

## **RECENT AUSTRALIAN PERSPECTIVES ON HEALTH AND SOCIAL INSURANCE**

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### **Abstract**

This article describes the background and continuing inquiry into major Australian health and social insurance systems in their primary context of national taxation based welfare provision and private insurance against injury. It aims to promote more cooperative and applied research into how health and social insurance design and management may be improved internationally. Australian policy makers have been particularly interested in the extent to which all health and related funds for services or pensions should be underwritten (owned) and managed by government or in the private sector, in order to gain the best outcomes for individuals, taxpayers, premium holders and the whole community. Nationally designed, health and related social service funds owned by government and industry, which are transparently, regionally and competitively managed, appear likely to provide superior outcomes to market based underwriting of risk, which also provides services or pension style support. Approved and applied principles of risk management should be taught in vocational education. This is the means of promoting critical understanding and implementation of relevant national and international standards and an evidence based approach to work performance.

Australian policy appears to make funding available for applied industry research and education.

**Keywords:** social insurance, health insurance, workers' compensation, disability insurance, risk management

### **Defining insurance, social insurance and risk management**

Historically, insurance developed before a great deal of social welfare provision and related taxation. Social insurance systems usually developed even later, and may combine elements of both systems of provision. Insurance has been defined as a mechanism for contractually shifting the burdens of a number of pure risks by pooling them (Rubin 1991: 360). Private individuals, business entities or other groups have traditionally purchased insurance from private sector insurance companies which underwrite (i.e. bear the risk) of various potential economic failures which the premium purchaser may experience as a result of injury and legal suit, unemployment or other unfortunate specified circumstances. Some systems for insurance may require the proof of fault, prior to the court determination of lump sum compensation, as in the case of third party motor accident insurance. Others are social welfare style insurance systems without a fault-based element, as in the case of workers' compensation insurance. The major architect of the post-war British welfare state, Sir William Beveridge (1942: 11), described social insurance as 'the system by which every citizen of working age contributes, 'in the appropriate class', according to the security that is needed'. He believed that each person should ideally be covered for all needs by a single weekly contribution on one insurance document, and that all the principal cash payments, (for example for support through disability or unemployment), should continue so long as the need lasts, without means test. He believed that payments should ideally be made from a social insurance fund built up by contributions from the insured persons, from their employers, if any, and from the state.

Beveridge regarded the development of such a comprehensive system of social insurance as vital because of a popular objection to means testing for the provision of government welfare benefits provided from taxation. He thought this came from general resentment at any policy which appears to penalise those who undertake the duty of working and saving in order to provide for their personal needs. However, he did not closely address appropriate service delivery systems and the extent to which government should underwrite and therefore own funds, or be the service and pension provider. Neither did he discuss appropriate systems related to fault in the case of injury, which is a

major topic largely beyond this paper's focus on fund management. In regard to the above definitions of insurance and social insurance in the Australian context, it is also necessary to understand differences between risk rated premium setting, community rated health care provision paid for primarily through government taxation plus additional private insurance, and other benefit systems which have their primary purpose in assisting general accumulation of savings for old age, called superannuation. These different systems are briefly described later in the Australian context.

In developed economies, health and social insurance services and related pension supports are most easily and appropriately understood in the national context of the guaranteed welfare provision, which is broadly provided and funded by government through general taxation. Government has sought, through such provision, to establish guaranteed minimum welfare standards to which entire communities are entitled. From the public policy perspective, the primary aim of social insurance and its management should therefore be to assist achievement of this generally required minimum standard of social support as effectively, equitably and sustainably as possible. Achieving these aims also requires effective administration and related risk management, which may be defined as the informed and consultative identification, prioritisation and treatment of risks related to any activity and its environment. Monitoring and evaluation of activity outcomes are also necessary to produce a better evidence base for a data driven approach to future management of any organization, community and environment (Standards Australia/Standards New Zealand 1999). This is consistent with the requirements of quality management and environment management as outlined in international standards, and also with those of health promotion (Wass 1994) and action research (Hart and Bond 1995). Rubin's Dictionary of Insurance Terms (1991; 360) describes risk management in a related way, as 'a procedure to minimize the adverse effect of a possible financial loss by identifying potential sources of loss, measuring the financial consequences of the loss occurring, and using controls to minimize actual losses or their financial consequences'.

