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GOVERNMENT HEALTH AND WELFARE EXPENDITURE ON OLDER AUSTRALIANS*

Introduction

There are concerns, in many countries, that government expenditure on older people is growing at a high and unsustainable rate. In Australia (where there is a universal health care system and a well-developed aged care system, both funded largely from government taxation) there are concerns that the rapid growth in the 1980s and the early 1990s in government expenditure on older people is not sustainable. Some reports to government projected or assumed very high rates of growth in health expenditure because of the ageing of the population. These reports called for an immediate curtailment of health and aged care costs (Clare & Tulpule 1994 and National Commission of Audit 1996). The assumptions behind these projections have been variously questioned. (Gibson & Goss, 1998. Madden & Goss, 1988).

This paper examines at the level and patterns of government health and welfare expenditure on older Australians. It describes the main areas of expenditure, and argues that the controls put in place in each of these areas to contain costs have resulted in a manageable increase in government expenditure.

Major areas of health and welfare expenditure

Older persons in Australia have access to mainstream social security and health care systems and the specialised aged care system. The main expenditure areas funded by government are:

- the government age pension (including veterans' pension),
- hospitals,
- medical services (including general practitioners and specialists as well as pathology and imaging/screening services),
- pharmaceutical services,
- residential aged care services (nursing homes and hostels), and
- non-residential services (home and community care).

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Government age pension (including veterans' pension): $15,700 million (1995-96). Annual real growth,1990-91 to 1995-96, 3.5%

The age pension, funded out of Commonwealth government taxation, is subject to a means test on income and assets. Generally the family home is exempt. In the 1970s, those aged 70 and over were exempt from the means test, but this exemption was removed in the mid-1980s. The age pension is also subject to tax. The qualifying age was 65 years and over for males, and age 61 and over for females in 1996-97. In 2013, the qualifying age for women will be increased to 65, the same as that for men.

In 1995-96, a total of $15,700 million was spent on pension for the aged, and this included widow's pension, wife's pension and pension for veterans.

With the ageing of the population, age pension outlays have increased rapidly since 1975-76. In 1991-92, legislation was passed to make it compulsory for employers to contribute to employee superannuation. The rate of contribution was set at 4% of employees' salary in 1992-93. In 1997-98, it was 6%, and will rise gradually to 9% by 2002-2003.

This legislation has the effect of rapidly increasing the number of employees having superannuation coverage, from 52% in 1990 to 80% in 1992 and 86% in 1996. The coverage by age group as at 1996 is shown below:

Age	**% of employees with superannuation cover**
15-19	**51**
20-24	**86**
25-34	**90**
35-44	**91**
45-54	**92**
55-59	**89**
60+	**73**

Source: Australian Bureau of Statistics, Yearbook 1997.

The relatively lower coverage in the age group 15-19 years is affected by many in casual jobs that do not attract compulsory superannuation contributions. The figure for those aged 60 years and over is not useful as it is affected by the large proportion of people in this group who are no longer employed.

The high coverage of those in the prime working ages would indicate that they should be able to finance some or most of their income needs when they reach

retirement, as intended by government. With compulsory superannuation and means testing of the age pension in place, the rise in government expenditure on the age pension may be reduced in future in spite of the continuing ageing of the population. The success of any means testing of the aged pension and compulsory superannuation scheme to reduce reliance on government would, of course, depend on how financial arrangements of retirees might affect their eligibility for government funded pensions.

Hospitals: $3,900 million. Annual real growth 3.6%

Public hospitals in Australia are administered by State and Territory governments with part funding from the Commonwealth. In the 1980s, States have provided more funds to hospitals than the Commonwealth, but this was reversed in the early 1990s. In the mid 1990s, Commonwealth funding exceeded State funding by a small margin, but the shares have returned close to equality. Treatment in public hospitals as a public patient is free of charge to Australian residents under the Australian Medicare scheme. (Medicare is a universal health benefit scheme funded by through personal income tax. It provides a rebate for visits to doctors, other medical services such as pathology and imaging services, and provides free public hospital services.)

There is a continuing debate on the containment of hospital expenditure and the services they provide. The Commonwealth Government makes its contribution to the States under the Commonwealth/State Medicare Agreement. State governments have progressively introduced case-mix costing and funding in order to plan their funding of hospitals and to seek increased output per dollar spent.

Private hospitals handle about 31% of all hospital patients. Private hospital costs are not covered by the Medicare scheme. (However, government benefits are payable to cover 85% of the schedule fees of doctors' charges in private hospitals, as distinct from hospital charges.) Patients' charges are covered by health insurance or met by out-of-pocket payments. Hospital insurance premiums have increased sharply in recent times, partly because of withdrawal of government subsidies and partly because of falling membership. Benefits paid do not always cover 100% of costs. There has been also little incentive for the young and healthy to join the funds. The population coverage of private hospital insurance has been dropping since Medicare was introduced in 1984.

