06 February 2003

The Secretary
Standing Committee on Ageing
House of Representatives
Parliament House
CANBERRA ACT 2600

Dear Secretary

The ageing of the Australian population will continue and will have a greater impact than before on the need for strategies to deal with the cost of health and aged care.

In 40 years time, Australia will be a much wealthier nation than it is today. Our wealthier economy will be able to deliver essential services to ***all*** our citizens, including affordable housing and access to high quality health and aged care. It is important that consensus on distributional issues is reached early on, such that a balance between community responsibility and individual participation can be achieved.

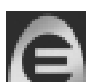
But a change in thinking is required. We ought to see the provision of high quality health and aged care as an opportunity, rather than as a problem. We ought to perceive the very important contribution that older people can make to society in many capacities.

Some aspects of the systems for providing and financing health and aged care are unsustainable. Catholic Health Australia has made a number of recommendations in its submission to address the issues.

I commend this submission and its recommendations to the House of Representatives Standing Committee on Ageing.

Yours sincerely

Francis Sullivan
Chief Executive Officer



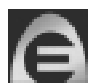
CATHOLIC HEALTH
AUSTRALIA

Strategies to Address the Ageing of the Australian Population Over the Next 40 Years

Submission to the House of Representatives Standing Committee on Ageing

November 2002

Catholic Health Australia acknowledges the assistance of Access Economics in the preparation of this submission.



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Executive Summary

- In 40 years time, Australia will be a much wealthier nation than it is today. Our wealthier economy will be able to deliver essential services to ***all*** our citizens, including affordable housing and access to high quality health and aged care. It is important that consensus on distributional issues is reached early on, such that a balance between community responsibility and individual participation can be achieved.
- Intergenerational issues are not novel. Over the past 30 years, the Australian population has already gone through significant demographic change. Occupational superannuation (SG) was introduced with a view to easing future budget pressures. Our health system is under pressure, but has not collapsed.
- The ageing of the Australian population will continue and will have a greater impact than before on the need for and cost of health and aged care. In future, intergenerational transfers will continue as a source of finance, but Australia will have to become less dependent on them. A savings vehicle to finance future health and aged care is paramount.
- The Federal Government's Intergenerational Report (IGR) makes a useful contribution to kick-starting a debate about intergenerational equity. That said, the report is in some respects flawed. Good policy will recognise that intergenerational equity is not just an issue for the Federal Budget, and will not lose sight of social equity issues. Catholic Health Australia does not accept the implicit proposition in the IGR that government revenue ought not to increase as a share of GDP. A significant ongoing role for public financing of health and aged care must remain, to ensure distributional equity and adequate safety nets for the most disadvantaged Australians.
- But a change in thinking is required. We ought to see the provision of high quality health and aged care as an opportunity, rather than as a problem. We ought to perceive the very important contribution that older people can make to society in many capacities (including as volunteers and carers). We need to adopt wellness strategies based on the premise that more ageing does not necessitate more disability.
- Some aspects of the systems for providing and financing health and aged care are unsustainable. But we must avoid the "shoot the messenger" approach of excessive cost containment for faster growing programs and over-reliance on rationing of services through queuing. Waiting lists are clearly not producing the best outcomes for the people most in need.
- Catholic Health Australia notes that adequate retirement incomes will continue to be a very important issue for an ageing Australia, and urges further reform to address the inadequacy of the 9% SG rate and disincentive in triple taxation of superannuation. Reform should recognise that three big issues for older people are their needs for retirement income, housing, and health and aged care. There is scope for a more integrated policy approach to these three. This includes public and private savings options to make it easier for people to meet their lifetime health costs and options for people to unlock the equity in their homes to meet needs in older age.

- Catholic Health Australia has made a number of recommendations to address these issues. Section 2 addresses retirement incomes. Section 3 addresses housing. Section 4 addresses health and aged care. A compendium of these recommendations is included at page iii following.

I commend this submission and its recommendations to the House of Representatives Standing Committee on Ageing.

Francis Sullivan
Chief Executive Officer
December 2002

Compendium of Recommendations

- Adoption of a balanced approach – avoiding the dangers of both 'scorched earth' and 'do nothing' policies, that must include the scaling down of *intergenerational* transfers, but maintenance of tolerable and sustainable levels of *interpersonal* transfers to ensure social equity.
- Adoption of a holistic forward-thinking approach, which treats health spending more as an investment than a cost – rather than merely a Federal Budget approach as per the Intergenerational Report – and which includes:
  - analysis of impacts of demographic ageing on State and Territory budgets, especially in relation to investment in capital infrastructure and housing stock in the aged care sector;
  - acknowledgement of the need for health and aged care spending to increase in real and relative terms, with strategies for successfully managing the change;
  - transition towards health ageing strategies – in particular for home-based aged care services, public health programs and community-based health services – that reduce costly hospitalisations and residential care needs;
  - community consensus on the shares of public and private sector financing, which would most likely include extension of private health insurance coverage together with effective safety nets for the most vulnerable;
  - avoidance of myopic and regressive spending cuts in areas of dominant health therapy, such as pharmaceuticals; and
  - changes in attitudes towards older people as being extremely valuable as workers, volunteers, carers, and consumers.
- In order to achieve adequate retirement incomes:
  - Removal of taxation on superannuation contributions (and simplification of superannuation arrangements), retaining full imputation credit entitlements;
  - If and only if taxation is reduced, incremental increase in the SG levy to between 12% and 15%, including quarantined health and aged care savings components ("Grey Levy", Health Savings Funds) and with negotiated employer and employee elements;
  - Retain the age pension, means and asset tested, to increase from 3% to 4.5% GDP; and
  - Increase public spending on aged care to compensate for its falling share of welfare payments in recent years.
- To soften the dependency burden:
  - Measures to retain more mature workers in the workplace;
  - Measures to maintain or enhance immigration inflows; and
  - Woman-centred measures to provide incentives for higher fertility.
- To ensure that affordable and secure housing is part of the package of health and ageing essential services:

  - Adopt a "whole economy" approach to housing assistance policy, recognising the positive health implications of improved housing;
  - Review trends in the nature and location of housing and develop policy that encourages both new construction and renovation in a manner consistent with healthy ageing – including the appropriateness of internal design aspects, proximity to facilities (especially health facilities), and good public transport, especially in relation to retirement villages;
  - As demographic growth slows, promote innovative strategies, such as renovating office blocks into apartments for plus 50s, including security and health safety features;
  - Monitor and encourage affordability, eg through measures to reduce escalating costs of land and strata titles in coastal and city retirement areas; and
  - Address financing issues and support services (eg, respite) for residential aged care and home-based care options.
- To manage and improve health and ageing outcomes:
  - Introduce health savings accounts, possibly linked to superannuation as outlined above;
  - Extend unsubsidised private health insurance coverage possibly with tiered premiums based on socio-economic status, improve the emphasis on genuine risk-sharing (perhaps by removing the subsidy on some ancillary items), and improve competition in and evaluation of the PHI sector;
  - Introduce a Medicare Grey Card for low-income people over 70 to access certain private hospital services after a defined waiting period on public hospital queues;
  - Review copayments including in relation to the proliferation of Health Care Cards, to reduce moral hazard so that marginal costs at the point of service delivery are appropriate to the income and assets of service users, especially in relation to general practice, hospital queues and PBS items; and
  - Introduce an Aged Care Benefit Schedule for low income elderly people with schedule items including residential care services, home-based care services, respite and other services based on level of disability and mental health needs, with rebates linked to age as well as income and asset group and capable of being determined electronically and reviewed periodically.

1 Setting the Scene

1.1 Demographic change in retrospect

A focus on intergenerational issues is not novel. Australia has seen significant demographic change in the past. Birth rates have fallen and life expectancy has increased. Family sizes have fallen and family structures have changed. More people live alone, with implications for the support systems they need. And the population has aged, with the change in the age structure from 1971 to 2001 illustrated in Charts 1 and 2.

Chart 1: Population by Age 1971

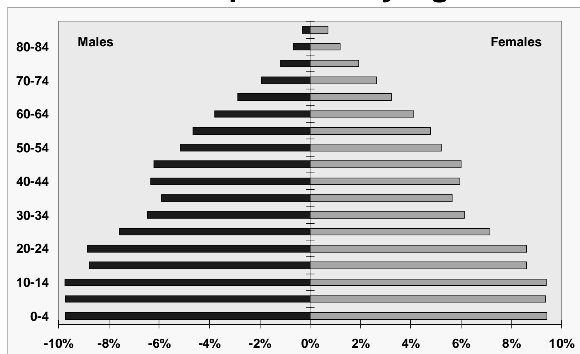
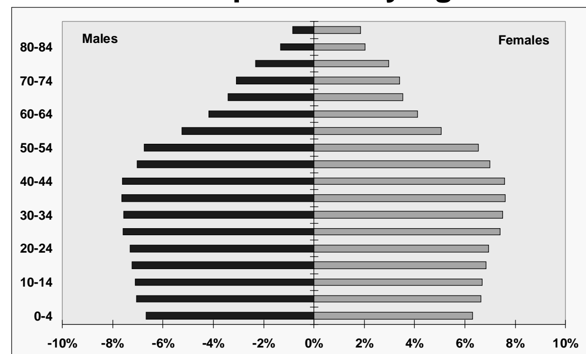


Chart 2: Population by Age 2001



Australia has coped with the demographic changes. The health system is under pressure. It has had to change and adapt, but it has not collapsed. Perhaps change has not always been well managed, but it has happened nonetheless.

