent more (Anderson and Poullier, 1999).

To pretend that there is no connection between administrative overhead and clinical productivity would be bold; surely, to some extent the higher U.S. spending on administrative overhead surely enables health care professionals to focus on their jobs. There is bound to be a tradeoff between the two and an optimal point on that tradeoff frontier. In the present case, one may well ask whether overall social well-being in Germany (or in the United States, for that matter) would be enhanced by wringing ever more clinical productivity out of the health care delivery system, to the point of severely demoralizing the health work force along with patients, only to fritter away the achieved savings in added administrative overhead and other overhead. The McKinsey team in this instance, and health policy analysts in general, pay insufficient attention to this tradeoff. With a wave of the hand, American health policy has always abstracted from transactions costs, as if they were somehow not relevant to the efficiency of total health spending. In fact, transactions costs represent real resources.

Along with other nations, the United States is now engaged in a massive research effort on "evidence-based medicine." The objective of evidence-based medicine is the discovery of best *clinical* practices. In view of the extraordinarily high administrative overhead loaded onto the American health system, it is remarkable that there has been almost no research on evidence-based administrative practice. A major assault on that economic problem seems long overdue.

Intra-U.S. Variation in Health Spending

An assumed global superiority of American care has led Americans to question the policy relevance of data from other nations' health systems. It is therefore illuminating to supplement cross-national data with intra-American data on health spending.

Table 4 presents inter-county variations in total Medicare outlays per Medicare enrollee in 1996. These per capita spending figures have been adjusted for inter-county variation in the age and gender composition of the elderly, in health status indicators and in the cost of operating medical practices. Even after these statistical adjustments, Medicare outlays per elderly still vary by a factor of two across counties.

Medicare uses a common fee schedule for physicians and hospitals, with only minor interregional adjustments for the cost of practice. For the most part, the observed differentials in per capita spending therefore reflect differences in the use of health services. In 1996, for example, 49 percent of Medicare patients in Miami, Florida, were admitted to the intensive-care unit in hospitals during their last six months of life. The comparable numbers for Minneapolis, Minnesota, and Portland, Oregon, were 23 and 22 percent, respectively. The price-adjusted total Medicare reimbursement for inpatient care during the last six months of an elderly

Table 4
Total Medicare Outlay Per Enrollee, 1996, by Hospital Region

Miami, FL	$7,783	100%
Tampa, FL	$5,658	73%
Tallahassee, FL	$4,958	64%
Baton Rouge, LA	$7,700	99%
New Orleans, LA	$7,317	94%
Shreveport, LA	$3,923	50%
New York City	$6,055	78%
Buffalo, NY	$4,199	54%
Albany, NY	$4,026	52%
Rochester, MN	$4,148	53%
Duluth, MN	$3,760	48%
Minneapolis, MN	$3,700	48%
Bend, OR	$4,213	54%
Portland, OR	$3,923	50%
Eugene, OR	$3,506	45%

Source: Wennberg and Cooper (1999, end table to Chapter 1).
Data are adjusted for interregional differences in age, gender, health status and practice costs.

patient's life in Miami was $15,000. The comparable numbers for Minneapolis and Portland were $7,775 and $7,285, respectively. Finally, such patients received 48 physician visits in Miami, but only 13 in Minneapolis and 12 in Portland (Wennberg and Cooper, 1999, ch. 6).

The spending variances shown in Table 4 have been known for decades to health policymakers in Congress. One would think that a government which frets incessantly over the economic consequences of an aging population would have shown a keen interest in understanding what differences these variances make to the health care and well-being of the elderly, and which of these numbers should be used as a benchmark for projecting future outlays by Medicare. After all, if during the next decade or two the providers of health care in the high-cost areas of the country could be induced to adopt the more conservative practice styles of their colleagues in the lower-cost regions, then the fiscal problem posed by the aging baby boom would be considerably less onerous.

Remarkably, the U.S. Congress has never shown much interest in the clinical significance of these medical practice variations. It seems to accept them as a state of nature. Although the pattern of financial flows triggered by Medicare over the years is unlikely to have been the product of a deliberate attempt at regional income redistribution, the health systems in the different regions now have come to rely on these flows. Trimming these flows in the high-cost regions probably would be politically delicate even if it could be established, from a strictly clinical viewpoint, that these regions use health care excessively (Vladeck, 1999).

The large geographic spending variations under the Medicare program, however, will stand in the way of current proposals to privatize Medicare. Whatever the particulars of these proposals may be, all of them would allow the elderly to opt out

of the traditional Medicare program into a private health plan. The traditional Medicare program would continue to exist for those choosing to remain in it, or as a permanent fallback program for elderly who had ventured into private insurance but might want to return to the traditional program. All such proposals require Medicare to make annual, risk-adjusted lump sum payments to the private health plans that are chosen by the elderly. A central question confronting any such proposal is whether these lump-sum payments should perpetuate the geographic spending variations long tolerated by the Congress. If so, they are likely to cause a political backlash, for these geographic differentials seem inequitable on their face.[2]

Whose Income is Medicare Spending?

Because rival claims to that fraction of real output that is commercially traded are exercised by tendering money, it has become customary to frame the problem of resource sharing by the young and old mainly in terms of these monetary claims. Consequently, we rarely mention real resources at all in our debate on the aging population. Instead, we worry about the future account balances of the Social Security and Medicare trust funds and about the private retirement savings accounts that could supplement the financial resources that the elderly receive from the public funds. Once the problem of allocating real resources has been translated into its monetary facet, it seems natural to lump Social Security and Medicare together and to treat Medicare spending on health care for the elderly simply as part of a large transfer of income from the working population to the elderly (Vogel, 1999).