Hospital utilisation is higher for older people than for younger people, both in terms of 'separations' per 1,000 population and the average length of stay (AIHW 1997, p25). Expenditure in hospitals is high for those aged 75 and over (and also for females at child bearing ages). In 1993-94, those aged 65 and over (around 12% of the population) consumed about 34.7% of hospital expenditure (Mathers et al. 1998 p 36).

Older patients in hospitals cost more because they are admitted more often and because they stay longer than younger patients. While older patients do stay longer in hospitals, an early study showed that only a very small proportion of older hospital patients are very long stay patients (more than 34 days) - between 0.8% to

1.3% in 1988-89. Most patients are discharged to the community, and only a very small proportion is transferred to a nursing home. In terms of bed days used, these older long stayers who were transferred to a nursing home used 7% of all bed days (Renwick, Gillett & Liu 1992). With the length of hospital stay being reduced rapidly in recent years and the increased provision of aged care in the community (see later section), it is unlikely that this has become more serious.

A recent study of the case-mix funding for elderly patients in several hospitals in Victoria has shown that, for the majority of case-mix categories, elderly patients do not cost more than their younger counterparts. (Duckett & Jackson 1998).

Medical services: $1,600 million. Annual real growth 8.5%

Medical services include expenditure on consultations with general practitioners and specialists as well as pathology tests and screening and diagnostic imaging services. It also includes medical services provided to patients in both public and private hospitals. Medical service providers receive rebates from Medicare.

A schedule of fees has been established and benefits for services provided by private practitioners relate to that schedule. Doctors are not obliged to adhere to the schedule fees, but if they charge above the schedule fee, the patients must pay any additional amount. This 'gap' is not insurable.

Government pays a benefit of 85% of the schedule fee. Many doctors choose to only charge 85% of the schedule fee, so the patient does not have to pay. This is to encourage patients to see doctors who charge the schedule fee and directly bill the government. The schedule fee is adjusted regularly, and there is debate on whether the schedule fee is adequate. The setting of the schedule fees is the main mechanism of control over medical services expenditure.

Medicare covers all permanent residents in Australia. There is no restriction on the choice of doctor or the number of times a person sees a doctor.

The level of use of medical services is higher among older people compared with younger ones. It is estimated that, in 1993-94, 24% of medical services were used by people aged 65 and over (who comprised about 12 per cent of the population). This compared with about 20% of medical services being used by this group in 1989-90.

Pharmaceutical services: $780 million. Annual real growth 13.1%

The Pharmaceutical Benefits Scheme (PBS), funded out of the taxation system, subsidises the cost of a wide range of drugs, but does not cover drugs provided in hospitals. Patients are grouped in two categories. Concessional beneficiaries, generally people of lower income and receiving various forms of government benefits, pay a set contribution for each item, currently around $3.20, irrespective of the cost of the items. This contribution is indexed each year. General beneficiaries, ie all others, pay a higher contribution for each item. Their contribution is also indexed and is at present up to a maximum of $20 for each item. If the cost is less than $20,

the patient pays the total cost. The pharmacist claims from the government the difference between the client contribution and the basic price of the item.

The PBS also includes a safety net that sets separate upper boundaries for concessional and general beneficiaries, beyond which all costs for drugs for the rest of the year are met by government.

The items that attract benefits, the basic price and the benefit level are reviewed regularly. These reviews are the main mechanism for the control of government pharmaceutical expenditure, as there is no 'cap' on the number of items and repeats used by patients. Recently, government has encouraged the use of generic drugs rather than brand name drugs in an attempt to reduce costs, and would only refund the cost to the value of the generic drugs if they were available.

As would be expected, usage of pharmaceutical items is higher among older people compared with younger ones. It is estimated that, in 1993-94, 31% of pharmaceutical services were used by people aged 65 and over. In 1989-90, the proportion of pharmaceutical services used by people aged 65 and above was about 35%.

Residential care (nursing homes and hostels): $2,600 million. Annual real growth 2.9%

Nursing homes and hostels are a central part of the Australian system of long-term aged care. Until early 1998, nursing homes and hostels were funded differently and they catered for people with different levels of dependency - nursing homes for very frail older people and hostels for those with a lower level of dependency. Funding subsidies from the Commonwealth government were higher for nursing homes than hostels. Both nursing homes and hostels charged daily fees, but hostels also charged new residents who were capable of paying an accommodation bond that provided funds for refurbishment and new buildings. Nursing homes were not allowed to charge an accommodation bond and did not have the same potential to build up a pool of funds for large scale refurbishment.

