

Contesting Welfare State: Health Care System in Australia

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Abstrak

Kebijakan kesehatan adalah salah satu sumber penyebab pasang surut politik dan pergantian kekuasaan di Australia semenjak pemilu pada tahun 1940-an. Hal ini terjadi karena adanya perbedaan dan konflik ideologi dari berbagai kelompok kepentingan dan stakeholders di sektor kesehatan yang saling memperjuangkan kepentingan mereka di berbagai lini. Nuansa perang kepentingan itu terlihat jelas dari ketidakstabilan kebijakan kesehatan akibat perubahan dan pergantian kebijakan yang biasanya didahului oleh pergantian kekuasaan. Bila partai yang berkuasa adalah partai liberal yang propasar, maka kebijakan kesehatan diarahkan pada minimalisasi peran negara dalam layanan kesehatan dan mendukung peran yang lebih besar bagi sektor swasta dan individu. Sedangkan bila partai sosial demokratik yang prorakyat berkuasa, mereka berjuang sekuat tenaga untuk mendorong peran negara yang lebih besar dalam mewujudkan negara kesejahteraan khususnya dalam menjamin layanan kesehatan. Meskipun kebijakan kesehatan mengalami pasang surut seiring pergantian kekuasaan dan resesi ekonomi yang menyebabkan biaya kebijakan sosial makin mahal, Australia sampai saat ini mampu menjamin akses layanan kesehatan gratis untuk semua warganya (universal coverage) dengan tidak mengurangi mutu dan kualitas layanan kepada semua warganya. Bahkan Australia saat ini termasuk salah satu negara dengan kualitas layanan kesehatan terbaik di dunia.

Introduction

Health policy continues to be one of the most disputed policy realms in politics today, with conservatives and liberals taking significant stances in opposition with each other (Harris, *et al.* 2008: 74). The universal and nationwide Medicare policy in Australia is fiercely fought between its various interest groups. Interest groups do work together, structurally within the policy-making system to oppose or to promote change. Members of the liberal individualist groups consist of the Australian Medical Association (AMA), pharmaceutical industries, private insurance companies and Liberal Party and its coalition partner, the National Party (Gray, 1990: 223). They have typically taken a pro-

market individualistic stance, favouring minimum government intervention in health policy and shifting health care to private medicine and private insurance. While social liberal groups which consist of the Labour Party and disadvantaged poor people, have been viewing the government as having the obligation to offer vital coverage to people who are unable to afford health care services. Although the health care system in Australia was developed under such political tensions, Australia's health quality standards are among the best in the world (Bowtell, 2008: 189).

This essay aims to delineate the causality relationship between political changes and welfare state concept on health care systems in Australia. This study will initially discuss about the theoretical contestation of welfare state by contrasting and comparing three definitions of welfare state from three different scholars that can answer the trends and changes of welfare state. By doing so, this study will help to gain better understanding on the concept of welfare state. The second section of the study will discuss about health care policy and its historical background and followed by the discussion on how the competition and changes in political regimes influenced Medicare in Australia. Finally, the last section will delineate the practice of health care system between Australia and New Zealand as comparative measures of welfare state in developed countries.

Welfare state: contesting definition

It is surprising that the concept of welfare state has no clear definition of the meaning and the definition though it is fiercely contested and fought politically and ideologically. In contemporary English political vocabulary, the concept of welfare state is among the most ambiguous terms (Flora & Heidenheimer, 1981 as cited in Cousins, 2005: 3). However, there is a common agreement about the emergence of welfare state in modern society. The welfare state emerges in advanced capitalistic society and involves state activities to improve human well-being (Esping-Andersen, 1990; Goldberg 2002a; Cousins, 2005).

In modern society, the concept of the welfare state is influenced by various contexts and aspects. Esping-Andersen for instance, critically includes aspects of emancipatory, legitimation and accumulation when defining the concept of the welfare state since the welfare state involves state responsibility for securing some basic modicum of welfare for its citizens (Esping-Andersen, 1990: 19). In doing so, he tries to see the relation of the state and the economy in such different welfare state regimes and classified it into three categories: liberal, conservative and social democratic regimes. Further, he refers to a narrow and broad approach to the welfare state. The first, he sees it in terms of the traditional social policies of income transfers and social services. The broader view focuses on the state's larger role in managing and organizing the macro-economic steering of the economy.