The success of taxation, social insurance or insurance systems, as well as that of other business ventures, also depends partly on contributor trust. Ideally, this must be based on clear and easily available evidence that the structure and management of an operation is sound and meets contributor, consumer and community goals comparatively effectively. Transparent administration and reliable information about service outcomes are necessary for public confidence and effective development of any social system. Reliable information is necessary for identification and control of risk, as well as for operation of the market and democratic accountability. A risk management model based on the interests of stakeholders may challenge the traditional notions of business confidentiality, by requiring broader operating data than is normal in the stockholder driven management model driven by the pursuit of commercial interest. Australian development is considered later in this context.

### **Designing social insurance to meet the global needs of aged and vulnerable populations**

Measured by longevity, health is improving internationally and many nations now face growing problems related to provision of appropriate support for the elderly, the physically or mentally disabled, and others who may be poor or unemployed. Health and education are also recognised as primary drivers of productivity (Stiglitz and Muet 1999: xxvi; Leeder 2002). In any society the poor are invariably also found to have the worst health and education (Murray and Lopez 1996; United Nations 2003). The United Nations recently noted (UN 2003) noted that primary education provides the greatest return on investment, both for individuals and communities, and that this is also closely related to effective fertility control, which is generally necessary to avoid poverty. An important question for all communities is that of the appropriate roles of government, industry and competition in regard to health, education and all related welfare service. Since 1992 the UN Declaration on Environment has also committed signatories to ecologically sustainable development goals with the first principle being that health is at the centre of human development and that all

people are entitled to a productive life in harmony with nature. This is equally meant for future generations. In an increasingly international, competitive environment, continuing comparative discussion of regional health, education and related taxation and social insurance experience is important not only for sustainable development generally, but particularly for the most vulnerable. Later description and evaluation of Australian fund management policy is undertaken in this development context.

In comparatively poor agrarian countries the family may be the only welfare state. Adults are normally expected to care for their aged parents, and children may also have to work to help the family meet its ongoing needs. Some poor nations, such as Nigeria and Pakistan, expect to see the school-age population increase by two thirds during the next fifty years. In China, however, it is expected to decline by 23% (United Nations 2003: 9). While many developing nations face the problem of an aging population, in China the combination of high levels of economic growth, comparatively good population health (Murray and Lopez 1996) and the one child policy, have meant that the population is ageing faster than the norm and related potential stresses are therefore more obvious. By 2020 people over sixty will make up 16% of the population. The Chinese government is facing how best to provide for this group now and in the future (World Bank 1997). This also appears likely to be important for sustainable production in Australia, which is a major trading partner.

Comparative Russian and Chinese experience suggests that stable management and competition are more important than private property for effective functioning of the market and also for health (Stiglitz 2002; Murray and Lopez 1996). The Australian experience discussed later, generally supports this in regard to fund ownership and management. However, much more applied research is required in order to find out the insurance, social insurance and taxation mix which appears to support the broadest community interests most effectively. The situation of the poor requires particular consideration. Galbraith (1973) and others (Averitt 1968; Doeringer and Piore 1971; Gordon 1972) described market driven organizations, nations and the international economy as having a central tendency towards being planned or monopolistic, with a highly competitive but impoverished economic periphery where migrants or those with little or no education commonly seek to maintain themselves in work. Governments have sometimes been advised to bring dual economies into greater equilibrium by increasing competition in monopolistic sectors, and strengthening communities in peripheral sectors (Galbraith 1973). While a government planning perspective was unfashionable in the 1980s it now appears to be returning.

