Chapter 11

Health and Aged Care

Introduction

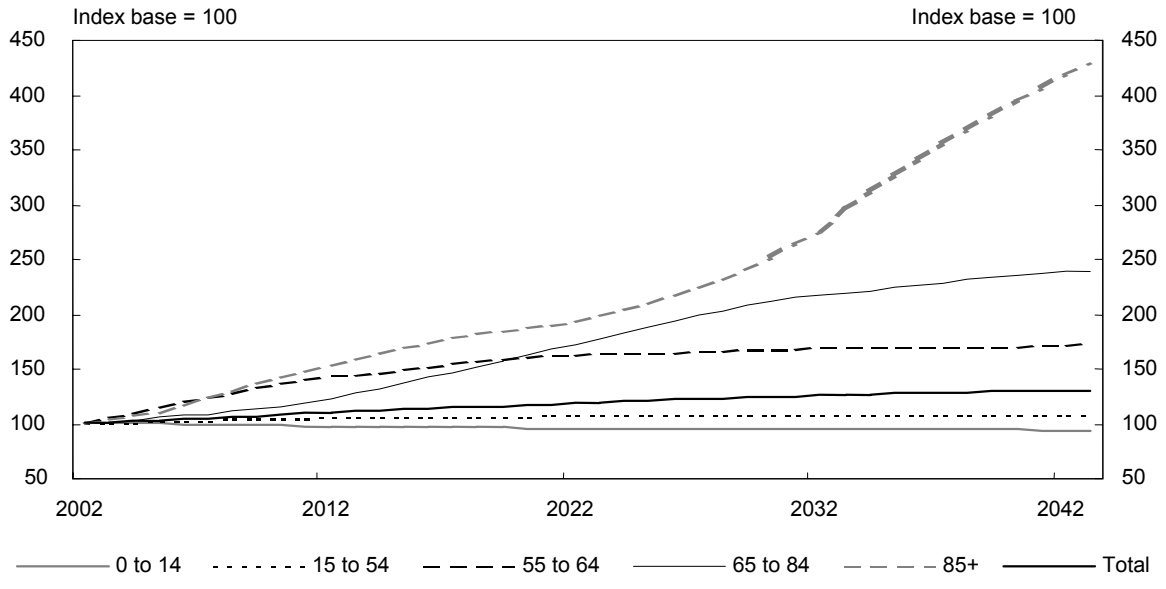
11.1 This chapter examines the potential for further integration of Australia's superannuation, health and aged care systems. Initially, it summarises information about the ageing of Australia's population, together with current and projected health care and residential aged care expenditure in Australia. Subsequently, it examines two alternatives for reform of funding of health and aged care in Australia:

- the introduction of health accounts through superannuation; and
- the introduction of compulsory health insurance through superannuation.

Australia's ageing population

11.2 Australia's population is ageing. Increasing life expectancy and decreasing birth rates together mean that the proportion of the total population that is over 65 years is increasing. **Chart 11.1** below shows projected growth by age group over the next 40 years in Australia.

Chart 11.1: Projected growth by age group over the next 40 years



Source: Commonwealth Treasury, *Intergenerational Report 2002-03*, p. 23.

11.3 Population growth in Australia is expected to continue slowing, from 1.2 per cent in 2000 to around 0.2 per cent by 2042. However, **Chart 11.1** shows that the growth rate of the population aged 85 or over is projected to accelerate sharply, while the youth population is anticipated to decline slightly. While the size of the

labour force is projected to grow by just 14 per cent over the next two decades, the number of people aged 55 to 64 is projected to increase by more than 50 per cent. This is expected to be the fastest growing group of labour force age.[1]

11.4 **Chart 11.1** also highlights the expected growth in the proportion of the population in the 'very old' cohort, that is over 85. Currently, around 1.5 per cent of the population is in this age range, but by 2042 that is expected to rise to over four per cent.[2]

11.5 The ageing of Australia's population brings with it an anticipated increase in health expenditure. Persons aged over 65 years have per capita health expenditure around four times higher than the rest of the population, are admitted to hospitals more often and stay longer, and have expenditure on pharmaceuticals 2.5 times higher than the rest of the population. While the elderly aged over 65 currently comprise 12 per cent of the population, they consume 35 per cent of health expenditure.

11.6 Most importantly, the health costs of the aged tend to be concentrated amongst the over 75 years age group, projected to grow rapidly in the next 50 years. There is considerable evidence that the increasing longevity of the elderly does not produce longer periods of life in ill health. It appears that severe disability tends to be concentrated in the last few years of life. Accordingly, the most expensive time in terms of health costs is the last two to three years of life.

11.7 With growing numbers of elderly expected to live well into their 80s, a strong increase in health costs for the aged over the next 50 years is anticipated.[3]

Health care expenditure in Australia

11.8 Funding and provision of health and aged care in Australia is distributed amongst all levels of government, together with the non-government sector (religious/charitable and private providers). In addition, consumers and carers have roles in funding, administering or providing services. This mix of responsibilities helps to ensure access and choice for consumers and sustainability of the national health and aged care system.[4]

11.9 Of the $53.7 billion spent nationally on health in 1999-2000, 48.0 per cent was provided by the Commonwealth Government, 23.2 per cent by State and local governments and the remaining 28.8 per cent by the non-government/private sector. The sources of the private expenditure were estimated to be 56.4 per cent from

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1 Commonwealth Treasury, *Intergenerational Report 2002-03*, p. 22.