While Esping-Andersen's conception is based on welfare state regimes, Nicholas Barr's focuses on the practice of the welfare state in United Kingdom and the United States. Hence, he defines the welfare state as state's activities in four broad areas: cash benefits, health care, education and food, housing and other welfare services (Barr, 1998: 7). These activities appear in the form of social welfare programs which consist of benefits and services to address basic human needs. These needs include income security, health, education, nutrition, employment, housing, a sense of belonging, and an opportunity to participate in society. The welfare state aims to address major issues of market failure; it achieves equity objectives which many people support; and it contributes to important of non-economic objectives such as social integration. Similar to Esping-Andersen, Barr also highlights the issues of distributional objectives as well as efficiency function in the welfare state. Distributional objectives of the welfare state can harm economic growth as well as harm incentive effects. Barr also points out four major changes that influence the concept of the welfare state and these are: demographic change, globalization, changes in family structure and changes in structure of jobs. When these changes occur, the market system and state institutions adapt and therefore he strongly objects to criticizing the welfare state. He assumes that the welfare state confronts problems and accordingly institutions adapt, however this does not represent that there is a crisis.

James O'Connor is also concerned with the issues of accumulation and legitimation and considers it as a mutually contradictory function in capitalist welfare state. Although there is no clear definition of the welfare state, he agrees that the welfare state assist both in ensuring social class and group integration, social order maintenance and in ensuring the continuation, stability and efficient working of the economic system (O'Connor, 1973: 6). Consequently, welfare state involved in both capital accumulation and legitimation functions and served both purposes simultaneously. Therefore, he sees the accumulation of social capital and social expenses as a contradictory process which leads to the crisis of economic, social and politic.

From the above definitions, it is apparent that the concept of the welfare state nowadays is developed based on the practice of social welfare programs in developed countries. The principle of the welfare state in Western countries is basically similar to the principle of social protection developed by the World Bank. It includes: improvement in earning opportunities and the quality of jobs; improvement in security through better management of risks; and improvement in equity and reduce extreme poverty through better assistance programs for vulnerable groups (Holzmann, 2009: 1-2). The root of welfare state itself however can be traced back in the Islamic history during the Islamic caliphates 14th centuries ago (As-Sallabi, 2007). During the first caliph of Abu Bakr, welfare state already established in the form of universal monthly stipend taken from the public treasury (*bayt al-mall*). The caliph

also distributed allowance to eight categories of people whom *zakah* is to be given. The second caliph, Umar Ibn Khattab, developed more advanced social protections than his predecessor by expanding the payment not only the universal allowance but also a measure of wheat for every month for every individual. The caliph was also allocating one hundred *dirhams* (silver coin currency) for every newborn (so called baby bonus in Australia) and also breastfeeding allowance to encourage mothers to complete the weaning period of 2 years.

These above definitions developed by Esping-Andersen, Barr and O'Connor to some extents are complementary to each other. They have common arguments claiming that the welfare state relates to government's responsibility in fulfilling basic human needs to enhance well-being. In other word, the welfare state is a society in which government is expected to ensure the provision for all its citizens of not only social security but also a range of other services including health, education and housing at a standard well above the barest minimum (Cousins, 2005: 6). In policy term however, the concepts of welfare state are contested and fiercely fought over ideologically and politically. The contestation in social policy sometimes represents the outcome of political struggles over the distribution of resources fuelled by its often competing social, economic, and political functions. Therefore, there should be strong political and other institutions to minimize the conflict between efficiency and distributional objectives (Esping-Andersen, 1990: 11). Further, the rise of global competition and market efficiency diminishes the social welfare programs.

Neoliberal policy came to be held responsible for bringing about all the ills of the welfare state. Through structural adjustment mechanism, countries were forced to moderate or even reduce wage costs, including the costs for welfare state programs and to increase the efficiency in public expenditures in order to stay competitive. Competitiveness has become the key word both for companies and national economies as well. Companies are forced to adjust their costs and states have to take side costs and social wage into account when formulating policies (Kautto, *et al.* 1999: 7). An intensive study from Ferguson and friends in *Rethinking Welfare State* also proves that neoliberal agenda is behind the cuts in various state welfare programs in Britain and in the US. Furthermore, this forced implementation of neo-liberalism has had a devastating impact on the provision of food, health, education and other welfare services within these countries (Ferguson, Lavalette & Mooney, 2002:1).