Stiglitz and Muet (201) have stated that economic crises have shown the need for greater world governance, especially to manage 'public goods' such as financial stability and environmental protection. At the same conference the French Prime Minister emphasised the need for a comprehensive and balanced approach to development and for 'governance' of the international economy. The President of the World Bank also lamented that traditional economic policies for growth have seldom been accompanied by an equal focus on governance for health, education and environment improvement and that those with a narrower professional or short-term commercial focus still drive development outcomes. Stiglitz and Muet conclude that many economists now seek to go beyond 'the Washington consensus' which they characterize as involving a plea for unconditional liberalization of markets, lack of attention to institutions, and macroeconomic policies geared too much towards lowering inflation and not enough towards development and employment. They claim there is a failure to understand how weak financial institutions lead to macro-economic instability as bad as large budget deficits, and also fuel dramatic financial crises. They view development success as requiring high savings, rapid capital accumulation, high levels of training, strong capacity to acquire new knowledge and rapid insertion into international trade. They also

state that improved world governance must closely involve employers and trade unions as well as non-government organizations. This Australian experience is discussed later in this context.

Some have argued that governments in developing countries should leave most social insurance or insurance to enterprise based or private provision and provide health services, education and social support only to poor and vulnerable groups (Saunders and Shang 2000). Developing countries may strongly promote a welfare state in the formal economic sector through social insurance for pragmatic reasons. This may also have the effect of increasing social inequality by excluding most farmers and others who are likely to be poor, unless steps are taken to avoid the problem. China currently has the aim of unifying all enterprise based pension systems so that organizations and workers covered under separate pension plans or not covered at all are eventually brought into a single system with common standards. Program management is to be transferred from enterprises to government agencies, and administrative management and fund management are being separated (World Bank 1997: 4). However, it has been argued that government commitment to a unified approach to addressing poverty on a national basis is necessary in China and that all related social security systems need to be re-focused in this general direction (Saunders and Shang 2002). Australian experience is also investigated for its relevance to other communities in this context.

### **The taxation based context of Australian health service and social welfare provision**

Australia is a former British colony, which became a federation of states in 1901. Its national health, education and welfare systems are primarily taxation based, but a major expansion of the enterprise based social welfare system is occurring very rapidly in relation to provision for old age, which is discussed briefly later. Government guarantees taxpayer funded primary and secondary education and a basic level of health care. Other education, hospital and related services may be purchased in the market and government may subsidise these operations when they meet its requirements. One in five people of workforce age are dependent to some extent on pension related support funded by the taxpayer, compared with one in seven a decade ago (Minister Assisting the Prime Minister for the Status of Women 1999: 1). This is generally paid on a means tested basis, from taxation, primarily to the unemployed, to people with disabilities and their carers, to lone parents, students and war veterans. The elderly also have access to a means tested pension. Housing support for the severely disadvantaged and government relief for natural disasters may also be available.

Australian hospitals have been provided with government support from taxation since the early 20th century. In 1984 the national Medicare system replaced hospital and medical insurance which consumers formerly purchased in the private sector with major government subsidy. Medicare guarantees universal, taxpayer-funded, basic hospital and medical care, administered by the national Health Insurance Commission (HIC) from general taxation revenues and an identified levy on taxable incomes. The HIC also administers the Pharmaceutical Benefits Scheme (PBS), which subsidises thousands of competitively priced drug brands. The Commonwealth government provides additional subsidies to health care consumers who choose to purchase extra care entitlements through private health insurers. From a government perspective, the major point of encouraging people to take up additional private health insurance is to increase the overall pool of health funds and public or private facilities available for general use (Industry Commission 1997). Since 1986 the Commonwealth government has also provided for health promotion programs which have been successful in reducing death from major health problems such as HIV/AIDS, cardiovascular disease, accidents and cancers primarily by changing the behaviour and environment of relevant populations through public education, screening and related improvements in technology and management.

The Australian population aged sixty-five or over is projected to rise to 18% by 2020 (Kendig and Duckett 2001). The National Strategy for an Ageing Australia (2000) identified a range of broad program areas for health. These include maintaining physical and mental health, engaging in physical activity, preventing falls and injury, maintaining adequate nutrition, detecting sensory loss early, managing incontinence and evaluating alcohol and other drug use. It has suggested strategies to maintain wellbeing at older ages should also centre on the development of more flexible employment patterns and better coordinated provision of all health and social services, with the aim of assisting everybody to maintain links with work, recreation and community service wherever this appears beneficial. It is also proposed that all Australian government provision for aged care services be pooled into a single fund to be managed at regional level. This would incorporate residential aged care, home and community care and related government activities, with the expectation that separate funding streams should exist for accommodation and for the delivery of flexible services based on client levels of disability and related need (Kendig and Duckett 2001).