Concern about the pressures on budgets due to ageing and potential intergenerational inequities is likewise not novel. The occupational superannuation (SG) arrangements were forged on the back of these very issues. However, when implementing the SG arrangements, the Government of the day only did half the job. Further reform will be needed to get sustainable retirement income policies in place. And retirement income is only one of the needs of old age. *Health and aged care needs also loom large, and it is in financing of these needs in particular where much more work needs to be done.*

1.2 Demographic change in prospect

Australian Bureau of Statistics population projections indicate that the Australian population has a lot more ageing to do over the next 40 years. Following is Chart 2 (2001) again, compared here with the projected age structure in 2041 (Chart 3).

Chart 2: Population by Age 2001

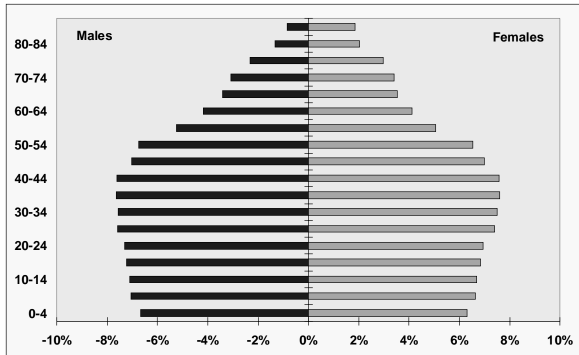
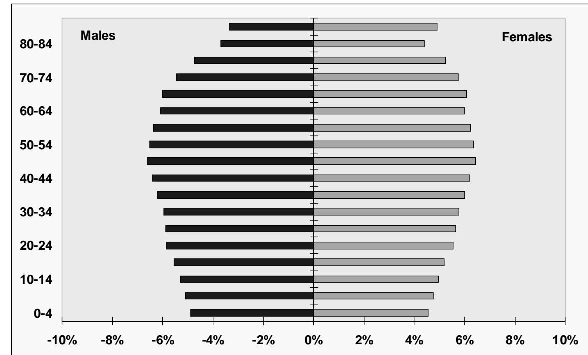


Chart 3: Population by Age 2041



In a nutshell:

- In 1971, Australia had relatively many more young people;
- In 2001, the baby-boomer bubble has meant relatively more middle aged people; while
- In 2041, Australia can expect to have relatively more elderly people.[1]

Indeed, by 2041, those aged 65 and over will represent 25% of the population compared with 8% 30 years ago and just over 12% currently. Chart 4 shows how this cohort of the population is expected to surge as a percentage of the total. Of course, this is just another way of retelling the story that is already told in Charts 2 and 3. But it is a point worth repeating—Australia will have many more older people in both absolute and relative terms. The implications of this for health and aged care spending are addressed below.

Chart 4: Persons Aged 65+ as a % of total

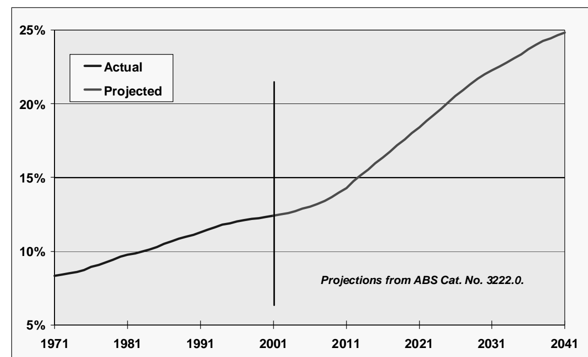
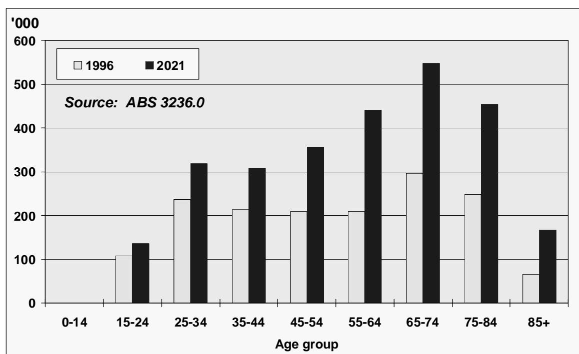


Chart 5: Persons living alone, 1996 & 2021



While the ageing of the population is the most dramatic demographic trend evident in Australia, it is not the only development worthy of attention. Chart 5 shows the expected increase (over a 25-year period) in the number of Australians who will be living alone. The number of single person households is projected to increase by over 70% from under 1.6 million in 1996 to over 2.7 million in 2021. For those aged 65 and over, the increase is 90%. This has obvious implications for the support systems that older people will need.

1 Chart 3 is based on the ABS Series II projections published in ***Population Projections***, Cat. No. 3222.0.

1.3 Implications for health and aged care spending

The ageing of the population over the last 30 years has increased the need and demand for health care and aged care. The ageing in prospect will add rather more again. Charts 6 and 7 show two measures of the way that health utilisation increases with age. Pharmaceutical usage also increases with age.[2]

Chart 6: Medical services per person by age

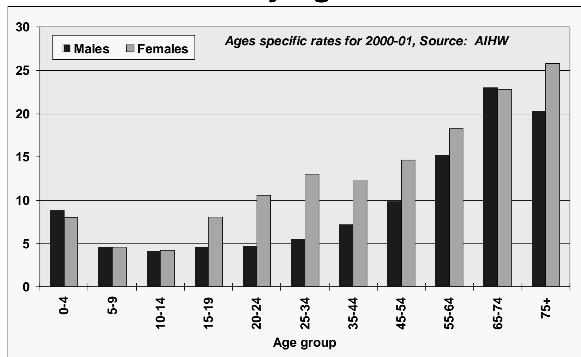
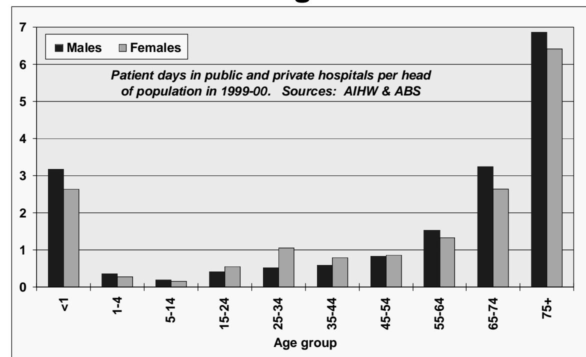


Chart 7: Hospital use per person by age



Those aged 65 to 74 use almost twice as many medical services per capita as those aged 45-54 and over five times as many as those aged 10 to 14. In the case of hospital utilisation, the age differences are rather larger. Those aged 65 to 74 use three to four times as many patient days in hospital per capita as those aged 45-54 and some 17 times as many as those aged 5 to 14 while those aged 75+ almost eight times as many patient days in hospital per capita as those aged 45-54 and 40 times as many as those aged 5 to 14.

If we were to assume that the utilisation rates for medical services remained unchanged, then the effect of an ageing population would be to increase the overall rate of utilisation by some 20%, from 11.1 services per capital per annum currently to 13.3 services by 2041. Similarly, if we were to assume that the utilisation rates for hospital days remained unchanged, then the effect of an ageing population would be to increase the overall rate of utilisation by slightly over 50%, from 1.18 days per capital per annum currently to 1.79 days by 2041.

The calculations in the preceding paragraph are essentially mechanical. Rates of utilisation of both medical services and hospital services have changed over time. They will continue to change in future due to many influences, including:

- **A changing epidemiology**—chronic and degenerative conditions such as Alzheimers/dementia, arthritis, osteoporosis and diabetes are heading for “epidemic” proportions. As these are mainly diseases of old age, the ageing of the population will be enough to drive up the prevalence rates (which may be rising for other reasons as well such as diet and exercise). But the increasing importance of chronic and degenerative conditions is not just a function of increasing prevalence. It also depends on the scope for treatments. And it depends on what is happening with other diseases. We are seeing inroads in

[2] See for example, Walker et al (1998) *A Microsimulation Model of Australia's Pharmaceutical Benefits Scheme*, NATSEM Technical Paper No. 15, which showed age to be the second largest determinant of pharmaceutical use.

other areas (falling death rates for cardiovascular disease, rising survival rates for cancers). Infectious diseases are much less of a threat than they were a century ago. Some new communicable diseases such as invasive meningococcal disease are frightening and may grab the headlines even though annual deaths are relatively very small. However, over time, it is a reasonable expectation that more and more health resources will be brought to bear on addressing chronic and degenerative conditions.

- **Changing health technologies**—which will save resources in some areas (further reducing hospital length of stay or even obviating the need for in-patient episodes of care), but make a claim for additional resources in other areas.
- **Changing patient expectations and preferences**—an older population will undoubtedly have a deeper concern with access to health and aged care. It is unquestionable that these deeper concerns will have an influence on political processes and outcomes. The grey vote will simply become too large and organised to ignore. The deeper concern with health care will also have implications for the willingness of people to contribute to their own health costs, either through taxation, through private health insurance premiums or through out-of-pocket contributions.

Of the three factors mentioned above, the impact of changing health technologies is the hardest to predict. Some new technologies seen in recent years have generated massive cost savings. Others have generated large cost increases. Policy makers concerned with the Budget impact of new health technologies often put the spotlight on initial high costs. However, the initial unit costs of new technologies can be a very poor indicator of the unit costs in later years. Once technologies have been proven safe and health-effective, the next challenge is always to find ways to deliver them in more cost-effective ways. And that "second wave" of innovation can be just as important as the initial discovery in terms of making new health technologies accessible to the population at large.