There are factors that increased the cost of welfare state such as economic recession, industrial restructuring, increasing unemployment & poverty, individualization and aging population, uncontrollable growth of social security expenditures, high wage costs, loss of competitiveness in world markets, budget deficits and welfare dependency (Goldberg, 2002b:

326-333; Waarden & Lehbruch, 2003: 6-7). Furthermore, the pressure from globalization process also causes nation-state in many less developed countries powerless and loses much of its autonomy and its control over national economic and social life (Taylor-Gooby, 1999: 5; Ferguson, Lavalette & Mooney, 2002: 133).

There are some effects of globalization that radically undermines the provision of public services in developing countries (Rudra, 2002: 414). First, welfare benefits are not considered as good market regulatory strategies since it creates the pressure of labor costs and adversely affect export competitiveness. Second, globalization discourages government from raising revenue through taxation since corporations can easily use 'footloose capital' strategy or the capacity to withdraw and shift, both productive and financial capital to evade the tax payments. Governments' tend to promote neoliberal policies such as tax reduction and tax holiday to attract international investors and to prevent capital flight. Also investment is deterred together with increased state borrowing that result in higher debt and interest rates. Evidently governments struggle to safeguard citizens from market-generated risks and inequalities due to the increasing global competition.

The fiscal crisis has also been intensifying the call for reform towards welfare state among professionals, white collar and monopoly sector workers and other tax payers (O'Connor, 1973: 163; Marklund & Nordlund, 1990: 21; Haggard & Kaufman, 2008: 181). They urge the governments' to shift more of the cost of insurance and services onto individuals, to expand private provision, to increase competition and accountability within the public sector and to target public spending more directly to the neediest (Haggard & Kaufman, 2008: 181). Relating back to the fiscal crisis during the late 1950s and early 1960s that was far less severe, evidently, state and local governments generally tried to keep welfare programs to a minimum (O'Connor, 1973: 163; Rudra, 2002: 416).

The History of Medicare: Health Care under Political Contestation

The history of the health care system in Australia can be traced back since 1946 when the Labour government, led by Ben Chifley, proposed free and universal national health services by introducing a national prepaid hospital system (Willis, 2009: 9). The idea of provision and funding of health services was originally influenced by the British labor government's decision on the National Health services (NHS) after World War Two (Palmer & Short, 2000: 68). Chifley introduced amendments to the Constitution in 1946, which gave the Commonwealth extra power in regulating social services, such as to legislate for pharmaceuticals, sickness and hospital benefits, and medical and dental services (Palmer & Short, 2000: 69; Hancock, 2002: 55; Swerissen & Duckett, 2002: 28; Jamrozik, 2005: 187; Foster & Fleming, 2008: 50). However,

Chifley's plan received strong opposition from the liberal coalition party and practitioners in the medical profession, that led Labour to lose in the election 1949 (Swerissen & Duckett, 1997: 27).

When the Menzies Liberal government took over the position of Chifley in 1949, the Minister for Health, Earl Page, modified the Chifley plan. Instead of a universal health scheme available to all irrespective of income, access to Commonwealth assistance was means tested and only available to the most disadvantaged, such as pensioners and the very poor (Willis, 2009: 9). This modification was an adjustment to the philosophy of the liberal party which favoured **greater reliance on individual rather than community responsibility** (Swerissen & Duckett, 2002: 28). Therefore, health insurance was limited for pensioners and everybody else had to join a private health insurance fund if they wanted medical or hospital cover (Kirkpatrick, 2006). Moreover medical practitioners fees were unregulated with health care financing provided by the Commonwealth government and health funds, but patients were left with high out-of-pocket openness (Leeder & McAuley, 2000). **Consequently**, the health system had become unwieldy, unjust and enormous cost. The health system continued falling apart because the government and the funds claimed that doctors kept increasing their fees and refused to control them in an unfettered way. While the medical profession claimed that the government had no right to interfere and limit their fees or control their potential income under the Constitution. They demanded a private fee-for-service system (Kirkpatrick, 2006). Therefore for several years, the number of people and families who could afford health insurance continued to plummet. By the late 1960s, around 17 per cent of the population was not covered by private health insurance or by government benefits (Swerissen & Duckett, 2000: 28).

