
8 Options for broadening the funding base

Key points

- Australians will have to pay more for the care of older Australians as our population ages. Finding the right balance between public funding and private funding is a sensitive and complex task. The burden of funding should be equitable and the mechanisms should be efficient in their design and application.
- There are a number of options for broadening the existing taxation and user contribution funding base for aged care — increased dedicated private savings (aged care saving accounts and quarantined superannuation contributions), equity release products and insurance (voluntary or compulsory).
- Increasing private savings dedicated to funding the private costs of aged care is not efficient. Some older people will save too much, others not enough. Private savings redistribute resources across a person's life, but do not allow pooling of the costs of aged care costs across the population.
- Many older Australians have built up assets over their working life that could be drawn on to pay for the more predictable and manageable costs of care. But equity release products can be complex and there is nervousness about current privately offered products. The Commission supports the introduction of a government-backed equity release scheme, under which money could be drawn down upon to cover aged care costs.
- Voluntary insurance is unlikely to work in anything but a very modest way because of problems on the supply and demand side of the insurance market. That said, with a lifetime stop-loss mechanism along the lines of that proposed by the Commission, there could be a role for private insurance to cover the more predictable and manageable costs of care.
- There are many similarities between the current tax-funded system supplemented by a lifetime stop-loss mechanism, and compulsory insurance — both involve risk pooling (to protect individuals from catastrophic costs), progressive mechanisms for raising funds and access to care based on need, rather than ability to pay. But there are significant design and transitional issues (and costs) with moving to a compulsory insurance model.
- Given the characteristics associated with aged care, the Commission supports the current pay-as-you-go tax financed system supplemented by higher co-contributions and a lifetime stop-loss mechanism, in preference to a compulsory pre-funded insurance scheme.

The current funding arrangements for aged care are supported by two pillars — a dominant taxpayer funded pay-as-you-go subsidy pillar and a user pay pillar. Under these arrangements, taxpayers bear the full financial risk associated with the public subsidy, including rising unit costs and the effects of population ageing on overall care costs.

A number of analysts (including Ergas 2010; Fine and Chalmers 1998; Howe and Sargeant 1999; Myer Foundation 2002) and participants to this inquiry (Bethanie Group, sub. 407; Melbourne Citymission, sub. 173; Medibank Private, sub. 250; National Seniors Australia, sub. 411) suggested the need to consider a third funding pillar. For some, the case for an additional pillar rests on concerns about fiscal sustainability. Others contend that, with population ageing, marked intergenerational inequities can arise under the current system.

Options for broadening the funding base for aged care include:

- increased dedicated private savings (aged care savings accounts, quarantined higher superannuation contributions)
- drawing on housing equity (equity release products or income contingent loans)
- insurance — voluntary or compulsory.

This chapter looks at each of these options with a focus on the incentives they create and their implications for economic efficiency, equity (including intergenerational equity), simplicity and sustainability. The merits of these options will be influenced by the relative importance attached to each of these considerations. However, a complete assessment should also balance the merits of any new arrangements with those of the existing funding base.

Section 8.1 examines the use of savings accounts and superannuation. Section 8.2 looks at the use of home equity to help individuals contribute to their care costs, while section 8.3 examines the insurance option.

8.1 Saving accounts and superannuation

Aged care saving accounts and the use of superannuation funds to cover the private costs of aged care were two ideas put to the inquiry to encourage individuals to save for their ‘later-life’ care costs (and, in turn, take some of the pressure off taxpayers). Alzheimer’s Australia NSW, for example, said:

... consideration should be given to creating a form of Healthy Ageing Savings Account (HASA) or similar mechanism to fund aged care. This account should be

considered in addition to current Medicare levies and superannuation arrangements. (sub. 455, p. 5)

Mercy Health said:

A greater emphasis should be placed on increased superannuation contributions, both employer and personal contributions to better position people to support themselves and their health needs in their latter years. Even with greater superannuation contributions, there will be a significant percentage of people who will be unable to pay for the services that they require. (sub. 215, p. 8)

Accumulated savings represent a form of pre-funding for future aged care costs. As such, they provide a mechanism for lessening the future call on public funds. They also help address concerns about perceived intergenerational inequities by evening out the burden of paying for care into the future. But it is difficult for individuals to estimate the amount of savings required to meet their aged care costs. In particular, people who face catastrophic costs of care (arising from extended and intensive periods of care) would be unlikely to have saved enough to cover these costs, whereas people who save for care by making higher contributions to a quarantined account, but do not subsequently require aged care, will have forgone the benefits of higher consumption or other forms of saving. As Deeming and Keen point out, it is ‘socially inefficient’ for everyone to save for the possibility of needing long term care in older age:

Saving for long-term care is not an efficient option for individuals. Not everyone will need long-term care, therefore it would be unrealistic and socially inefficient for everyone to save to meet the average cost of needing care, let alone the maximum cost. (2001, p. 84)

Private savings, because they do not permit risk pooling, are unable to facilitate the redistribution of resources between individuals according to need (or provide protection from catastrophic costs). As Glendinning et al. argued:

Private savings approaches are not likely to provide equal resources for equal needs. They redistribute resources across the life cycle, but do not redistribute from those with lesser to those with greater needs for long-term care. They are more costly for women; as women face a higher risk of needing care, they need higher savings than men. Savings approaches would not be widely affordable and moreover, involve no pooling of risk. (2004, p. 4)

Barr also said:

Self-finance (i.e. financing long-term care out of personal savings of a long-term care savings account) is an inferior solution. Where someone is risk-averse the possibility of pooling risk is welfare-enhancing. (2010, p. 372)

As such, private savings are best suited to cover everyday living and accommodation costs and contribute to basic support and care costs that are more modest and predictable. The unpredictable and potentially catastrophic costs

associated with intensive long term care (that have a relatively low probability) are better suited to some form of insurance or stop-loss arrangement.

Having individuals pay for some of the more predictable care costs from private savings could provide an incentive for the greater use of preventive and early intervention measures. International evidence on healthy ageing savings accounts suggests that these accounts can encourage individuals to be more conscious of the costs of their care and to take greater responsibility for their health (box 8.1). The Aged Care Association of Australia (ACAA) and Deloitte also argued that a private savings option could reduce concerns about moral hazard (or over-use):

... if consumers are using their own savings to finance care, moral hazard in care decisions may be reduced, which is likely to be especially important for domiciliary care. (sub. 285, p. 8)

Box 8.1 Healthy Ageing Savings Accounts — international experience

A review of international experience with HASAs suggests the following lessons:

- *Accounts encourage efficiency.* A case study of Discovery Health in South Africa found efficiency gains as members were more conscious of cost when paying from personal savings, since the marginal cost is explicit.
- *Accounts deliver better health outcomes* particularly if coupled with wellness programs (e.g. screening, health checks, vaccinations, lifestyle modification) and rewards (such as flyer points) as people take greater responsibility for their health.
- *Lower income groups take up accounts*, potentially more attracted to saving for their own needs rather than pooling risks through insurance. In the US, a third of accounts have been taken up by previously uninsured people and around 40 per cent of accounts were taken up by people with incomes below the median.
- *Incentivisation* is necessary to overcome moral hazard in relation to saving; in New Zealand a HASA product failed due to a lack of tax-deductibility.

Source: Access Economics (2009b).

Some participants suggested that dedicated aged care savings accounts would need to be additional to current superannuation. Because there are no restrictions on how superannuation income is spent, the concern was that older Australians might have an incentive to spend their retirement incomes on other less essential items and fall back on the public safety net to cover the cost of their care needs. In this context, Access Economics argued that:

This moral hazard underpins the need for a parallel, complementary private saving mechanism. (2009b, p. 123)

Looking forward, while many Australians are likely to have larger superannuation and other asset balances when they retire (chapter 7), increases in average life expectancy will mean that the assets have to provide income for a longer period of time (box 8.2). In this context, the Henry Review said:

As the superannuation guarantee scheme matures, cohorts of older people should have larger assets balances available to them at retirement. However, these assets will need to provide an adequate stream of income over a person's retirement, the duration of which is uncertain for individuals. The expected increase in average life expectancy is likely to add to this risk. Further, the use of aged care services is particularly intensive for people aged 85 and upwards, once many have been in retirement for 20 years or more. (2010, p. 642)

Box 8.2 Retirement — funds for around 20 years required

Retirement and retirement expectations have changed dramatically over the past 100 years. When the Age Pension began in 1909, the maximum payment was 12 per cent of male average weekly earnings (10 shillings per week). Only half of all people born lived to age 65 years and of those who lived to 65, their life expectancy was another 11.3 years for men and 12.9 years for women. Because of strict means testing and other eligibility criteria, few received the pension — just 23 000 or 28 per cent of those aged 65 years or more.