While we cannot easily foresee the full impact of technological change, there is nonetheless a substantial bundle of evidence for the proposition that the demographic change in prospect will generate higher demand for health and aged care than the demographic change in retrospect.

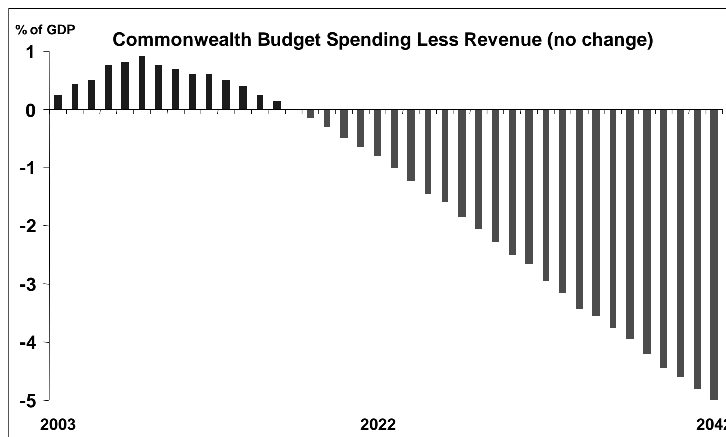
1.4 Less dependence on intergenerational transfers?

It is the considered view of Catholic Health Australia that it will not be possible to meet all the reasonable expectations of the Australian community (in regard to adequate retirement incomes and access to high quality health care) were we to seek in future to rely on intergenerational transfers to the same extent as we do today. The crude dependency ratio (the proportion of people over 65 relative to the population) will double in the next four decades, as shown in Chart 4, which will severely reduce the capacity of those of working age to finance – through the taxation of their earnings – the retirement income of the elderly, including their age pension, health and aged care needs. The tax base has been broadened in recent years so that there is potential to raise revenue by increasing the GST. However, it is noteworthy that health items do not attract GST yet are increasing as a proportion of total expenditures, not to mention the political dimensions of this option.

That said, of course there will need to be intergenerational transfers in future. It may be helpful to consider two extreme approaches.

- **A "scorched earth" policy** to reduce intergenerational transfers would involve rapid and immediate movement of responsibility onto private individuals for their ageing needs. Many young people (and hence also politicians) may be averse to this policy, preferring current consumption and investment to forced savings. They would pay twice – once to meet the needs of the present aged and once for themselves for their own aged care. There would also be considerable risk of those outside safety nets "falling through the cracks" with no provisions. A scorched earth policy would inevitably create more problems than it would solve.
- **A "do nothing" policy** may result in gradual but substantial increases in the taxation burden on the current generation of working age, to finance the needs of ageing baby boomers and, ultimately, baby busters. They'd pay once, but increasingly heavily (see Chart 8). There would be less and less flexibility in the financing system, and increasing discontent, particularly with myopic governments ignoring world wide trends to redress the financing anomalies.

Chart 8: The implicit burden of future tax increases for fiscal balance



Clearly what is needed here is a measured policy to trim the flight path and set course for a sustainable financing framework that must include a tolerable level of interpersonal if not intergenerational transfers. The measure of what is sustainable and tolerable is multi-dimensional. It extends far beyond issues of budgets and taxation. Policy must also be sustainable in a social context. We will expand on these themes in later sections.

1.5 The Government's Intergenerational Report

The Federal Government announced the details of the Charter of Budget Honesty in August 1996, a follow-up to a 1996 election commitment. The commitment was to produce an intergenerational report on a 5-yearly cycle. The first of these reports, issued in 2002, has been a long time coming. Has it been worth the wait? We think so. The IGR addresses important issues. They are issues the community might prefer to avoid, but they won't be avoided. Needs for retirement income, health and aged care will rise and we have to find the ways for the community to fund all that.

The IGR helps to “kick start” the debate, and that in itself is a useful contribution. It helps to identify the issues, but it does not propose an ***explicit*** strategy to address them (it does have some ***implicit*** directions).

The IGR is based on a 40-year forecasting framework. The function of the IGR is to:

> “… *assess the long-term sustainability of current policies, including taking account of the financial implications of demographic change*.”[3]

Given that, and given also that the next 40 years will be a period of significant demographic change, the 40-year horizon makes some sense. However, even small errors in assumptions are capable of generating huge discrepancies over a 40-year period. And as we have seen, even short term budget forecasts are subject to large margins of error. Therefore, the projections on which the IGR is based can hardly be regarded as firmly based. On the contrary, they are at times wild and unreliable numbers. In projecting health care, for example, the IGR assumes that:

> “*Most of the projected growth in health spending reflects the increasing cost and availability of new high technology procedures and medicines, and an increase in the use and cost of existing services.*”[4]

In other words, the change is driven by technology and expectations, not ageing per se. However, as we have noted above, the impact of health technology is extremely difficult to predict. Some people are holding out huge hopes for gene technology. It would be a brave (and foolish) person who would confidently predict that none of these hopes will be realised. A cure for diabetes, for example, may generate very large downstream savings in health expenditures.

In the considered view of Catholic Health Australia, the IGR is flawed in a number of respects. These flaws do detract somewhat from its overall credibility. Yet few would argue that the IGR invents an imaginary problem. Indeed, the early sections of this submission generally support the contention that Australia needs to change some policy settings to achieve sustainable outcomes.

A key issue is whether or not the IGR gives a reliable indication of the likely magnitude of “the problem”. Catholic Health Australia considers that the House of Representatives Standing Committee on Ageing needs to grapple with this issue. We note that it may require particular expertise to be invoked. Community groups can contribute to the understanding of the issues, but are not necessarily well placed to deal with all the technical aspects of the IGR on a blow-by-blow basis.

Ultimately, lengthy criticisms of the IGR are unlikely to be helpful or effective. For one thing, the IGR presents the results of modelling based on many hundreds if not thousands of assumptions, only a few of which have been disclosed. The external (to Government) observer is, of course, disadvantaged by the lack of transparency. A particular concern about the scope of the IGR is addressed in the next section.

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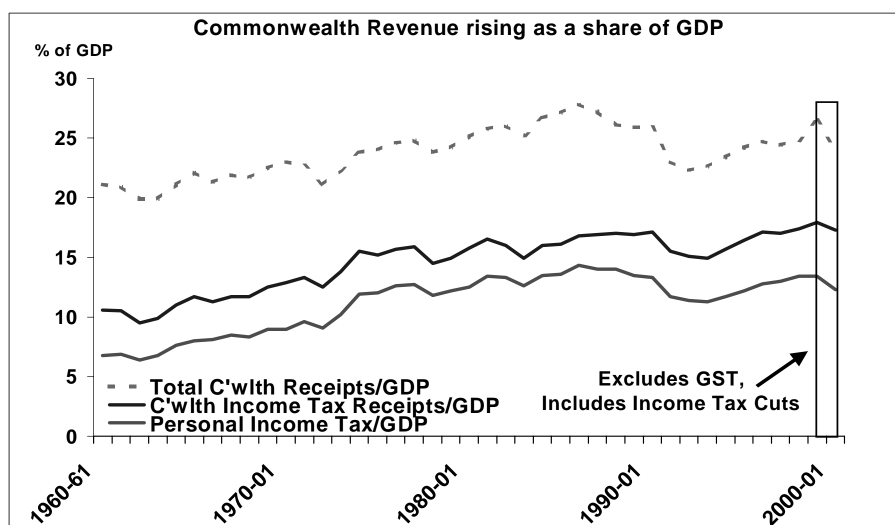
[3] Statement by the Hon Peter Costello, Treasurer, “***Charter of Budget Honesty***”, 20 August 1996, AGPS.
[4] IGR, page 38.

Before moving on to that, we briefly mention three assumptions underpinning the IGR which have attracted a significant degree of adverse comment:

- **Labour productivity**—The IGR assumes that labour productivity will grow at its long-term average for the last 30 years of 1.75% per annum. The implication is that real GDP growth per person falls back to 1.4 to 1.5%[5] on average per annum in the 2010s, 2020s and 2030s, significantly lower than seen recently. Expert commentators have asked why the recent rates of growth are seen as unsustainable. The IGR also provides some sensitivity analysis.[6] The very wide gap in outcomes between the high and low growth scenarios serves to underline the significant uncertainties in the projections.
- **Labour force participation by older workers**—the IGR assumes that labour force participation among older age groups is broadly flat.[7] Again, the plausibility of this assumption is questioned by expert commentators who point to a longer living, healthier population with larger needs for retirement incomes on the one hand, and a potential shortage of skilled labour on the other.
- **Revenue to GDP**—the baseline projections assume that revenue will remain constant as a proportion of GDP.[8] This assumption is critically important to the overall findings of the IGR, yet it is not one where any sensitivity analysis is attempted or alternative scenarios presented. Notwithstanding the attempts by the Federal Government to mask the effect of higher indirect taxation by attributing GST revenue to the States and Territories, government revenue has increased relative to GDP in the past (about 3% of GDP over the past 40 years) as shown in Chart 9 below. Since the reasons are due to fiscal creep—tax cuts return only part of revenue gains, since politicians prefer to spend rather than hold taxes stable. There is no apparent reason why this trend would not continue.

Chart 9: Long term trends in Commonwealth Revenue relative to GDP



5 IGR, Table 4, page 30.
6 IGR, Table 5, page 31.
7 IGR, Appendix B, pp 72-73.
8 IGR, page 33.

The constant revenue assumption has two effects. First, it results in some potential overstatement of “the problem”. Second, it implicitly restrains the discussion of policy options for funding future needs of an ageing society. Catholic Health Australia does not accept such a restraint on the canvassing of policy options.