2 Commonwealth Treasury, *Intergenerational Report 2002-03*, p. 22.

3 Australian Institute of Health and Welfare, cited in P.Downes, 'Sustainable Retirement – An Old Concept, New Thoughts', DOFA paper, April 2002, p. 39.

4 *Submission* 80, Department of Health and Ageing, p. 7.

individuals, 24.7 per cent from health insurance funds, and 19.0 percent from other sources including workers' compensation and third party motor vehicle insurers.[5]

11.10 The health and aged care systems operate in conjunction with social safety net payments and concession cards, the tax system (30 per cent private health insurance rebate, the Medicare levy, the Medicare levy surcharge for high income earners without private health insurance) and the insurance sector (private health insurance, medical indemnity, workers compensation).[6]

11.11 Through Medicare – Australia's universal health insurance scheme – the Commonwealth funds the Medicare benefits schedule (MBS; which provides subsidies for medical practitioner services, optometry, diagnostic imaging and pathology) and the Pharmaceutical Benefits Scheme (PBS; which subsidises a select list of pharmaceuticals). In addition, the Commonwealth provides:

- funding for hospitals services provided by State and Territory governments through the Australian Health Care Agreements;
- the 30 per cent (tax) rebate to subsidise the cost of private health insurance; and
- funding for medical research, health promotion and protection, indigenous health services, health information management and access, health safety and quality, and medical workforce development and infrastructure.[7]

11.12 The substantial private sector provides private hospitals and private health insurance, and private practitioners provide most community based medical, dental care and diagnostic services. Consumers contribute through various co-payments and may choose to provide for their own health care through private health insurance.[8]

11.13 Accordingly, Medicare (publicly insured) services are complemented by additional services privately purchased at the consumer's own cost, including services refundable under private health insurance.[9]

Projected health care expenditure

11.14 The Commonwealth Government's *Intergenerational Report* for 2002-03 notes that Commonwealth spending on health is projected to increase from 3.96 per cent of

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5 AIHW, *Health Expenditure Bulletin No.17*, Canberra, September 2001 – most recent comparable data across all government and non-government sectors. The AIHW includes high-level care residential aged care (nursing homes) as health costs. The number of people with private health insurance has increased significantly since the introduction of Lifetime Health Cover in July 2000, so the contribution of the private sector will have increased since then.

6 *Submission* 80, Department of Health and Ageing, p. 8.

7 *Submission* 80, Department of Health and Ageing, p. 8.

8 *Submission* 80, Department of Health and Ageing, p. 8.

9 *Submission* 80, Department of Health and Ageing, pp.7-9.

Gross Domestic Product (GDP) in 2002-02 to 4.3 per cent of GDP in 2011-12 and to 8.1 per cent of GDP in 2041-42. This is roughly equivalent to a real non-demographic growth rate for all Commonwealth health spending of about 2.6 per cent per year over the next four decades.[10] This is shown in **Table 11.2** below:

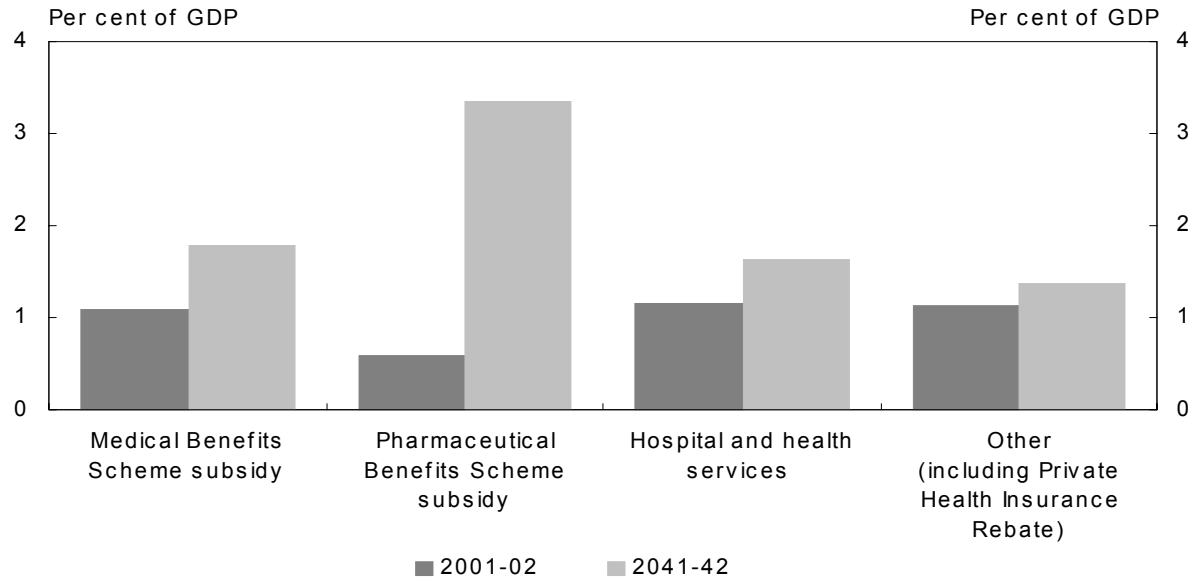
Table 11.2: Projected Commonwealth health spending by component (per cent of GDP)

	2001-02	2006-07	2011-12	2021-22	2031-32	2041-42
MBS subsidy	1.09	1.10	1.15	1.33	1.56	1.78
PBS subsidy	0.60	0.63	0.79	1.31	2.15	3.35
Hospital and other services	1.16	1.16	1.20	1.34	1.51	1.63
Other	1.12	1.14	1.16	1.22	1.29	1.37
All health	**3.96**	**4.02**	**4.30**	**5.20**	**6.51**	**8.13**

Source: Commonwealth Treasury, *Intergenerational Report 2002-03*, p. 39.

