EMERGING PATTERNS OF SOCIAL PROTECTION IN AUSTRALIA

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I. INTRODUCTION.

Contemporary social protection and associated policy settings for the ‘new longevity’ of society (Ellison, Schetzer, Mullins, Perry and Wong, 2004) must take account of demographic, economic and cultural change. Alterations in family formation and dissolution, the rising incidence of dementia associated with ageing (Access Economics, 2003) and compositional changes in the workforce—are among the many forces contributing to law and policy reconfigurations of social protection. The capacity of civil society, especially women and daughters, to continue to carry the gendered load of informal care is also diminishing due to changed employment patterns, transitions in job mobility and career aspirations (Hancock, 2002).

Some international organisations—particularly the International Monetary Fund (IMF), the World Trade Organisation (WTO) and the World Bank—have promoted neoliberal policies which privatise and personalise welfare risk; for example, through prescriptions for ‘defined-contribution’, individualised retirement income accounts and international ‘social development’ initiatives at odds with ‘welfarist’ traditions (Page, 2004: 39). The ILO has maintained more solidaristic policy settings (Deacon, 2007; Ramia, Davies and Nyland, 2008), but voices...
effectively contesting neoliberal policies have been few (McGillivray, 2003: 417; Ramia and Wailes, 2006).

Australian social policies for people of workforce age elevated neoliberalism through ‘work-first’ approaches under the former Howard Liberal/National Coalition (conservative) Government of 1996 to 2007 (Carney, 2006c; 2007c; Carney, Ramia and Chapman, 2007; Carney, 2008a). Decentralist neoliberal reforms were also pursued in labour law, intensifying the combined effects of the two policy settings (Carney, 2005b; 2006c; 2006b: Ch 7).

Retirement income policies in Australia over recent times have retained the tradition of widespread coverage offered by the flat-rate, state-funded and means-tested age pension. This is one of three sources of retirement income alongside occupational and private pensions, or in Australian parlance, ‘superannuation’ schemes. In 2006-07 income transfer payments totalled AUD $71.6 billion (or 6.8 per cent of GDP), of which the largest share was devoted to the aged pension ($26.1 billion or 2.5% of GDP) (DFaHCSIA, 2008: 2). Parametric changes to expand ‘choice’ and favour defined-contributions arrangements over defined-benefit schemes, have to date been confined to the other two possible sources of retirement income: mandatory contributions to the ‘Superannuation guarantee’ arm of policy; and private superannuation. This is something of a distinction without a difference perhaps, since the age pension already complied with the World Bank’s prescriptions for the ‘safety net’; other than its comprehensive means-testing which includes superannuation income, thus weakening the combined value of age pension and other superannuation income streams. The 2008-09 Pension Review may lead to changes in 2009 to government pension payments, such as increased rates for singles (DFaHCSIA, 2008).
With the exception of State and Territory\textsuperscript{2} ‘workers compensation’ payments (re-named as ‘Work Cover’ in the State of New South Wales, for example), or common law damages payments for occupational injury—all main medical and health benefits are provided under ‘Medicare’, the national universal health care system (see below). Few worker’s compensation or damages awards are the result of contested hearings and judgments. Instead most often a compromise is reached to ‘settle’ cases before hearings. All such settlements are caught by a federal cost-shifting rule that deems half of the settlement to be monies for ongoing living support, serving to preclude payment of any social security for the period of time covered (the number of ‘weeks of preclusion’ achieved by dividing half of the value of the compensation award by a weekly rate of social security only slightly greater than the standard payment) (Carney, 2006b: 164-68).

Parameter changes to Medicare in anticipation of an ageing population have been less than significant, being confined mainly to encouraging young people to take out supplementary private health cover, principally by setting higher ‘penalty’ rates surcharges for those joining later in life, and in the case of aged care by way of changes to ongoing and capital works funding of residential aged accommodation.

In August 2008 the Government announced a Departmental Review of the Age Pension, due to report by February 2009, as part of the broader review of the Future Tax System announced by the Australian Treasurer in May. The focus will include the pension rates for people who do not own their own home, such as single pensioners, private renters and those who were unable to save for retirement or supplement the pension with part-time earnings due to age, disability or carer responsibilities (DFaHCSIA, 2008: v). Policy changes based on the report of this review are anticipated in the first half of 2009.

\textsuperscript{2} As explained in the next section of the report, these are the two categories of sub-national or provincial government in Australia.
The challenge of ‘succession planning’ by ageing parents of middle aged offspring with disabilities, however, remains poorly addressed due to under investment in services or crafting of special case exceptions to tight means testing of social security (Carney and Keyzer, 2007a; 2007b).

Taken in their entirety, measures to deal with demographic change in Australia indicate efforts to increase self-reliance on the part of dependent populations. As discussed in the text of this report, while there was no revolution in social protection change under the previous conservative government led by John Howard, a stronger form of neoliberalism was discernible. This acted to test the social democratic credentials of the incoming Labor government led by Kevin Rudd, which has been in office since November 2007.

1. Legal framework.

Australia began as a British colony, before the self-governing States came together in a federation in 1901. This resulted in two tiers of government—the national (‘Commonwealth’ or ‘Federal’) government and State (and ‘Territory’) governments—each level having its own legislative, executive and judicial branches of government. Both levels of government follow the ‘Westminster’ model, and are elected by full adult suffrage.

Australia is a common law country. A peak court—the High Court of Australia—adjudicates on constitutional matters, including defining the content and boundaries of the respective powers of the Commonwealth and State governments. The High Court is also the final court of appeal on all legal questions, hearing appeals from the peak courts of the States or Territories, which are called Supreme Courts.

There is no Federal or State Bill of Rights, other than the Human Rights Act 2004 in the Australian Capital Territory (the seat of national Government) and the Charter of Human Rights and Responsibilities Act 2006 in the State of Victoria, which cover civil and political rights and adopt the more ‘persuasive’ model which leaves Parliamentary discretion to override adverse rulings. Other
jurisdictions may follow. Western Australia published a consultative report on a draft *Human Rights Bill 2007* (WA, 2007), but is awaiting likely federal developments, while the Tasmanian Report recommended a model similar to Victoria, but *including* economic, social and cultural rights (Tasmania, 2007: Rec 15, pp 118-122). While Queensland and NSW have decided against such legislation, social and economic rights like that relating to welfare are stated in imprecise and conditional, or ‘aspirational’, form due to their resource implications; so such instruments may be but weak at best (Carney, 2006a).

Since the 1970s there has been an extensive and popular federal system of administrative review of departmental decisions about citizens’ entitlements to government largess. Tribunals hear reviews and hand down decisions based on the merits (that is to say ‘stepping into the shoes’ of) the original decisionmaker. The Tribunals are independent, multi-disciplinary, and applicants incur minimal cost for proceedings (Carney, 1996; 1998). State tribunals offer similar avenues in many areas.

**a. Constitutional powers.**

Under the *Australian Constitution*, the Commonwealth Government is responsible for defined functions, including defence, foreign relations, customs, taxation, trade and commerce, and certain other matters. Unless the topic is one of those listed in the *Constitution*, only the States can make a valid law about it. However, if the Constitution does allocate a topic to the Commonwealth, then its laws will prevail over any inconsistent State laws.

Until 1946 the Commonwealth Parliament was restricted in the field of social welfare mainly to making laws about age and disability pensions, and veterans affairs. Following passage of a referendum to amend the *Constitution* in that year, the Commonwealth acquired additional power to make laws about

S 51 (xxiiiA) The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances.
As a consequence of its passage, the national government was able to introduce its Pharmaceutical Benefits Scheme (PBS) and later its universal health care system, called ‘Medicare’.

**b. Legislative provision.**

Current income transfer programs such as the age pension or carer payments are mainly grounded in the 1946 transfer of State to Federal power (Carney, 2001: Ch 1), which supports the enactment of the *Social Security Act* 1991 (Cth) and the *Social Security (Administration) Act* 1999 (Cth) in providing for such payments. Family payments, including child care benefits, are separately provided for by other legislation.

Community services, such as Federal involvement in aged care and education, rely on the power to attach conditions to financial grants (Carney & Hanks, 1986). This is the basis for the *Aged Care Act* 1997 (Cth), which regulates the terms on which residential aged care is funded (or ‘nursing home’ and ‘hostel’ care, as it was formerly known).

States and Territories, exercising their otherwise plenary powers for the ‘peace and good order’ of their citizens, are able to pass laws in all other spheres, such as those regulating ‘retirement villages’ catering for healthy and active aged who wish to acquire more suitable housing within a community of older people, but who do not meet the tests for federally-subsidised residential aged care (Lewis, 2004: 235-254). States and Territories are also responsible for the legal regulation of professions and the framework governing the operation of state-run or private hospitals.