1.6 Not just a Budget problem

The IGR addresses intergenerational issues as if they were concerns only in the context of the Federal Budget. The IGR is, of course, a Federal Budget paper issued in a Budget context. Naturally, it tackles intergenerational issues from that singular point of view. However, it would be a grave error of perception to limit policy and planning considerations to the Federal Budget impacts only.

There are certainly implications also for State and Territory Budgets, and not just in relation to the significant level of State and Territory outlays on health care. Capital expenditure by the State and Territory governments has been low, and significant parts of State infrastructure have been allowed to decay. For example, several NSW railway tragedies have now been attributed to the dilapidated state of the permanent way and associated equipment. The failure to maintain and renew the capital stock is tantamount to the current generation enjoying lower taxes now at the cost of imposing higher tax burdens on future generations.

In the health and aged care sector, the Gregory Report (1994) identified a significant decline in the capital expenditure and hence the quality of nursing home buildings, as providers were not allowed to charge variable fees nor entry contributions and the funding arrangements did not provide an adequate return on investment in capital stock. Reforms in aged care introduced in 1997 included certification processes to ensure that that new buildings must now meet defined resident per room and other standards and existing residential aged care facilities must meet quality standards by 2008. The reforms did not, however, solve the financial aspects of the capital investment problem, which needs to be at the forefront of further structural reform and deregulation of the residential aged care sector, and well before the first wave of baby boomers turn 60 in 2005. A plethora of issues are related to this problem, including the likely increased concentration of ownership of providers, locational aspects of nursing home and hostel closures, capacity for disability and mental health care, access for lower income people and implications for home-based care services to allow baby boomers to “age in place”. [9]

Another issue and policy direction that has previously been highlighted by CHA, and identified again in this paper is the call for a National Ageing System, rather than the myriad of disparate programs currently operating. As a mechanism for initiating public debate, CHA proposes a number of policy initiatives that would underpin a more coherent approach to ageing. It is seeking to promulgate the development of a National Ageing System. The outcomes of existing initiatives such as the Aged Care Pricing Review also need to be considered in the context of the achievement of such a system.

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[9] Recent international perspectives include the UK report *The residential care and nursing home sector for older people: an analysis of past trends, current and future demand*, 2002 on www.doh.gov.uk/careanalysis/index.htm and the *Report of the US Senate Special Committee on Aging*, 107th Congress, June 2002 on www.aging.senate.gov/issues/longtermcare.html

People aged over 65 account for 12% of the Australian population, 30% of hospital admissions, and 43% of hospital bed day use (Howe, 2002). Despite the constant blame game between the Commonwealth and the States over the existence (or not) of phantom aged care beds as a result of a severe capital crisis in the high care end of residential aged care, the fact remains, the elderly and frail are the losers in this game.

The key to a robust, efficient and effective health system is improved integration of care services between the acute, residential, transitional, mental health and home and community care sectors. The current situation of ineffective integration leaves consumers at a loss in moving through the system and results in unnecessary duplication and piecemeal health and aged care. Strategies must be implemented to improve the continuity of care across programs and to address any cost shifting, service fragmentation and jurisdictional duplication measures that impede quality care.

Indeed, population ageing introduces a whole range of behavioural change issues across the health and ageing portfolios, stemming in part from budget pressures. Notable examples include declines in average length of stay in hospitals and policy directed towards avoiding costly hospitalisations through prevention and managed care models – for example first fracture clinics and day surgery procedures to manage the increasing number of hospitalisations of elderly women with osteoporotic fractures. There are also workforce issues, education issues (re-orienting training towards chronic degenerative illnesses), and technology issues. “Healthy ageing” – at the lowest cost while ensuring quality – is becoming an international catch-cry, resulting in public policy campaigns for injury prevention, healthy eating, smoking cessation and physical activity. Multi-faceted approaches to enable healthy ageing include re-orientations within the health care system (emphasising self-help strategies), translation of information into action by creating supportive psycho-social environments, involvement of seniors at all levels, emphasis on diversity and sustainability, and policies that combat age discrimination.[10]

There are also significant intergenerational equity issues with private health insurance (PHI). Before the introduction of the 30% rebate, a key factor in the decline of PHI coverage was the loss of younger members who were rapidly losing interest in voluntarily cross-subsidising the health costs of older members. To keep the younger members “in the game”, we have seen significant policy change involving both incentives (carrots to make participation attractive) and disincentives (sticks to financially penalise those who chose to be non-members, at least while young and healthy). For one thing, funds can now offer exclusionary products, allowing younger members to obtain cheaper health cover relating more closely to their own health risk profile, limiting the scope for the young to cross-subsidise the old. More importantly, the Government introduced Lifetime Health Cover (lifetime community rating) under which members joining past the age of 30 years pay a higher annual premium than those who join by 30, to enhance equity in the lifetime cost of PHI. In short, transitions to address intergenerational equity issues are already underway in PHI, forcing changes that reduce young-to-old cross-subsidies

[10] See, for example, the report from the Canadian *Healthy Ageing Workshop*, November 2001, including a transtheoretical model of change, available on www.hc-sc.gc.ca/seniors-aines/pubs/healthy_aging/intro_e.htm

and thus diminish the threat that the younger members of the future will have to carry an inequitable burden. Further reform of PHI may in the future be linked to personal responsibility for healthy ageing (diet, exercise, lifestyle).

If one starts with the view that intergenerational equity issues only arise in the context of the Federal Budget, then it follows that much of the problem can be avoided by reducing the role of public health insurance and increasing the role of PHI. The reality is that simply switching health insurance from the public sector to the private sector merely serves to privatise the problem of achieving intergenerational equity. It does not solve the problem at all. In order to achieve equity, high participation is essential. Otherwise, people just game the system to avoid sharing the risks with high users of care. In order to achieve high participation, it seems that we have to use a policy construct involving both carrots and sticks. If PHI is effectively mandated by these arrangements, then the premiums assume many of the characteristics of taxation anyway. Moreover, those in the lowest income categories continue to need safety nets.

Australia needs an holistic approach to achieve and maintain intergenerational equity. A limited and piecemeal strategy (trying to solve the issues to the extent that they arise in the Federal Budget but not addressing them elsewhere) would be poor policy.

1.7 A balanced view of intergenerational equity issues

Catholic Health Australia holds strongly to the view that Australia needs to develop a balanced view in relation to intergenerational equity issues. Social equity remains an issue of very considerable importance and concern. Good policy will find a way to simultaneously address issues of social and intergenerational equity.

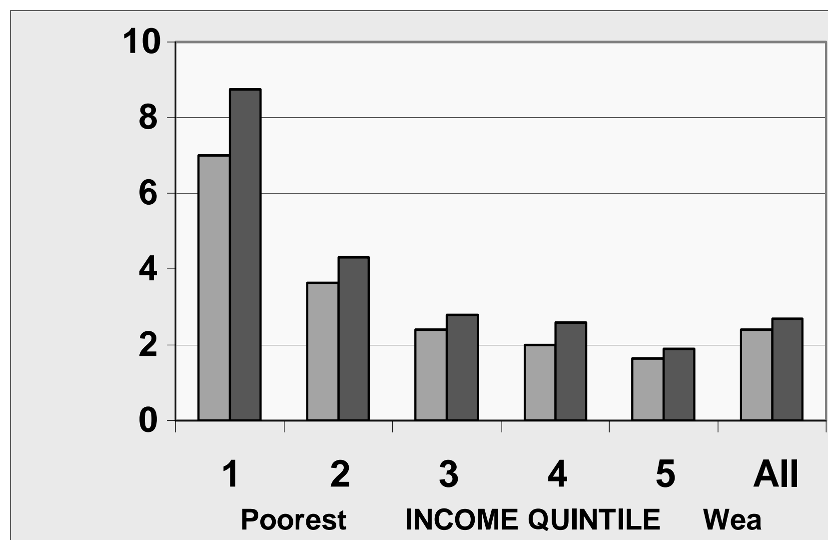
The Budget proposals for dramatic increases in PBS co-payments illustrate the sorts of conundrums that arise. The PBS attracted “razor gang” attention on the rebound from previous Cabinet decisions to list new drugs (including Celebrex, Vioxx and Zyban). Most of the effect of that was seen in the year 2000-01 when PBS outlays increased by 21.4%. The growth of PBS outlays was deemed to be unsustainable and the Government proposed co-payment increases in both the concessional and general parts of the scheme of some 28%.

In the long term, it is difficult to dispute the Government’s contention that the growth in PBS outlays is unsustainable. Were growth rates of more than 10% per annum maintained indefinitely, ultimately PBS outlays would consume the entire health budget, then the entire Federal Budget, then the entire GDP. Each of these are, of course, impossible scenarios. However, it was never likely that these growth rates would be sustained. Furthermore, it is certainly arguable that Australia had not “hit the wall” in regard to national pharmaceutical spending. Indeed, by international comparisons, Australia is a relatively modest spender on pharmaceuticals due in small part to the Government’s tough negotiations with pharmaceutical manufacturers over prices for PBS listed drugs. Many of the prices paid are below world parity prices.

Patient co-payments are not necessarily and universally "bad", but like everything else a sense of balance is required. If the proposed sharp increase in PBS co-payments are warranted by current circumstances (and we are not convinced that they are), then the proposal should have ensured that the changes could be implemented in a manner that was not socially regressive. In short, the structure of income taxes and social security payments needed to be changed ***at the same time*** so that the higher co-payments did not have the effect of pushing more of the tax burden onto lower income groups.