The time was ripe for a reform in the nation's health insurance when the Whitlam labor government came to power in 1972 (Willis, 2009: 9). On 1st July 1975, the Labour government introduced the universal health insurance scheme called Medibank. Medibank was devised in 1968 by two well-known Australian health economists, John Deeble and Richard Scotton, well before the Whitlam government came to office. Medibank was designed as a public, non-contributory, national health insurance model, which provided universal access to medical and hospital services, regardless of income (Swerissen & Duckett, 2002: 29). Medibank provided a universal health insurance covering for all Australians. It retained a fee-for-service model providing rebates for medical practitioners' services and eventually also provided full cover for hospital treatment as a public patient (Livingstone, 2009: 52). Medibank paid 85 per cent of the schedule fee, with a maximum copayment by patients of \$5 per service (Browning, 2000). Medibank was financed through the taxation system so that generally speaking the more income you earned, the more tax you paid and therefore, the more you were contributing to financing the

health care system (Kirkpatrick, 2006). Medibank also replaced the system of doctors providing honorary care to patients in public hospitals by employing doctors in hospitals, either on a full-time basis as salaried staff specialists or through sessional or other sorts of part-time payments for doctors who primarily remained in private practice. However, similar to its antecedent, Medibank came after intense political struggle against well-organized oppositions, mainly from the Australian Medical Association (AMA) and the conservative coalition parties by rejecting Medibank legislation twice in the senate (Livingstone, 2009: 52). Its existence was short-lived because the Whitlam labor government was in office less than three years.

Fraser Liberal Government (1976-83)

As with the return of the Liberal Coalition to power in 1975, The Fraser administration made a promise to maintain Medibank. During the Fraser government, some reforms were introduced to modify the previous health care scheme. First of all, the original Medibank had no discrete taxation levy, but Fraser introduced a 2.5 per cent levy on taxable income in 1976 under Medibank Mark II with a provision for those with Private Health Insurance (PHI) to opt-out of paying the levy (Duckett, 2004: 295). However, two years later the Fraser government then abolished the levy in 1978. Second, Fraser government made the bulk billing payment available only for pensioners and socially disadvantage people, while the rest of the population charged a co-payment for medical expenses, and by 1981 the rebate was only available to those who had private insurance and paid at 30 per cent of schedule fee. Lastly In 1981, the Fraser Liberal government also abolished free care in public hospitals (Gray, 1996: 592; Duckett, 2004: 295).

Although Fraser promised to maintain Medibank, the scheme was gradually emasculated and then completely abolished (Leeder & McAuley, 2000; Jamrozik, 2005: 190; Willis, 2009: 9). In 1981, the Fraser government had successfully returned to a version of the pre-Medibank arrangements. The pressure from various interest groups such as Australian Medical Association (AMA) coupled with the Liberal Coalition's own desire to cut back public expenditure, made the dismissal from the Medibank possible (Livingstone, 2009: 52). In line with liberal ideology, the Liberal government encouraged people to be responsible for themselves for their health costs, by taking up PHI, which attracted a 32 per cent income tax rebate, and the health care benefits were only available to pensioners and socially-disadvantaged people on health care cards (Jamrozik, 2005: 190; Livingstone, 2009: 52). In addition, the Commonwealth grants to the states and territories for hospital care were substantially reduced and abolished, and hospitals were required to charge both inpatient and outpatient fees for all, except a minority who qualified for free care (Livingstone, 2009: 52).

During the Fraser government, people were allowed to opt-out of Medibank completely if they paid private health insurance (Kirkpatrick, 2006). Consequently, half of the population chose private insurance because it was cheaper than if they had paid an income-related contribution through the taxation system for Medibank. This exacerbated the problem of funding Medibank since the major contributors of the universal system of health care, the high income earners, opted out of the scheme and took up private health insurance. This left Medibank with almost no contribution in income, because it was only treating low income earners and the poor. All the high income earners and wealthy who would have paid enough through their income-related contributions to fund Medibank and a universal system of health cover had opted out and gone into the private sector.