11.15 As shown above, of all the components of Commonwealth health expenditure, spending on PBS subsidies is projected to grow the fastest. As a proportion of GDP, the PBS is projected to grow more than five times from 0.6 per cent of GDP currently to 3.4 per cent of GDP in 2041-42. Spending on MBS subsidies as a proportion of GDP is expected to grow by 60 per cent, with hospital and health services spending growing by 40 per cent. This is shown in **Chart 11.3** below.[11]

Chart 11.3: Projected growth in components of Commonwealth health spending



Source: Commonwealth Treasury, *Intergenerational Report 2002-03*, p. 38

10 Commonwealth Treasury, *Intergenerational Report 2002-03*, p. 37.

11 Commonwealth Treasury, *Intergenerational Report 2002-03*, p. 37.

Committee view – health care expenditure

11.16 While mindful that some of the modelling assumptions behind the *Intergenerational Report* have been queried by some commentators, the Committee notes that the increase in health care expenditure from 3.96 per cent of GDP in 2002-02 to 8.13 per cent in 2041-42 is highlighted in the Government's *Intergenerational Report* and other reports published in the last decade as one the main factors contributing to an increase in projected Commonwealth demographic spending[12] from 13.9 per cent of GDP in 2001-02 to 19.2 per cent of GDP in 2041-42. By 2041-42, the gap between Commonwealth spending and revenue is projected to have grown to around 5.0 per cent of GDP.[13]

11.17 Accordingly, the Committee considers that every effort should be made to find savings in the health care system, while meeting community health expectations, or to increase the provision for health care funding in the future. This is discussed later in this chapter.

Residential aged care expenditure in Australia

11.18 The aged care system is structured around two main forms of care delivery: community and residential care. Together these systems offer older people a broad range of services and support depending on their needs and circumstances.[14]

11.19 The Government's residential aged care programs assist people to stay in their homes where they generally want to be. When frail, older people can no longer be assisted to stay in their homes, care is available in residential aged care facilities. Of older Australians aged 70+ years, only about eight per cent are in residential care and 13 per cent make use of community services and support. Even amongst the very old (85+ years), only about 25 per cent are cared for in residential care and around 50 per cent receive some help to live active lives in their own homes (eg, centre day care, home meals, domestic assistance, lawn mowing).[15]

11.20 In 2000-01, the Commonwealth government spent $5.5 billion (0.72 percent of GDP) on residential aged care, which comprised expenditure by both the Department of Health and Ageing and the Department of Veterans' Affairs (DVA), which arranges services for war veterans and their widow(er)s.[16] Of this:

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12 Demographic spending includes spending on health and aged care, age and service pensions, disability support pensions, parenting allowances, unemployment allowances, family tax benefits, education, and unfunded government superannuation.

13 Commonwealth Treasury, *Intergenerational Report 2002-03*, pp. 57-59.

14 *Submission* 80, Department of Health and Ageing, pp. 9-10.

15 *Submission* 80, Department of Health and Ageing, pp. 9-10.

16 Commonwealth Department of Health and Ageing, *Aged Care in Australia: Aged and Community Care*, Canberra, February 2002. This publication provides an overview of the aged

- $4 billion related to residential care subsidies to more than 3,000 aged care homes providing 143,400 places;
- $248 million provided close to 24,700 community aged care packages through some 731 service outlets; and
- $615.5 million was contributed to the health and community care program (approx. 60 per cent of total program funds) with the States and Territories providing an additional $396.7 million (40 per cent). In some states this includes contributions from local government. There are about 4,000 health and community care funded services, providing services to around 300,000 people at any given time, or about 470,000 people per year.[17]

11.21 The Department of Health and Ageing advised that recipients of residential and community care make a financial contribution to the cost of their care, with the Commonwealth regulating the maximum level of charges to ensure that, in its view, care is affordable for all:

- in residential care, residents may pay daily care fees (set at 85 per cent of the age pension), income tested fees, and accommodation bonds or charges. On average, residents contribute 28.5 per cent of the total cost of their care. Contributions vary from 23.2 per cent for high care residents, to 46.2 per cent for low care residents (ie, the greater the need for care, the more support the Commonwealth provides); and
- fees for community services depend on the type of service and the consumer's capacity to pay. For community aged care packages, recipients contribute, on average, 14.1 per cent of the package cost.[18]

11.22 About 2.3 million carers, usually female family members, assist people to continue living in their homes. The Commonwealth funds a range of respite, information and practical support services for carers, and provides a carer allowance for carers looking after people with high level needs in their own homes.[19]

11.23 Many older Australians also choose to buy or lease independent living units in retirement villages at their own cost. This allows them to use their capital to obtain housing more suited to their life stage in a supportive and secure social and physical environment. In 1997, there were an estimated 1,700 retirement villages with 70,000 units of accommodation and 90-95,000 occupants. Many retirement villages offer privately funded services equivalent to low level aged care, particularly where there are 'serviced apartments' in the village. Some offer low income residents furnished, serviced, independent units together with meals and other services, for payment

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care system and provides details of the wide range of program components funded by the Commonwealth. It may be accessed at: http://www.health.gov.au/acc/about/agedaust/agedaust.htm

17 *Submission* 80, Department of Health and Ageing, pp. 9-10.