Australia has the knowledge to assess the financial impact of such policy change in a social context. We know, for example, that the highest income groups spend less than 2% of their incomes on pharmaceuticals while for low income groups who sit just outside the thresholds for concessional PBS access, pharmaceuticals claim 7% of family income, which may increase to nearly 9% within the next five years, as illustrated in Chart 10.[11] A recent study found that almost 20% of Australians reported not filling a prescription in the past year due to the co-payment cost, yet these people are the ones who need it most as socio-economic status increases the risk of poor health in old age.[12]

Chart 10: Proportion of family income spent on PBS-subsidised drugs by general patients



We should use this knowledge to protect vulnerable groups. The higher PBS co-payments proposed in the Budget amount to a tax on the sick and the poor. They were not a balanced response to intergenerational pressures. And they are based on a spurious assumption: that we can cut funding now or raise taxes to pay for it. A more forward-thinking approach, which treats spending on dominant health therapies as an investment rather than a cost, is suggested below.

[11] Source, including Chart 10, from "Projecting pharmaceutical expenditure by patients and government" *NATSEM News*, Issue 18, February 2002.
[12] Kinnear, P "Ageing: will the real culprit please stand up?" *Australian Policy Online*, 31 May 2002.

1.8 Problem or opportunity?

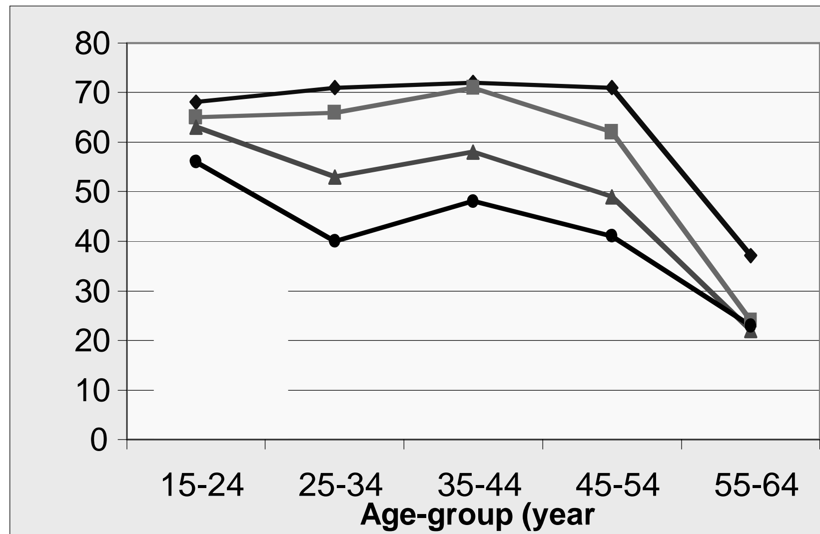
In 40 years time, Australia will be a much wealthier nation than it is today. Even on the very conservative figures in the IGR, GDP per head of population will be over 80% higher than it is today. It is simply not plausible for anyone to suggest that a much wealthier Australia will be unable to offer ***all*** its citizens access to high quality health and aged care. To the extent that it does so will ultimately be a matter of choice reflected in social and economic policies adopted by the governments of the day.

Catholic Health Australia contends that we need a change in the national mindset. Australia ought to see the provision of high quality health and aged care as an opportunity, rather than as a problem. As part of that process of rethinking the issues, it is clearly important that policy makers and the population at large come to understand that older people are a valuable "resource" with the potential to make a strong positive contribution to society in many difference capacities (including as volunteers and carers).
Some key issues in this context are:

- **Workforce participation by older Australians**: There are many reasons why workforce participation may increase, and policy settings should support continued participation. Professors Dowrick and MacDonald from ANU argue that older workers will be better placed in a knowledge-based economy because future cohorts will be more likely to have commenced work later in life, less likely to work in manual labour, had more experience of changing jobs and retraining and be more likely to have dependent children. "Without any changes in policy, the chances of considerably increased labour force participation for men in the 45-64 age group is high. With healthier ageing, employment beyond age 65 could also be a future prospect. Beyond these social changes, over such a long period of time, it is well within the bounds of policy potential that incentives for early retirement that pervade the system at present will be reversed and become incentives to remain in the labour force. National variations in levels of early retirement have been shown to be due primarily to differences in the incentive system. Countries that provide strong incentives to retire early have early retirement."[13] There is evidence that attitudes towards mature workers are already becoming more positive, particularly in high growth industries.[14] Female participation rates are also likely to continue to increase, particularly at the older end, as shown in Chart 11.

[13] Dowrick S and McDonald P, *Comments on the Intergenerational Report*, Faculties of Economics and Demography, Australian National University 21 June, 2002; also the source for Chart 11.
[14] See, for example, the supply and demand study in the business services sector in See Bittman M, Flick M and Rice J, "The recruitment of older Australian workers: A survey of employers in a high growth industry" Social Policy Research Centre, 2002.

Chart 11: Female participation in the labour force, 1971-2001



- **Changing patterns of demand**: The greater wealth of the future will be concentrated among the elderly. Already the over-55 head up households that own 39% of the nation's household assets, as well as accounting for 25% of all disposable income available for consumption and almost half of the deposits in Australia's financial institutions. As reported in "The Silver Market Goes Platinum",[15] mature consumers will increasingly drive demand patterns as they have more time and money on their hands to spend on leisure (holidays, books, magazines, telephone), on outsourced services (household repairs, maintenance and heavy gardening work) and health care (pharmaceuticals, health insurance, fees and charges). Mature consumer spending is forecast to grow by 61% over the next ten years, compared to the national average of 32%, accounting for more than 43% of growth in retail spending. Healthy ageing will thus be increasingly important for sustained cross-sectoral growth in consumption, with incentives for domestic producers to invest in the high-growth areas.
- **Public health initiatives**: Dr Pamela Kinnear, Research Fellow at the Australia Institute, calls for a change in mindset in relation to public health spending, and that cutting funding to essential services, such as pharmaceuticals, will only exacerbate the long run problems. She cites the Australian Institute of Health and Welfare estimate that 80% of health-related conditions in old age are preventable or postponable if corrected in time, yet spending on public health initiatives is currently only 2% of total health expenditure while funding for public research has declined by around 21%: "If we want the majority of people to enter old age as healthy as possible, then making it harder and more expensive to gain access to quality health care – especially for low income earners who are most vulnerable to poor health – is hardly going to achieve that end."[16]

[15] Access Economics, "The silver market goes platinum" *in Population Ageing and the Economy*, Report to the Department of Health and Aged Care, January 2001.
[16] Kinnear P (2002), *op cit*.

1.9 Don’t shoot the messenger

The mere fact that health and aged care costs have been growing quickly (and claiming a growing share of Budget outlays) is not a reason to excessively ration services or shift costs to households. It is completely logical that in an ageing society, such areas will claim higher priority, as they should. The IGR acknowledges both sides of this issue. It notes, for example, that a changing demography implies not only relatively more older people, but also relatively fewer younger people (therefore, education will fall back as a share of total outlays).

Governments that fail to perceive and meet the wants and needs of the electorate are inevitably setting themselves up for the experience of Opposition. The discussion of the issues needs to be in the framework that health and aged care spending has to increase, and the task is not to prevent that from happening but to successfully manage the change.

2 Retirement Income

2.1 Current asset projections

The Australian superannuation system, with assets approaching $500 billion, is now the largest financial asset class in the household sector, exceeding bank deposits. The growth of Australian superannuation assets as a percentage of GDP is much higher than in most OECD countries. Treasury projects further robust growth. Assuming Government decisions to further strengthen the superannuation system including: spouse contributions, Retirement Savings Accounts (RSAs), improved preservation arrangements and choice of fund, assets are projected to grow to 116.5% of GDP by 2020 (Table 1).

Table 1: Treasury projections of superannuation assets to 2020[17]

Year at end-June	Public DB funds $bn	Private DB funds $bn	Private DC funds $bn	Total SG funds $bn	Personal & rollover funds $bn	Self-employed $bn	Total all funds $bn	% GDP
2000	90	79	50	56	63	33	426	68.7%
2005	123	111	77	109	92	40	643	82.2%
2010	163	153	115	181	120	47	931	95.6%
2015	206	203	163	272	150	53	1,280	107.0%
2020	254	262	222	381	181	60	1,699	116.5%

2.2 Adequacy—How much is enough?

The Association of Superannuation Funds of Australia (ASFA), however, is less confident in the future prognosis. Over recent years it has argued that there is a lack of confidence in the system (weak employer contributions, the Superannuation Surcharge), that superannuation is overtaxed (see AFSA, 1999b and Access Economics, 1998[18]) and that contributions are too low to adequately fund retirement incomes (AFSA, 1999a).

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17 Source: Tinnion J and Rothman G (1999), *Retirement Income Adequacy and the Emerging Superannuation System: New Estimates*, Retirement Income Modelling Unit, Paper for the Seventh Colloquium of Superannuation Researchers, University of Melbourne, July 1999, Attachment A.