The Commonwealth Government provided recurrent subsidies to both nursing home and hostel residents (which include an amount, often considered insufficient, for up-keep of the premises). Government also provided capital grants for building hostels and not-for-profit nursing homes. Available capital grants for hostels were instrumental in encouraging the building of more hostels.

Residents who were government age pensioners were required to pay 87.5% of their pension as fees to nursing homes and hostels. Residents of hostels who had income above the government pension were charged an additional fee. However, for nursing homes, those who could afford to pay were not charged an additional fee until March 1998.

In the 1970s, there was a very rapid increase in the number of nursing homes and beds because government responded to the lengthening of nursing home waiting lists and provided subsidies for both capital and recurrent purposes. There was also a large movement of dementia patients out of State psychiatric hospitals into nursing

homes and this movement was made possible because of the expanding (and Commonwealth funded) nursing home sector (AIHW 1993, p 204).

1985 Aged Care Reform

In 1985, government commissioned a review of nursing homes and hostels, and initiated a process of reform. The key components of the reform were a progressive reduction of nursing home beds, a substantial increase in hostel places, increases in the range and level of non-residential services, and the development and extension of assessment procedures to increase the appropriateness of service use.

The review proposed to maintain the existing national ratio of 100 residential care places per 1,000 persons aged 70 years and over. However, it recommended a substantial change to the balance between nursing home beds and hostel places. This was to be achieved by reducing the ratio for nursing home beds from 67 (in 1985) to 40 and to increase the ratio for hostel places from 32 in 1985 to 60 by the year 2011. The intention was to counter some inappropriate admissions to nursing homes and to expand hostel and home and community care. The desire of older people to remain at home was also recognised and the expansion of home and community care was an important policy change to respond to this desire. Home care services of a more intensive nature (called Community Aged Care Packages) were introduced as part of the reform, and the target of 60 hostel places was revised to 50 hostel places and 10 community aged care packages by the year 2011.

The reduction of approved nursing home beds since the 1980s has meant that there has not been a great deal of new investment in nursing homes in the last 15 years. This is particularly the case with for-profit nursing homes that did not attract separate capital funding. In recent years, the amount of capital grant funding provided by government has not been sufficient for replacement and up-grade purposes (Gregory 1994, p10). Many of the existing nursing homes are now old, needing refurbishment and not ideal, with some 40% of residents living in rooms of 4 or more people. There was increasing pressure on nursing home operators to raise additional money for this purpose.

Population ageing and the reduction of nursing home beds meant that the dependency levels of residents in both nursing homes and hostels had risen, and there was an increasing need for highly dependent hostel residents to move to nursing homes. However, while hostels had vacancies, nursing homes were mostly full and had long waiting lists. The scarcity of nursing home beds was particularly a problem for couples with different levels of dependency who could not be accommodated in a single establishment. This means that a couple might need to be separated if one partner was offered and accepted a nursing home bed.

1997 Aged Care Structural Reform Package

In late 1997, the Commonwealth Government made further major changes to the residential aged care system. The separate funding of nursing homes and hostels was simplified by bringing these two sectors together under the Aged Care Structural Reform Package. It took into consideration the increasing dependency

level of both nursing home and hostel residents, and the consequential need for residents to move from hostels to nursing homes.

This reform introduced new income testing arrangements for fees, means tested annual accommodation payments, and a new accreditation and standards system.

Fees

A basic fee of $21.10 a day was set from March 1998 for pensioners. For non-pensioners and part-pensioners, the basic rate is $26.40, and depending on their income, the maximum fee payable by them is $63.30 a day (all rates are indexed). The fee paid by residents is not affected by their level of dependency. Level of dependency and the amount paid by the resident affect the amount of subsidy that the government gives direct to the aged care facilities.

Accommodation payments

Accommodation payments are levied by the operators of aged care facilities to enable up-keep and improvement of buildings. Two types of accommodation payments are levied and they are regulated by government.

The first is a one-off accommodation **bond** levied by the facilities on residents entering hostel level care. Most of the bond is refunded when the resident leaves the facility. While the bond is not capped, accommodation payments are not allowed to be so high as to leave the residents with less than $22,500. This arrangement is a modification of the accommodation bond that had operated for hostels in the past.