States and Territories are also responsible for provisions for private planning of affairs through durable (‘enduring’) powers of financial/property attorney or of personal guardianship (Carney, 1999a), as well as the tribunals which provide for substitute decisionmakers to be appointed (‘adult guardianship’) (Carney, 1997).
c. Common law provision.

In Australia nearly all the entire body of law on social protection is statutory. The common law does not speak extensively to retirement policy issues, other than in clarifying the meaning of terms and concepts adopted in major legislative initiatives such as those outlawing discrimination on the basis of age, or imposition of mandatory retirement ages (for details, Carney, 2007a). There is no constitutional counterpart to the US distinction between laws sourced in the so-called ‘police power’ (in the interests of the health and safety of citizens generally) and the protective *parens patriae* power which underpins their guardianship or committal laws (Kapp, 1996: 468).

The main areas where the common law does have potential influence include the equitable doctrines which allow higher courts to set aside oppressive contracts or other transactions, including those entered into by people with vulnerable mental capacity or as a result of unreasonable pressure (Burns, 2002; 2003; Lewis, 2004: Ch 4).

d. Administration (‘institutional framework’).

As explained below, social security policy is made on advice from a federal department of State, the Department of Families, Housing, Community Services and Indigenous Affairs (‘DFaHCSIA’), but it is administered by a statutory corporation, called ‘Centrelink’, which is contracted by various Departments (including Veterans Affairs) to operate as a ‘service delivery agency’ for claims and payments; while job-matching services (PES) are now fully contracted-out to a ‘quasi-network’ of not-for-profit and profit-making providers (Carney, 2005a; 2008a).

Health and medical costs under the Medicare scheme or the cost of drugs under the Pharmaceutical Benefits Scheme, along with residential aged care (and home support ‘packages’), are the responsibility of the federal Department of Health and Ageing. The Department operates in association with several ‘partner’ agencies (particularly the delivery agency ‘Medicare Australia’ within the Human Services Department) including the Private Health Insurance
Administration Council, or the Aged Care Standards and Accreditation Agency Ltd. Health services delivery, however, is effectively in the hands of the relevant professionals—medical practitioners or pharmacists in private practice: salaried doctors or fee-for-service consultants in hospitals—or, in the case of residential aged care, is the responsibility of the for-profit or not-for-profit aged care providers. In other words, it is a ‘mixed economy’ in these spheres.

Apart from the normative power of conditions and regulatory frameworks laid down as conditions of subsidy (or related heads of federal law-making power), much of the regulatory framework, and much of the administrative accountability for policy, arises under State and Territory laws or their relevant Departments of State and associated agencies. Laws regulating prescription and non-prescription medications come under this category. The same is true for the professional registration boards.

e. ‘Types’ of law (‘legal instruments’).

The source or form of relevant law discussed in this Report, as already explained, is virtually all to be found in various legislative instruments: Acts of Parliament, regulations or standards issued under those Acts; or ‘government contracts’ authorised by law (or imposed as templates), including Federal-State ‘Agreements’ in areas where legislative and administrative responsibilities are shared by two levels of government.

For purely analytical purposes, it is possible to classify those laws as being variously protective, supportive, preventive, or empowering (Doran, 2003). Some laws are protective, such as common law relief from enforcement of oppressive contracts for the elderly (Lewis, 2004: Ch 4), or the protective aspect of adult guardianship (Carney and Tait, 1997; Carney, 2003). Social security and residential aged care are examples of supportive laws, while the ability to sign a ‘durable’ or enduring power of attorney for future management of property (or personal affairs in many instances) is a good example of a preventive function (Creyke, 1993; Carney, 1999a). Empowerment is instanced by laws securing rights of residents to participate in management of aged care or retirement
villages (Howe, 1997; Whitton, 2001), or even rights of merits review of decisions. Regardless, however, it is worth repeating that the Australian welfare rights framework is thin (Carney, 2006a).

Most laws serve mixed functions, however, muting the value of such analytical distinctions. More pragmatic typologies can be applied, such as the descriptive distinction between constitutional, statutory and common law origins (Kapp, 1996: 467-68); but in the absence of anything meaningful in the first of these, this is of no real assistance. That leaves the functional ‘roles’ of law (Kapp, 1996: 469), such as: prevention and harm-mitigation (e.g. laws controlling research on demented patients); financing programs (like medical or aged care services); controlling and regulating human resources (by educating or licensing/accrediting staff); ensuring acceptable quality of services (as under Australia’s aged care laws); and securing personal rights (e.g. the right to give advance instructions anticipating future loss of capacity, or laws protecting informed consent). However this taxonomy is too bland to be of much assistance in charting the future in the social world of the ‘new longevity’.

So at best there may be some limited value in adopting Doran’s (2003) more ‘goal-oriented’ approach by asking whether or to what extent particular laws continue to express the ‘security’ and support characteristics of a ‘welfare state’, rather than the neoliberal values of personal responsibility, private provision/ordering, and family support.
II. AGEING OF THE POPULATION AND ITS IMPACT ON PENSION SYSTEMS.

Population ageing is a definitive reality for legal and policy authorities in Australia to deal with. However, its impact is mild compared to that experienced in Japan or parts of Europe (Takayama, 2003: 203). Europe’s health systems are facing pressures associated with an ageing population and falling birth rates:

This double demographic challenge, of ageing and of declining population numbers, will in turn lead to a rise in the so called old age dependency ratio. While today there are about four persons of working age for every person over 65 within the EU, there will be not quite two in 2050, changing the ratio from 25 percent to over 50 percent (Rynning, 2008: 299).

While the pressures of accommodating new medical technologies and issues such as finding the optimal design for financing health also play a part (ibid, 300), ageing remains a major vector (Imai, Fujii, Fukuda, Nakao and Yahata, 2008).

1. Ageing of the population profile.

By 2021 the number of Australians over 65 years of age is expected to rise to 18.7 per cent (4.47 million), up from 13.3 per cent or 2.73 million in 2006 (Victoria, 2008: 2). This is slightly greater than the 4.2 million predicted for 2021 in the 2003 report by the Australian Institute of Health and Welfare (2003: 280). By 2051 older residents are projected to reach 25.6 per cent of the population, or 7.28 million (Victoria, 2008: 2).

Whereas Australia’s demographic profile previously resembled a pyramid or ‘beehive’—with larger younger cohorts topped by comparatively tiny aged cohorts—it is being transformed to resemble a ‘coffin’, to use the Productivity Commission’s metaphor (Productivity Commission, 2004: 6). The general evening out in the sizes of age cohorts is slowed at the top of the gradation by the rising numbers of people in the oldest age groups—rates of growth are proportionately largest for the over 80s—while lower fertility patterns have shaved the child and adolescent populations at the bottom of the gradation.

Given the historic youthfulness of Australia’s population profile and its high migrant intakes, this trajectory of population ageing is mild by world standards, matching that of the USA. By 2050 it is predicted that Australia will still rank only
53rd of 193 countries in terms of high age ratios (Productivity Commission, 2004: 11); by then experiencing age dependency ratios akin to those currently found in many parts of Europe. Currently Australia’s population ageing is nowhere near as dramatic a challenge as that in countries such as Japan or Sweden (Australia Treasury, 2004a).

2. Trends in demographic ageing.

Australia’s historically delayed and somewhat unpredictable conversion from being an artificially youthful society to one comprising high proportions of older people, is a product of many factors. Chief among these are the flow-through effect of the post-war cohort of ageing baby boomers, fluctuations in migration and birth rates, and medical advances (McCallum, 1997; Borowski and McDonald, 2007: 21).

a. Fertility.

Fertility in Australia has declined steadily ever since the post war ‘baby-boom’ generation, so most of its impact is already in the pipeline.

In 1921 the ‘total fertility rate’ (Borowski and McDonald, 2007: 21) stood at 3.1 births for each woman of child bearing age, dropping to 2.1 in the Great Depression and building to a peak of 3.6 in 1961, from which point it declined quite sharply and stabilised from 1976 onwards at a level below the replacement rate of 2.1, most recently standing between 1.73 and 1.76 (Ibid, 21-22; Productivity Commission, 2004: 19). Consequently, fertility decline, rather than the ageing of the baby-boomers (whose presence delayed the ageing of the demographic profile) is principally responsible for the projected ageing of the profile over the next 40 years (Borowski and McDonald, 2007: 22). Although the Productivity Commission’s (2004: 3) prediction of a decline to 1.6 births by 2011 has proved unduly pessimistic for reasons canvassed by Borowski and McDonald, below replacement fertility immediately translates into higher proportions of the aged, when other factors are set aside.
The factors that are likely to shape Australia’s demographic profile over the next fifty years include the state of the economy and the supply of labour, changing social attitudes to child-bearing, the level of immigration and rising life expectancies (McDonald, 2007). Taking these factors into account, and assuming a reasonably prosperous economic future, a life expectancy of around 95 years, variations in immigration and the fertility (either remaining constant at 1.8 births per woman or decreasing to 1.3 births per woman), McDonald (2007: 44-49) predicts that the percentage of Australia’s population aged 65 years or over in 2049 will be between 28.2 and 32.2 per cent of the total population. The low fertility projection, resulting in the figure of 32.2 per cent of aged, would be accompanied by a 20 per cent decrease between 2004-49 in the number of people aged 25-39, which would result in labour shortages and, consequently, make it difficult to provide necessary care for the aged (ibid: 38; 49).