In 1990 the Council of Australian Governments (COAG) agreed to establish national standards for health and environment protection and reviews of legislation accordingly commenced. The National Competition Policy Reform Act (1995) requires equal competition between public and private service providers unless another course of action can be shown to be in the public interest. There is increasing agreement about the necessity to separate policy from competitive regional administration and related service provision, in order to identify comparative service outcomes more effectively, whether they are provided by government or in the market. Australian social insurance systems should ideally be conceptualised and developed to meet the requirements of this broader public policy context. The health insurance systems discussed later are under constant government and independent inquiry to achieve greater national uniformity and understanding of the comparative benefits of planned and market driven approaches to all service provision. However, applied research and education appear likely to be potential components of international trade and cooperative project development which require more broadly coordinated policy and stakeholder based management approaches, in order to achieve a broader range of community aims than is possible through the normal commercial models which are managed in the stockholder interest.

### **Key forms of social insurance and saving systems in Australia**

The most recent, large and untested element of Australia's social insurance system involves provision for the aged. It was introduced to cover the whole workforce in 1992 through national legislation which requires 'a superannuation guarantee'. This ideally ensures payment to supplement or replace government pensions and many other private industrial arrangements. All employers are accordingly required to provide entitlements for provision in old age for all their employees. Government and workers also contribute to the funding pool. Superannuation funds may currently be managed in a variety of ways and industry managed superannuation funds have quickly become spectacular new investors on behalf of members. The self-employed may also select appropriate insurance and investment products. The primary purpose of funds is to provide a savings pool which is sufficient for maintenance in old age. However, the effective investment of these funds, so that they support international health and development goals, is a vital secondary issue. As Attanasio points out (Muet and Stiglitz 1999; xvi) capital invested in less developed regions could yield higher returns to finance the retirement of Western baby boomers and at the same time could help development in other regions. However, one would not like to lose one's nest egg or innocently injure those already disadvantaged in the process. Think of the meteoric rise and fall of Enron (McLean and Elkin, 2004) and the recent collapse of the insurer HIH, which in 2003 lead to a Royal Commission in Australia. Accumulation of superannuation funds is a big investment responsibility.

Australia's oldest enterprise based system of health and related social insurance is workers

compensation insurance, established at the turn of the 20<sup>th</sup> century. The origin of state workers' compensation legislation is the Employers' Liability Act introduced in Britain in 1883. The act primarily provided for weekly benefits for injured workers. It was considered necessary because the common law suit, which required an injured worker to sue their employer for negligence, was failing to meet workers' needs. It was then being argued successfully in the courts that in doing the work, the worker was also taking on the risk of its undertaking. The British act, and the Australian legislation that followed it, conceptually transformed the insurance premium from payment to protect the employer against legal suit, to a 'no-fault' system of enterprise based welfare provision. In contemporary Australia, premiums pay for health care provision, work related rehabilitation services, and pension support for those off work. Lump sum compensation is available for the permanently injured. Self-employed contractors not deemed employees in legislation must make their own insurance arrangements. Forms of 'top-up' or extra insurance and related benefits may also exist. (Industry Commission 1994). Premiums are risk rated on the basis of the extent to which an industry and organization appears to be engaged in high-risk activities. This is designed to reflect economic reality and to provide incentives for risk reduction.

Historically, state workers' compensation schemes have been repeatedly established either as government monopolies or with competitive insurer underwriting, depending on the political persuasion of the government in power. There is now increasing commitment to national uniformity based on the managed fund model of service delivery which was first introduced by the New South Wales (NSW) Labor government in 1987, in addition to requirements for work related rehabilitation services (Australian Heads of Workers' Compensation Authorities 1996). Under this social insurance model, the government and industry own the premium pool and underwrite the scheme. A statutory authority with a board of experts drawn from government, employers, workers and insurers establishes the level of benefits for injured workers, and the level of premiums. It licenses a dozen insurance companies and pays them to collect premiums, administer claims, invest funds, and collect data on its behalf. Government and industry own the funds but very large employers may be approved to self-insure instead of joining.