18 *Submission* 80, Department of Health and Ageing, pp. 9-10.

19 *Submission* 80, Department of Health and Ageing, pp. 9-10.

similar to that in nursing homes (ie, 85 per cent of pension plus 100 per cent of rent assistance).[20]

11.24 In the 2002-03 Budget, the Government committed $14.9 million over four years for a pilot program to provide aged care packages in retirement villages. The program aims to ensure that residents in retirement villages have access to the same range of support services as they would have if they continued to live in their own homes.[21]

11.25 The Committee notes that in its written submission, the Council on the Ageing (COTA) strongly supported the residential aged care system in Australia as both cost effective and offering the aged an opportunity to maintain their independence:

> Services such as Home and Community Care which help older people to remain independent and living in the community must also be retained as they are very cost effective, and highly preferable to early admission into residential care.
>
> Residential aged care will only ever be used by a small proportion of the population. Most people will continue to live independent lives in the community. Community care is a much more economical alternative, and is the preferred option for most older people. Ensuring that individuals remain independent and able to care for themselves is an important policy goal in itself, as well as presenting the most cost effective solution. However, special attention must continue to be paid to those who are in need of residential care as they are most vulnerable.[22]

Projected residential aged care expenditure

11.26 The Committee notes that projected expenditure on residential aged care is estimated by Treasury to grow to 1.77 per cent in 2041-42. This is shown in **Table 11.4** below.

Table 11.4: Projected Commonwealth aged care spending by component (per cent of GDP)

	2001-02	2006-07	2011-12	2021-22	2031-32	2041-42
Residential aged care	0.58	0.59	0.65	0.81	1.10	1.45
Community care	0.14	0.16	0.17	0.21	0.27	0.32
All aged care	**0.72**	**0.75**	**0.82**	**1.01**	**1.37**	**1.77**

Source: Commonwealth Treasury, *Intergenerational Report 2002-03*, p. 39.

11.27 In the *Intergenerational Report* for 2002-03, Treasury noted that most of the projected growth in health spending reflects the increasing cost and availability of new

20 *Submission* 80, Department of Health and Ageing, pp. 9-10.

21 *Submission* 80, Department of Health and Ageing, pp. 9-10.

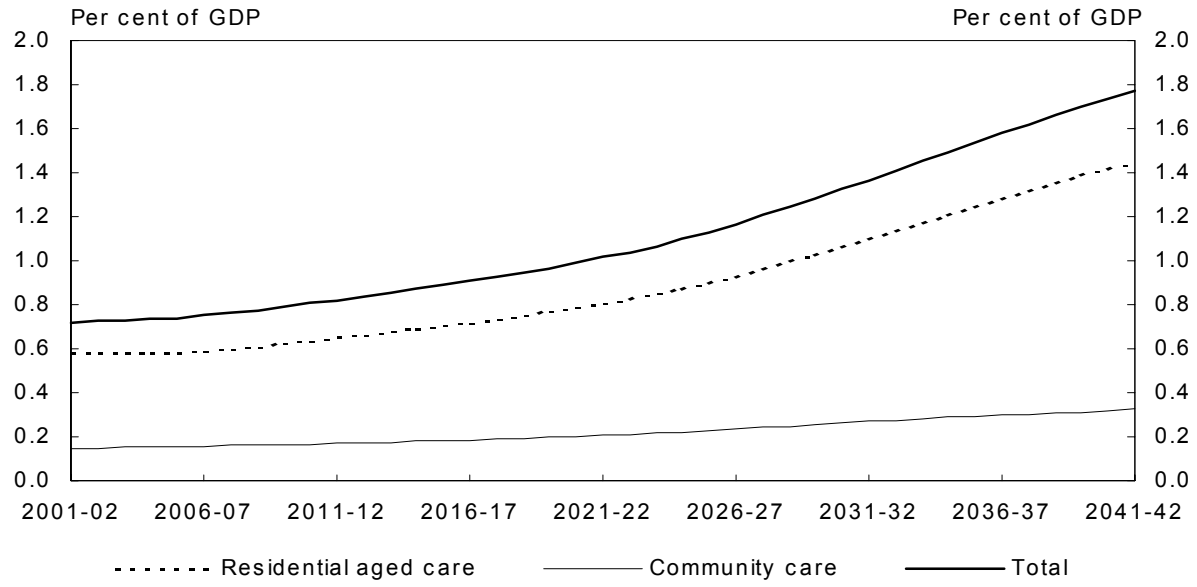
22 *Submission* 63, COTA, p. 32.

high technology procedures and medicines, and an increase in the use and cost of existing services. Consumers have a high demand for more effective treatments, and expect these treatments will be provided to them soon after the technology first becomes available.