The fertility rate is closely tied to prevailing economic and social conditions especially in so far as they shape women’s attitudes to child-bearing (see generally McDonald, 2006). Indeed, contrary to perceptions that the lower fertility rate is merely the result of women exercising a preference for having no, or fewer, children, it is rather that institutional constraints, in particular the difficulty in balancing further education and career goals, make it difficult for women to have children (Lee and Gramotnev, 2006: 18).

b. Death rates.

Death rates themselves have been falling for some time, but over the last three or four decades the health and other improvements have extended lifespans for people towards the end of life (immediately increasing the numbers of older people) rather than reductions in infant mortality which take a generation to fully work through the demographic profile (Borowski and McDonald, 2007: 24). Indeed approximately a million people are now alive who would have died, had the mortality rates of the 1979s not since declined. This significantly boosts the size of the current aged cohort (ibid).
Crude death rates—not adjusted for the demographic profile—dropped from 12.2 per 1,000 in 1901 to 6.6 per 1,000 by 2001 and fell further to 6 in 2006, the last available year (ABS, 2008: Table 1). When adjusted for the rising numbers of older people in the population (the ‘standardised death rate’), death rates almost halved in the three decades to 2001 (down from 10.5 in 1971 to 5.4 in 2001). This is mainly due to declining infant mortality (Productivity Commission, 2004: 13).

c. Life expectancy.

Australian life expectancy is more than 30 years greater than it was in the 1880s (Productivity Commission, 2004: 13). It is among the highest in the world, and rose by 4.7 years for males and 3.3 years for females over the period 1988 to 2003 (AIHW, 2007: 2). Over the decade 1997-2007, life expectancy at birth rose by three years for males (from 75.7 to 78.7 years) while for females it rose by a little over two years (from 81.4 to 83.5 years) (ABS, 2008: Table 1). By way of perspective, in 1901-10 male life expectancy at birth was just 55.2 years (Borowski and McDonald, 2007: 24).

As the Productivity Commission pointed out, but for increased longevity, the aged dependency ratio would merely double by 2050, rather than roughly quadruple as anticipated (Productivity Commission, 2004: 15). Some models suggest that the projected rises in longevity may still have been underestimated (Borowski and McDonald, 2007: 25).

3. Future projections.

Because older workers have lower labourforce participation rates, the ageing of the demographic profile, and expected doubling of those over 65 by 2044-5 to comprise around a quarter of all Australians, will likely see aggregate workforce participation rates decline.

The Productivity Commission predicted that the then participation rate of 63.5 per cent may decline 8 points to around 55.4 per cent (Productivity Commission, 2004: xviii, xxvii), or 11 points below where it would be projected to
be were it not for the ‘ageing effect’ (ibid, xxvi). These trends necessarily narrow the size of the group of working age taxpayers available to pay for whatever services may be needed by retirees or other dependent members of the community; including declining numbers of young people.

Various government initiatives in recent years have sought to counteract such declines in workforce participation by encouraging older workers to remain in the workforce in some capacity, or maximise their hours. This has seen strong increases in participation rates by mature workers, which rose by 6.2 percentage points between October 1996 and 2006 (AIHW, 2007: 88).

4. Migration effects.

Migration served to delay the pace of ageing of the Australian population profile, but the large intakes after World War 2 now also contribute to high numbers of current retirees who were born overseas, largely offsetting the initial de-ageing effect.

As international competition for migrant settlers has become more intense, Australia has maintained and indeed increased its quotas for migrants and refugees. Net migration added between 46,500 and almost 118,000 a year between 1993-94 and 2003-04 (Borowski and McDonald, 2007: 26-27), but the contribution to the slowing population ageing is now very small. Rather, it is the contribution made by this and other streams of longer-term temporary workers to the economic capacity of the country which has been more significant in recent years.

Thus, in recent years Australia has granted work rights to approximately 100,000 backpackers from countries deemed at low risk of overstaying their 12 month ‘working holiday maker’ visas (Parliamentary Library, 2006: 12-13). The temporary business (long stay) ‘457’ visa has also enabled around 50,000 overseas workers and their families to enter Australia each year to fill skilled occupations under the sponsorship of approved businesses—though not labour supply agents—for renewable periods of two years, subject to meeting identified
skills needs and minimum salaries; and with rights to apply for permanent residence (ibid, 16-17).

A small guest worker scheme for people from four Pacific nations was announced in mid 2008, but Australia has otherwise maintained its focus on policies of building a nation of permanent settlers (Carney, 2008b).

5. Financing retirement income and social security in Australia.

Levels of economic growth, labourforce participation by older workers, and population are all notoriously difficult to forecast (Borowski and McDonald, 2007: 35). Along with defective assumptions, this led to significant reductions in the projected burden of financing retirement income, social security and associated outlays (such as health expenditures) between the Australian Government’s first ‘Intergenerational Report’ in 2004 (Treasury, 2004) and the second in 2007 (Treasury, 2007). This is no surprise, since Creedy modelled some of these ‘sensitivity’ measures in his original work on expenditure projections of population ageing (Creedy, 1998: 48-55).

In 2004 the Productivity Commission (2004: xxxii) was forecasting declining GDP growth and rising fiscal outlays, mainly due to rising health and aged care expenditure (ibid, xxxiv). Health care as a proportion of GDP was forecast to rise from 6 to nearly 11 per cent (ibid, xxxvi); while aged care costs, mainly associated with people aged over 80 years, were predicted to climb by between 180 per cent (if disability rates drop) and 250 per cent (if health improvements do not eventuate). This translated to between 0.85 and 2.1 per cent of GDP (ibid, xxxix). Had assumptions remained unchanged, this would have resulted in a 7 per cent GDP ‘gap’ between revenue and outlays, or around AUD 2,200 billion of unfunded liabilities over the next forty years (ibid, xxxl).

Within the period of merely three years between the first and second Intergenerational Reports, assumptions altered sufficiently that the anticipated ‘GDP gap’ had roughly halved (from approximately 5 per cent to under 3 per cent by 2040; or from 7 to 3.5 per cent by 2050), bearing out Creedy’s sensitivity
analysis on the degree of uncertainty or slippage involved in making such long-range predictions. Turning specifically to retirement pensions and aged care, the latest projections contained in the Second Intergenerational Report 2007, are for Age Pension payments to increase from 2.5 per cent of GDP in 2006-07, to 4.4 per cent by 2046-47, and for aged care costs to rise from 0.8 to 2 per cent of GDP over the same period (AIHW, 2007: 6). Health care costs are now forecast to rise from 4 percent of GDP in 2001-02 to 6.8 per cent by 2041-42 (previously 8.1% in IGR1) a large proportion of which continues to be attributed to growth in PBS outlays (0.6% of GDP in 2001-02) but now placed at 2.2 per cent rather than the previous estimate of 3.4 per cent of GDP by 2041-42.


Two possible trends warrant mention here. The first is a shift towards ‘capacity building’ or social development, and the second is a conditional ‘bundling’ of social security with other services or behavioural expectations.

a. Social Development Policies.

Having introduced its ‘education revolution’ policy during the 2007 election (ALP, 2007a), the new Rudd Labor Government has placed education and skills formation at the centre of its policy agenda (DEEWR, 2008: 12-14). By doing so, the Government aims to forestall skills shortages (exacerbated by an ageing population) that will imperil future economic growth (Commonwealth of Australia, 2008c) by, for example, promoting vocational training and providing career development skills to young people (DEEWR, 2008: 12-14). Moreover, consistent with another policy promise (ALP, 2007b), it has appointed a high level national ‘Social Inclusion Board’, reporting to the super-ministry of the Deputy Prime Minister, Julia Gillard. The Social Inclusion Board reports ‘on how to improve social inclusion across the country’. To date the Board has considered, amongst other things, programs for children at risk of long-term disadvantage and the plight of ‘jobless families’ (SIB, 2008).