In NSW, the Australian state with a third of the total population, the traditional adversarial determination of levels of permanent disability and the award after an accident at work have recently been replaced by compulsory conciliation, directed by medical panels. NSW has also led in deciding that workers' compensation premiums should also pay for administration of state occupational health and safety (OHS) acts which were introduced during the 1980s, following the Robens Committee report produced in Britain in 1972. This 'duty of care' legislation provides the basis for an increasingly holistic risk management perspective which can be contrasted with that of 'black letter law'. The latter traditional legal approach is driven by disputes and related court decisions in which the letter of the law is of primary importance. In contrast, the focus of Australian OHS acts is on the need for comparatively scientific and preventative approaches to gaining safe outcomes from work. Accordingly, all employers have a general duty to provide a safe place of work and to ensure the health and welfare of workers, contractors and visitors as far as is reasonably practical. Workers are expected to cooperate and work safely. There is a requirement that products provided to the work place will be safe when properly used. The legislation also requires workplace risk management to identify, prioritise and control risks, in consultation with workers who have been provided with appropriate training.

Industry standards and codes of practice are also called up by the legislation. People are expected to apply the relevant codes of practice to guide work unless another course of action can be shown to be as safe. Government inspectors or trade union representatives may fine employers or take prosecutions for dangerous work practices, whether or not death or injury has occurred. The risk management approach required of all workplaces by OHS acts provides the legislative context for a

generally more professional attitude to work which can be compared with that already required of health workers (Johnson 1997). For example, a doctor is ideally expected to identify a problem and to know and apply treatment after consideration of the relevant body of scientific evidence. However, the treatment may vary as far as this appears to be necessary to meet the specific health needs of an individual's situation. The reasons for deviation from the generally expected expert practice should be documented. This should then contribute to a body of related information which is broadly studied in order to improve the general treatment. In order to promote efficient and equitable management of all injury, consistent protective approaches should normally be taken to those who are injured at work, or allegedly at the hands of a product or service provider, or as a result of other misfortune or negligence in the community. Australian policy makers and health practitioners are aware of the need to move towards more uniform and effective approaches to the management of risk, in order to avoid withdrawal of services to the public and also to avoid any further collapses of major insurance companies. (Senate Economic References Committee 2002; The HIH Royal Commission 2003; Productivity Commission 2003).

### **Inquiries into health care provision, insurance and related social insurance systems**

In Australia, major debate occurs on a continuing basis about the best forms of insurance, social insurance and related taxation. A key question has been the extent to which insurance funds should be underwritten by government and industry or by the private insurer, in order to achieve the best service outcomes for key stakeholders. Some critics of increased competitive contracting by government (Hancock 1999; Smyth and Cass 1998) have tended to ignore the relationship this may bear to national and state regulatory processes which have progressively extended government and industry ownership of health, workers' compensation and retirement funds over the past two decades. Formerly, such funds were privately owned and commercially driven, supposedly in the interests of shareholders. On the other hand, research into the Australian insurance experience often indicates that private sector underwriting and competition on premium price inhibits injury prevention, rehabilitation, fund management and cost containment. This is discussed later.

Internationally based insurance companies which have the largest slice of the Australian insurance market are commonly regulated under state legislation and are also subject to national controls. Many current insurance systems retain strong links with the ancient, lawyer driven operations of the British common law, in that a lump sum award is provided to the injured only if a court finds a plaintiff's adversary is the cause of their injury. Third party motor accident insurance, professional and public liability and product liability insurance are examples of fault-based schemes, normally underwritten in the private sector, which supposedly address harm and disability to people other than the premium holder. Although such schemes may penalise, they often do not provide the data which would assist injury prevention programs or establishment of proper premium setting (Senate Economic References Committee 2002; The HIH Royal Commission 2003) Regulators have indicated, for example, that insurance companies do not distinguish motor accident premiums in any way from their other general insurance funds, so there is no basis on which to exercise the powers of financial monitoring provided in relevant legislation (Standing Committee on Law and Justice 1997). Whether it is possible for government to achieve disclosure and monitoring when insurers underwrite the business appears a moot question.