Today, 87 per cent of men and 92 per cent of women live until age 65 and can expect to live for around a further 20 years (18.7 years for men and 21.8 years for women). The introduction of compulsory superannuation in 1992 ensures that everyone working as an employee will have something saved for their retirement. That said, more than three-quarters (77 per cent) or 2.3 million older Australians currently receive either the Age Pension or Department of Veterans' Affairs Service Pension.

Sources: ABS (2010e); Harmer (2009); NATSEM (2009).

While quarantining part of an individual's superannuation funds for aged care would lessen the scope for early draw downs prior to needing to contribute to the costs of aged care, it would also constrain consumption choices. And, for those individuals who do not require care in old age, they are likely to leave behind larger bequests than they might otherwise have chosen. As ACAA and Deloitte put it:

This excess bequests distortion (and the associated reduction in life-time utility) is obviously especially large if the mandated savings level is set in line with average expected life time care costs while the distribution of those care costs is bimodal or in any event, highly skewed (so that many consumers will experience costs well below the mean, while some others will experience costs many times the median). (sub. 285, p. 8)

A compulsory aged care savings account is likely to be more distortionary than unrestricted superannuation as it can only be drawn on for aged care expenditure (or

if unused, left as a bequest), while unrestricted superannuation can be used for any purpose once it is accessed.

Compulsory saving imposes a deadweight loss as it distorts decisions about which savings vehicles to use as well as between consumption and savings. In particular, younger people may be less able to invest in their preferred mode of savings (for example, owning their own home, which is a tax effective savings vehicle and offers social benefits).

As a compulsory savings mechanism already exists in the form of the superannuation levy, the administrative costs of expanding savings in this way would be minimal (although not necessarily the administration costs of quarantining them). Medibank Private noted that such an approach could be implemented with relative ease, but also noted the additional burden on the working population:

Advantages of this model include the relative ease of management if the scheme is aligned with current mandated superannuation contributions. However, this model relies on the working population who may feel they are already overburdened with taxes related to retirement and future needs. (sub. 250, p. 10)

Some participants suggested the need to provide subsidies or tax incentives to increase the attractiveness of making extra savings to cover the potential costs of aged care. However, such subsidies perform poorly on equity grounds as they offer the greatest benefit to those with the greatest capacity to save (being also those most likely to have the capacity to contribute to their own aged care in the future). And, without compulsion, subsidies for saving for aged care are unlikely to significantly increase overall savings for aged care costs. As Barr put it:

Many people realize that they need to save more for their old-age security and intend to do so — but somehow it never happens. (2010, p. 370)

The challenge is to provide people with incentives to save in their preferred savings vehicles to fund both their retirement and the predictable costs of their aged care. The more generous the safety net for aged care, the lower the incentive to save for these likely, but not certain, costs. But a reasonable safety net is required to ensure that all older people have access to an appropriate quantity and quality of care.

An alternative approach is to change people's attitudes towards funding their aged care. There is currently an incentive to save in assets, notably the home, that delivers a service as well as a store of value, especially if this asset is tax free. Under the Commission's proposed lifetime stop-loss limit, individuals will have greater certainty about the maximum cost of care and therefore a greater incentive to ensure adequate savings/income to cover the predictable costs of care (chapter 7). Also, in the vast majority of cases, older Australians have built up assets over their working life that could be drawn on to pay for their costs of care.

The least distortionary approach would be for these assets to be available to contribute to the costs of aged care — especially if the draw down against the wealth of their share of their principal place of residence is structured so that their owner could continue to use the house, while drawing against it to pay for aged care costs (see below). A comprehensive means test for assessing an individual’s rate of aged care co-contributions, combined with a mechanism that would allow people receiving care to continue to use their house while they can do so, could form the platform for a change in attitude towards accepting responsibility for contributing to one’s own aged care costs.

8.2 Drawing on housing equity to pay for care costs

Accessing housing equity is a contentious issue, yet most Australians recognise that the home is the main means of long term saving. From participants’ input into this inquiry, there seems to be a growing sentiment that many Australians could tap into the wealth they have tied up in their primary residence to pay for aged care costs. The Country Women’s Association of NSW, for example, said:

We are of the opinion that the thought that ‘the family home being sacred and having to be passed on’ is slowing changing. This is evidenced by the baby-boomer generation selling the family home, buying mobile homes and ‘seeing the country’. (sub. DR669, p. 3)

The Little Company of Mary Health Care, also said:

Given that approximately three-quarters of older people in Australia own their own home, this most important source of funding cannot be ignored. (sub. 289, p. 22)

Cam Ansell and Jim Toohey called for action to:

Further broaden the choices for residents to meet the costs of their accommodation and services beyond lump sum refundable deposits including the option to levy deceased estates for an agreed amount incurred in the provision of aged care. These agreed deductions, over and above any government subsidy, can include costs for the provision of extra nursing and personal care where the resident and/or the family feels that such care is necessary or desirable. (sub. 464, p. 8)

And the ACAA and Deloitte said:

Many elderly Australians have limited assets and income, and a substantial share of what assets they own involve the family home. While that home can be sold at the time of entry into residential care, it may not be so readily sold if only one member of a couple is going into care. Moreover, domiciliary care provided in the family home obviously cannot be funded through the sale of that home, though there may be ways other than sale of unlocking the consumer’s equity in his or her home. (sub. 285, p. 7)

As discussed in chapter 12, just over 83 per cent of Australians aged 65 and over own or are buying their home. Looking forward, older cohorts are likely to have significantly more wealth in real terms. Kelly (2002), for example, estimated that the share of Australia's total family net wealth for those aged 65 and over is likely to increase from around 22 to 47 per cent between 2000 and 2030.

Equity in housing can be released by selling and moving into something less expensive, with the balance being used for other purposes (see chapter 7 for a discussion covering a proposal for an Australian Age Pensioners Savings Account to protect eligibility for the Age Pension). Alternatively, housing equity can be drawn down via an equity release scheme or an income contingent loan. Equity release schemes allow people to borrow against the equity in their home with no (or limited) repayments made until the home is transferred to another person. An income contingent loan¹ is broadly comparable to an equity release scheme and, as described by Bruce Chapman, works in the following way:

An individual entering a nursing home, for example, would be allowed to borrow funds using her/his home or other assets as collateral. A given sum of money provided by the government, say \$100 000, could be set aside and drawn down over time to cover the costs of nursing home care. At the end of the person's time spent at the nursing home, in most cases meaning the death of the individual, the remainder of the loan would be returned to the individual's estate, which has a debt equivalent to the original amount borrowed. This debt would be considered to be a debt of the estate. (2006, p. 2)

The advantage of schemes that draw on housing equity is that they allow people with housing assets to meet the costs of extra spending, including spending on aged care, without having to sell their home to finance it. These schemes can be an attractive option when a partner goes into residential care while the other remains in the home, or to fund care while remaining in the community.

For those older people with limited superannuation (including most of the current cohort of those aged 85 or older), access to housing equity could improve their capacity to contribute to the cost of their care and to purchase additional services. This would allow the government's funding of care to be greater for those with less capacity to pay (and/or reduce the tax burden on future generations), and provide more choice for older Australians. That said, the current market for equity release products is limited by the value (and expected changes in valuation) and condition of the homes of older people (an issue particularly relevant for many people living in rural and remote areas).

¹ Australia's higher education contribution scheme provides an example of an income contingent loan arrangement.

There are two broad ways to release equity:

- reverse mortgage — where the equity in a home is used as security to borrow money. The loan can be taken as a lump sum, a regular payment stream, a line of credit, or as a combination of these. No repayments are made on the money borrowed until the home is sold
- home reversion — where a proportion of the equity in the home is sold (usually up to a maximum of 50 per cent). A lump sum payment is received in exchange for a fixed proportion of the future value of the home. The proportion of the future value of the home belongs to the scheme provider, but is only paid to them when the home is sold (ASIC 2009).

