Submission to the Royal Commission on Aged Care Quality: Aged Care Financing

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Sep 2020

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Introduction.

This submission has grown from a series of interactions with the Commission secretariat, broadly focused on the question of financing aged care. Communications with the Commission have included a series of questions on this topic. In what follows, we respond to these questions, but provide a broader frame for context and coherence.[2]

Summary

1. ***An equitable and efficient system:*** A good aged care financing system would generate adequate funds to meet community expectation of quality care, responding to need regardless of financial circumstance of care recipients. It would set incentives such that appropriate choices are made between and within modalities of care, enhancing the efficient use of available resources. It would take account of impacts on the economy, including the efficiency of funding bases, allocation of informal carer time, and the tendency to self-insure by retirees. It would achieve equity and efficiency over time, remaining sustainable in the face of technical and demographic change.
2. ***Predominantly public responsibility:*** A series of challenges, mainly related to information, inhibit the ability of private insurance to play a significant role in financing aged care. Publicly financed insurance with means tested client contributions, frequently referred to in this submission as co-payments, should continue. One insurable event for those with sufficient resources relates to additional and extra services in residential care. This could be covered through combination lifetime retirement products that pay an income to purchasers in active life.
3. ***Better means testing of co-payments:*** Means tested co-payments should continue to play a role. Those with insufficient resources should continue to have their aged care costs met by the state, including accommodation costs in residential care. For low-income care recipients, living costs should continue to be covered by the Age Pension. The daily fee, which is related to living costs, could be increased for non-supported care recipients, using similar mechanisms for regulating higher accommodation costs. Means testing could be altered to seek greater contributions from those with greater means. The design of means test tapers, thresholds, caps, and scope of resources tested should be fully investigated. For example, tapers could be steeper, caps should remain but could be higher, and more of the home could be tested (facilitated by the Pension Loan Scheme). In all cases, revisions of fees should be cognisant of the role co-payments play in affecting service utilisation (for example, co-payments could better reflect relative costs in the system).
4. ***Hypothecated Aged Care Levy:*** Other than client contributions, the major source of finance for aged care services will be the public purse. We consider a range of alternatives, and conclude that a hypothecated tax or levy on a taxable income base would be the best option. This would align with the Australian approach to social risk pooling, based on needs not rights. An Aged Care Levy (ACL) could be at a constant rate, or progressive across income range (making use of existing tax schedules), and/or set at differentiated rates by age. The ACL would meet current and projected aged care outlays on a pay-as-you-go basis. Given demographic disequilibrium, reserves from the ACL would be expected to accumulate over the next decade/s. These will require prudent and professional management, possibly in a special account managed by the Future Fund.
5. ***Enhanced oversight of quality, costs, and prices:*** The oversight of these arrangements and the sector overall will require independent advice on quality, costs, and prices. First, there is a need for information on the inputs necessary for quality provision. Second, there is a need for the costing and pricing of these inputs. Together these would provide information about the funds needed from an Aged Care Levy and means tested co-payments. These functions could reside in separate authorities.

[2] Further material on Aged Care produced by CEPAR is summarised in Chomik and MacLennan (2014a,2014b) and Chomik and Townley (2019).

1. What must be publicly funded and financed?

Aged care services usually require a considerable degree of public funding. There are several important drivers for this. Perhaps most importantly, there is a strong community expectation that adequate aged care services should be available for those needing them, regardless of financial circumstance.

Beyond an 'adequate provision' threshold, however, it may be natural to think of insurance as a mechanism for funding further aged care provision. Only a proportion of the population is expected to need aged care, and insurance is a possible mechanism to respond to this risk. Insurance is less costly than self-insurance (each person contributing to an insurance pool needs to save less than if each had to saves the amount paid out by insurance). But private long term care insurance has achieved very little penetration anywhere in the world. Various factors, mainly related to information, inhibit the development of such markets, and provide the rationale for public finance extending beyond basic provision for those facing financial hardship.

Private aged care insurance confronts three sets of challenges which are not present in domains where private insurance works successfully, such as home or car insurance. First, in many cases, premiums would need to be paid to cover a contingent event in the far future. As populations live longer but not necessarily morbidity-free lives and as technology of service provision evolves, it is difficult to estimate future costs of aged care with certainty (Tumlinson et al. 2009).

Second, a condition for a well-functioning market – not just in insurance but more generally – is that information is common to buyer and seller. Asymmetries operate in two relevant ways. For example, if the buyer knows more about their chances of needing aged care services than the insurance company, then the market will fail through adverse selection – that is, higher risk individuals will buy the insurance, driving up premiums for low risk individuals to the point where they do not find it attractive to purchase. A second market failure arises when, as a result of holding an aged care insurance contract, you are more likely to make use of the services provided (subject to meeting eligibility criteria) than without such insurance, a phenomenon known as moral hazard.