Although Australian health care is funded primarily from taxation the structure often interacts with workers compensation and motor accident insurance systems and also influences all private health insurance. All Australians have a right to taxpayer funded hospital and medical care, which may be delivered either in public or private sector settings, as the need arises. Although Australian and U.S. health care systems both employ the term 'managed funds' their design and fund ownership structures differ. The universal coverage of the Australian Medicare system and its integrated

requirements regarding voluntary private health insurance put downward pressure on the prices that all doctors, hospitals and insurance companies charge. The private health insurance system is not traditionally risk rated, like a normal insurance system, but is ‘community rated’, like Medicare, because it is recognised that people who are sick should not also be heavily penalised economically. Neither are high premium penalties likely to lead them to be able to improve their health situation. Complex administrative arrangements, which are sometimes called ‘re-insurance’, therefore link private health insurers to Medicare, to prevent the private insurer becoming insolvent because of an escalating proportion of elderly clients and related treatments (Industry Commission 1997).

In the U.S., on the other hand, employers take out private health care insurance cover for their employees, or individual consumers may purchase it from competing private health care funds on their own behalf, if their employer does not carry it for them. The government provides a safety net that applies to a small, comparatively old or impoverished population. In a review of evidence, Duckett (1997) found the Australian Medicare system outperformed the U.S. health care structure on social indicators related to service access, equity and cost, but not service quality. Findings of comparatively poor service quality in Australia may appear surprising in the light of the scope Medicare potentially provides for the collection and analysis of reasonably consistent and reliable health service data across all public and private sector hospitals and general practitioners. However, research has also pointed out the need for better-coordinated professional and academic organization and practice, in order to achieve the transparent, data driven management systems which are necessary for of quality management and related research. Problems outlined in the following reviews are partly related to inconsistencies in state based insurance systems, which ideally require a nationally coordinated, transparent approach to policy and service administration. (Review of Professional Indemnity Arrangements for Health Care Professions 1995; Industry Commission 1995: 221-243; Australian Health Ministers’ Advisory Council 1996; National Expert Advisory Group on Safety and Quality in Australian Health Care 1999; Senate Employment, Workplace Relations, Small Business and Education References Committee 2001).

Commonwealth Labor government established a national commission of inquiry into accident compensation and rehabilitation in Australia as early as 1973. It was chaired by Justice Woodhouse who had headed a previous inquiry in New Zealand, leading to the introduction of a comprehensive accident scheme providing rehabilitation to injured people regardless of fault. The Australian committee marshalled a great deal of evidence on the capricious and selective results, and the poor effects upon rehabilitation of adversarial court structures. It recommended a similar scheme to the New Zealand model but this was opposed by many, including insurers, lawyers, trade unions and some areas of government. The Labor government lost office and the plan was never implemented. Between 1973 and 1989 ten separate inquiries into workers’ compensation came to the conclusion that the adversarial system is detrimental to rehabilitation (NSW WorkCover Review Committee 1989). There were five insurance company insolvencies in the mid eighties in New South Wales, when there were over forty insurance companies underwriting workers’ compensation. Competition between them led to pricing wars and to the reserves of some insurers running low at a time when the courts were making increasing lump sum payments to injured workers (NSW Government 1986). A state Labor government introduced the current competitively managed fund structure in 1987, and it was retained by an incoming Liberal government after an inquiry concluded there was a lack of evidence of benefits from private sector underwriting, and that other factors, including quality of scheme administration, provide more important indicators of performance (NSW WorkCover Review Committee 1989). Later national inquiries into workers’ compensation (Industry Commission 1994; Australian Heads of Workers’ Compensation Authorities 1996: 132-133) agreed with this perception.

Later inquiry into the ongoing operation of the NSW workers' compensation scheme (Grellman 1997) found that its rising costs were being caused primarily by lack of ownership of the requirements for effective risk and injury management at the workplace level. The most recent national inquiry into workers' compensation and OHS has stated that the major significant issues now arise from differences in state and industry schemes which generate heavy compliance burdens and costs for multi-state employers (Productivity Commission 2003). The inquiry has recommended steps for more self-insurance and for the progressive establishment of a consistent national workers' compensation scheme. Private sector underwriting is recommended, in spite of the fact that the only reported Australian case for this was made by the Insurance Australia Group. This got some lukewarm support from the NSW Labour Council, a historically surprising group of trade union bedfellows, who also publicly admitted to being uncommitted in the longer term.