Explaining the difference between the two products, Deloitte Access Economics for Homesafe Solutions said:

Reverse mortgages involve the accumulation of debt over the life of the contract whereas home reversion is debt-free. Under a reverse mortgage, longevity risk, interest rate risk and property value risk are borne by the homeowner, whereas under home reversion these risks are transferred to the provider. This is a crucial distinction since homeowners are generally less well placed to bear such risks compared with commercial providers who can diversify and lay off risks to investors through the capital market. (sub. DR600, pp. 6–7)

Both products are available in Australia, but generally only for people aged 60 years or over. Reverse mortgages are the most common product, while home reversion schemes are relatively new and only available in certain areas of Sydney and Melbourne (ASIC 2010). In commenting on the narrow spread of the home reversion product, Deloitte Access Economics for Homesafe Solutions said:

Since home reversion involves the sale of a share of the future sale proceeds of a home, providers naturally focus on locales expected to provide sustainable long-term capital growth. They also gravitate to houses in more desirable locations within those areas, and to cities rather than country towns. At present, Homesafe Solutions only offers its home reversion product in Greater Sydney and Greater Melbourne, for example. (sub. DR600, p. 15)

Equity release products can be complicated financial products and there is some nervousness about them amongst consumers. This may explain the low take up rates to date. As AMP Capital Investors said:

Reverse mortgages have been available in Australia for some time now, however their attractiveness for investors has been slow to develop. (sub. 342, p. 10)

Medibank Private also said:

Many current private equity release schemes have not offered good terms to homeowners and there is an opportunity for the private sector to offer better product packages with government support. (sub. 250, p. 10)

A number of participants expressed concerns about the use of equity release products for aged care. The Financial Planning Association of Australia (FPA), for example, said:

While reverse mortgages or equity release products have the potential to significantly improve the quality of life of older people with few assets other than the family home, they have significant risks and are not suitable in all cases. Such loan products are very complex, are commonly very expensive, and the FPA is concerned that existing laws do not adequately protect consumers. (sub. 376, p. 5)

A recent FPA member survey highlighted a number of concerns about reverse mortgage products including:

- clients' ability to comprehend how the critical features and risks of the products may affect them in the future, particularly when conditions and circumstances change
- future uncertainties (interest rates, property values and longevity) affecting the suitability of the product
- beneficiary discontent
- high implementation costs for the product
- the long term, irreversible nature of the contract. (sub. 376, pp. 5–6)

Reverse mortgage products can expose home owners to financial risks, largely because of a number of 'unpredictable' factors including interest rates, real estate prices and life/independence expectancies (box 8.3). As Bridge et al. said:

Reverse mortgages can yield cash quickly but they are complicated and can expose vulnerable homeowners to potentially serious financial risks. These risks include: negative equity; rising interest rates; falling property values; and default conditions that could, for example, trigger immediate loan repayment and negate 'no negative equity' guarantees. (2010, p. 8)

Box 8.3 **The risks of equity release products**

The Australian Securities and Investments Commission (ASIC), an independent Australian Government agency responsible (among other things) for consumer protection in financial services, noted that while equity release products can provide benefits, they also have significant risks:

- they can be difficult to understand
- they can be relatively expensive compared to other types of loans with regular payments
- if certain terms and conditions are breached, the person may have to sell their home and replay the loan
- if property values don't increase as much as expected, or if they fall, the person might end up with less money than expected when selling their home
- circumstances and financial views can change as people age — if a person releases too much money early in retirement they may not have enough later on.

Because of compound interest and fees, and not making any repayments, the amount owed on a reverse mortgage can grow very quickly. What is owed can end up being more than the value of the home. Most reverse mortgages protect against negative equity by putting a limit on how much can be owed with a No Negative Equity Guarantee, but not all reverse mortgages offer this feature.

Source: ASIC (2009).

Reluctance to reduce the 'kids' inheritance can be a further barrier to the use of equity release products. The Council on the Ageing (COTA) Australia commented that the issue of 'estate beneficiaries' needs to be tackled directly:

It is also time that we directly confront the 'estate beneficiaries' issue and ask who wants to put their hand up publicly and say that they want to put part of their inheritance at a higher priority than the partial cost of care of their parent? Or that when parents do have means to contribute to their care (and only up to a maximum limit) they should not need to because their children would like to inherit the funds, when this will lead to taxpayers on lower incomes subsidising the inheritances of those much better off. (sub. DR565, p. 11)

A survey of 7000 Australians aged 50 years and over undertaken by the Australian Housing and Urban Research Institute (AHURI) suggested that concerns about leaving inheritances are becoming less evident. AHURI concluded that:

The attitudes of many men and women towards inheritance has shifted as to what previously would have been considered 'the right thing to do' in terms of traditional obligations and responsibilities to their children. Our data strongly suggest that many older people's attitudes have taken on more of those of their Baby Boomer children;

that is ‘put yourself first’. The desire to bequeath assets to the next generation seems to be significantly diminishing. (2005, p. 13)

A Deloitte study commissioned by the Senior Australians Equity Release Association of Lenders (SEQUAL) found that as of December 2009, the market in Australia consisted of just under 39 000 reverse mortgages with total outstanding funding of \$2.7 billion and an average loan size of just under \$70 000. The number of reverse mortgages more than doubled between 2005 and 2009 (table 8.1).

Table 8.1 Number of reverse mortgages, outstanding market size and average loan size, 2005-2009

	2005	2006	2007	2008	2009
Number of reverse mortgages	16 584	27 898	33 741	37 530	38 788
Outstanding market size (\$ billions)	0.85	1.51	2.02	2.48	2.71
Average loan size (\$)	51 148	54 233	60 000	66 150	69 896

Source: SEQUAL (2010).

It is unclear, however, whether reverse mortgage products are being used to fund aged care or to fund other consumption (Access Economics 2010c). One provider indicated that it had clients using equity release products to fund aged care costs. Fortus said:

Our company has a client with a \$50,000 per annum income, but requires another \$50,000 per annum from Equity Release in order to have 24 hour care at home. Whilst this is an extreme example, the funding for Community Aged Care Packages (CACPs) has not kept up with inflation or demand, and more elderly want to receive special care in their home rather than an aged care facility. (sub. DR755, p. 2)

Internationally, the uptake of equity release products by older home-owners has been relatively low. The complexity of schemes, limited information and the failure of providers in the past, have been factors contributing to the hesitation of consumers to use these products (appendix D). According to the Organisation for Economic Cooperation and Development (OECD):

... in most countries, [reverse mortgages] are still scarcely used, including because they require a relatively high degree of household financial education. Even in the United States, where the reverse mortgage market has developed rapidly in recent years, it remains very small. (2005b, p. 51)

Is there a role for a ‘public equity release’ scheme?

There are a number of reasons why government involvement in equity release products might be justified to assist older Australians to contribute to their aged care costs.

- Information asymmetries — the evidence suggests that older Australians lack the information about how such schemes work and they have poor financial literacy. In the context of Debt Free Equity Release Products, Access Economics argued that information asymmetries arise due to the relative infancy of the market, which means that both consumers and investors have insufficient knowledge about the product and are unable to make informed decisions. Also, many consumers and investors may be unaware of the product.
- Older Australians may be vulnerable to exploitation and hence may need protection. Bridge et al. (2010) found that people typically make the decision to investigate or take out a reverse mortgage when they experience an unexpected change in their circumstances and/or an ongoing shortfall between their income and their expenses. As Access Economics (2010c, p. 31) said: ‘government should be mindful above all of the vulnerable circumstances of the older Australians’ who are most likely to consider such products.
- Equity release products can be costly to set up and this can be problematic if the amounts required for aged care are small (and not suited to the flexible drawing down of relatively small amounts against a line of credit).

The Australian Government could play a more active role by simply providing information about equity release products and educating older Australians about the role such products can play in paying for retirement activities and services. Deloitte Access Economics for Homesafe Solutions said:

To some extent, information gaps can be filled through advertising and product awareness campaigns. However, government-backed education programs would also help to boost financial literacy and consumer confidence in this new product. (sub. DR600, p. 10)

To a large extent, however, the Government is already active in providing information. For example, ASIC provides information to consumers about equity release products, alerting people to potential risks and providing scenarios for different circumstances (box 8.3).