Hawke Labour Government (1984-88)

Medicare was first introduced on 1 February 1984 when the Labour government won the election in 1983 under the Prime Minister Bob Hawke. The system of universal public health cover was immediately brought back to life by the Hawke government. At that present time, the Hawke government ditched to name their system 'Medibank' and replaced it with 'Medicare' in order to detach itself from the reminiscences of Whitlam. Yet, Medicare remained to be the same scheme with only slight developments to their system (Kirkpatrick, 2006). This initiative came successfully after intense political struggle for over two decades, against a well-organized opposition including the AMA, health insurance funds and non-labour parties (Jamrozik, 2005: 190). The provision and funding of Medicare emerged as the embodiment of the Labour party's philosophy to ensure those vulnerable groups and those who are economically or socially disadvantaged have adequate access to affordable and high-quality health care. Besides, in most industrialized countries, governments have to bear the responsibility for the provision and funding of health care services. therefore, the provision of cost effective health services is a necessary and socially desirable means for addressing poverty and disadvantage, including the poverty that might result from having to pay unexpected large health bills (Podger & Hagan, 2000: 116).

The major principle of Medicare in Australia is to remove or reduce financial barriers to access health care for all Australian residents (Brown, 1983: 3). Another justification is to give federal government more power in the health care field than was provided for in the Constitution and to replace private insurance with public insurance (Duckett, 2004: 44). Medicare in Australia is a compulsory, universal health insurance scheme based on the principle of equal access for all Australians. The access to Medicare is eligible to all residents in Australia and short term visitors from countries with reciprocal health agreements (Palmer & Short, 2000: 63; Willis, 2009:

4). The responsibility for health in Australia is shared between the Federal government and the states. The health care system is funded by the various level of government through taxation, the Medicare levy and council rates. Each level of government i.e. federal/commonwealth, state/territory and local government, provides some form of health care. The Medicare levy is set at 1.5% of each person's income or 2.5% for those individuals of families who earn over a certain amount who do not have private health insurance (Willis, 2009: 4).

The main role of the Commonwealth in the health care system is related to the provision of financial support. The grants provided by the Commonwealth to the states and territories are equivalent to 50 per cent of the funds needed, and the states and territories provide the rest from their own revenue (Somjen, 2000: 61; Willis, 2009: 4). Besides, state and territory governments have a major role in the provision and management of health care services. It includes the planning, provision and administration of public sector health services such as hospitals, including acute and psychiatric hospitals and community health services (Foster & Fleming, 2008: 52). While local governments focus on the provision of immunization services, maternal and child health services and home and community care for older people and people with disabilities.

Medicare consists of two main components, one is the funding of the public hospital and the second is the provision of direct payments to medical practitioners for care (Willis, 2009: 5). With Medicare, patients can access free treatment in public hospitals (Gray, 1996: 592). Direct funds are available for the payment of medical practitioners and some optometrists' procedures. The commonwealth provides these funds and all Australians are eligible for a rebate of up to 85 per cent of the scheduled fee set by Medicare for any consultation with a general practitioner. This leaves a 15 per cent gap, but it can be reimbursed 100 per cent by the family safety net (Willis, 2009: 5). Bulk billing also can be used as an alternative payment for doctors when they charge the patients for the schedule fee. Under bulk billing, patients do not pay a gap, and the medical practitioners receive 85 per cent of the schedule fee. However, when a patient uses their private health insurance for a medical procedure at a public or private hospital, they are reimbursed 75 per cent of the fee and the safety net does not cover the gap for in-hospital fees.