11.28 The ageing of the population also is projected to require increased health spending, as older people tend to have a greater need for health services. However, this is projected to have a much smaller effect on spending than the growing cost of new health care technology, increasing use of services and strong consumer demand and expectations.[23]

11.29 **Chart 11.5** below shows the projected growth in Commonwealth aged care expenditure.

Chart 11.5: Projected growth in Commonwealth aged care expenditure



Source: Source: Commonwealth Treasury, *Intergenerational Report 2002-03*, p. 39.

Committee view – residential aged care expenditure

11.30 The Committee recognises that community care programs that help the elderly to remain independent and living in their homes have been judged to be very successful, are very cost efficient, and are preferable to early admission into residential care.

11.31 The Committee notes evidence from witnesses that the current arrangements in relation to community and residential aged care are adequate. However, the Committee considers that, in the light of the projections identified in the *Intergenerational Report* and other reports published in the last decade, community

23 Commonwealth Treasury, *Intergenerational Report 2002-03*, p. 39.

and residential aged care programs should be kept under review to ensure their effectiveness and sustainability.

Alternatives for reform of the health system

11.32 The Committee has noted in this chapter the projected sharp rises in the cost of health and aged care over the coming four decades. This raises the question of the ongoing sustainability of Australia's health and aged care system in the future.

11.33 In its written submission, the Department of Health and Ageing argued that 'the fundamentals of Australia's retirement income and health and aged care systems are sound', and that 'Australia is well placed to respond to the challenges of an ageing society.'[24]

11.34 However, the Committee also notes an article by Dr FitzGerald entitled *Refocussing and Reinvigorating Retirement Policy – A Stocktake and Suggested Agenda for Advance*, dated March 1999, in which Dr FitzGerald argues that Australia's health and aged care systems are not sustainable.

11.35 Dr FitzGerald notes that unlike the age pension, publicly funded health care is not means–tested, and it is utilised by people across the income range, as indeed is private health insurance. Accordingly, looking ahead 40 years, he argues that with the projected substantial growth in public health care costs, principally due to the ageing of the population, there is no effective way to prevent an unbalanced share of the financial burden falling on future young Australian taxpayers unless:

- reliance on the 'free' public health system shrinks and the private sector share increases – which he argues seems unlikely to happen on any scale as long as the public system remains 'free'; or
- some kind of patient contribution is phased in, presumably over an extended period, within the public system. Such a contribution could be met by people from funds built up via some 'add–on' to the superannuation system, or separately. There would appropriately be 'safety net' exemptions and the contribution could be capped at an annual limit. The limit could be broadly income-related (e.g. a basic amount – subject to safety net provisions[25] – plus one or two steps applying to people on higher incomes).

11.36 Given his concerns, Dr FitzGerald suggested in his paper two options for reform of funding of health care in Australia, based on a closer integration of health care and the superannuation systems.

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24 *Submission* 80, Department of Health and Ageing, p. 14

25 Presumably such safety net provisions would not generally exempt retirees with adequate balances in their health care accounts (as discussed in the text following), other than in circumstances of hardship.

11.37 First, Dr FitzGerald proposed that individuals could contribute directly to their own accumulated 'health care accounts' in a similar manner to their contributions to their superannuation nest eggs. One practical argument for this is that the superannuation industry has established systems to collect contributions (related to wage and salary income) from almost every employer in respect of virtually all employees.[26]

11.38 Secondly, and alternatively, Dr FitzGerald proposed that superannuation could be used to fund compulsory health insurance. Under this model, individuals could pay their insurance premiums under a lifetime community rating system through savings built up before retirement. Dr FitzGerald continued:

> As a related element of security in retirement, the balances in the accounts could be used by self–funded retirees to 'buy' the PHB card (now more accurately called the 'health concession card'), for an annual payment equal to its average cost to the government for pensioners. It is believed from attitudinal research that many self–funded retirees would be prepared to pay considerably more than the card would actually cost the Government in order to gain security against the downside financial risk posed by unforeseen substantial health expenses. The card should be able to be provided to non–pensioner retirees for $4 to $5 per week ($200 to $250 per year) on a revenue neutral basis.[27]

11.39 Under this model, health care accounts residing with superannuation could serve to build up the means (especially ahead of retirement) from which to on–pay premiums to specialised private health insurance funds, but also to cater for those who do not wish to pay such premiums. Also, excess balances could simply be added to ordinary superannuation provision.

11.40 Dr FitzGerald proposed the bones of these two approaches could be as follows:

> a) The co–contribution concept could be brought back into the debate, with (say) a two or three per cent co–contribution phased in and earmarked to a health care account within individual's superannuation fund (or as one 'compartment' under a master trust). Such a contribution could be phased in in steps of 1 per cent at two–year intervals following completion of the phasing–in of the Superannuation Guarantee in 2002. There should be no difficulty in incorporating this element into defined benefit funds; almost all such funds have an accumulation component for members' own contributions.

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26 Dr V.W.FitzGerald, *Refocussing and Reinvigorating Retirement Policy – A Stocktake and Suggested Agenda for Advance*, paper presented at the Conference of Major Superannuation Funds, March 1999.