A public scheme could play an important role in inspiring confidence in equity release products and stimulating market development, although it could also crowd out the further development of private schemes. But as Harper said, there are also problems around the supply of such products, particularly outside Sydney and Melbourne:

People are rightly wary of a relatively new financial product, especially when they are older and naturally more cautious about their biggest asset. However, demand for the product is not the real problem. A debt-free equity release product is already on sale for homes in inner Sydney and Melbourne through a single private supplier in partnership with a regional bank.

The problem is supply. For the product to be available beyond Sydney and Melbourne, institutional investors need to recognise a new asset class, namely, pooled residential real estate. This is new territory for investors as much as for homeowners, and it is here there is a bellwether role for government, as the Productivity Commission rightly identifies. (2011)

Internationally, some governments have sought to increase the attractiveness of equity release products and/or have put in place public measures to defer the payment of aged care costs.

- The New Zealand Government has put in place an interest-free ‘Residential Care Loan Scheme’. Under the scheme, the government advances funds to facilities, on the care recipient’s behalf, for residential care services. The aim of the scheme is to assist older people who, because they own their home and have assets above the applicable asset threshold (and therefore are not eligible for a care subsidy), are obliged to pay for the cost of care services.
- In the United Kingdom, eligibility for public support for the cost of residing in a nursing home is subject to an asset test, which can take into account the value of a care recipient’s principal residence. For those individuals who meet the asset test, some local councils provide a scheme that allows them not to sell the home, but rather to move all or part of the nursing-home fees through a deferred-payment agreement. Interest is generally not paid on deferred payments over the period of the agreement and until a period after the death of the resident at which point the deferred amount must be reimbursed or the residence sold.
- Under the United States (US) Medicaid system, the value of a principal residence is generally excluded from the assets test, but can be subject to an estate recovery after the death of the resident (Colombo et al. 2011).

A government-backed (but not necessarily operated) equity release scheme may be more acceptable to some older people. The higher uptake of government-sponsored schemes, relative to private provider schemes, in the US suggests that the added security from government backing can help dispel nervousness about using the products (appendix D).

Such a scheme could take a charge over the equity in an older person’s home (up to a maximum amount, say 40 to 60 per cent) and draw against this to help finance their accommodation and care costs. To avoid gaming, any sale or transfer say

within five years prior to entering a residential aged care service could be deemed as being included in the asset test at market value.

Alternatively, the Government could expand the existing Pension Loans Scheme to allow small regular sums of money to be drawn down to cover care costs. The Pension Loans Scheme is an equity release scheme offered by Centrelink that allows older Australians to draw an Age Pension or top-up their part pension using their home equity (box 8.4). The scheme is currently not available to people on the full rate Age Pension and only allows relatively small amounts (fortnightly payments) to be made available rather than one-off large payments.

Box 8.4 Pension Loans Scheme — how it works

People of Age Pension age (or their partners) who cannot get a pension because of their income or assets (but not both), or those who only receive a part pension, can access capital tied up in their assets under the Pension Loans Scheme. The Pension Loans Scheme is not available to people who are paid the maximum rate of pension.

The Pension Loans Scheme is a voluntary arrangement that provides support in the form of a loan, for a short time or for an indefinite period. It is paid in regular fortnightly instalments. Compound interest is charged on the balance of the loan and calculated on a fortnightly basis. The Pension Loans Scheme loan must be secured by real estate owned in Australia.

Features of the Pension Loans Scheme include:

- a No Negative Equity Guarantee (a guarantee that no matter how long the loan runs, the borrower can never owe more than the value of the security)
- minimum age 65 years or pension age if less
- capped at the maximum Age Pension plus pension supplement and rent assistance
- underwritten by the Australian Government
- available Australia-wide
- available as an income stream only
- interest rate fixed by the Minister for Families, Housing, Community Services and Indigenous Affairs.

An example of how it works: Tim has a property valued at \$210 000 which he offers as security for his loan. As he wants to be sure that he has the flexibility to move into a retirement village when the need arises, he nominates a guaranteed amount of \$85 000 for that purpose. His eligibility for payments under the Pension Loans Scheme is based on \$125 000, the value of his property less the guaranteed amount.

Source: Centrelink (2009).

There were 710 Pensioner Loan Scheme loans outstanding as at 30 June 2010 (Medicare Australia, sub. DR804, p. 20).

An equity release scheme such as the Pension Loans Scheme that allows small withdrawals, so that payments accumulate over time, is less likely to be attractive to private operators. A small loan at the outset that grows over time is unlikely to be offered by the market without a large upfront fee.

In responding to the draft report, a number of participants supported the Commission's proposal for a government-backed equity release scheme (box 8.5). COTA Australia, for example, said:

We welcome the proposal for a government endorsed equity release scheme which we believe should be on a shared equity basis or a HECS-like loan recoverable from the estate, rather than a compounding interest loan. (sub. DR565, pp. 9-10)

And the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) said:

FaHCSIA's Money Management Branch is broadly supportive of a government-backed Equity Release Scheme, which could include an aged care equity release scheme as we can see advantages in terms of consumer protection and a tightly focused equity release goal. (sub. DR673, p. 1)

National Seniors Australia (NSA) suggested that the uptake of such a scheme would be sensitive to its design:

While not opposed to this recommendation, on the basis that it adds to consumer choice, we think that the take-up of the proposed Aged Care Equity Release Scheme is likely to remain limited unless it incorporates innovative design features that address the key drawbacks associated with the traditional models. (sub. DR832, p. 22)

Other participants, however, raised concerns. For example, the Orana Branch of the Combined Pensioners & Superannuants Association said:

The very thought that having worked very hard all our lives and paid off our homes, when we need a nursing home in our twilight years, we will have to take out a reverse mortgage, in other words having lived frugally, saved and reared families, paid our taxes and settled that mortgage debt we will be lumbered with another with extremely high interest rates until we and our spouses are dead. What a disgrace. (sub. DR671, p. 1)

Box 8.5 Support for a government backed equity release scheme**The Benevolent Society:**

The proposed government backed equity release scheme and relaxation of the pension assets test are supported. (sub. DR805, p. 4)

The Australian Guardianship and Administrative Council:

We give cautious support to the concept of a Government-run or backed equity release scheme provided it addressed all of the risks that currently attend to reverse mortgages. (sub. DR 663, p. 2)

Medibank Private:

Medibank is ... supportive of the recommendation that the Australian Government establish a government-backed Aged Care Equity Release scheme which would enable individuals to draw down on the equity in their home to contribute to the costs of their aged care so that people are able to access funds on better terms than those that are currently available in the market. (sub. DR819, p. 4)

Law Institute of Victoria:

An Aged Care Equity Release scheme would provide flexibility to care recipients who wish to retain the family home and make periodic payments. (sub. DR897, p. 6)

ACAA:

ACAA supports the proposal to establish a government-backed Aged Care Equity Release scheme which would enable individuals to draw down on the equity in their home to contribute to the costs of their aged care and support. (sub. DR777, p. 4)

Pam Webster:

The notion of broadening the funding base with the establishment of a government backed Aged Care Equity Release Scheme and the Australian Pensioners Bond scheme is excellent. (sub. DR617, p. 2)

Deloitte & Retirement Village Association:

The PC has recommended a government backed equity release scheme be introduced to enable care recipients to draw down on the equity in their home. We note that one of the key issues affecting the industry is access to capital and hence the development of a viable economic business model that attracts investment and delivers to market needs is vital. (sub. DR900, p. 1)

It was also pointed out the some older Australians will not have homes that are suitable for equity release (due to the low value of the home, its location, and purchasing arrangements within retirement village settings). Fortus, for example, said:

... with the increasing use of Retirement Villages, in most circumstances these facilities are of a leasehold nature, and are not considered as suitable security for Equity Release. (sub. DR755, p. 2)

Deferred payments (a call on the estate) are an option in cases where equity release is not feasible. Some participants support this option above an equity release scheme. Michael Fine, for example, said:

The problems of equitable contribution also deserve attention through the taxation system — in particular through the levying of a modest estate duty following death, at the time property and other resources are being passed on through inheritance. Australia is the only advanced economy without such duties. The wisdom of attempting to introduce payments based on housing equity for aged care in their absence is dubious. (sub. DR592, p. 6)