This emphasis on upgrading skills through longer-term training or education may yet evolve into social security and labour market programs more
akin to British or European ‘Third way’ policies, which pursue durable jobs and place greater emphasis on building an educated and skilled workforce as the basis for economic prosperity and international competitiveness (Carney, 2007b). These are potentially promising developments, but as yet no sufficiently detailed blueprint has emerged for alternative pathways of welfare reform, leaving the measure open to the charge that it has the potential to ‘[diffuse] responsibility for addressing specific issues’ (Hayes, Gray and Edwards, 2008: 21).

b. ‘Integrated’ social security, health and education schemes.

Due to concerns during the year about child neglect, violence and social breakdown, selected groups, such as indigenous communities and neglectful parents, were singled out by the Howard Government for the ‘authoritarian’ form of highly paternalistic and compulsory ‘management’ of their welfare payments. This forms part of a suite of health, education and other measures, costed by then Minister Brough in September 2007 at a significant AUD 1.3 billion over 4 years.

The new ‘income management’ regime component of this suite of measures extends, at varying times, to three groups of people (further, Sutton, 2008): those living in declared (indigenous) geographic areas (essentially confined to the Northern Territory); those individual Australians designated because of concerns about child protection, school enrolment or truancy; and those indigenous citizens living in Queensland individually designated by a new State body (Social Security (Administration) Act 1999 ‘S(A)A, 1999’: s123TA). The legislation operates to quarantine (or ‘ring fence’) all or part of welfare payments, restricting expenditure to paying for ‘priority needs’ as defined by government; such as food, clothing and housing (s 123TH). Expenditure on ‘excluded items’ such as alcohol, gambling, tobacco and pornography is barred (s 123TI). According to the Government’s 2008 Review Board Report, in the Northern Territory where mandatory blanket quarantining applies to designated geographic areas—as at June 2008 there were ‘over 13,300 individuals’ subject
to the scheme; covering ‘53 communities within prescribed areas and in 46 town
camps located in major centres’ (Australia, 2008).

The new provisions are co-located in the relevant legislation with those
dealing with ‘nominee payments’, but go much further than equivalent
‘representative payee’ provisions used in the USA for people such as those with
mental illnesses and addictions (Rosenhek, 2004). Instead they provide for a
series of ‘in-kind’ transfers akin to, but more extensive than, ‘food stamps’ in the
USA (Tschoepe and Hindera, 2001). The measure was criticised by the peak
welfare body, the Australian Council of Social Services, as an unduly sweeping
response given the availability of nominee payment and other tools for achieving
similar results (ACOSS/CAO, 2007: 16).

These reforms had their philosophical origin in the Aurukun ‘community
justice agreements’, later expanded to knit together management of education,
health, housing and income support (Hatami, 2006: 27). In turn, this
underpinned the ‘mutual responsibility agreements’ (McCausland and Levy,
2006) which were to be negotiated in conjunction with the 100 or so health,
housing and other programs (worth around a billion dollars annually), which
reverted to Federal government administration under new but un-tested whole-of-
government and one-stop-shop coordination structures, following the 2004
abolition of the statutory self-management body, the Aboriginal and Torres Strait
Islander Commission (ATSIC) (Anderson, 2006).

Although subject to review after 12 months, these policies were initially
maintained by the Rudd Labor Government while the review was completed. In
October 2008 the Government decided to extend them for another 12 months
(including mandatory quarantining of welfare), despite a recommendation from
the NT Evaluation Review Report that quarantining be elective and individualised
(Australia, 2008: np, section 2.1).
III. BUDGETARY TRENDS AND SOCIAL EXCLUSION.

Social policy challenges and trends reflect shifts in the external environment, such as major changes to the demographic profile. As Creedy (1998: 3-4) points out, this was the kind of change that sounded the death knell for social risk management through ‘friendly societies’, and gave rise to the provision of age and disability pensions at the beginning of the 20th century.

Population ageing is arguably a second such transition, which may bring undone the ‘social contract’ between older and younger populations about meeting the costs of aged care.

1. Basis of retirement income in Australia.

Australia’s retirement income policy is currently built on three ‘pillars’: a needs-tested age pension as the first tier; a compulsory ‘Superannuation Guarantee’ as the second; and voluntary private contributions and savings as the third tier (Australia Treasury, 2004b: 1). This implements the 1994 World Bank plea for adoption of neoliberal reform solutions in its Averting the Old Age Crisis Report—recommending three pillars: safety net redistribution, social insurance and private savings (World Bank, 1994: 10). However, it is unusual in that the age pension is the ‘safety net’ behind the Superannuation Guarantee, and that the pillars are poorly integrated (Bateman and Piggott, 2003: 6, 13, 20-21).

Australia’s retirement income provision commenced in 1909 as a taxpayer funded, flat-rate, means-tested pension, later joined in 1992 by additional pillars of mandatory contributions to superannuation and other incentives to foster private savings, including tax-favoured additional voluntary contributions to private superannuation (Bateman and Piggott, 2003: 5-6; Borowski and Olsberg, 2007: 196-201; Carney, 2007a: 366-68).

The Age Pension (or its equivalent for Veterans) covers approximately three quarters of the population over the qualifying age, and by 2005-06 it accounted for expenditures of AUD $20.6 billion (AIHW, 2007: 93). Over time, the compulsory superannuation entitlements will build sufficiently to increase the
proportion of people receiving a *part-rate* age pension from its current one third of pensioners to two thirds of pensioners by 2050 (ibid), as private superannuation income streams reduce the rate of age pensions under the means (or ‘income’) test (Carney, 2006b: 93, 101-106). However current rates of contribution are too low to totally remove many retirees from pension, other than relatively high income earners whose assets may already bar many under the property-based tests in any event (Carney, 2007a: 366-68).

Most pensioners qualify for various ‘fringe benefits’, the most valuable of which is the Pensioner Concession card (AIHW, 2007: 93). The card reduces the cost of pharmaceuticals below the levels already provided by Australia’s Pharmaceutical Benefits Scheme, delivering a wide range of subsidised medications (Faunce, Jefferys and Johnston, 2008) as part of the universal system of health care—as well as providing access to ‘bulk-billing’ of medical care (provision at the maximum rate reimbursed by government to the medical practitioner, rather than with any premium added).

State government services such as reduced public transport charges, private motor vehicle registration or other concessions, also tend to adopt the concession card as the basis of qualification. In New South Wales, for example, a valid Pensioner Concession Card garners its holder half-fares on buses and trains (NSW Ministry of Transport, 2008), and, unlike holders of the Seniors Card, four free intra-state train journeys per year (ibid). The Pensioner Concession Card also entitles holders to exemptions from fees on drivers’ tests, licences, motor vehicle tax and registration (RTA, 2008), free ambulance transport (Ambulance Service of NSW, 2008), free dental services at the Sydney Dental Hospital (Sydney Southwest Area Health Service, 2008), and rebates on water (Sydney Water, 2008) and energy (NSW Department of Energy Utilities and Sustainability, 2008). Some local councils also offer rebates on council rates to Pensioner Concession Card holders (see e.g. Pittwater Council, 2008).
2. Age pensions; the Public pensions.

Australia was at the forefront of moves to provide publicly funded retirement incomes for the aged, after Germany’s contributory pension in 1889 and non-contributory pensions in Denmark in 1891/2 and New Zealand in 1898.

Responding to public pressure to look after ‘founders’, aged pensions were introduced in Victoria and New South Wales prior to federation, followed by Queensland (Kewley, 1973: Chs 2, 3). State schemes lacked universality (Victoria insisted on exhausting family support: Gunn, 1989). But such limitations were abandoned by the national scheme of 1908 (commencing June 1909) with its means-tested flat rate pension payable irrespective of family support (Kewley, 1973: 74). Although in theory subject until 1974 to meeting tests of ‘good character’ and social obligations like maintaining dependents (Carney, 2006b: 25-26), the conditions for qualification were otherwise straightforward: meeting an age threshold and demonstrating a residential connection (See: Carney, 2001: Ch 3, Part C). A period of 10 years residence was and still is insisted on. Originally the qualifying age for males was set at 65 years and for women at 60. In 1994 the pension age for women began its rise from 60 to 65 years. Women born before July 1935 remained eligible from age 60, while the cohorts born on or after 1 January 1949 qualify only on turning 65 (on and after 2014). Between those birthdates the age pension age increased in 6 monthly intervals.

Means-testing, of both income and assets, has been part of the architecture of the age pension from its inception. Initially the test applied a 100 per cent reduction (i.e dollar for dollar in current currency), but by the 1950s various liberalisation measures such as exclusion of the family home from assets testing in 1912 expanded coverage from the initial one third to three quarters of the aged population (McCallum, 1990: 60). In 1969, when ‘abolition’ of means tests was politically popular, the test was reduced to a 50 per cent taper for income.