27 See D. Schofield, 'Re–examining the distribution of health benefits in Australia: Who benefits from the Pharmaceutical Benefits Scheme?', NATSEM Discussion Paper No. 36, University of Canberra, October 1998.

b) Subject to consistency with an overall reform of the structure of taxation applying to superannuation, the health care contributions should be

– treated as salary sacrifice contributions; and

– taxed as for other superannuation amounts.

c) The health care account could be used:

– for hospital–related costs, either private hospital costs or, in future, to meet a possible income–related (and capped) patient contribution to the cost of treatment in the public health system (as outlined above); and

– would attract the private health insurance rebate when so used.

d) Alternatively, the health care account could be drawn upon to pay private health insurance premiums (with eligibility only once for the private health insurance rebate). Those so insured would of course also pay the patient contribution when they used the public system—as many privately insured patients do on occasion.

e) Purchase of the health concession card in retirement would be a further eligible use but would presumably not attract any rebate.

f) Any excess balances in the accounts[28] could be transferred to one's ordinary superannuation accumulation account. At retirement the account balance would remain invested under something like the allocated pension regime. Rules would need to be devised to phase down the maximum balance while recognising the higher demands in very old age.

11.41 Dr FitzGerald noted in his paper that the above proposal is not fully fledged, and that introduction of such a scheme would obviously be contemplated only in conjunction with consideration of parallel reforms to Medicare itself. Ideally, the Medicare funding arrangements (at government level) should also be moved towards pre–funding for the future. For example, if the Medicare system were operated through a trust fund, that fund could be managed so that projected income from relevant sources, including patient contributions, would (together with anticipated fund investment income) meet projected future liabilities.

11.42 Similarly, the system of patient contributions outlined would need to be introduced only after a significant lead time and would, as discussed, ideally involve a

28 Research would be required to determine an appropriate maximum balance, amounts in excess of which could be 'swept' across into one's ordinary superannuation account. Ideally this would be income–related in some simple way (e.g. a basic amount plus additional amounts for those in upper income bands).

system of income-related caps and appropriate safety net provisions – particularly over the transition period.[29]

11.43 The Committee took evidence from Dr FitzGerald during its hearing in Sydney on 10 July 2002 during which Dr FitzGerald reinforced the case for additional contributions through the superannuation system to help fund health care in the future:

> The idea that I have put forward to help fund health care in the future is essentially a matter of using the superannuation system as a front-end or collection device since it is ubiquitous now—it stretches into every workplace and is administratively efficient in bringing the funds together. I think also that the superannuation funds management industry is very efficient at holding funds in suitable investments for this purpose, which might be rather more orientated to fixed income sorts of investments rather than growth investments. What happens to it after that depends on the policies for health financing. The way I suggested it might work is that, once such a system were phased in and people had a balance in their accounts that meant they could afford it, some sort of contribution could be introduced into the public system with an annual cap to protect people from charges beyond a certain level.[30]

11.44 The Committee considers below the response of parties during the inquiry to Dr FitzGerald's two alternative proposals for funding the health care system in the future.

Health accounts through superannuation

11.45 In its supplementary submission to the inquiry, the Department of Health and Ageing made a number of responses to Dr FitzGerald's proposal for compulsory health savings accounts funded through additional superannuation contributions:

> a) Firstly, the Department argued that health accounts would fit more comfortably within a managed care health system such as that in the United States, than within the Australian mixed public/private health and aged care system. This would depend on the detailed design of any specific model proposed for the Australian context, include assessment of the potential substitution of these savings for discretionary savings and private health insurance membership or premium levels.
>
> b) Secondly, the Department argued that health savings accounts would not cater for variations in health care needs between individuals and from year to year. In addition, health care costs tend to be concentrated in the last few years of life. Accordingly, the Department argued there needs to be some pooling of health care costs. In addition, research shows that high health care

29 V.W.FitzGerald, '*Refocussing and Reinvigorating Retirement Policy – A stocktake and suggested agenda for advance*', March 1999, pp 23-24.

30 *Committee Hansard*, 10 July 2002, p. 291.

expenditure is more likely to be required by those who are least likely to be able to pay for it.

c) Thirdly, the Department argued that individuals have limited capacity to assess their health risk and quantify what future resources will be needed to deal with that risk, particularly in old age. This is compounded by the fact that people with higher health care needs often have low or interrupted workforce participation and low lifetime income.

d) Fourthly, the Department argued that the higher the proportion of income directed into health care accounts, the greater the amount of money likely to still be in accounts when people die. The money left over would in effect be 'wasted', as it was put aside to cover health needs but not spent on health.

e) Finally, the Department also questioned who would own any money remaining in a health account at the time of the account holder's death. Bearing in mind that the funds have been contributed not only by the account holder but also by employers and the Government (through forgone taxation revenue) would these other contributors receive any of the funds remaining?[31]

11.46 In its written submission to the inquiry, ASFA also did not support the concept of compulsory health savings accounts funded through additional superannuation contributions. It noted that at current rates of contributions, superannuation does not have the capacity to meet the projected increase in aged care and health costs. As previously noted, the *Intergenerational Report* projects health and aged care costs to increase by 5.2 percentage points of GDP over the 40 years to 2042, whereas the flow of income from a fully mature superannuation system is likely to be around three per cent of GDP. In addition, ASFA noted that:

> In any event, self insurance through access to savings type accumulation accounts would not be an effective mechanism at an individual level. Personal savings generally will be either too much or too little to deal with health and aged costs. Most individuals do not have the capacity to deal with the large or catastrophic costs of health care and aged care that are faced by just a minority of the aged population. Money set aside for such costs will either be wasted and form part of the estate of the person, or will be nowhere sufficient to meet the costs that might be involved.
>
> Governments will and should have ongoing roles in providing what is in effect community based insurance against health and aged care costs which would be catastrophic at the individual level.[32]

11.47 Similar concerns were expressed to the Committee during hearings. For example, in evidence on 19 July 2002, Mr Schneider from the Australian Health

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31 *Submission* 140, Department of Health and Ageing, pp. 2-4.