Crowding out the private sector in the area of equity release was also raised as a concern. SEQUAL, for example, said:

The Australian Equity Release market is both efficient and ethical. Older Australians have access to well-designed products both in the form of Reverse Mortgages and Home Reversion Schemes. A degree of competition between major banks and non-bank specialist providers delivers a robust environment for consumer benefit. It is therefore not necessary for a Government-backed equity release scheme to be developed. (sub. DR820, p. 13)

Challenger also said:

If the government has reason to believe that there are deficiencies in the operation of existing reverse mortgage providers there would be wider social value in the government addressing those concerns than by establishing a government reverse mortgage provider. (sub. DR785, p. 8)

And Deloitte Access Economics for Homesafe Solutions argued that rather than recommending a government-backed scheme, the focus should be on removing the obstacles to the development of the private market in home reversion:

This submission welcomes the Commission’s focus on equity release, particularly home reversion, as a viable source of supplementary funding for aged care in Australia. Rather than recommending the establishment of a government-backed equity release scheme, however, this submission urges the Commission to recommend that government actively consider how best to remove obstacles to the development of the private market in home reversion. (sub. DR600, p. 17)

The Commission agrees that any equity release scheme should be focused on seeking to achieve benefits that are additional to those that would arise through private decisions (that is, avoid crowding out). However, if the Government requires care recipients with low income, but with assets, to contribute to their care costs, a vehicle is required that allows recipients to draw down small regular sums of money. Such a scheme is unlikely to be attractive to private providers and, if offered, is likely to involve very high set-up costs. SEQUAL acknowledged that ‘there may be a limited place for government operated schemes which fill the “gaps” that are less attractive to private providers’ (sub. DR820, p. 13). Deloitte Access Economics for Homesafe Solutions also said:

There may be a case for a residual government-run equity release scheme, akin to the existing Pension Loans Scheme, but targeted to those whose homes are for whatever reason unsuitable for equity release through the private market. (sub. DR600, p. 6)

Any proposed government-backed equity release scheme would need careful design to ensure its acceptance in the community, drawing from the experience of private and government-backed reverse mortgage schemes and the Pension Loans Scheme.

Clarification was sought from participants on specific design features of any proposed scheme. For example, some participants expressed concern about the situation where partners, carers and siblings or dependent children share the same house as a person who needs to access care or move into residential care. COTA Australia, for example, argued for continued protection and flexibility in recovering any deferred contribution so that any dependents would not be required to move from the home in order for the contribution to be paid out of the home equity, noting:

In any scheme there should as now be protection for the partner, primary carer, cohabiting sibling or dependent child that ensures that person is not required to move from the home in order for the contribution to be paid out of the home equity. In such cases, the repayment should be required only once the dependent dies, moves to other accommodation, or is no longer a dependent. (sub. DR565, p. 10)

The Commission agrees that, in such situations, payment should only be required when the partner, carer or dependent child ceases to permanently live in the home or ceases to be a dependent.

The Commission's proposed government-backed scheme would be akin to a line of credit and could, therefore be titled an Aged Care Home Credit scheme. Some of the key features of the proposed scheme would include:

- eligible individuals accessing a government-backed line of credit secured against their principal residence (or their share, generally 50 per cent, where a couple is living in the home)
- flexibility in the rate at which the line of credit could be drawn on up to a specified limit (assessed at the time of the loan), provided it was applied to aged care services, including residential aged care accommodation charges
- relatively low upfront charges
- preferential interest charges (equivalent to the consumer price index), calculated on a daily basis and accrued on the loan outstanding (not the undrawn portion of the maximum amount)
- payment of the loan from the person's estate upon death (unless a partner, carer or child still lives in the house). In the latter situation, the outstanding balance of

the line of credit would be repayable when the spouse, partner or dependent child ceases to permanently reside in that home or ceases to be a dependent

- once the loan amount is drawn down (together with interest charges), and reaches the maximum allowable amount, no further equity could be drawn, and no further interest charges would be applied — in effect a no negative equity guarantee, with a minimum guaranteed level of remaining equity
- access to funds through the scheme would not be treated as an income stream (therefore would not adversely affect any pension benefits) provided the funds were used for approved expenses and not accumulated
- design features to make it work with the existing and potential private market rather than as a competitor.

As an example, if a home was valued at \$800 000 and up to 50 per cent of a person's share of the equity in the home owned could be accessed, an amount of \$200 000 could be drawn on. The person could take out relatively small amounts (say \$250 per week) to pay for aged care and accommodation costs. The interest (at the CPI rate) would be calculated daily and would accrue on the loan outstanding. Once the \$200 000 limit was reached, that would remain the final nominal amount repayable.

In order to maintain equity with those people who do not own a principal residence, the Commission suggests that if the minimum asset threshold for a supported resident is set at \$X, a person should be able to borrow until their share of the equity in the home has fallen to \$X. For example, if a home owned by a couple was worth \$800 000, and one of them required aged care services they should be able to draw down their equity to \$X leaving the total equity in the home at \$400 000 + \$X. Once the home equity for the individual was drawn down to \$X, the interest rate should revert to zero so there would be no further loss in home equity.

It should also be noted that as assets are drawn down, an individual's co-contribution to care would fall — for example, a person may start paying a co-contribution of 25 per cent but as the home equity (share) falls towards \$X, the co-contribution would also fall.

A further concern raised by participants was the case where a part owner refused to sign a contract that would put the Government (or its agent) on the mortgage title deed. From the perspective of a reverse mortgage (or deferred payment) where the government takes security over a property, the title would be a tenancy in common. As such, the person requiring care could deal with their share with the government without the other person's permission. The government could facilitate the

conversion of the interest to a tenancy in common and then offer the line of credit or deferred payment.

Conducting an information campaign to educate older Australians about the option of equity release will also be important to ensure the new arrangements benefit those whose circumstances make this an attractive option. FaHCSIA recommended that the National Information Centre for Retirement Investments Inc, an Australian Government program funded under the Financial Management Program — aimed at building financial resilience and wellbeing among those most at risk of financial and social exclusion and disadvantage — should have a role in communicating the existence and operation of the government-backed equity release scheme (sub. DR673). The Australian Seniors Gateway Agency (the Gateway) should also provide extensive information about any aged care equity release scheme with links to other relevant websites.

RECOMMENDATION 8.1

The Australian Government should establish a Government-backed Australian Aged Care Home Credit scheme to assist older Australians to make a co-contribution to the costs of their aged care and support.

- ***Under the scheme, eligible individuals would receive a Government-backed line of credit secured against their principal residence, or their share of that residence.***
- ***In establishing the line of credit, the Australian Seniors Gateway Agency would arrange a valuation of the principal residence and specify a minimum level of equity for the person's share of the home. The individual could draw progressively down to that minimum to fund their aged care costs. The drawdown on the line of credit would be subject to interest charged at the consumer price index. If the outstanding balance and accumulated interest reached the minimum limit set by the Australian Seniors Gateway Agency, the interest rate would fall to zero, and no further draw down would be permitted under the scheme.***
- ***The outstanding balance of the line of credit would become repayable upon the disposition of the former principal residence including upon the death of the individual, except where there is a protected person permanently residing in the former principal residence.***
- ***In the latter circumstances, the outstanding balance of the line of credit would be repayable when the protected person ceases to permanently reside in that former principal residence, or ceases to be a protected person. (Protected person is defined in the Aged Care Act 1997 and includes, for example, a partner, dependent child or a carer.)***

8.3 Insurance for aged care

Aged or long term care insurance (LTCI) would cover care services not covered by Medicare or private health insurance. Such insurance would pool the risk of aged care costs across those participating in the scheme. As discussed in chapter 6, given the unpredictable nature of incurring very high aged care costs, there would be welfare gains from having a mechanism in place that pools these costs. A number of participants acknowledged the advantages of a pooled funding approach. Laurel Hixon, for example, said:

The need to focus on insurance options stems from the fact that certain aspects of aged care represent a textbook case of an insurable event ... Australia should be prepared to have in place strategies that anticipate the future demand for aged care and mechanisms to spread the financial risk of aged care over the *widest possible population and over time*. (sub, 328, p. 2) [emphasis in original]

While voluntary insurance would allow risk-averse individuals to insure against the possibility of high care costs, it is unlikely to work in anything but a very modest way because of problems on both the supply and demand side of the insurance market (box 8.6). As Barr put it:

There are potentially large welfare gains if people can buy insurance that covers the cost of long-term care. However, technical problems — largely information problems — face both the providers of insurance and potential buyers. These problems on both the supply and demand sides of the market suggest that the actuarial mechanism is not well suited to addressing risks associated with long-term care. (2010, p. 359)

Internationally, private insurance plays a relatively small role in financing aged care.