18 Access Economics (1998) *Measuring Superannuation Taxation Concessions*, Estimates prepared by AE for the AFSA, September 1998, concluded that "There are different possible approaches to setting the benchmark for assessing whether the tax treatment of superannuation and other forms of saving is concessional and to what degree. One approach, favoured by the Treasury, treats all superannuation contributions as cash in the hand of the member, even though a member might not receive the benefit of the contributions for some decades, and even then may in some limited circumstances receive only part of the benefits of contributions. An alternative approach which has strong theoretical and practical underpinnings is to apply a benchmark that tax should only be due when benefits are paid (that is, when the member may actually spend that money), and that taxes on contributions and fund earnings are inappropriate. Using this latter approach, analysis of official tax statistics indicates that in recent years superannuation has been overtaxed. On AE estimates, superannuation was concessionally taxed to the tune of a very modest $55m in 1993-94 (compared to the Treasury estimates of a large concession of $7,665m in that year); superannuation was overtaxed by $803m in 1994-95 (cf. Treasury concession of $5,770m); and superannuation was overtaxed by $775m in 1995-96 (cf. Treasury concession of $8,315m)." AFSA references are (a) Association of Superannuation Funds of Australia (1999a), *Achieving an Adequate Retirement Income – how much is enough?* AFSA Research Centre, October 1999 and (b) Association of Superannuation Funds of Australia (1999b), *Superannuation Tax Concessions – Recent Levels and Trends*, AFSA Research Centre, April 1999.

Current benchmarks for adequacy vary, reflecting different judgements, relativities and social context. Benchmarks range from the age pension, at one quarter of average weekly earnings (AWE), to 100% replacement of pre-retirement income (PRI). Financial planners suggest 50-75%, with 60% of PRI (or of pre-retirement expenditure) commonly quoted as "adequate".

A huge range of modelling proliferates which assesses the adequacy of various scenarios - single and partnered; men and women; low, average and high income earners; pension-self-funded mixes; various yield rates; and the balance of government, employer and employee provision. ASFA (1999a) argues that at 9% Superannuation Guarantee (SG) from 1 July 2002 the 60% is unlikely to be achievable and a figure of at least 12% over 30 years is more consistent.

2.2.1 The industry viewpoint

> *"Australia has one of the most complex, convoluted and highly taxed systems of superannuation in the world. It is one of the only countries which taxes "super" at all three levels—on contributions, earnings and end benefits. Our superannuation legislation is piecemeal, full of anomalies and in desperate need of reform… The superannuation system must be stripped back and simplified—or face a future where our ageing population cannot afford to retire…"*[19]

The industry sees four key areas to address—equity, adequacy, incentives to save and simplicity. A broad industry consensus on these issues is summarised below:

- **Equity**: Equity—that is, taxing those who can most afford to pay—is best served by focussing taxes at end benefit stage, because contributions are taxed at a flat 15 per cent regardless of the amount you are paying in, whereas end benefits are taxed on the benefit you are receiving.
- **Adequacy**: Adequacy is a fundamental issue that must be resolved. The 9% SG rate will not be adequate to move from the age-based pension to self-funded retirement. Between 12 and 15% is required to ensure adequate retirement income.
- **Incentives to save**: There is currently a disincentive to save—people are taxed 15% on contributions, with high-income earners slugged an extra 15% superannuation levy on top of that. 30% tax on contributions is hardly an incentive to voluntarily contribute to your superannuation.
- **Simplicity**: People are confused because the legislation is inconsistent and ad-hoc. Government needs to get back to basics—decide on adequacy, give people an incentive to save and ensure equity. While ideally tax at both the contribution and earnings (or accumulation) stages should be abolished, preserving just the end-benefits taxation (as in the US), from a revenue point of view is not feasible in Australia. A compromise solution should be developed in consultation with industry and consumers that increases incentives and retirement incomes. Moreover, anomalies and complexities such as the eight

[19] Price Waterhouse Coopers (2002), *Superannuation – is it off the rails?* Australian Tax Services, available on www.pwcglobal.com/Extweb/service.nsf, for quote and the industry perspective below.

categories of tax at the end-benefit stage, which take into account the pre-1983 regime and so forth, should be overhauled.

2.2.2. The consumer/voter viewpoint

A September 2001 ANOP survey[20] revealed that adequacy of retirement savings is perceived by consumers as a key issue for government, ahead of economic issues such as the GST and balancing the budget. Currently the Federal Government is seen as not doing enough to address the adequacy of retirement savings. The key call from voters is still to reduce taxes on superannuation and increase incentives to save.

The large majority of voters in the survey recognised that the current level of SG is insufficient alone to provide adequate retirement savings. There is clear support for a progressive increase of the SG to 12% to 15%. The preferred option is that additional contributions come from both individuals and government.

When informed about the points at which superannuation is taxed (contributions, earnings, end benefits, surcharge) voters of all persuasions in the survey reacted adversely. ***Voters would prefer to see superannuation taxes addressed rather than increasing the retirement age***. ***There is a very strong preference for removing the superannuation contributions tax rather than having a modest income tax cut***—and this preference is strong across all voter groups.

2.3 Non-super sources of retirement income

AIHW (2001) reports that 1.8m Australians receive the Age Pension and a further 0.4m aged 60 and over receive pensions from the Department of Veterans Affairs (DVA). The majority of these (excepting compensation pensions) are income and assets tested. Women comprise 62% of age pensioners and 55% of DVA 60+ pensioners. In 1997, 71% of retired people aged 65 and over were dependent on a pension or benefit as their main source of income, while only 10% cited superannuation as the main source of income. Superannuation, however, is increasingly becoming more important, as shown by Table 2. The average payout increases sharply in real terms for those age 50-64, reflecting both the growth of the superannuation system and also the longer work experience and accumulation of those retiring later. Later in the projection period, additional superannuation income becomes a very substantial supplement to the age pension, even after reductions because of the pension means test and income tax.

[20] ANOP Research Services (2001) *The Importance of Retirement Savings and Taxation of Superannuation as Electoral Issues*, Survey of Voters in Two Marginal Federal Seats: Richmond and Makin, September 2001, pp3-4.

Table 2: Retirement incomes, 1997-98 to 2015-16[21]

Year retiring	Average Super Payout ($)	Ratio of Payout to average financial assets of retired ($)	Estimated annual extra income ($)	Extra Income after reduction of pension ($)	Extra Income after pension and tax reductions ($)
1997-98	52,241	0.9	2,012	2,012	2,012
2000-01	69,484	1.2	2,874	2,737	2,737
2005-06	93,083	1.3	4,054	3,327	3,191
2010-11	115,051	1.3	5,153	3,876	3,662
2015-16	216,281	1.9	10,214	6,407	5,504

Chart 12: Projected cost of age & veterans' pensions (% of GDP)[22]

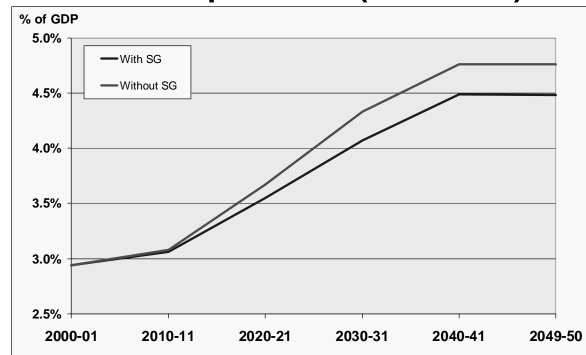

Chart 12 projects the cost of the age and veteran's pensions, which is likely to increase from 3% GDP currently to reach 4.5% GDP by the middle of the century, stabilising as the ageing process slows. This is well within manageable limits and is far below that of other OECD countries. Without SG the pension bill would reach 4.8% GDP.

The aged pension was nonetheless the slowest-growing area of aged care, as illustrated in Table 3. While the pension was the largest item (over $16.6b), pharmaceutical & medical services and home-based care were the fastest growing items in the 1990s, followed by residential care and public hospitals. As a percentage of all government outlays on health, social security and welfare, expenditure on older Australians declined by over 10% from 42% in 1980-81 to 32% in 1998-99.[23] Aged care spending was stable relative to government outlays and GDP, however, over the 1980s and 1990s. The issue emerging once again is that adequate retirement income is about funding health services rather than just funding pensions, or superannuation.

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21 Source: Rothman G P (1998), Projections of Key Aggregates for Australia's Aged – Government Outlays, Financial Assets and Incomes, Retirement Income Modelling Unit, Paper for the Sixth Colloquium of Superannuation Researchers, University of Melbourne, July 1998, p11. Constant 1997-98 dollars.

22 AE chart based on Treasury forecasts, Rothman (1998) *ibid*, p11.

23 Australian Institute of Health and Welfare (2001), *Australia's Welfare, 2001* AIHW Cat. No. AUS-24, available on www.aihw.gov.au/publications/aus, p 246 and Figure 6.6.

Table 3: Expenditure on people aged 65 & over by service type, 1998-99[24]

Service type	$million	Average annual growth 1989-90 to 1998-99
Age Pension[25]	16,611	2.7
Public hospitals	5,228	4.9
Medical services	1,874	7.5
Pharmaceutical services	959	8.6
Residential aged care	3,423	5.6
Home-based care[26]	905	8.6

2.4 Options

Outlined below are the key elements of coordinated strategies that Catholic Health Australia considers necessary to ensure the adequacy of retirement incomes and the aged and health needs of Australians.

2.4.1 Options to reduce dependency

Options to reverse working age depopulation by expanding the size of the working population centre around three principles:

- **Retaining more mature workers in the workplace**—the average "retirement" age for Australian men is 59 and for women 44, reflecting what is often the result of poor labour market opportunities for older workers.[27] Access Economics (2001), especially in Chapter 1 entitled "Too Valuable to Waste," looks at the capacity to encourage increased workforce participation of older people, especially for women, and the scope to change workplace attitudes in this regard. The premise is that workforce participation is very responsive to policy and to awareness-enhancing information provision, and that effective strategies could be employed to introduce more flexible work practices, provide retraining, and encourage later retirement. Retaining older workers in the workplace increases the national income and reduces dependency ratios. Incentives would be more popular than mandating an increased retirement age.
- **Increasing immigration**—because immigrants tend to be in younger cohorts (typically 30-49), immigration is sometimes perceived as a means towards retarding population ageing.[28] While this is true to some extent, demographic analysis shows that it is a relatively blunt instrument. For example, tripling net immigration program intakes to 150,000 compared to 50,000 would reduce the median age of the population from 47.2 in 2051 to 44.6. There are many other socially justifiable reasons for immigration, however.
- **Measures to encourage fertility**—measures that support the combination of motherhood and paid employment are a more efficient means of offsetting

24 *ibid*, p 245, Table 6.27.