32 *Submission* 73, ASFA, pp. 34-35.

Insurance Association indicated his concern that the provision of health savings through the superannuation system or a similar system would be difficult. Mr Schneider argued that it would be unlikely that an individual could generate sufficient savings in their lifetime to be quite sure of covering any health costs they could face in retirement. At the same time, the paradox is that some individuals may indeed have a very large surplus, because not all people need health care before they die. Mr Schneider continued:

> … I think it would be a policy error to transfer the funding that is currently provided to the health insurance rebate to a long-term savings scheme. The outcome of that would be that many people would drop their health insurance totally, which would immediately drive premiums up, and that would have to be met by the people who remain insured, who would tend to be older or sicker. So there would be an immediate negative impact and that would compound over time, which would mean that again the cost of even buying insurance in retirement would become unaffordable. I would prefer the rebate to be retained and emphasis placed on continuing to generate growth within the insurance system from younger people or lower risk people. Younger people are not necessary all lower risk but the majority of them are lower risk than those who are older.[33]

11.48 In evidence to the Committee on 8 October 2002, Dr Knox also opposed any proposal for separate health accounts through the superannuation system:

> My third point concerns health funds and super—whether we should have health funds as an extra account area. My view at the moment is that we should not, for a couple of reasons. Mr Gallagher highlighted the fact that individual health expenditure is incredibly variable. When we retire, most of us expect to live for 10, 20 or 25 years and have a fair idea of what our income needs will be. Some of us will have very significant health costs in retirement, and some of us will have almost nil—we will live a healthy life for 10 years and drop dead on the golf course or something like that. There is incredible individual variety—much more so than in retirement income—and you will therefore need some pooling. So, at the moment, I do not think the super system is the way to go. I would also make the point, which we talked about this morning, that it is important to get the super system for retirement income right before adding health—to get the adequacy and the tax system appropriate before adding another area of complexity. So my view at the moment is that we should not add health to super; we should get the retirement income component right first.[34]

11.49 In response to these concerns regarding a compulsory health savings accounts funded through additional superannuation contributions, the Committee notes the evidence of Dr FitzGerald at the Canberra roundtable on 8 October 2002:

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33 *Committee Hansard*, 19 July 2002, pp. 574-575.

34 *Committee Hansard*, 8 October 2002, pp. 720.

> The issue is not about whether it is a good or a bad thing to provide good health care for that generation. We will do it and we will want to do it. Really the issue is about how it is to be equitably funded. Given that it is a large future foreseeable need of a similar kind to the retirement income we are funding for, one would think that some sort of pre-funding has to be part of the solution. Some of that pre-funding might be what we already see around us—that is, the money that is going into superannuation or into our houses—and the question then becomes: how do you have the baby boomers, in their old age, with enormous assets, pay a fair share as against the future young taxpayers? …
>
> That was the set of thoughts that led me, as the one who threw this into the ring a couple of years ago, to think of having something like health accounts in the superannuation system. This would not be a full-service health insurance type operation—because obviously, as a couple of the speakers have said, everybody over 65 can pay regular premiums, but the actual need for health services is highly variable. So there has to be some pooling aspect; but I do not see that as being done in the superannuation system. It may be done as it is now in the public system, by sharing all the imposts on the budget and having them met either by taxpayers or by individual contributions that we make when we go to the chemist and so on. But my view is that the balance does have to shift, otherwise the situation looks inequitable.[35]

11.50 The Australian Prudential Regulation Authority suggested that an alternative to superannuation health accounts could be the provision of a Retirement Savings Accounts type product, outside the superannuation system, to meet health costs. Any preservation requirements imposed as a trade off for concessional tax treatment or rebate could be tailored specifically for such purposes rather than attempting to fit it on to the superannuation system.[36]

Compulsory health insurance through superannuation

11.51 In response to Dr FitzGerald's second proposal for compulsory health insurance through the superannuation system, the Department of Health and Ageing made the following points in its supplementary submission:

> a) Firstly, the Department noted that this approach is a feature of employer benefits schemes in the United States. There, most health fund members are younger and in good health, with the result that most health insurance products tend to be very limited in scope. Coverage may also be limited to the worker, with the result that family members have no health coverage. Workers may also drop out of health coverage when they retire or leave a particular employer, and believe themselves to be covered when this is no longer the case. In addition, the system tends to exclude those who are

35 *Committee Hansard*, 8 October 2002, pp. 721-722.