- In the US, where insurance is voluntary and privately provided, less than 10 per cent of the population aged 65 years and over are insured for aged care, despite tax incentives.
- In Germany, private insurance is available for high-income individuals and as supplemental coverage for all. Participation rates are less than 10 per cent.
- In France, 25 per cent of people over the age of 60 have private insurance.

Myopia in planning for the risk of dependency, failure to recognise the potential risks of needing care into the future, and the high cost of care are factors explaining the relatively small size of the private LTCI market in the above countries. Private providers, in seeking to extend the market have simplified insurance products (moving towards policies that provide fixed cash benefits) and introduced hybrid financial products, including combined life and long LTCI cover. In France, for example, around 150 000 individuals have LTCI coverage as part of their life insurance policy (Colombo et al. 2011).

Box 8.6 Voluntary insurance — problems on the supply and demand side of the market

While voluntary insurance would allow risk-averse individuals to insure against the possibility of high care costs, problems on the supply and demand side of the market limit the extent and coverage of such insurance, including:

- a lack of knowledge about the risk of needing care and competing priorities for the premium payments (mortgages, childcare costs). Also difficulty in predicting care needs and framing an acceptable level of coverage
- affordability problems for consumers arising, in part, from the limited number of people likely to take out insurance which in turn increases the costs of premiums. Individuals also tend not to think about purchasing insurance until late in life, and the later in life the insurance is purchased the higher the premiums. The greater risks of requiring aged care for females — related to their morbidity and mortality profiles — means they will face higher premiums
- low incentives to insure because of existing safety net mechanisms and uncertainties about future age care policies
- the unpredictable nature of future care costs and life expectancy for any individual makes it difficult for insurers to calculate appropriate insurance premiums
- adverse selection problems — people with the worst health profiles and highest likely future care costs are most likely to buy insurance. If insurers are unable to set differential premiums, a common rate premium would discourage potential lower-risk purchasers. Identifying people more likely to claim aged care benefits involves more than assessing their health and future probability of becoming disabled as availability of a carer or preferences of individuals and their families towards using paid care can also determine whether a claim is made.

While insurers can counteract some of these problems (by requiring co-contributions or limiting what can be claimed) this further reduces the attractiveness of insurance.

Sources: Barr (2010); Colombo et al. (2011); Gleckman (2010); PC (2003).

It is often argued that governments could provide tax incentives to improve the attractiveness of private insurance. However, the merits of providing such incentives are frequently contested because incentives largely involve transfers from taxpayers to policy owners who would have purchased insurance anyway rather than inducing people who otherwise would not have purchased insurance to take out insurance. Further, where incentives are provided as tax deductions rather than rebates, they provide disproportionately large benefits to those with high taxable incomes. As Colombo et al. (writing in an OECD Health Policy Studies paper) recently said:

... in the context of voluntary pooling arrangements, public initiatives have generally had limited success in broadening access to private LTC coverage. But, some public

initiatives seem to be less cost-effective than others. For instance, preferential tax treatment needs to be considered carefully in terms of its effectiveness to affect demand. More specifically, most of the fiscal cost of a tax measure can take the form of a ‘windfall’ to those relatively better-off individuals, who would have purchased the insurance even in the absence of the tax reduction. Alternatively, support towards the purchase of a private LTC insurance could be targeted to lower-income individuals thereby compensating for the regressiveness of risk-related premiums. (2011, p. 259)

Under a lifetime stop-loss taxpayer model where the Australian Government covered costs above a nominated cap, there could be a role for private insurance for the more predictable care costs as the government would be taking on the ‘long risk’ that individuals and insurers are less willing to accept. As the OECD noted, supplementary private insurance would be considerably more affordable for individuals:

Supplementary private insurance could play a stronger role in the future to cover private cost-sharing. Private insurance on top of a basic universal public insurance, for example to pay for the cost of accommodation in nursing homes, covers a risk that is easier to calculate and therefore to insure for the private insurance industry compared to full coverage of the risk of care needs in old age. And it is more affordable for private households. (2005, p. 14)

With a government funded lifetime stop-loss mechanism in place, insurance is really a form of pre-saving for the more predictable costs of aged care. Hence, insurance brings with it an added issue of prudential regulation to ensure that the insurance policy can be redeemed when it is needed, a long time into the future. While voluntary insurance may complement other forms of funding it is — for the reasons outlined in box 8.6 — unlikely to provide an adequate funding mechanism for a large share of the population. Nonetheless, the Commission considers that any unnecessary legislative restrictions on personal insurance being offered by the private sector should be removed.

An alternative approach which addresses these problems is compulsory insurance.

Compulsory insurance

Compulsory care insurance can be provided publicly or privately, although it is usually discussed in terms of public provision and referred to as social insurance. Compulsory contributions under a social insurance scheme are typically collected via a levy on income and put into a designated (hypothecated) fund. In contrast, contributions under a private compulsory insurance arrangement would typically be collected as premiums related to an assessment of the underlying insured risk and placed in an insurance pool as reserves to meet subsequent claims.

As with voluntary private insurance, compulsory insurance represents a pre-funded approach to funding the costs of aged care. By extending coverage, compulsory insurance provides a more effective risk pooling mechanism that, in principle, provides individuals with an assurance that funds would be available if needed.

Over the past decade or so, commentators and key stakeholder groups have suggested introducing compulsory insurance, usually in the form of social insurance, to broaden the funding base for aged care (box 8.7).

Box 8.7 Past interest in compulsory care insurance

Over the past decade or so, many commentators and stakeholders (including those representing providers, consumers and workforce groups) have listed compulsory insurance among the possible options for raising the level of funding for aged care through increased user contributions.

In the late 1990s, interest in social insurance was kindled following the public backlash against substantial increases in user contributions, and, in particular the proposal to introduce accommodation bonds in high care (Fine and Chalmers 1998; Howe 1999).

In 2002, the Myer Foundation suggested a pre-funded social insurance scheme, funded by a compulsory premium on national wages similar to the Medicare Levy, could be introduced to enable individuals to contribute more to the costs of their care when they can afford to. Although the 2004 *Review of Pricing Arrangements in Residential Aged Care* did not include a social insurance scheme among its recommendations, many participants to that review did raise this option, including 24 peak industry members of the National Aged Care Alliance (NACA 2003). Participants to the Senate Inquiry into Quality and Equity in Aged Care (SCARC 2005), including Aged and Community Services Australia on behalf of 10 other peak industry bodies, also proposed that the scope for a social insurance scheme to broaden the funding mix, such as that currently operating in Japan, should be investigated.

More recently, in recognition of the growing pressure on the taxation system, the Henry Review (2010, p. 641) recommended the Commission consider the ‘potential for insurance to play a role in helping to fund aged care as Australia’s population ages’.

Despite the seemingly significant level of in-principle interest, past reviews have been unable to determine whether a compulsory insurance scheme would represent a significant improvement over the existing arrangements.

Howe, for example, observed that:

Current aged care funding relies on only two ‘pillars’ — taxation revenue and user charges. Adding a pillar of social insurance would add a third pillar and so strengthen the whole of the funding arrangements. In particular, by providing a source of forward funded capital, social insurance would serve as a buffer against downturns in the wider

business cycle for aged care investment, and in turn, marginally moderate the business cycle.

A social insurance approach to aged care funding in Australia is highly consistent with and would complement both the Medicare Levy and the Superannuation Guarantee that are already in place. Both have proved ‘painless and popular’ taxes with the community, and a social insurance scheme for aged care could be expected to gain similar acceptance. (2003, p. 8)

A number of participants to this inquiry also supported a compulsory insurance type scheme, many suggesting an increase in the Medicare Levy (box 8.8.).