In the early 1970s the ‘income disregard’ figure (where income is ‘free of testing’) was doubled. After a brief period in the mid 1970s when the test was
removed for people over 70 and then asset testing abolished for everyone in 1976, it was soon restored in 1985. While the income disregard figure is now reasonably generous (AUD $138 for singles and AUD $240 for couples in 2008), the taper has not been significantly eased, standing at a 40 per cent (40 cents in the dollar) reduction (Bateman and Piggott, 2003: 8). However, other measures, such as the pension bonus scheme rewarding delayed claims, or the threshold of around $25,900 before a single pensioner faces income tax on combined income from pension and other sources, serve to provide work incentives (DFaHCSIA, 2008: 9).

Means tests do have limitations, such as imperfectly measuring social need since ownership (the key under the law) and enjoyment of property do not always coincide (Carney, 1999b; 2006b: Ch 6). In this way social equity and efficient targeting of benefits are difficult to reconcile, as means tests generally ignore moral obligations of pensioners; such as where children of a pensioner earn a part-living from a farm (Voyce, 1993; 1999), or occupy property in return for provision of domiciliary care.

3. Superannuation.

From the early 1980s, the Australian government sought to correct the extremely low levels of superannuation coverage or other savings for retirement, initially by encouraging their inclusion in wage determinations. Changes to superannuation policy formed the prime expressions of the desire to address savings deficits and the income needs of the ageing population into the future.


The 3 per cent superannuation levy was introduced in 1992 following difficulties in enforcing superannuation as a benefit bargained under industrial awards since 1985 (Bateman and Piggott, 2003: 9), introducing a limited form of the mainstay of European social security—lifecycle preservation of income relativities.

The levy was raised to 9 per cent by 2002, but not to the 15 per cent level promised by the outgoing Labor Government in its 1995-96 Budget; which would
have entailed another 3 per cent each by Government and employers (Commonwealth of Australia, 2008a: 21). Projected retirement incomes from superannuation therefore remain too low to provide adequacy on their own for many workers. At least 12 per cent of salary is thought to be required to achieve this (Shirlow, 1992: 3).

Taking replacement of personal spending (not the income enjoyed while working) as the test, 30 years of full contributions achieves only 76 per cent replacement levels (Australia Treasury, 2004b: 5), or just 52 per cent of final salary (AUD 18,000 pa) for a person earning AUD $35,000 (Sampson, 2004: 8). Thus in 2004-5 superannuation was reportedly the principal income for only 12 per cent of fully retired people (AIHW, 2007: 92).

b. Private superannuation.

Tax concessions for superannuation contributions have a long history in Australia. Until July 1983, taxation of retirement benefits was exceedingly modest, creating perverse incentives to take and spend lump sums prior to retirement age. Lump sum payments were taxed at just 5 percent, as were pensions or annuities, removing any incentive to prefer pensions over lump sum payouts (Bateman and Piggott, 2003: 14). Superannuation funds were often set up by employers as a ‘tax sink’, or a source of business operating capital. Undistributed fund earnings were untaxed, while employer contributions were tax deductible.

For their part, employee benefits were neither vested (‘owned’), nor ‘preserved’ for retirement. Women, low-income and part-time workers fared worst, losing portions of their work-income only to see it later offset against their pension. They were also often unable to make contributions during spells of unemployment or child rearing, and frequently saw their nest eggs eroded by the inherent inefficiencies of managing multiple small entitlements in different funds (Rosenman and Winocur, 1991).

These taxation settings changed slowly, and then only for future contributions. Tax on lump sums increased in 1983 if the amount was not ‘rolled
over’ into a pension or annuity. New accumulations in genuine retirement schemes were taxed at payout at 15 per cent on the first $55,000 and 30 per cent for the balance; or 30 per cent for the whole sum if drawn down before age 55. Then, in 1988, a dual-stream collection arrangement was introduced. Fund earnings were now taxed—at 15 per cent pa, against a corporate rate of 33 per cent—and a 15 per cent per annum advance collection was levied on funds as an up-front ‘contributions tax’ (paid on behalf of contributors, based on contributions made in the tax period), off-set by a rebate of that amount on payout (Bateman and Piggott, 2003: 15). This altered the taxation of the ‘contributor’s share’ from an original stepped 15 or 30 per cent rate at payout, advancing taxes previously paid only on retirement many years later.

‘Reasonable benefit limits’ (RBLs) introduced in the 1960s to serve a tax avoidance goal (Pitman, Herbert, Land and O’Neill, 2003) were expanded at this time to promote greater equity. A 1985 tax ruling which capped lump sum payments qualifying for deductions at seven times the person’s final average salary, irrespective of affluence, was altered in 1988 to minimise discrimination against low-income earners. A sliding scale of (diminishing) benefits was phased in over 5 years for incomes over $35,000 (indexed); together with a differential (and more generous) treatment of annuities. This effectively allowed a ratio of 11.5 times the base for these contributions, provided at least 50 per cent was taken as a pension.

Private superannuation savings continue to be encouraged in various ways, including currently by matching contributions by lower and middle income earners up to a cap of $1,000, and by allowing payments of voluntary super contributions up to age 75 (Australia Treasury, 2004b: 14). The 2004 reforms eased the ability to make tax concession-qualifying superannuation contributions between the ages of 18 and 65, irrespective of having a work history in the previous 2 years, removing the former ‘work test’ precondition (Australia Treasury, 2004b; Costello, 2004: 8), and it provided new contributions and cash-out rules for those aged 65 to 74.
Under fiscally expensive reforms which took effect from July 2007, income tax was removed from superannuation benefits paid (from a taxed source) to a person aged over 60, whether as a pension or as a lump sum. Reasonable benefits limits were abolished altogether, and the property side of the means test was liberalised, with effect from September 2007, by halving the ‘yield’ attributed to the value of those assets (dropping from AUD $3 a fortnight per $1,000, to $1.50 per fortnight) (AIHW, 2007: 94).

4. Pension and superannuation ‘adequacy’.

The age pension is indexed by law to maintain its level at 25 per cent of male average earnings (Bateman and Piggott, 2003: 8). Consequently the ‘safety net’ function of the pension rates favourably within the developed world, in 1991 surpassed only by Canada (ibid, 9).

Because a tax offset results in no income tax being payable by a person reliant on their pension alone—that is, for ‘full-rate’ pensioners with no significant other income sources—their ‘replacement rate’ is 37 per cent of income (ibid, 8). The poverty protection and maintenance of living standards in the lower reaches of income is therefore relatively strong. However, the means-testing of age pensions means that it fares poorly in terms of preservation of earnings differentials enjoyed by middle and higher income earners during their working life.

From July 2007, the removal of income tax from superannuation pay-out income—whether derived from compulsory Superannuation Guarantee or private superannuation—boosted the value, and thus the overall adequacy, of retirement income derived from these sources; but its removal provided disproportionate advantages to high income earners able to build significant superannuation portfolios and then rely entirely on their savings. This is because for age pension income-testing purposes, superannuation income is counted, subject only to small discounts to encourage people to take life-time or long-term pensions rather than lump sums (Bateman and Piggott, 2003: 11, 13).
The removal of income tax from superannuation pay-outs reduced from three to two the points at which Australia had been taxing superannuation (the 15% tax rate both on contributions and fund earnings remain: ibid 15), and it served to add to the incentives for older workers to remain in the work-force, principally by taxing such earned income at lower tax rates because superannuation income is not added to lift income earners into a higher tax bracket (Commonwealth of Australia, 2008a: 25-26). The exemption of superannuation benefits from tax applies to payments drawn after age 60, with drawings prior to that date taxed at concessional rates (ibid, 26).

For higher income employees especially, there are also incentives to ‘salary sacrifice’ additional income payments into superannuation, by taxing such contributions to complying schemes at 15 per cent (with a flat 15% on fund earnings) rather than the standard rate of income tax (ibid, 25). Preferential treatment of qualifying retirement income for social security purposes also applies, as the Treasury-coordinated ‘Background’ paper for the Henry Review of Taxation observes:

Different rules apply to superannuation benefits for the purposes of assessing the rate of payment for social security entitlements. Under the income test for pensions, superannuation income streams are generally assessed on the basis of gross income, reduced by an allowance for the return of the capital used to purchase the product. For the majority of people who have acquired their income stream with an accumulated lump sum, this method of assessment is not linked to the taxation treatment of the income stream (ibid, 26).

5. Measures to secure adequacy of non-contributory Age pensions.

Australia’s historic reliance on social security income transfer payments as all but the sole source of income support in retirement is slowly altering due to the growth in occupational and private superannuation coverage promoted by government incentives, or mandatory requirements for employers to contribute.