Keating Labour Government (1991-96)

Under the Keating Labour government, Medicare went through some slight changes. Keating increased the tax levy of each person's income from 1 per cent to 1.4 per cent in 1993 and 1.5 per cent in 1995 (Ducket, 2004: 295-6). Under the Medicare Agreements 1988-1993, the Commonwealth provided the grants for hospitals based on the population of states and territories. These grants were subject to the provision that the states maintain a minimum proportion

of the total bed-days in the state for public, non-chargeable patients (Palmer & Short, 2000: 82). In 1995, the Keating government introduced amendments to the Health Insurance Act 1973 and the National Health Act 1953 in order to improve the value of private health insurance to consumers (Swerissen & Duckett, 2002: 31). The amendments provided increased competition between insurance funds and gave them greater power to negotiate with private hospitals and medical practitioners on behalf of their members. The amendments strengthened the rights of private patients to access proper information on which they could make decisions, and also gave private patients access to complaints mechanisms if they felt aggrieved. In 1996, the Labour government provided incentives for those privately insured to retain their membership and imposed a financial penalty on those high-income earners without private cover.

Keating's commitment to support Medicare was a little bit degrading in term of financial support. The proportion of total health expenditure funded by the government dropped from 71.9 per cent to 68.7 per cent between 1984-85 and 1996-97, whereas the non-government sector's proportion rose from 28.1 per cent to 31.3 per cent respectively (Duckett, 2004: 83). In 1996-97, 45.5 per cent of Medicare expenditure was provided by the Commonwealth and 23.2 per cent by states and local governments (AIHW, 1998: 163).

Howard Liberal Coalition Government (1996-07)

When the Howard Liberal government came into power in 1996, Medicare was dramatically changed. Between 1996 and 2000, the Howard government progressively introduced Private Health Insurance (PHI) with a 30 per cent subsidy for low income earners taking out private health cover (Swerissen & Duckett, 2002: 32; Hancock, 2002: 73; Kirkpatrick, 2006). In other words, the government wanted to encourage the people into private health cover, and the subsidy would allow these people a choice between Medicare and private health funds at a price that they could then afford. The official reason for the concern with private health insurance was the threat to the viability of private hospitals, posed by the decline in the proportion of the population covered by this form of health insurance (Palmer & Short, 2000: 78). They argued that the reduction in the use of private hospitals would flow over to the increased pressures on public hospitals for which the Commonwealth and the states would share financial responsibility. However, the Howard's proposal did not have much effect on the number of low income earners taking out private health cover. In fact, the number of people with private cover continued to fall (Kirkpatrick, 2006). In 1999, the 30 per cent subsidy was extended to everybody. Surprisingly, this did not make much difference to the number of people taking private cover either.

To boost private health insurance, the Howard government introduced two further changes. First, the government introduced private health insurance and a Medicare levy surcharge on those earning more than \$50 000 per person or \$100 000 per household who did not take out private health insurance (Lewis, 2006: 205). Second, they introduced what was 'lifetime' health cover in 1999 which provides incentives for younger, lower-cost members to take up private health insurance and penalties for older entrants (Hancock, 2002: 73; Gray, 2004: 56). However, there was a lot of uncertainty about what lifetime cover meant. Despite the very strong tax incentives, it appeared that once again the numbers of privately insured people were slowly falling (Kirkpatrick, 2006).

In 2004, the Howard government introduced the Medicare Plus package to encourage doctors to bulk bill concessional patients (normally pensioners and poor and socially-disadvantaged people) with financial incentive, but there is no incentive to bulk bill all patients to reduce out-of-pocket costs (Lewis, 2006: 205). Under this scheme, poor people guaranteed their access to GPs (General Practitioners). However, others saw a decline in bulk billing. The Howard liberal national coalition also increased the levy to 2.5 per cent for individuals and families who did not have private health insurance. It could be argued that access to medical care improved under the Liberal National Coalition since families and individuals could now apply for a rebate on costs above the scheduled fee charged by medical practitioners (Willis, 2009: 9).

Howard's government also introduced the Medicare Safety Net in 2004 targeting low-income earners and concession card holders who qualified for the benefits as part of broader strengthening Medicare initiative (Foster & Fleming, 2002: 56). The Medicare safety net was introduced as a targeted, eligibility-based initiative, rather than a universal principle. The change to the principles of Medicare had more to do with the increasing preference of the government for a residual welfare state system and a stronger emphasis on the private sector (Grbich, 2002). Stronger emphasis on the private sector includes the role of private citizens in contributing towards the cost of health care, either through direct personal payment or through voluntary contributions made to private health insurance funds (Foster & Fleming, 2002: 57).