Box 8.8 Some participants supported the introduction of a Medicare type levy and compulsory insurance

Melbourne Citymission:

The Government should examine introduction of an Aged Care Levy in the taxation system, as a social insurance levy similar in function to the Medicare Levy ... Australia currently has transparent mechanisms to help fund the public health system and citizens’ retirement. Why not introduce an Aged Services Levy in addition to the Medicare Levy? (sub. 173, p. 21 and p. 23)

Baptcare:

Baptcare agrees that many people may not have adequate superannuation for their needs in the long term or may choose to utilise their superannuation payout to live well for the period whilst they are fit and healthy. To combat this, we suggest the Government extend the Medicare levy to cover aged care costs. This could be applied to all taxpayers, with an additional impost on high-income earners who do not choose to take out private insurance for aged care costs, such as the longevity insurance products suggested by the Henry Review. (sub. 212, p. 30)

Medibank Private:

The benefits of this model [mandated social insurance] include the development of a sense of individual responsibility to fund aged care needs as well as the benefits of sharing costs and pooling risk at a population level. However this model requires that premiums be set at a high enough rate to ensure future sustainability of the scheme and is a long term strategy which relies on people in the transition phase having assets to draw on to support their ageing care needs. (sub. 250, p. 10)

Blue Care:

Blue Care **recommends** that the government considers introducing social insurance by an increment to the present Medicare levy ... to close the present residential aged care funding gap of some \$1 billion. We estimate that the required increment at around 0.15% to 0.2% (percentage points). In the longer term, the increment could be increased to meet the rising cost of care of the ageing population. (sub. 254, p. 16) [emphasis in original]

A well-designed compulsory insurance scheme for aged care could offer several advantages:

- because compulsion means that risks are fully shared, individuals would be protected against catastrophic costs and there would be enforced savings for predictable costs
- spreading the costs of aged care across a wide range of individuals would address the adverse selection and information problems associated with voluntary insurance, which in turn helps improve affordability
- if contributions to the scheme are means tested and proportional to income (as with the Medicare levy), a broad cross-section of individuals would be covered under the scheme, with contributions from those on higher incomes effectively extending the benefits available to low income participants.

As Barr observed:

while compulsion makes politicians nervous, it has economic advantages, including:

- It recognises the evidence from behavioural economics that people do not always make decisions in their own self-interest.
- It avoids adverse selection, since good risks cannot opt out and bad risks cannot choose to buy inefficiently large amounts of cover.
- A system that is compulsory allows some redistribution; thus it is possible to charge a contribution to x per cent of earnings, respecting ability to pay. (2010, p. 317)

Another argument advanced in favour of a compulsory insurance scheme is that it can smooth intergenerational transfers. In this regard, younger generations may be more prepared to support older generations who have contributed to the cost of their own aged care costs. But as Ergas said:

... if incomes are rising, the welfare cost of reducing current consumption exceeds that of reducing future consumption. Moreover, the reduction in current consumption would be greater for the transition generation, as it would have to cover both the costs of care for current, unfunded, consumers and provision for its own care costs. Indeed, if the real rate of return is less than the 'biological rate of interest' (i.e. the sum of population growth and productivity growth), then a PAYG scheme is generally efficient.

The mere fact of moving to a funded scheme therefore need not increase welfare. Whether it does depends on its impact on efficient risk-allocation and service provision, and on its overall effect on savings. (2010).

In the case of aged care, the opportunity to smooth the higher costs associated with the bulge of the baby boomers has largely passed.

It is also often argued that the hypothecation of funds provides greater protection from the vagaries of the government's budget process, as money can be more securely ring-fenced than through simply increasing taxation. In this context, Colombo et al. observed:

... there can be advantages in having 'dedicated' financing channels for LTC as in the case of social LTC insurance in Germany, Japan, Korea, Luxembourg and the Netherlands. It can ensure a reliable and predictable source of revenue streams, relative to non-earmarked taxation; it can also create a sense of entitlement for people, raising their willingness to pay for such an entitlement. (2011, p. 222)

But, hypothecation can also introduce rigidities in the way funds are allocated and it does not necessarily provide a guarantee about the level of specific funds available (Barr 2010). As Catholic Health Australia said:

It has been suggested an advantage of a dedicated social insurance scheme is that it would provide greater certainty of funding for aged care, but this has not necessarily been borne out in other countries. What tends to happen instead is that the funding debate moves to the adequacy of the levy to meet needs and the normal variables which affect cost and affordability such as eligibility, what services are in scope and the level of service. (sub. DR748, p. 12)

The appropriateness of hypothecation needs to be considered having regard to the specific characteristics and policy objectives of the service sector under consideration. While there are arguments for and against hypothecation of funding, this debate is secondary to the question of the appropriateness of having a social insurance scheme for aged care.

Advances in medical and assistive technologies over time as well as potential changes covering other variables have the capacity to alter the future cost profile for aged care in ways which are inherently hard to predict. If the contribution rate (premium) is set too high, there will be excessive savings (reserves) relative to the future costs of care while if set too low, additional funds would be required from general tax revenue (or higher premiums).

International examples of compulsory insurance

A number of OECD countries — Germany, Japan, Korea, the Netherlands and Luxembourg — have adopted dedicated social insurance arrangements for long term care services (table 8.2). Common features of the arrangements include:

- separate funding channels for LTCI and health insurance, but with the same social insurance model
- mandatory participation for the whole population or a large section of the population (for example, in Japan everyone over 40 years of age)

-
- predominantly financed through employment-based payroll contributions, but seniors can also be asked to pay contributions. A share of the cost is funded out of general taxation in most countries (Colombo et al. 2011).

Under Germany's insurance scheme, insurance premiums are means-tested and paid for through payroll tax. Around 90 per cent of the population is covered by the scheme, with the remainder opting for private insurance (high income earners, the self-employed and civil servants have the option to take out LTCI with a private provider). The government determines eligibility for aged care services and makes all capital investment for residential aged care facilities (Arntz et al. 2007). Eligible beneficiaries can opt for a cash payment (at a lower value), in-kind professional services, or a combination of the two.

Japan introduced an LTCI system in 2000. The scheme is funded by a combination of general tax revenue and income-related premiums (payroll tax) levied on those over the age of 40 years. Anyone over 65 years of age in need of care (eligibility for care is determined by the government) is granted access as are people aged 40-plus suffering from age-related disabilities such as stroke or Parkinson's Disease.

LTCI was introduced in Korea in 2008, covering people aged 65 years and over assessed as needing care and younger people with geriatric diseases. The working-aged population contributes around 5 per cent of wages to the National Health Insurance scheme, 4.78 per cent of which goes towards LTCI. The government pays subsidies equal to 20 per cent of contribution receipts and care recipients pay an out-of-pocket contribution of between 15 per cent of the cost for in-home services and 20 per cent for institutional services.

For details of the schemes in the Netherlands and Luxembourg see table 8.2.

A recent OECD Health Policy Studies paper (Colombo et al. 2011) observed that, as a share of GDP, long term care spending is around the OECD average of 1.5 per cent for those countries who have adopted LTCI models, apart from Korea (0.3 per cent) and the Netherlands (3.5 per cent).