Beyond the extension of generous taxation and other incentives to encourage a gradual shift to greater reliance on superannuation, the legislative entrenchment of pension indexation at 25 per cent of male average earnings (Bateman and Piggott, 2003: 8), and slow trends towards liberalisation of the means tests (a larger income disregard zone and lower withdrawal rates for
income above those thresholds)—all serves to secure the ‘safety net’ adequacy of pensions from a legal perspective.

From the more important, political dimension, the very high levels of coverage of the age pension means that it would be suicidal for a Government to contemplate reductions in the current levels of adequacy. And, while a 37 per cent replacement rate of income (or around three quarters of spending at the average wage) may be low by comparison with earnings-related benefits under contributory schemes (Bateman and Piggott, 2003: 8-9), the high levels of home ownership combined with the principal home exemption from the assets test, means that retirement income adequacy for middle income earners is also relatively strong. Indeed replacement rates can be judged in several ways, as the DFaHCSIA Background Paper for the Pensions Review observes when noting that the single age pension provides 61 per cent of net earnings of a minimum wage worker, while income support for a single person of working age was just under 46 per cent in January 2008 (DFaHCSIA, 2008: 15).
IV. HEALTH CARE FINANCING.

Australia has a relatively universal, and mildly redistributive, set of policies for health care, medicines and aged care.

1. Organisation of public and private sector financing.

Health care financing for the purposes of this report can be divided into three categories, between medical and hospital care, pharmaceuticals, and residential aged care.

a. Medicare.

Australia operates a publicly funded, universal system of medical benefits known as Medicare, principally funded by the federal government. Medicare reimburses medical providers a ‘scheduled fee’ component of medical costs, and which funds state and territory governments under a cost-sharing agreement to provide hospitals and other infrastructure. Special provisions apply to very costly procedures like medical imaging and other diagnostic or therapeutic technologies.\(^3\)

The universality of Medicare is secured by a very wide definition of persons eligible for these payments. An ‘eligible person’ covers both Australian residents and certain non-residents. Australian residents include Australian citizens as well as the holders of permanent visas and people on temporary visas in the course of applying for a permanent visa, and their family members (Health Insurance Act 1973 (Cth): s 3(1)(a), (b), (f)). Classes of people can be added to this list by Ministerial order (s 6), and arrangements can be made to extend all, or all except designated medical services to holders of temporary visas, or for a

\(^3\) Imaging and other services covered by Medicare (with a 75% or 85% rebate) are listed in the Health Insurance (Diagnostic Imaging Services Table) Regulations 2007. Some rare/costly procedures may be added under Section 3C(1) of the Health Insurance Act 1973 via a ministerial declaration. Positron Emission Tomography, for example, was added to the Regulations for a specified time period expiring in June 2008 (see Health Insurance (Positron Emission Tomography) Determination HS/05/07). The most recent amendments to the Medicare Benefits Schedule will come into effect on 1 November 2008 (Department of Health and Ageing, 2008b).
stipulated time (s 6A), and coverage extends to illness on a domestic journey within Australia which was destined to end overseas (s 10(1)-(1B)). New Zealand citizens are covered while lawfully in Australia (s 3(1)(c)) and reciprocal agreements may be entered between Australia and other countries for mutual provision of medical care to residents of the other country (s 7). Reciprocal arrangements have been concluded with countries including the United Kingdom, Italy and Sweden.

The scheme reimburses 85 per cent of the scheduled fee for out-of-hospital services and 75 per cent of the scheduled fee for in-hospital services, subject to a ‘cap’ on the gap between that reimbursement and the scheduled fee (s 10(2)-(5)). Changes in 2004 increased the reimbursement to 100 per cent of the scheduled fee for visits to a general practitioner (Health Insurance Amendment (100% Medicare Rebate & Other Measures) Act 2004 (Cth)).

Treatment at public hospitals is billed directly to Medicare. Under a ‘bulk-billing’ arrangement practitioners also may charge Medicare directly, provided they accept the Medicare reimbursement as full payment for their service. Responding to widespread criticism at declining bulk-billing rates in rural and regional areas in particular, the Government in 2003 announced a system of additional incentive payments for practitioners providing bulk-billing to holders of Commonwealth concession cards and children under 16 years of age.

Higher incentive rates apply in non-metropolitan areas, certain urban areas and Tasmania. Advice from the Office of Rural Health points out that the ‘scheme’ simply comprises three Medicare items—‘bulk billing incentive rebates’ (items 10990, 10991 and 10992) providing an additional rebate. The conditions to attract the rebate differ slightly, but

the rebate mean that medical practitioners can claim these as well as the particular rebate they are also claiming for whatever attendance they provided to the person who also holds a Commonwealth concession card or who is aged under 16. In short, they give doctors an extra few dollars for bulk billing these people (personal communication, Gerard de Ruyter, 22/10/2008).

Other bulk billing incentives apply to pathology (items 64990 & 64991) and diagnostic screening (74990 & 74991): ibid.
b. Pharmaceutical benefits.

The Government also subsidises the costs of a wide variety of medications through the Pharmaceutical Benefits Scheme. A safety net system also operates in relation to pharmaceutical benefits for the population in general, making medications purchased in excess of relevant thresholds either inexpensive or free.

Operating under Part VII of the *National Health Act 1953 (Cth)*, the PBS automatically subsidises medicines prescribed and dispensed by approved medical practitioners and pharmacists. It is administered by Medicare Australia under the *Health Insurance Act 1973 (Cth)* and covers those medicines listed in the ‘Schedule’. The patient pays only the co-payment contribution, not the full cost of the drugs. Medicare pays the pharmacist the difference between the ‘scheduled’ amount and the co-payment.

The amount payable to pharmacists is set by the price of the medicines obtained by negotiations conducted with suppliers by the Pharmaceutical Benefits Pricing Authority (PBPA), as supplemented by dispensing fees and mark-ups and applied by way of the community pharmacy agreement struck between government and the Pharmacy Guild.

c. Aged care.

By tradition, aged care policies in Australia have been controlled by an inter-generational model, splitting costs between the national budget and user payments connected to the age pension (Howe and Healy, 2005). However, increased emphasis on self-financing through hostel bonds and nursing home charges among other things have eroded this model in recent years, and commentators suggest that, like other countries including the United Kingdom, Australia is gradually moving towards intra-generational funding of aged care (Howe and Healy, 2005).

The federal government funds two types of Australian aged residential care facilities: nursing homes and aged care hostels. Respectively these are now called ‘level 1’ residential care and ‘level 2’ aged care. Providers must be
approved, including demonstrated compliance with ‘aged care principles’ and
other conditions under Part 2.1 of the Aged Care Act 1997 (Cth), along with the
‘certification’ process set out in Part 2.6, and quality accreditation standards in
Part 4.1. Facilities are built and operated by for-profit or not-for-profit charitable
(mainly religious) organisations. Apart from provision for direct capital grants to
providers (s 3.5 and Chapter 5), the main government subsidy is paid as a
‘residential care subsidy’.

Because the majority (98%) of residents are ‘permanent’, in June 2007,
there were 153,426 such permanent residents of these facilities, and a total of
156,549 residents overall (AIHW, 2008b: 42). This compares to a total of
154,872 on June 2006 or 135,991 in 2000. Approximately 50,000 new residents
enter each year (AIHW, 2007: 106).

2. Coverage of health care in Australia.

Health care coverage is essentially universal for all Australian citizens or
permanent residents.

Medical care: The growing distinction between bulk-billed concessional
patients and those required to pay in full or in part for their medical treatment has
been interpreted as a retreat from the philosophy of universalism towards a
‘welfare’ approach to health care (Senate, 2003: xiii). Simultaneously,
Australians are being strongly encouraged, via a generous tax rebate and other
measures, to take out private health insurance.

Private health insurance coverage increased over the decade 1997 to
2007, accounting for 43.5 per cent at the end of the period compared to 31.9 per
cent in 1997 (ABS, 2008: Table 1). In June 2004, 12.2 per cent of the pool of
privately insured people were 65 years of age or over (PHIAC, 2004: 14). People
in particular income brackets (earning above $50,000 for singles and $100,000
for families) must pay a Medicare Levy Surcharge calculated as 1% of their
earnings—in addition to the standard 1.5% Medicare levy—if they do not hold
private health insurance (Commonwealth of Australia, 2008b). In October 2008
the Government increased the income threshold at which a person or family is penalised for not holding private health insurance to $70,000 for singles and $140,000 for families (Ryan, 2008).

**Pharmaceutical benefits:** The coverage of the PBS is as universal as that of Medicare, covering Australian citizens and permanent residents in respect of the approved costs of ‘scheduled’ drugs and medicines, less the co-payments. Approximately 80 per cent of prescriptions are currently subsidized under the scheme (Department of Health and Ageing, 2008a). In the year to June 2007 the PBS covered approximately 170 million prescriptions, or around 8 scripts a year per person (ibid).