Rudd Labor Government (2007-09)

The Rudd Government announced in May 2008, its controversial proposal to raise the income threshold, whereby people will incur an extra surcharge for not having private health insurance from \$50,000 to \$100,000 for singles and from \$100,000 to \$150,000 for families. State Health Ministers from Queensland, Western Australia and Tasmania afterward, demanded extra funding for healthcare agreements, disputing that Rudd's decision would increase the public hospital queues. The public health system is characterized

by long waiting lists and a lack of resources, and the Australian Health Insurance Association warned that the shift might immediately cause 400,000 people to abandon taking health insurance to turn to the already hampered public health system (*The Australian*, 13/5/2008). In October 2008, the bill that lifts the income threshold to avoid the 1 per cent Medicare Levy Surcharge was accepted in parliament. The figure was lifted to \$75,000 from \$50,000 for singles, and raised to \$140,000 from \$100,000 for couples (*The Australian*, 18/10/2008).

As of recent, the latest controversy is over the Treasurer Wayne Swan's plans to diminish the 30 per cent private health insurance rebate for singles earning from \$74,000 and couples earning from \$150,000 and subsequently no rebates will be available for those earning \$120,000 to \$240,000 respectively. Additionally, higher penalties will be charged to middle and high income earners who drop their cover because of the soar in premiums. Accordingly, Rudd Government may have to deal with another Senate blockade if they pursue the budget plan to cut \$1.9 billion in private health insurance cuts (*The Australian*, 8/5/2009).

Table 1. Timeline of health care insurance program 1946-2007

Period	Program	Government	Prime minister
1946-49	Proposal for national health scheme	Labor government	J.B. Chifley
1953-72	Earle Page health insurance	Liberal country party government	R. Menzies H. Holt J. McEwan J. Gorton W. McMahon
1972-75	Medibank	Labor government	G. Whitlam
1976-83	Medibank Mark II	Liberal National Coalition government	JM. Fraser
1984-88	Medicare Compensation Agreement	Labor government	B. Hawke
1988-93	Medicare Agreement	Labor government	B. Hawke P. Keating
1993-98	Medicare Agreement	Labor up to 1996, then Liberal National Coalition government	P. Keating
1998-2003	Australian Health Care Agreement	Liberal National Coalition government	J. Howard
2003-2007	Australian Health Care Agreement	Liberal National Coalition government	J. Howard
2007-present	Australian Health Care Agreement	Labor government	K. Rudd

Source: Willis, 2009: 10.

Australia and New Zealand Compared

It is fascinating to compare the health care systems between Australia and New Zealand. There are some similarities and differences in health care

system between Australia and New Zealand since both countries have a long history of securing universal access to a comprehensive range of health services and protection against the impoverishing effect of illness (Bloom, 2000: 3). New Zealand was the first industrialized country who implemented the universal and nationwide health care system in the world with National Health Services (NHS) while Australia has the most ideal or workable model in health care system in the world and has highest life expectancies worldwide (Grbich, 2009: 16). Also the standard of health care provided in both countries is impressively high (Bloom, 2000: 5).

Political ideology plays a significant role in shaping public policies in both countries. The characteristic of social policy in Australia has been influenced by welfare or social liberalism where state involvement in public policy is sturdy. Whereas the ideological spectrum in New Zealand have been occupied by liberal market-driven ideology (Gray, 1996: 608). In Australia, the government highly involves and supports the provision of the health care system through the Medicare scheme through a mixture of public and private funding (Lewis, 2006: 198). Medicare is compulsory and universal health-financing scheme (Hindle & Perkins, 2000: 90). It provides free access to public hospitals, subsidized access to medical practitioners and access to subsidized pharmaceuticals, mainly prescription medication (Bloom, 2000: 20).