Both the German and Japanese schemes have begun to face increasing cost pressures because contributions have been insufficient. In Germany, contributions were increased in July 2008 from 1.7 to 1.9 per cent of gross salary for people with children (of any age) and from 1.9 to 2.2 per cent of gross salary for people without children. Commenting on the pressures faced by these countries, Featherstone and Whitham said:

Both Germany and Japan ... are struggling to ensure long-term financial sustainability of these systems. In Japan, costs of care have escalated and, in 2005, they excluded hotel costs (care home accommodation as opposed to care home nursing costs) from the benefits package. Currently lowering the minimum age of contribution to 21 is under

consideration. The German system now only covers about half of the cost of institutional care, leaving some older people forced to pay out-of-pocket to cover their long term care. (2010, p. 29)

Table 8.2 Universal long term care insurance (LTCI) schemes in selected OECD countries

	<i>Introduced</i>	<i>Financing sources</i>	<i>Contributions</i>	<i>Eligibility</i>	<i>Benefits</i>
Germany	1995	Payroll and income-related contributions	1.95% payroll tax (additional premium of 0.25% for those with no children) Paid by all working age and retired population Approx 11% opt out and are obliged to buy private insurance	Needs based assessment regardless of age	In-kind or cash at user's choice
Japan	2000	General revenue (45%) Contributions (45%) Cost-sharing (10%)	Paid by over 40 year old population Individuals aged 40-64 years pay 0.9% of wages	65+ assessed as needing LTC 40+ with certain diseases	In-kind
Korea	2008	Tax (20%) Payroll contributions (45%) Cost-sharing (15-20%)	Paid by working-age population through contributions to health insurance. National Health Insurance contributions set at 5.08% of wages, 4.78% goes toward LTC	65+ assessed as needing LTC Younger people with geriatric diseases	In-kind or cash
Netherlands	1968	Payroll and income-related contributions Means-tested copayments	Contribution rate is based on income. Paid by working-age and retired population (all citizens over 15 years with taxable income)	Disabled assessed as needing LTC, regardless of age	In-kind (institution) Cash (home, personal budgets)
Luxembourg	1999	Taxation (about 45%) Contributions Special tax	Paid by working-age and retired population. Contribution set at 1.4% of income	Disabled assessed as needing LTC, regardless of age	In-kind and/or cash, at user's choice

Source: OECD (2010c).

Designing and implementing a compulsory insurance scheme

Moving to a compulsory insurance scheme would be a big change from the current aged care arrangements and would raise significant design and transitional issues.

In designing a compulsory scheme, policy makers would need to resolve a number of important questions.

- What costs should be covered — only care costs or also accommodation and everyday living expenses?
- Whether the scheme should be administered by the public or private sector, a single insurer or multiple insurers?
- If provided by the public sector:
 - would the contribution rate be based around a hypothecated levy with a flat rate or a progressive income-related rate?
 - would the contribution rate be imposed on the entire working-age population or only those above a certain age?
 - how would the scheme deal with non-taxpaying individuals or those not in the workforce?
 - what level should the contribution rate be set at, how would it be adjusted as expected future costs change and how would fund surpluses be distributed or shortfalls be funded?
- If provided by the private sector:
 - should the premiums to be paid be mandated by the Government or subject to conditions set by Government as with private health insurance?
 - should premiums be allowed to vary on the basis of risk?
 - what regulatory framework is needed for the operation of the insurance scheme and to manage contingent liabilities for government should an insurer fail, or if coverage falls short of expectations?
 - how would equity issues be addressed if premiums rather than a flat rate or income related rate was used?
 - what regulatory mechanism would be used to enforce compulsion and how should premiums be collected?

There may be significant operational and administrative efficiencies which can be achieved by having a single insurer. And, at least in principle, a single insurer would have a greater capacity to impose strong disciplines on service providers to encourage cost effectiveness and efficiency. In contrast, a multiple insurer arrangement offers scope for competition between insurers, which may promote

greater efficiencies and a more dynamic market over time. A private insurance market would need to be highly regulated and government would need to subsidise insurance for those who could not afford to purchase cover.

In the Commission's view, whether the economies of scale and buying power of a single insurer would outweigh the potential dynamic efficiencies of multiple insurers is an empirical question, about which there is little evidence. More fundamentally, the regulatory regime required to underpin a compulsory private insurance system for aged care may well undermine the scope for efficiency gains, and it is highly likely that government would, in effect, become the insurer of last resort.

Similarities between a tax-funded scheme and compulsory insurance

There are many similarities between the current aged care taxpayer funded system supplemented by a lifetime stop-loss mechanism and compulsory insurance — both involve risk pooling (to protect individuals from catastrophic costs) and can involve progressive mechanisms for raising funds. Access to care is based on need, rather than ability to pay.

Laurel Hixon suggested that the ability for governments to control costs may be more difficult under compulsory insurance than a taxpayer funded scheme.

General revenue funded programs have greater cost controls because they have to compete with other government spending priorities and these priorities are reviewed on a regular basis. In contrast, because of their 'entitlement' nature, it is more difficult to impose cost controls on social insurance programs. (sub. DR830, p. 4)

Further, as noted earlier, the introduction of a compulsory insurance scheme for aged care would also raise significant transitional issues. A key one relates to how to treat different age cohorts relative to the likely timing of prospective demands by their members for aged care services. For those who have already retired, or are nearing retirement, the magnitude of their accumulated contributions under any scheme is likely to be small relative to their potential drawdowns. Hence, the scope for compulsory insurance to handle the population bulge associated with the ageing of the baby boomers is arguably becoming limited. A number of participants agreed with this assessment while others considered that the option of compulsory insurance warranted further analysis (box 8.9). Michael Fine, for example said:

A social insurance model, such as that of the National Disability Insurance Scheme (NDIS) proposed in the Productivity Commission's *Disability Care and Support, Draft Inquiry Report (PC, 2011b)*, could be extremely successful as a form of user pays instrument that helps fund an expansion of services. It does so by spreading the risk amongst all potential users. The costs would not fall simply on the unfortunate enough to require assistance, but on all people who contribute. (sub. DR592, p. 6)

Box 8.9 Participants views on compulsory insurance

Catholic Health Australia:

CHA agrees with the Commission's analysis which led it to reject voluntary insurance as an option for broadening the funding base for aged care.

CHA also shares the Commission's assessment that compulsory social insurance would not represent a significant improvement over a pay-as-you go tax financed system, supplemented by higher copayment for those who can afford to pay and a stop-loss mechanism to address the unpredictability of incurring very high aged care costs. A stop-loss mechanism would serve the same purpose as risk pooling in a social insurance arrangement without the overheads of managing an insurance scheme and the intergenerational transitional issues involved. (sub. DR748, p. 12)

Medibank Private:

Medibank holds the view that a long-term compulsory insurance scheme targeted at funding the costs associated with aged care will not offer a significant improvement on the current funding model. (sub. DR819, p. 4)

Anna Howe:

The Draft Report is correct in noting that the time has passed for introducing a standard contributory insurance scheme as it would not allow those who have already retired or are approaching retirement to accumulate sufficient funds to cover likely costs of aged care. The most effective option for handling the population bulge associated with the ageing of the baby boomers instead rests on drawing on the contributions that they have already made to superannuation and the subsequent earnings of their superannuation funds. These balances will peak at the time of retirement and there are strong grounds for recovering a small part of the substantial tax benefits on contributions and earnings that have added to these balances. (sub. DR856, p. 8)

Combined Pensioners & Superannuants Association of NSW:

CPSA calls for an aged care insurance funding scheme to be established to move away from the user-pays funding model. An insurance scheme would avoid penalising aged care recipients for accessing care services, ensure that funding was spread evenly regardless of the care recipient's wealth, and safeguard funding adequacy over the long-term.

An insurance scheme, similar to Medicare, would raise revenue in accordance with capacity to pay as tax-payers contribute to the scheme in line with their income. In effect, this achieves the same principle as the Commission's recommendations pertaining to wealthier aged care recipients paying more for their care. The difference is that an insurance model spreads responsibility among both care recipients and non-care recipients, thus removing barriers to aged care access that may arise under a user-pays system. As the Commission points out, "access to care is based on need rather than ability to pay." CPSA considers aged care services, especially high care services, healthcare services should therefore be universally available. (sub. DR760, pp. 13–14)

Christine Mifsurd:

I also support the concept of a **social insurance scheme** to provide for older age, though I acknowledge that this may not be politically feasible in the current climate. (sub. DR660, p. 2) [emphasis in original]

A key difference between the aged care and disability sectors is that the probability of needing to receive care and support in old age is much higher than the probability of acquiring a non age-related disability. Older Australians needing aged care services have generally had the opportunity to purchase a home and to accumulate other wealth such as retirement savings, and therefore have the financial capacity to contribute to the costs of their care. Care co-contributions by older Australians, and ongoing responsibility for providing their own accommodation, achieve a measure of intergenerational equity. Also, as the baby boomers are moving into their retirement years, their scope to contribute to an insurance pool is limited.

After weighing up the pros and cons, the Commission does not consider that a compulsory insurance scheme, in the context of aged care, represents an improvement over the pay-as-you-go tax financed system supplemented by higher co-payments by those with the financial capacity to make them and a lifetime stop-loss mechanism (to achieve risk pooling) for the high costs of care.