As an ageing baby boomer myself, perhaps I should declare my interest. Like most people, it’s not my ambition to be a burden on the health and aged care systems, although I confess to an increasingly intimate relationship with the pharmaceutical industry – all in order to stay healthy, mind. It’s good to see that the doomsday approach of the first Intergenerational Report (2002) – ‘we’re about to drown in millions of pesky empowered oldies’ – has been toned down a bit in the latest one (2010).

But the projections are still scary. Health and aged care spending, plus increased pension payments, remain the major future pressures on the federal budget, with Federal health spending estimated to almost double in GDP terms over the next 40 years (from 4.1% to 7.1% by 2050); Federal aged care spending more than doubles (from 0.8% to 1.8%); and age and service pensions increase by almost half (from 2.7% to 3.9%). Total national Government spending goes up by only 1.1% of GDP over the 40 years (that is, of course, a lot of dollars), but together, health, aged care and pensions grow to be nearly half of that total Federal spending. The main shrinking sectors are defence and education.

But don’t leap to the conclusion that we really ought to send every third baby boomer out to the desert to die cheaply – less than half of the predicted increase in spending is due to population growth and ageing combined. The rest comes from ‘demand for higher standards of care’ and ‘rapid technological innovation’ (p51) which presumably benefit everyone, not just the oldies.

There are two important omissions in the report’s extensive modelling of our health and aged care futures. Firstly, for the frail and bewildered aged, there is an assumed trend away from low-care residential places to community care (with a matching increase in the costs of support for carers) – let’s hope they’re right about that. But there is no recognition of caring responsibilities as a barrier to workforce participation by older people (p30) – Treasury needs to talk to older women more. Secondly, the projections of hospital costs appear not to include any thought of change to the admission rate of older people, particularly those over 85, for whom it is desperately high. We need to do more than hope that they’re wrong on that one. While it’s not for Treasury to figure this out, it would be pretty awful if we are not able to do anything in the next 40 years to change the way that we deal with the last years of life.

I will never forget seeing a group of five elderly ‘long stayers’ on a visit to an adult ICU – all of them were going to die; and only one was conscious. That one had declared her intention to stop treatment and she was on her way home. The others were not able to speak for themselves and, for different reasons, no-one else was able to speak for them. They seemed destined to stay there – not a good place or way to die. Given the choice, I think more than half of us would rather be that one who could and did decide.

Here is where the baby boomers might pay their way – we might be able to seize more control of our endings, and achieve gentler good nights than our elders are currently allowed. And that means more focus on making Advanced Care Directives* workable, and more provision for timely serious discussion with one’s healthcare providers. Activism may again be required, but we’re good at that – provided we get to it while we can still remember what it was.

*See Patrick Bolton’s article in this issue.