The second is the accommodation **charge** for residents entering nursing home level care. This charge is means-tested and residents who cannot afford the charge are not asked to pay. Before the 1997 changes, nursing homes could not charge an accommodation charge or bond. The 1997 changes were designed to align nursing home level residents with hostel level residents. Initially, government intended to allow facilities to levy a bond similar to that paid by hostel level residents. But this was objected to vocally by the public and was dropped in favour of an annual charge that is not allowed to exceed $4,380 a year. The annual charge is paid for a period of up to five years. However, aged care facilities may be approved to provide places or beds with higher levels of accommodation, food and other services. Places or beds with such extra services attract accommodation bonds.

The administration of the policy on accommodation bonds and charges is complex. Income and asset testing for new entrants and the treatment of hostel bonds on transfer from hostel to nursing home level care are complex. Options for delayed payments are available so that charges (with interest) can be deducted from the estate of a former resident. The Commonwealth Government has a Financial Information Service to assist people who may have difficulties in understanding the income test and payment requirements and options.

While the policy change is designed to bring the nursing home and hostel sectors together, it will take some time before this can be achieved, as the physical structure of hostels and nursing homes will need to be changed to make them suitable for both

types of residents. This is particularly the case where major or expensive upgrades are involved.

Aged care facilities are now subject to accreditation by the new Aged Care Standards Agency. Any facility that is not accredited by January 2001 will no longer receive government funding.

Funding of aged care residential facilities

Recurrent funding of aged care residential facilities is based on the level of dependency of the resident. The 1997 change to combine nursing homes and hostels has given rise to a new dependency and funding classification scheme for residents in the combined facility. The Resident Classification Scale has 8 categories, with categories 1 to 4 representing high care levels and 5 to 8 representing lower care levels. The amount of subsidy varies according to the level of dependency of the resident. An initial evaluation of the new scale for the combined facility has shown that the amount of subsidies has increased (Commonwealth Department of Health and Family Services 1998 and Australian Catholic Health Care Association, Newsletter, April 1998).

Capital funding of the new facilities is now available from the pool of funds collected as accommodation bonds and accommodation charges.

Australian nursing homes cater also for younger disabled persons. It is estimated that about 5% of nursing home expenditure in 1993-94 was on younger persons under the age of 65.

Non-residential care (Home and Community Care): $651 million. Annual real growth 7.8%

Australia has a large and varied non-residential aged care system, the core of which is the Home and Community Care (HACC) program. HACC is jointly funded by the Commonwealth and the States. HACC was implemented in 1984-85 by pulling together a variety of home based services and has been greatly expanded since. Real growth in government expenditure in the first 5 years of operation (from 1985-86 to 1991-92) was 104%, and it has since grown further by 26% to reach $651 million in 1995-96. Although HACC services are not fully means tested, clients who can afford to pay are asked by service providers to pay for HACC services. There are plans in most States to move towards a more uniform charging policy for those who can afford. This is in line with most Australian welfare and social security programs and benefits.

The range of services available under HACC includes home help, personal care, food services, community respite, day care centres, transport, home maintenance, and home and community nursing. More recently the Community Aged Care Packages (CACP) were expanded. Expenditure on CACP was $33 million in 1995-96 and is expected to grow further in coming years. Respite care programs are increasingly being established, both in residential facilities or community centre settings and at

home, to give carers breaks from their caring responsibilities, to enable them to care for their older relatives or friends for longer.

The policy towards encouraging and funding more home and community based care rather than residential care is driven not only by the higher costs of residential care in general. The policy recognises the desire of many older people to remain in their home and community for as long as possible. As a result the burden of carers is becoming heavier. The government recognises this, and in April 1998 announced a large increase in funds to expand the number of Community Aged Care Packages, to support carers and to provide more respite care.

The Home and Community Care program caters for both the young and the old. It is estimated that about 75% of HACC expenditure was consumed by people aged 65 and over.

Aged Care Assessment Teams are established throughout the country to provide screening of older people who may need HACC assistance or who may need to be admitted to a residential facility. These teams work mainly from community and public hospitals and are staffed by health professionals. Admission to residential facilities requires an assessment by an Aged Care Assessment Team and the Teams also refer people to HACC services.

Government health and welfare expenditure

The complex systems of health and aged care in Australia described above indicate that government health and welfare expenditure on older people is large and increasing. This is particularly true when the population has grown older in the last 20 years.

30 June	% of population aged 65+	Population aged 80+ as % of population 65+
1976	8.9%	17.4%
1981	9.7%	17.6%
1986	10.5%	18.7%
1991	11.3%	19.7%
1996	12.0%	22.0%

In 1975-76, 9% of the Australian population was aged 65 and over. Of them, 17% was aged 80 and over. These proportions increased to 10.5% and 18.7% respectively in June 1986 and to 12.0% and 22.0% in June 1996.