That approach may be useful in some contexts. It can also be misleading, however, because there is a distinct difference between funds transferred to the elderly through Social Security and funds that flow through the Medicare program. Social Security payments bestow upon the elderly generalized monetary claims on all of the goods and services traded in the entire global marketplace. The elderly can use that generalized purchasing power in any manner that maximizes their own utility. In the process, the elderly do lay claims on real resources, of course, but those claims truly originate in their own decisions.

By contrast, tax-financed spending on health care does not become generalized purchasing power in the hands of the elderly. It flows directly from some members of the working population to other members of the working population,

[2] Since the mid-1980s, the elderly have been able to enroll in qualified health maintenance organizations (HMOs). To this day, the lump sum payments made to these HMOs on behalf of their Medicare enrollees are based strictly on the average per capita spending Medicare experiences under its traditional fee-for-service program in the elderly's county of residence. Although that arrangement has long been tolerated by the public, the Minnesota Senior Federation has recently filed a class action suit challenging the legality of these differentials. Minnesota Attorney General Mike Hatch has joined the lawsuit. See Howard (1999, p. 20A).

intermediated by the elderly only to the extent that they decide to contact the health system and to acquiesce in the treatment dispensed to them by that system. Although that intragenerational income transfer also will shake loose real resources that flow to the elderly, it is an open question to what extent the elderly actively *claimed* these real resources on their own volition or merely *accepted* them as trusting patients (often as comatose and dying patients). Is it at all reasonable to assume that 75 year-old women in Baton Rouge actively claim, *with their own decisions*, twice as many real health care resources for themselves than do 75 year-old women in Minnesota and in Oregon?

In forging Medicare policy, Congress has always been highly responsive to those members of the working population who book health spending as income, often at the expense of taxpayers paying into the Medicare trust fund. To illustrate this point, in 1995 policy analysts recommended that Congress combine the hitherto separate payments Medicare made for acute and post-acute inpatient care into one payment made to the hospitals, and to let hospitals make the clinical and economic decision whether to render post-acute care within the hospitals' walls or in freestanding skilled nursing facilities. The proposal was controversial, because the artificial division of an inpatient episode into "acute" and "post-acute" care had given rise to a fast-growing, highly profitable skilled nursing facilities industry that was reimbursed by Medicare on a retrospective, cost-plus basis. Because the average occupancy ratio in American hospitals is about 60 percent, the leaders of the budding skilled nursing facilities industry vehemently opposed the proposed policy, fearing that with bundled payments, hospitals would prefer to deliver post-acute care in their own excess hospital beds, rather than shifting patients to free-standing skilled nursing facilities.

Analysts for the House Budget Committee had estimated that bundling the two separate payments into one would yield Medicare savings of $19.3 billion over a seven-year period. Even so, in the end this eminently sound idea died in the relevant appropriations committee. As one prominent member of that committee remarked before an assembly of the American Health Care Association (Gardner, 1995, p. 12), the trade association of skilled nursing facilities, combining the payments would "cut off a very healthy, vibrant area" of the health care economy—home care, skilled nursing facilities and rehabilitation providers." Speaking to reporters after the meeting, the Congressman stated: "I'm not wild about a payment system that involves telling a bunch of innovative entrepreneurs that they can't be in the business anymore."

To be sure, Congress's decision not to combine acute and post-acute payments did serve to draw added real resources into newly built skilled nursing facilities that were fiscally nourished by the existing policy. But it can it be said that the elderly actively *claimed* these real resources, with their own disposable income, and on the basis of their own informed decision? In their *The Quality of Medical Care in the United States: A Report on the Medicare Program*, Wennberg and Cooper (1999, pp. 2–3) cite the National Roundtable on Health Care Quality of the Institute of Medicine as follows:

> Serious and widespread quality problems exist throughout American medicine. These problems, may be classified as underuse, overuse and misuse. . . . Millions of Americans are not reached by proven, effective interventions that can save lives and prevent disability. Perhaps an equal number suffer needlessly because they are exposed to the harms of unnecessary health services.

David Cutler remarks on this point as well in the present symposium.

It seems odd to assume automatically that an elderly person's income has risen when Medicare uses the taxes paid by some members of the working population to increase payments to other members of the working population, especially if some of the health services rendered as part of that tax-and-transfer scheme are of dubious or no clinical value.

Concluding Remarks

At its core, the problem of aging populations involves the political economy of sharing among the young, the working population and the old the potential real output that could be had from an ever expanding real resource base. The real burden that health care for the elderly will impose upon the working population, for example, consists of the human and non-human real resources that the working population must devote to caring for the elderly, rather than producing output for the younger generations. The word "must" in this context refers to the minimum package of real resources required to deliver to the elderly health care judged adequate by the polity. If the working generation chooses to waste real resources in this process, to trigger added income transfers within the working population, that gives the word "burden" quite another meaning.

Ideally, the debate on the real economic burden of aging should be conducted mainly in terms of real variables. With regard to health care, for example, that debate should focus on the real resource transfers that are actually needed to render adequate care to the elderly. A good starting point in that debate might be to explore why that real resource use now varies so much within the United States and across nations. If Americans could set aside their innate pride in matters of health care, they might on this point learn a useful lesson or two from the experience of other nations.

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