**Residential aged care:** Access to approved residential aged care facilities is regulated by a multi-disciplinary ‘aged care assessment team’ (ACAT), which determines the level of medical need and capacity for community based care (s 22.4) in accordance with Ministerial guidelines called the ‘approval of care recipient’s principles’ (s 19.2) and other requirements of Part 2.3 of the *Aged Care Act 1997* (Cth). Classification of the requisite level of care, and its associated subsidy entitlement, is regulated by classification principles and procedures laid down in Part 2.4 of the legislation.

Residential aged care beds per 1,000 people aged over 70 years of age has fallen slightly in recent times, from 89.2 per 1,000 in 1997 to 85.6 in 2006 (ABS, 2008: Table 1), but there has been greater emphasis on, and commensurate growth in, support for aged people living in the community (AIHW, 2007: 102-113). While more aged people are still reliant for support on informal rather than formal community care, the latter increased by 48 per cent over the 5 years to 2006 (ibid, 146), though the numbers are still low.

3. **Regulation of the costs of health care.**

Health care costs in Australia are affected by a combination of pressures, including those stemming from advances in high-cost technological medicine (Productivity Commission, 2005b: xl), expansion in the range and ‘marketing’ of
pharmaceuticals (Moynihan and Henry, 2006), rising proportions of the frail aged population (Productivity Commission, 2008: viii; but see Coory 2004: 581), rising costs of professional and other staff (Productivity Commission, 2005a: xvii-xviii), and higher health expectations of consumers (Ikegami in Gray, 1998: 912-13).

The rate of growth of health care costs in Australia has been greater than the rate of growth of GDP, but slower than that experienced in many other developed economies, due to the regulatory components of Medicare and the PBS. By 2007 health expenditure comprised 9 per cent of GDP, compared to 7.8 per cent ten years earlier (ABS, 2008: Table 1).

Changes to Medicare and the PBS are made after consultation with independent committees of experts. Two separate committees consider proposed changes to subsidies in the Medicare Benefits Schedule: the Medicare Benefits Consultative Committee, which includes representatives from the medical community and the Department of Health and Ageing and is concerned with changes to existing services (AMA, 2008); and the Medical Services Advisory Committee which advises the Minister of Health and Ageing on the addition of new services to the Schedule following an application by a medical professional or medical company (Medical Services Advisory Committee, 2008). Changes to the PBS are made after the Pharmaceutical Benefits Advisory Committee, comprised of medical professionals, consumer advocates and others, has considered an application (usually by a pharmaceutical company) and makes a recommendation to the Minister for Health and Ageing that a new drug should be added to the PBS (Department of Health and Ageing, 2008c).

The main cost-containment measures are the fixing of the ‘scheduled fee’ for medical services provided under Medicare, and the role of the Pharmaceutical Benefits Advisory Committee (PBAC) in assessing efficacy, cost and accessibility under the PBS.

**Medical care:** Growth in health expenditures is partly driven by market pressures (the fees charged by medical and health personnel) and practitioner (defensive medicine ordering of tests) and consumer behaviour (frequency and
seriousness of consultations). The scheduled fee provides downward pressure on costs by limiting the size of additional ‘gap charges’ which citizens will be prepared to pay.

Growth in usage of Medicare services has been modest. Over the decade 1997 to 2007, the average number of claims per person each year rose from 10.7 to 12.3 a year. Because the aged cohort is rising (and has a higher demand for medical care) the aged now consume a larger proportion of Medicare services, up from 23.6 per cent in 1997 to 29.7 per cent in 2007 (ABS, 2008: Table 1).

Expressed in constant prices, the cost of health services per person, per year, rose from $2,286 in 1997 to $4,226 in 2006, the latest available year (ibid). In the future, Medicare outlays as a proportion of GDP are forecast to rise only very slightly, from 1.1 per cent of GDP in 2006-07 to 1.3 per cent by 2046-47 (Treasury, 2007: Appendix A at p 93). By contrast the proportion of GDP devoted to hospital and health services is expected to rise from 1.2 to 2.3 per cent over that period, and the outlays on residential age care from 0.6 to 1.5 per cent of GDP (and on community-based aged-care from 0.2 to 0.4%) (ibid). The contribution to cost escalation from dysfunctional features of relations between the two levels of government is real (Eccleston, 2008: 42) but hard to assess. The Rudd Government’s program of ‘cooperative federalism’ may yet prove to be too mild a solution to slowing the rate of such growth, as Eccleston fears (2008: 48).

**Pharmaceutical benefits:** Increased co-payment charges and higher safety net thresholds were announced in the 2002-03 Budget, but not legislated until 2004. Further measures effective from August 2007 to reduce the price of generic medicines and maintain price cap protection for patients were estimated to save AUD$3 billion from forward estimates over ten years.

These parametric changes and the efforts of the PABC appear to have paid dividends, in the short term at least. Writing in November 2007, Lesley
Russell of the Menzies Centre for Health Policy\(^4\) wrote that total cost of the PBS had slowed to 2.8 per cent growth, less than the CPI, compared to average growth of 12 per cent a year over the period 1999-97 to 2004-05, though prescription numbers had also declined, raising questions about possible reductions of coverage (Russell, 2007).

On current policy settings the costs of the PBS are nevertheless projected by Treasury to rise from 0.7 per cent of GDP in 2006-07 to 2.2 per cent by 2041-42 and 2.5 per cent by 2046-47 (Treasury, 2007: 50).

**Residential aged care:** Following the substantial un-met funding needs of aged care as identified by the Hogan Review (Hogan, 2004), new instruments were developed to measure the costs of aged care.

From March 2008, changes were made to the way residential aged care is funded for older individuals. First, the previous pensioner and concessional resident supplements were amalgamated into one ‘supported residents’ payment, payable in respect of all pensioners or self-funded retirees whose assets are lower than a stipulated ceiling. Second, the accommodation charge—which is additional to the ‘daily fee’ set at 85% of basic pension—is not payable by a person whose assets are lower than $AUD $39,500 (indexed). High care residents able to afford to contribute can still be asked to do so, and accommodation bond arrangements for high care remain unchanged. As the Australian Institute of Health and Welfare describes (AIHW, 2007: 110):

Resident contributions towards the cost of care will be made up of a basic daily fee and, for some residents, an income-tested fee. One maximum basic daily fee (85% of the basic age pension) will apply to all new residents, regardless of their social security status. A new income test treats all income (pension and private income) equally.

Residents who are required to pay an income-tested fee will pay an amount equal to 41.67% of total assessable income above the maximum income for a full pensioner (no income-tested fee is payable on the first $659 per fortnight, subject to indexation). The maximum daily care fee payable will continue to be capped at $53.96 per day as at 20 March 2007.

\(^4\) This is a joint initiative between the University of Sydney and the Australian National University.
The main changes are that lower-income, self-funded retirees gain access to the ‘supported residents’ subsidy, and that aged care providers no longer suffer any financial disadvantage depending on whether lower income pensioners or self-funded residents are admitted.

4. Co-contribution payments by patients.

Co-contribution is not a major feature of health care coverage in Australia, but the level differs depending on the sector.

**Medical care:** Co-contributions towards health care costs mainly arise due to medical practitioners and health providers charging patients an amount greater than the ‘scheduled fee’. Private insurance permits this gap to be closed.

Patients who do not have private health insurance cover must rely on a Medicare safety net system providing 80 per cent of the gap between the Medicare reimbursement and the fee charged by the practitioner. Concession card holders and families with dependent children must pay the first AUD $365.70 in gap fees before the safety net is triggered, and others pay the first AUD $1,058.70.

Patients usually pay for most ‘allied health’ services, however, including physiotherapy, optical and dental care, and natural therapies. However, for patients with private health insurance some of these costs may be covered by the insurer (AIHW, 2008a: 11). Dental health, for example, is not covered by Medicare (see e.g. Medical Benefits Schedule A.34), and thus the dental health of Australia’s population is linked directly to socio-economic status (Sanders, 2007: viii). People on low incomes who are unable to afford private health insurance must either to use the state dental system (if eligible to do so) or pay for dental care themselves.

**Pharmaceutical benefits:** Co-contribution is required under the Pharmaceutical Benefits scheme, but the amounts are comparatively low, since the scheme principally relies on Government regulation of the price of
pharmaceuticals (rather than consumer demand), along with scheduling of what pharmaceuticals to ‘list’, as the basis for controlling costs.

Commonwealth concession card holders, including social security recipients and others on low incomes, now pay the nominal rate of AUD $5 for most medications, while general patients pay AUD $31.30. The rise in the general co-contribution amount in 2004 was a 23 per cent increase on the previous amount (Russell, 2007).