The ageing of the population in the last 20 years has seen an increase in both general health expenditure and health and welfare expenditure on older people, but not in an unmanageable way.

Health expenditure in general grew at a rate higher than GDP. But there has been sufficient growth in GDP that the proportions of GDP and of all government outlays allocated to health have not increased greatly.

Government health and welfare expenditure on older people as a proportion of GDP has also remained rather stable.

General health expenditure

General health expenditure in Australia has grown at an average rate of 3.9% a year in the last 10 years (constant prices), slightly above the growth of the GDP. For the past 6 years, health expenditure has remained at about 8.4% of GDP, having risen from around 7.5% in the early 1980s. This places Australia in the middle range of OECD countries, with the USA at around 14%, France at 10% and Sweden, New Zealand and the UK at around 7%. Health spending is affected by the age structure of the population, and Australia's population is relatively young compared with many European countries but is similar to the population structures of the USA, New Zealand and Canada.

About 68% of health expenditure is funded by government (46% Commonwealth and 23% States), and 32% by the non-government sector (health insurance premiums and out of pocket payments). The government component has remained relatively stable; it was slightly over 70% in the early 1980s.

The above health expenditure figures are for the population as a whole. Government health and welfare expenditure on persons aged 65 and over are estimated below.

Government health and welfare expenditure on older people

As a percentage of GDP, government health and welfare expenditure on older people aged 65 and over has remained relatively stable; it was around 5% in the mid 1970s, increasing to 5.4% in the 1980s and remaining at around the low 5% level until now. In the last 10 years in real terms (1985-86 to 1995-96) Australian GDP has grown 35%, while health and welfare expenditure on older people has grown 33%.

As a proportion of all government expenditure (and in particular as a proportion of expenditure on health, welfare and social security), health and welfare expenditure on older people has actually declined quite markedly since the 1970s. This has largely been caused by the large increases since the mid-1980s in government expenditure on the unemployed and on the family (for example, single parent payments and childcare assistance).

The table below sets out the constant price expenditure on each area of health and welfare expenditure on older people.

	1975-6	1980-81	1985-86	1990-91	1995-96
			$ millions ($1989-90)		
Aged pension*(a)	8225	10282	11320	11728	13935
Hospitals (a)	1634	2037	2547	2886	3447
Medical Services (a)	369	254	700	923	1388
Pharmaceutical (a)	298	215	288	375	693
Nursing Homes*	732	979	1580	1805	1923
Hostels	31	39	79	184	371
Non-residential**	43	86	242	397	578
Total	11332	13891	16756	18298	22335
Total as % of GDP	4.8%	5.1%	5.2%	5.0%	5.1%
Total as % of Government outlay	13.4%	14.1%	12.3%	12.5%	13.4%
Total as % of health, social security and welfare outlay	40.1%	43.0%	37.9%	35.6%	32.8%

*Includes veteran pensions

**HACC, CACP, DNCB, and ACAT.

Source: Australian Bureau of Statistics, Year Book, various years, and Australian Institute of Health and Welfare, unpublished data.

(a) Adjusted to represent expenditure on persons aged 65 years and over, using the following factors: hospitals (1993-94 0.346; 1975-76 0.276; other years pro-rated), medical services (1975-76 0.160; 1985-86 0.194; 1993-94 0.240 ; other years pro-rated), and pharmaceutical (0.31), and nursing homes (0.95), home & community care (0.75) (Source: Mathers et al 1998. P 36).

Conclusion

This paper has described in very broad terms the Australian aged care system and how government health and welfare expenditure on older people is subject to controls. The data show that in the past 20 years, the population has aged a great deal, exerting pressure on expenditure on the older population. In this period, changes have been made to various aspects of the health and aged care systems. These changes are designed to maintain care at an affordable level and also to introduce some control over costs.

There are continuing debates on the impact of ageing on government expenditure and the sustainability of the current level and expected increases in health and welfare expenditure. Many in Australia argue that the Australian health and welfare systems have coped well with the ageing of the population and that the present trend in expenditure in Australia could accommodate an older population such as those already present in Europe (Gibson & Goss 1998; Goss et at 1994; Howe 1997).

The data presented in this paper show that the improvements in health and aged care services in the last 20 have been made possible by the growth of the economy as measured by the GDP. Economic growth has allowed more funds to be made available for government services, and some of these additional funds have been allocated to health and welfare services for the older people.

In areas of community and welfare services, calls on government funding have come from a range of sources in addition to aged care. Most prominent among theses are unemployment, and family services such as child care and family payments. It appears that these areas have attracted increases in government funding at least equivalent to those directed to aged care over the last two decades.

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