In general, inquiries have found that private sector underwriting is not transparent, and premium price competition promotes general economic instability rather than injury prevention. It is also more costly. Private underwriters require high profit margins to guard against the effects of competitive premium price-cutting, global economic fluctuations, unexpected court awards or long tail claims, poor investment decisions and inefficient administration practices. Such events have produced major insurer insolvencies in Australia. Whenever the national premium pool is broken up and owned by competing insurers, they require international reinsurance as well as high profit margins to guard against insolvency. All these costs must be borne by individuals, the government and the community of premium holders. On the other hand, when funds are owned by government and industry, and when premiums and benefits are established by legislation, the insurers contracted to manage the system ideally compete for market share by providing premium holders with risk management and investment services, rather than premium price cuts. In addition, the benefits of managed fund investments return to scheme stakeholders if they also underwrite the fund!

Shiller (2003) provides an opposing U.S. perspective on the appropriate management of financial risk in the 21<sup>st</sup> century. His market driven approach to insurance appears to support unlimited protection for risk takers who pay the premiums required. The assumption of risk can also be contracted out freely. This does not appear to be a proposal which can promote injury prevention or contain business cost for the majority, although the opportunity to continue to shift costs onto bystanders may please major risk takers and their supporters. In Australia, on the other hand, it is becoming clearer that there is considerable scope to improve social welfare and reduce costs through better national integration of the aims and administration of Medicare, private health insurance, workers' compensation and a range of other injury prevention, rehabilitation and insurance services.

### **Taking risk management research and education to the community**

The earlier discussion suggests that risk management education and related research should be an international priority. Research collaboration related to combined OHS and social insurance pilot systems for large development projects may appear particularly appropriate. Cooperative risk management education and research aims might be effectively coordinated with government support for regional health, welfare and education developments, especially for the poor. The Tokyo Declaration on Work Related Stress, which was sponsored by the Tokyo Medical University and the WHO in 1998 and signed by representatives of the European Union, Japan and the U.S. has been commended to policy makers everywhere as a framework for appropriate action. The Committee of Review of the Australian Overseas Aid Program (1997) also recommended that aid programs assist developing countries to reduce poverty through sustainable economic and social investment. The Review of Business Programs (Mortimer Report 1997) recommended all business support should be more focused and that a review of the education system should be undertaken to drive it as a source of comparative advantage for Australia. The Prime Minister then announced additional grants to

assist small business research and development. Tertiary education institutions should accordingly consider pursuit of research and risk management education partnerships, including those related to the consultative development of OHS and social insurance systems for major development projects.

In 2001 the Australian Prime Minister announced a new research and development tax concession rate for high spending companies to address concerns about the drop-off in private sector research activity. Additional research and development support included the ability for small firms to gain the equivalent of 125% research and development taxation concession (The Australian Financial Review 29.1.01: 1). The provision of such public subsidy for organizations to undertake research and development may be beneficial for the whole community. However, comparatively few Australian employers will be in a position to undertake or support scientific and technological research and development alone, or purely on their own behalf. On the other hand, it could be of great benefit to Australia if industry leaders, their organizations and members are willing to participate in research and education plans to achieve mutually agreed objectives of national development related to health, welfare and sustainable development which are managed on an industry and related community basis.

## Conclusion

The populations of many nations are ageing, and the aim of remaining healthy and independent for as long as possible is shared by the elderly and governments alike. The importance of an effectively coordinated policy approach to all health, welfare and related social insurance provision is increasingly being recognised in this context. In Australia, a number of health and related social insurance and insurance inquiries have suggested that the benefits of industry and community ownership of funds are comparatively clear, as long as funds are managed transparently, competitively and effectively. This requires policy driven, consultative risk management where administration is focused clearly on evaluation of service and environment outcomes. Ideally, these pursuit should also be effectively coordinated with the regional management focus on related health, welfare and education needs of aged, disabled and poor communities. Partnerships for education and research into such social service provision would assist the general attainment of national and international development aspirations. This is the overarching context in which all core management and vocational skills might be taught and funded by government and industry.

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