Once a general patient reaches the ‘safety net threshold’ of prior expenditure during the year, of AUD $1,141.80 or AUD $290 in the case of a concession card holder, then subsequent scripts will cost only $5 in the case of a general patient and will be free of any co-contribution in the case of concession card holders.

**Residential aged care**: Low income residents of residential aged care facilities, such as those on the full rate of age pension and without home or other assets, are fully funded for their care. To ensure some mix of incomes, all facilities were required to offer a proportion of beds to these ‘concessional’ residents, and an additional subsidy loading is paid to providers (*Aged Care Act 1997* (Cth) ss 44.6-44.7).

The residential care subsidy is worked out for each resident in accordance with Part 3.1 of the *Act*. The rate calculator for this subsidy (s 44.2) includes supplements for certain types of resident (e.g. concessional residents) or residential care needs, and reductions in the level of subsidy based on income testing wealthier residents (ss 44.21-44.26).

It should not be forgotten, however, that low income residents contribute 85 per cent of their pension toward their care, but pay no more than this ‘daily fee’. Above the protected thresholds, residents may be charged higher daily fees, but this is ‘capped’ (at $38.35 in March 2007) (AIHW, 2007: 141). These part-pensioners or wealthier residents will also normally pay an additional co-contribution, based on their ‘capacity to pay’.
This additional daily charge is income tested, on 25% of income over the pension free area, and may not exceed three times the standard pensioner rate or the cost of care. In March 2007 this worked out as just under $54 a day (ibid, 143).

5. Fraud and cost containment.

Given that social security is a tax-funded and government administered scheme, with comparatively simple eligibility rules (Bateman and Piggott, 2003: 4) hinging on current residence, citizenship or permanent residence status and past residence, fraud has been well contained. Medicare and the PBS may be a more open question.

Cross-matching social security records with other data sets held by government (such as taxation or migration records) or the private sector (such as bank records, real and personal property records, employment and salary records) has long provided powerful tools for electronic ‘data-matching’ (Greenleaf, 1991). Australia has deployed IT extensively, particularly in areas such as social security (Henman and Marston, 2008: 194).

Consequently a major part of the debate in social security has been about the limits of and protections for privacy and other civil rights, and concerns about the development of ‘surveillance’ as a form of (more onerous) governance (Henman, 2004), especially through use of information technology (Henman and Adler, 2001; 2003; Henman and Marston, 2008: 194-96).

Medicare and PBS fraud is currently dealt with through the Professional Services Review Scheme governed by the Health Insurance Act 1973, on reference from Medicare Australia, which administers both Medicare and the PBS. Medicare fraud was officially estimated by the then Health Insurance Commission to run at about 1 per cent of expenditure, but in 2004 a former investigator with the HIC claimed that the true level may run at closer to ten per cent or $2 billion pa. In making the Government case for an ‘access card’ in early 2007, the then Minister leaked details of a KPMG (the business and
government consultancy firm) report to support a Departmental spokesperson’s claim that ‘audits put Medicare fraud and leakage in 2004-05 at $1.1 billion’ (Dearne, 2007).

The relevant parts of the KPMG report were not made public and the estimates were heavily contested prior to the apparent abandonment of the ‘access card’ proposal by the former Government in mid 2007 and its formal abandonment by the Rudd Government in December 2007. Hence the levels of leakage effectively remain unquantified in the health area.


Immigrants face barriers to qualification for social security, including a residence test insisting on either citizenship or a permanent residence visa, and must then serve out a two year ‘non-payment period’ before being eligible for payments (further, Carney, 2008b). As already explained, health coverage extends to citizens and permanent residents, along with some temporary visa holders. Guest workers and irregular migrants are generally excluded from coverage.

Australia, in common with countries like the US and Canada, was founded by, and on, migration. Its migration and cognate policies are predicated on ‘nation-building’; and the nation does not view itself as a temporary destination for guest workers in the tradition of the EU or elsewhere (Parliamentary Library, 2006: 5-8). Currently, approximately one-quarter of the population was born outside Australia. Due to the large influx of migrants following World War 2, their median age (47 years) is 14 years higher than that of the rest of the population (33 years), and they accounted for 35 per cent of people over the age of 65 years as at June 2006. Those from non-English-speaking countries comprised 21 per cent of the population of older Australians, posing special challenges for service providers for the aged (AIHW, 2007: 84).

While catering to the cultural and linguistic needs of the larger groupings of such people from countries such as Italy, Greece, Germany, the Netherlands, China or Poland pose issues for residential aged care (and dementia care where
later acquired skills such as English language skills regress), the Australian Institute of Health and Welfare rightly suggest that it is the aged of migrant backgrounds represented by small numbers who are the greatest challenge (ibid).

Migrant workers historically have been discouraged in Australian public policy, with the preference being for permanent settlers who will contribute to the nation-building goal. While retirement pensions (e.g. the Age pension) are to some degree portable, or are able to be combined pro rata with entitlements from the migrant's country of origin in certain circumstances (Carney, 2006b: Chap 9), there is essentially no portability of working age payments, whether for immigrants or citizens (Carney, 2008b).
V. OVERVIEW: HEALTH AND RETIREMENT INCOME FUTURES COMPARED.

Ageing has risen in political importance in recent years. In 2001 the Australian government adopted a ‘national strategy’ on ageing, with a focus on promoting aged participation in society (AIHW, 2003: 282), while the 2002/3 Budget tabled a major economic analysis of ageing (AIHW, 2003: 275). This was followed by policy initiatives in 2004, such as provision of incentives for people to continue working at least part-time beyond retirement age (Australia Treasury, 2004b).

While countries with contributory social security as their mainstay see retirement pension outlays as the major additional cost of population ageing, followed by residential and other aged care costs, and then health expenditures (Visco, 2001; Capretta, 2007)—the first of these is taken out of play in Australia. Some parametric changes have been effected from March 2008 in funding of residential aged care (see DoHA, 2008), and the disproportionate rise of the cost of health and pharmaceuticals against population or GDP remains a challenge (as discussed above). However, the latter is a whole-of-community factor rather than specifically a population ageing issue.

5 Participation as adopted for these purposes resonates with TH Marshall’s (1963) conception of the attributes of ‘social citizenship’ with its potential for engagement with work, leisure, or civil society.

6 Over the last several years, Government has offered incentives to encourage people over pension age to remain in the workforce. One such measure was the July 2000 expansion of the tax off-set for people who continue working beyond 65 (eliminating tax for a single person on incomes up to AUD 20,500, with reduced rates up to AUD 38,340: Australia Treasury, 2004b: 13). The reduction in the severity of the claw-back of pension by liberalising the income test taper (from 50 to 40 per cent) when the goods and services tax was introduced in 2000, also favoured greater workforce participation. As did the earlier 1998 initiative of a lump sum ‘bonus’ for people who defer claiming once becoming eligible (Australia Treasury, 2004b: 13). Likewise the 1997 measure allowing employer superannuation guarantee contributions to be made between age 65 and 70 (Australia Treasury, 2004b: 14), to encourage working beyond retirement age (Encel, 2001).

The 2004 Election added a further monetary incentive, in the form of a ‘mature age’ worker tax-offset (of AUD 500 pa for workers over 55 earning up to AUD 48,000pa), a measure estimated to be worth AUD 1 billion over 4 years (Gittens, 2004). For self-funded retirees, a once a year AUD 200 lump sum ‘utilities payment’ was also announced during the campaign (with AUD 100 payable for those on pension), at a cost of around AUD 900 million over four years.
In relation to trends in the direction or style of policy adopted, Australia has recently witnessed a strong embrace of neoliberal policy prescriptions, particularly for people of working age. ‘Activation’ policies, which if successful help to expand the employment and tax base to shoulder some of the cost burden associated with population ageing, became a new form of ‘governance’ in Australia (Considine, 2001; Carney and Ramia, 2002; Ramia and Carney, 2003), as in many other parts of the world (van der Ah and van Berkel, 2002), especially for the unemployed; despite guarded benefits (Bredgaard and Larsen, 2008).

Some commentators despair of reversing this neoliberal cast of policies, especially given their strong espousal by global organisations such as the IMF, World Bank or WTO, and instead urge political engagement, at national or localised levels (Dean, 2007: 9). Arguably there is evidence of the wisdom of this to the extent that the unpopularity of the labour law reforms—misleadingly entitled WorkChoices—was credited with the defeat of the Howard Government in Australia in 2007.

Despite the challenges of an ageing society, Australian policy settings appear to strike the right balance between fiscally responsibility and robustness. Neoliberal market reforms already hold significant sway in key areas of policy, and the case for their further expansion is less than compelling (see generally Coburn, 2004: 54; Perkins, Nelms and Smyth, 2004: 11-14).
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