25 Includes Age Pension, Veteran's Pension, Widow's Pension and Wife's Pension.

26 Includes community aged care packages, Commonwealth-funded respite services, the Aged Care Assessment Program, HACC and Cover Allowance.

27 Kinnear P (2001), *Population Ageing: Crisis or Transition?* The Australia Institute, Discussion Paper No. 45, December 2001, pvii.

28 See, for example, Withers G, "Population Ageing and the Role of Immigration", *Australian Economic Review* **35**: 1:104-12.

population ageing. With the fertility rate now down to 1.7 and projected to continue falling, fertility measures require a commitment to gender equity, both in the workplace and in the domestic sphere. Options include tax deductibility of child care, flexible family friendly policies at work, greater work-from-home options, and distributing caring and domestic work more equitably between men and women. As is well documented, fertility decline is also highly correlated with greater access to contraception and termination services in Australia. There may be a case for reviewing the evidenced based medicine (EBM) rationale for Medicare-financed termination services which, while now arguably safe and "legal" (not prosecuted), are by no means rare, with around 1 termination for every 3 live births in Australia.[29]

"There is a lot of middle ground between maximum and minimum reproduction that is largely unoccupied." Cathy Sherry, *The Age,* 7 April 2002 "Baby, or not baby, that is the question".

2.4.2 Options to improve superannuation

- **Improving taxation arrangements**—in line with industry and consumer priorities for incentives to save, equity and adequacy, there is a strong case for removal of the taxation on contributions. While in economic purist terms there is also a strong case for removal of the taxation of earnings, a realistic compromise position to preserve the Federal fiscal position might be to retain tax (15%) on earnings but leave in place the full imputation credit entitlement.
- **Increasing the SG rate**—a consensus position on adequacy needs to be developed in conjunction with industry and consumers, utilising common modelling techniques. It is likely that the consensus position would suggest an increase in the SG element. So as not to impact too harshly on lower-income earners, any increase should be phased in incrementally over a period of years and there would need to be compelling consensus evidence to increase SG beyond 12%. Part of the levy could be quarantined for specific usage for ageing and/or health expenditures.
- **Simplification of the superannuation system**—many anomalies have arisen in recent years, indicating the need for a review and overhaul including distilling the eight categories of tax at the end-benefit stage into one category, with benefits taxed on a sliding scale.

2.4.3 Options to finance pensions and ageing

- **Grey Levy, a SG-type "quarantined" percentage**—the data above suggest that growth in the pension area may be eminently manageable although growth in the cost of care for the ageing (nursing homes and home-based) is a more pressing issue. A small levy could be imposed, in SG style, ideally cost shared between employers and employees, which would not be accessed until the person needed the care. Moreover, being an insurance-type asset it would not become a part of the estate thus assisting in keeping the levy level as low as possible. Alternatively, the levy could be higher and the coverage extended to

[29] Health Insurance Commission, Item 35643 services and benefits paid.

finance public health care needs also. This approach is discussed in Section 4 (the Medicare Grey Card).

3 Housing

3.1 Historical overview[30]

Since Federation, Australian governments have encouraged a high rate of home ownership through a sympathetic tax system, funding via building societies and state banks and supportive legislation such as home loans to working families, War Service Home Loans and, more recently, First Home Owners Grants. By the 1940s, about half of Australia's population either owned or was buying their own home, a rate not matched in most other countries for more than half a century. Governments have also played an important role in introducing regulations and planning controls to ensure that housing met a minimum standard of health and amenity and to address housing shortages. This began with the establishment of state housing commissions and, in 1944, the first Commonwealth State Housing Agreement (CSHA), which was the first time State and Federal governments intervened directly in supplying housing to low-income families. In the post war period, new houses were built on large estates, subsidised to tenants or buyers and housing was linked to industrial development. States have responsibility for providing new public housing (including various finance products for low-income households) while the Commonwealth has been closely involved in funding and in shaping the nature of direct supply of social housing. In 1958 the Commonwealth introduced supplementary allowance to assist invalid and widows pensioners, in recognition of additional costs encountered by those renting privately, boarding or lodging. Supplementary allowance was extended to many additional groups from 1965 onwards and in 1985 was renamed Rent Assistance. Since then thresholds and maximum rates payable have seen significant increases. Rent assistance is now available to people receiving all pensions and allowances, except Austudy Payment.

During the 1980s there was a reduction in the number of new houses being built and a re-orientation towards areas of lower concentration of public housing and towards those in most need, such as people relying on income support over the long term. Tied funding under the CHSA now includes the Aboriginal Rental Housing Program, the Community Housing Program and the Crisis Accommodation Program.

3.2 The picture today

Australia now has over 7 million dwellings with over 63% in capital cities. Over 70% of Australian households either own or are buying their own homes – higher (over 80%) for over-60s – almost 20% are renting privately, 5.6% are in social housing and the remainder are in other forms of housing (eg, residential care, nursing homes). 92% of people over 60 live in 1 or 2-person households. Over the age of 74, there are significant increases in single households, and in people moving in with relatives or in special dwellings.

During the 1990s there have been new pressures on social housing. Public housing stock is aging and demand extends beyond the provision of traditional housing services and towards a range of support services. This has contributed to an increase in the amount of community housing stock available in recent years.

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[30] This and the following section draw largely on reporting from AHURI (the Australian Housing and Urban Research Institute).

However, housing assistance funds have been declining in real terms, peaking at $6bn in 1990-91 and falling to $4bn in constant 2000 prices. Spending on the CSHA has declined from $2.5bn in 1986-87 to $1.3bn in 1999-2000. Spending on Rent Assistance has increased since 1980, and since 1994 has become larger than CHSA spending, although it too has been declining in recent years (since 1996-97), due to changes to the maximum rates payable to single people sharing accommodation, to $1.5bn in 1999-2000. Pubic housing rent subsidies are around $1.2bn. Commercial expenditure by the states, funded outside the CSHA principally for government home ownership programs and joint ventures, peaked in the early 1990s and has declined significantly since then.

Almost 1.5 million households in Australia (20% of the total) currently receive long-term housing assistance, with a further 133,000 households having received some form of short-term housing assistance. Direct housing assistance targeted to low-income households includes: long term assistance such as direct lending, public housing, indigenous and community housing; Rent Assistance and other rent subsidy programs; and short term assistance (eg, bond loans and rental grants).

One of the dichotomies of Australia's strong record of economic growth, however, has been an emerging gap between rich and poor, reflected in part by an increasing number of homeless people who have no adequate shelter provision.

3.3 Future projections and issues

An ageing society throws up some new challenges for housing, as does a society with many more single person households, particularly over-65 households (75% of which are single women) due to death, divorce and chronic illness. While Catholic Welfare has a strong interest in how the housing transition is managed, Catholic Health Australia also has an interest to ensure that affordable and secure housing is part of the package of health and ageing essential services that are provided for through social planning for future decades.

Analysis of government-provided housing assistance tends to concentrate on the direct impacts of assistance – the impact of a rent subsidy, for example, on a household's housing costs and as an element of government outlays. But housing assistance also has positive effects, for example, on people's education and health, on their employment prospects, and on crime and community cohesion. AHURI has conducted some excellent analysis in this area, in particular the recent report "Housing assistance: the lifetime impacts"[31], which looks at the impacts at the individual or family level and the associated impacts on government. This type of "whole economy" approach is excellent and should continue.

Catholic Health Australia believes that a just and equitable Australian society of the new millennium will house all its citizens well, echoing Brisbane Institute director Professor Peter Spearritt in his recent analysis of the future housing needs of an increasing elderly population.[32] The nature and location of housing is a crucial part of the dignity of our older citizens. Partly it is a matter of funding (private and public)

[31] King A, "Housing assistances: the lifetime impacts" Australian Housing and Urban Research Institute, July 2002.

[32] Spearritt P, *Unhappy Valley: housing options for the over 60s,* The Brisbane Institute, 10 July 2002 on www.brisinst.org.au

and in part it is also a matter of planning – internal design, walking distance to shops, public transport and community facilities – in a world where inner city housing options for lower income singles have declined as the desire for views has increased. Should rental affordability mean relocating to coastal caravan parks? Interestingly, health services are following older Australians to the coast – with a range of medical and pathology and other health services now being provided in east and south coast towns that previous struggled to find a GP.

However, as Spearitt points out, the housing developers are not yet seeing the future picture: "Most big housing development companies currently build either lower middle and middle class detached dwellings (the poorer you are the further out you have to live) or middle to upper middle class near city townhouses or apartment blocks. Far too many of the latter are built solely with an eye to the investment market - employed people who want to be negatively geared, retired people who want to place their super rollover somewhere - with remarkably little interest in who will actually live in the blocks." He also gives the example of poor internal design, such as the two bedroom flat with the toilet in the bathroom, despite the fact that tenants are more likely to be unrelated singles, where a separate toilet would be preferable.