36 *Submission* 100, APRA, pp 2-3.

most likely to need care, such as older people, people with chronic illness, people with disabilities and people of lower socio-economic status who work in jobs that do not provide health cover, in casual employment or the "underground" economy.

b) Secondly, on the basis of the US experience, the Department argued that a superannuation-based fund could discourage health fund membership for people outside the workforce, who are more likely than workers to need health services. For example, coverage for women could be adversely affected, due to their broken workforce participation especially during child-raising years. Alternate policies that cover a dependant spouse could create administrative difficulties and duplication where partners are in and out of the workforce.

c) Thirdly, the Department noted that a move to compulsory private health insurance coverage for any sector of the population could be seen to be at odds with the Government's commitment to choice in private health cover and universal access to Medicare. The introduction of compulsory additional superannuation coverage or funding through abolition of the Government's highly popular 30 per cent rebate would be a major shift from current Government policies.[37]

11.52 Mr Wells from the Department of Health and Ageing reiterated the Government's commitment to universal health coverage through Medicare with optional private health insurance at the Canberra roundtable discussion on 8 October 2002:

> The current system of universal coverage through Medicare with optional private health insurance is, as surveys have shown, supported by the Australian people and also has the support of the major political parties. The department sees on the horizon no pressure from those ends to move away from the current system.[38]

11.53 The Committee notes that other parties at the Canberra roundtable discussion on 8 October 2002 also did not support the proposal for compulsory health insurance through the superannuation system. For example, Mr Davidson from the Australian Council of Social Service submitted:

> In relation to health and aged care, the main issue is whether the superannuation system should be used for health insurance or health saving purposes. We are actually in favour of using superannuation, within certain strict limits, for a range of purposes, such as health care, housing or career breaks for further education or child rearing, but probably not specifically for health purposes. The reason for that is that we are not convinced that that is the best and fairest way to shift the incidence of the costs of health care

37 *Submission* 140, Department of Health and Ageing, pp. 4-5.

38 *Committee Hansard*, 8 October 2002, p. 707.

> from government to individuals or whether that is a desirable thing to do. Essentially, that is what you would be doing by using superannuation for health purposes. There would inevitably be a shift in the incidence of the cost of health care from government and general taxation to individuals through their super accounts, whether or not that is the intention of the policy in the first instance.[39]

11.54 The Committee notes, however, that although ASFA did not support the concept of individual health account through the superannuation system in its written submission, it offered conditional support to the concept of superannuation being used to meet health insurance costs:

> … enhanced retirement incomes do have the capacity, amongst other things, to facilitate the maintenance by individuals of membership of private health insurance in the post-retirement period, and to pay for ancillary services and a better quality of lifestyle. The primary goal should be to generate significant retirement incomes, which can then be used for a range of purposes according to the needs and interests of specific individuals.[40]

Dental health

11.55 COTA drew the Committee's attention to the lack of a comprehensive national dental health service, advising the Committee that this is 'perhaps the greatest deficiency in our health services'. COTA explained the importance of dental health:

> Poor oral health affects many older Australians, and failure to act to improve services will ensure that older people far into the future will continue to suffer the same problem. Oral health is fundamental to well being. Numerous other conditions and illnesses arise from it.[41]

Committee view – alternatives for reform of the health system

11.56 The Committee broadly supports the concept of additional funding being set aside through the superannuation system, or other savings vehicles, to meet future health care needs, and believes that a model of voluntary health insurance through superannuation could be examined further by the Government.

11.57 In the Committee's view, there could be administrative economies to be generated by closer cooperation between the private health funds and superannuation funds. They may include savings to be gained from the joint administration of private health funds and superannuation funds, for example through the collection of health insurance and superannuation contributions jointly, and streamlining the payment of benefits.

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39 *Committee Hansard*, 8 October 2002, p. 711.

40 *Submission* 73, ASFA, pp. 34-35.

41 *Submission* 63, COTA, p. 30.

11.58 However, the Committee acknowledges that voluntary health insurance through superannuation would raise significant issues that would need to be addressed before any proposal could proceed. In particular, as highlighted by the Department of Health and Ageing, any proposal for voluntary health insurance through superannuation would need to address the position of those outside the workforce, or those moving between jobs. As reported in this chapter, employer benefits-based health insurance products in the USA have tended to be limited in the coverage they provide, effectively excluding those who are most likely to need care, such as older people, people with chronic illness, people with disabilities and people of lower socio-economic status.

11.59 In addition, the Committee notes that any proposal to set aside additional funding through the superannuation system to meet future health care needs would need to be considered in the context of Australia's successful Medicare system. Surveys have shown that Medicare has broad support in the Australian community. The Committee would not envisage that any move to encourage those in employment to put aside additional savings towards their health care in later life would be at the expense of universal public health care for those without health care savings for whatever reason. The Committee believes in the benefits of the Medicare system.

11.60 The Committee notes that the cost of health care can vary significantly from individual to individual. However, as health care costs are expected to increase significantly in the next four decades, the Committee considers that proposals by which superannuation could be used to help meet these costs warrant further examination**.** In particular, a model of voluntary health insurance through superannuation could be examined further by the Government. In addition, the Government could examine whether there may be administrative economies to be generated by closer cooperation between superannuation funds and private health funds.

11.61 The Committee also notes the evidence of COTA about the importance of ensuring access to dental health services.

Recommendation

11.62 **The Committee recommends that the Government consider proposals by which the superannuation system could be used to help meet health care costs in Australia, including dental health costs, which are expected to increase significantly in the next four decades.**