New Zealand initially had free-universal coverage of National Health Services which was introduced in 1938; however after radical changes in the 1980s and 1990s, health care policy in New Zealand has been characterized by a high degree of market-oriented competition (Somjen, 2000: 64; Hindle & Perkins, 2000: 94). The economic decline was the major reason behind the implementation of economic and social reforms in New Zealand. The reforms were characterized by an increasing reliance on market forces. Since then, the government has been forced to have their hands off from health care provision and encouraged those who can afford to pay to fund their own primary care (Somjen, 2000: 57). Instead of providing adequate medical insurance for all New Zealanders, government financing would focus on those with the greatest need for health care by introducing Community Services Card (CSC) scheme which gives poor people access to health services at a discounted price (Hindle & Perkins, 2000: 94).

In terms of financial support, taxation plays a key role in the health care system. In New Zealand, health care is financed through taxation at the national level and New Zealanders are subject to neither payroll taxes nor to any dedicated health tax (Bloom, 2000: 36). Although taxation is the major source to finance the services, private finance also provides significant contribution to the health care. In Australia there is relatively large reliance on private finance that accounts for 30 per cent of total health care expenditure; while in New Zealand private finance accounts for around 20 per cent of total

expenditure. Therefore, the system of health care in both countries can be described as private provision, publicly supported (Hall & Viney, 2000: 50).

Both Australia and New Zealand have experienced milestones in health reforms in the late 1980s and the 1990s. For Australia, the defining date of the introduction of Medicare was 1984, while in New Zealand, in 1993 the culmination of a reform process had gathered pace throughout the 1980s and early 1990s. Up to 1990 the stability of the Australian and New Zealand health care systems contrasted greatly. National Health Services in New Zealand in one hand, had remained very stable, whilst the universal and nationwide coverage of health care system in Australia on other hand has been constant sources of political debate having been subject to many fundamental changes since 1945 (Donaldson & Gerard, 2005: 10).

The political culture also influenced the dynamic of reforms in both countries. Unlike New Zealand, the health reforms in Australia were never characterized by a comprehensive big bang approach. All reform initiatives in Australia have left the Medicare, mixed funding and multi-tiered (federal/state/local) division of responsibility unchanged. In short, the approach of health reforms in Australia can be characterized by incremental and syncretic, consisting of a range of independent but interactive measures in different parts of the system (Bloom, 2000: 22). In contrast, health care in New Zealand was characterized by a big bang approach after successful radical reform in 1993. This radical reform was possible in New Zealand under a new right-wing government because the political system in New Zealand parliament is unicameral, thus enabling strong action by one government (Gauld, 2003: 202). The characteristic of the political structure in Australia made it impossible to approve radical reforms. Like the US, Australia has a bicameral federal parliament and there has been a different balance of power between two houses in recent years in Australia. In addition, health is also the responsibility of the various state and territory governments. This makes it unlikely that there will be a political consensus on the direction of reform. And as a result, reform can be advanced only through incremental change (Hall & Viney, 2000: 53).

Conclusion

The study found that health care policy is one of Australia's most controversial issues and has been a major issue at every Commonwealth election since the 1940s. Until now, Medicare is still undergoing continuous changes and reforms influenced by its various interest groups. Providers want high profits and incomes, consumers want to be able to access quality services at an affordable prices and governments want to keep a tight control over expenditure. Many interest groups are structurally working together within the policy-making system to oppose or to promote change. Members of the

liberal individualist groups consist of the Australian Medical Association, pharmaceutical industries, general practitioners, private insurance companies and Liberal Party and its supporters have taken a liberal individualist stance, favouring minimum government intervention in health policy, with a large role for private medicine and private insurance. The Australian Labor Party, on the other hand, at least until very recently, has taken a social liberal position, arguing that health should be publicly financed, in order to achieve access and equity objectives.

Economic hardship and the rise of health care costs worldwide also create serious threats on the future of health care services. Neo-liberal policy came to be held responsible for bringing about all the ills of the welfare state. Through structural adjustment mechanism, countries were forced to moderate or even reduce wage costs, including the costs for welfare state programs and to increase the efficiency in public expenditures in order to stay competitive. The pressure from globalization process also causes many nation-states powerless and loses much of its autonomy and its control over national economic and social life (Taylor-Gooby, 1999: 5; Ferguson, Lavalette & Mooney, 2002: 133). Despite the economic hardship and strong pressure from promarket groups in both countries, Australia has retained universal access, whereas New Zealand has dramatically liberalized health care services by relying on private health insurance. ●

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