"A just society attempts to provide decent housing for all its citizens. In Australia today wealthy citizens have guaranteed options on good quality, well located housing and poorer citizens do not. All these issues are exacerbated in the case of the aged, with many of our older citizens relegated to substandard housing and locations so removed from educational, health and community services that they face a greatly diminished quality of life. The Howard federal government has lost interest in the quality of housing for the aged, concentrating its efforts on enticing younger voters with the first home owner grant. The costs of the outer-suburban sprawl will become apparent over the next two decades, another twist in the debate about intergenerational equity." Peter Speirritt, Brisbane Institute

Appropriateness of the housing stock: The majority of Australian homes (approximately 57 per cent) are 20 or more years old, with 70% living in detached housing with three or more bedrooms – the average dwelling size is increasing even though average household size is declining, and the fixtures and standards of dwellings are also increasing. As total population growth slows, we can expect less new construction and more renovation, less "urban sprawl" growth and a greater gentrification of inner suburbs, which would become increasingly unaffordable for lower income earners. The current housing stock may not be appropriate to needs under a changing demography and we need to start thinking more about how we can facilitate necessary changes – such as helping older people to either renovate their own homes to meet the needs of healthy and safe ageing, or to choose to move to more appropriate "downsized" housing when they no longer need a large family home, without the dislocation of having to move away from family and friends. One solution already occurring overseas is the reallocation of office blocks into apartments for people over 50, including special features such as ramps for wheelchairs, handrails and bathroom grab-rails, improved lighting over stairs (to help prevent falls) and other safe ageing features including security systems. These sorts of renovations can also be provided in existing homes, where location and access to facilities is suitable.

Affordability: The gross value of the housing stock in Australia is now estimated in excess of $500 billion, about on par with superannuation holdings, the other "major asset of retirement". The rate of growth in the value of the housing stock is not known (unlike superannuation, which is growing at around 14% per annum). Affordability relates very much to whether a household is renting privately – spending $163 or 19% of income; renting from state housing – $66 per week (18%); or an owner with a mortgage – $206 per week (16%). There are many measures of housing affordability or access, including the Commonwealth Bank of Australia/Housing Industry Association index of accessibility to first home ownership for an average first home buyer.[33] Affordability of housing (especially rental housing) within easy reach of services, especially for single over-60s is a key issue. Measures to reduce the escalating costs of land and strata titles in coastal and city retirement areas would help, together with good transport links between these centres and major local hospitals.

Retirement villages: Many older people feel pressures to move out of traditional homes, including rising council rates and maintenance burdens. Apart from these push factors, pull factors for moving to a retirement village include social networks and activities, amenities, sense of community, layout/design, position/locality, style and management, personal independence, security.[34] Providing public transport access or a Village bus are important considerations to improve quality of life in villages.

Residential aged accommodation and home-based care provision: There is an important nexus between the provision of appropriate housing and the balance between home-based and residential aged care. In so far as older households are more supported in their own homes, with health services, renovations and relocations if need be, the less reliant and the longer the deferral of nursing home services. Many of the considerations of design, location and meeting social needs are also important in the scheduled renewal of the stock of residential aged care facilities by 2008. Financing remains the key issue for residential care, with aged care savings accounts being an option together with an aged care benefits schedule for lower income elderly people. These options are discussed in Section 2.4.3 and further in the next section.

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[33] First home loans average $128,000 nationally ($163,000 in New South Wales and $71,000 in Tasmania), with monthly repayments varying from $1,282 in NSW to $624 in Tasmania.

[34] Manicaros/Stimson study, *Living in a Retirement Village*.

4 Health and Aged Care

Catholic Health Australia believes that there ought to be a continuing strong role for public financing of health and aged care. Higher levels of taxation overall are an option which is on the table and will stay on the table. But higher taxes alone may not accommodate the reasonable expectations of the community for access to health and aged care. So the task is to find a suitable mix of policies. Catholic Health Australia advocates five measures to improve the financing of health and aged care in the context of an ageing Australia.

4.1 Health savings accounts

Health savings accounts could be facilitated as an add-on to superannuation and managed in the same framework. Health savings accounts offer the potential for consumers to be better able to meet their lifetime out-of-pocket health expenses. Used properly, they would increase access to health care when older, when health needs are greater and when incomes are lower and assets harder to redeem (eg, the family home). To the extent that Australia needs to reduce its reliance on intergenerational transfers, it also means that the older generation will be assuming more of the financial responsibility. It is sensible to plan for that, and health savings accounts must be considered as an option. It is important to understand that health savings accounts are not intended or likely to replace health insurance. Rather, their role would be complementary. There is a good deal of variability in lifetime health costs from one individual to another. People will therefore wish to see the retention of a system that allows excessive financial risks of poor health to be shared. An insurance system will continue to be needed.

4.2 Private health insurance – unsubsidised extensions

The debate about how much health insurance should be private and how much should be public needs to be resolved through consensus and cooperation of the key players, importantly government at Federal and State/Territory levels. If PHI is mandated like occupational superannuation, premiums are effectively just a different form of taxation with arguably the deadweight losses to the economy like those expected from income taxes, but different to the extent of being regressive. There may be scope to address equity objectives through a tiered system of premiums based on income and assets assessments. As a softer option to mandating, the current system of income tax disincentives for those not holding PHI could be extended to capture a higher proportion of middle-income earners. Complementary policy may well be required to regulate the provision of PHI to ensure quality and competitive health insurance products that spread financial risk for catastrophe or big ticket items (rather than covering luxuries like running shoes). There may also need to be some form of evaluation to ensure that those who have PHI use it.

4.3 Medicare Grey Card

Regardless of what is done to improve the functioning of the private health insurance system, there still remains the need for ***safety nets*** for the elderly on the lowest

incomes. The introduction of a Medicare Grey Card would ensure that low-income people over 70 without PHI would be eligible to access elective surgical and medical services available in the private sector, when clinically appropriate waiting times for these services have been exceeded in public hospitals. The first step would be to identify benchmark waiting times for various procedures and treatments (eg, hip replacement, bypass surgery, cataracts), through a collaborative process involving Commonwealth, States, private sector and the medical professions. Financing could be achieved through removing the 30% PHI rebate on ancillary care (possible excepting physiotherapy) to release $400m in 2002-03.

4.4 Rationing issues – addressing moral hazards

There are three major drivers of rising health care costs: technology, ageing and patient expectations. The last of these is the most amenable to policy influence. There is considerable *moral hazard* in the current system—that is, patients will seek to use more services simply because they are free (no gaps). In economic jargon, where marginal costs are zero to the consumer, there will always be over-consumption. The current system, with highly constrained price signals, does not allocate efficiently and rations the over-consumption primarily through *queuing*, hospital waiting lists being the most widely publicised example. With chronic illness, queuing is unlikely to be either the most efficient allocation device or the most fair process. There seems to be some evidence that queues are getting longer as the population of patients get older.

The policy challenge is to introduce sensible price signals for most health consumers and most health episodes to combat moral hazard, while retaining limited safety nets to ensure that those in real need can access care. One area that needs to be addressed is the proliferation of Health Care Cards, where asset tests may be indicated, particularly in order to reduce pressures on general practitioners to bulk-bill their services. It may make little sense to heap more and more price signals on pharmaceuticals simply because PBS spending has been fast growing. The whole issue of co-payments needs to be revisited, and addressed across the whole spectrum of health care as co-payments were never just an issue for the PBS alone. In any revisiting, it is extremely important that the social equity objective not be lost. The removal of a subsidy is the same, in effect, as the imposition of a tax. Just as new taxes are assessed for their impact and their equity, so too must any proposals for removal of subsidies.

4.5 Aged Care Benefits Schedule

An Aged Care Benefits Schedule (ACBS) could be designed to provide aged Australians in lower socio-economic groups with an entitlement-based provision for key aged care services, similar in rationale to the Medicare Benefits Schedule (MBS), which provides an entitlement-based provision for all Australians for key health services. An ACBS as proposed by Catholic Health Australia, however, would be different from the MBS in that it would be designed specifically to provide a safety net and tiered rebate arrangement for aged Australians in lower socio-economic groups.

An ACBS could include schedule items relating to residential care services, home-based care services and in-hospital services (to be provided in private hospitals after

an agreed waiting time had elapsed in the public hospital system, as per the Grey Card proposal in 4.3 above). Rebate items might be based on the assessed needs of the individual, including levels of disability and mental health needs. Respite services for carers might also be incorporated in the schedule.

The formula for rebate levels and their indexation would need to be developed and agreed by a working group of key stakeholders. Rebate weights might be set on the basis of age and a sliding scale relating to income and asset testing, with greatest coverage for the oldest and most financially needy. Income and asset group (YAG) tests would also need to be indexed, and related to single/married status and other factors, possibly as per the age pension to reduce administrative complexity.

Entry to the ACBS might need to be limited to new entrants, for budget reasons as well as the complexity of welfare and equity issues associated with pre-existing buy-in schemes involving initial up-front payments designed to contribute to fixed (capital) costs of aged care.

Implementation might involve magnetised cards, similar to the Medicare Card (or the Grey Card), together with software developed for aged care providers and for claims through Medicare offices. Financial assessment would be conducted on application for the card with periodic assessment updates and an obligation to provide relevant changes to details. Card swiping would then automatically generate the calculated rebate based on the item and the rebate weight (through electronically stored YAG and age data) at the point of service provision.

Funding options might include a Grey Levy (mirroring the Medicare Levy) to cover the projected costs of aged care. Costing and discussion of financing options could be included in the context of the review of pricing of residential aged care subsidies, as announced in the May 2002 Federal Budget. Alternatively, the breadth of the issue, discussion and stakeholders may warrant a separate investigation and taskforce.

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