Third, there are consumer behaviour reasons why private aged care insurance may be inhibited. It is sometimes argued that older people are reluctant to take out aged care insurance because they would prefer being looked after by family, and holding insurance makes this outcome less likely (Pauly 1990). (This can be thought of as a form of moral hazard.) They may also be myopic in the same way that they are myopic about saving for retirement. A further source of consumer reluctance relates to the intergenerational implications of altruism. While self-insurance is generally considered wasteful compared to risk-pooling, a bequest motive reduces the efficiency cost of self-insurance. If a precautionary balance is not needed, it contributes to bequests. These 'incidental' bequests generate value for the donor as well as the recipient (Lockwood 2018).

Providing public coverage does not completely avoid these problems, but it does provide a functioning risk-pooling financing mechanism. For example, it overcomes the problem where contributions into the system (either via taxes or premia) need to exactly equal future risks or costs. This is because government has unique ways of raising funding and pooling risks within and across generations. Attempting to set a framework in which contributions approximate costs is the key challenge here and requires the types of mechanisms described below (see Barr 2010).

Aged care financing broadly conforms to the idea that (1) price-regulated accommodation costs are covered by the client, subject to means testing provisions; that (2) price-regulated costs of daily living and care are met by the client (set below the value of the Age Pension); and that (3) nursing and personal care, such as bathing, is subject to public insurance and subsidy alongside means testing

arrangements (See Appendix for fee structures and means testing details). This does seem to work, although often at a level of service and availability below community expectations.

It is important to explicitly introduce the role of informal care when considering what should be publicly and privately financed. The Commission is clearly aware of and acknowledges the importance of informal care, for example in its Interim Report, but the topic needs recognition in a specifically financing context. This is because the informal sector support carries with it implications around paid work, an ongoing tension which many in the community experience through middle age.

It is difficult to assess the value of informal care with precision, but it is very substantial. To give some sense of scale, Deloitte (2020) estimates the replacement value of informal carers at $77.9 billion, compared with formal public and private contributions to aged care of about $27 billion in 2018-2019 (The Commission's Consultation Paper 2, page 3). The important point here is that if aged care provision were to be reformed so that less informal care is required (for example through timely access to home care), there is likely to be a significant increase in mature labour force participation, and in thinking about overall economic cost, this needs to be in the calculation.

If more comprehensive public funding for aged care leads to gains from increased labour force participation of carers, then this benefit should be set against the cost of providing more aged care support.

In a world where more adequate provision of aged care services is the norm, client contributions to costs could well be higher, through adjustments to means tests as they impact co-payments. Better designed, this should serve to improve the efficiency of resource use as well as generate some additional financing.

With this preamble our responses to the Commission's more specific questions (provided in the Appendix) are as follows.

- Accommodation costs should continue to be paid by care recipients (through Refundable Accommodation Deposits {RADs} and/or Daily Accommodation payments {DAPs}) subject to safety net arrangements for people in financial hardship. However, there is scope for changes in the means testing arrangements by altering the means testing of the home. It is important that there continue to be flexibility between RADs and DAPs at an appropriate rate of exchange. These alternatives provide convenient channels for clients to accommodate consumption and bequest motives according to their preferences.
- Daily living costs should continue to be paid by care recipients, subject to appropriate price regulation, which allows costs to be paid out of Age Pension income
- Personal care, clinical care and some allied health care needs arising due to ageing should continue to be largely publicly financed. This corresponds to health care, for which we have universal access in Australia, largely publicly funded. However, there is scope for increased co-payments, either by linking these to the cost of care (i.e. proportion of cost) or by adjusting means test parameters, or by applying a combination of both.

2. Principles for evaluating aged care financing mechanism

The principles we would bring to bear in evaluating alternative aged care financing mechanism are:

- **Adequacy:** services are provided to all who need them at a level deemed adequate by community standards, and in a timely manner
- **Economic efficiency:** As far as possible, the financing of aged care leads to resources in the economy as a whole being allocated to their most advantageous use
- **Equity:** Ex ante, individuals are not substantially advantaged or disadvantaged by the financing mechanisms used to support aged care; and these mechanisms do not impose undue weight on

particular age cohorts. (The Adequacy principle above addresses the issue of adequate care being provided for those with insufficient resources.)

- **Administrative efficacy:** The financing set-up is as transparent to users, or clients, as possible, and does not impose undue costs in its execution
- **Sustainability:** The financing system should, so far as possible, provide a flow of funds into the future to ensure that aged care services will not be curtailed for future generations.

Application of these principles to the financing of aged care may sometimes require a broader view of the implications of alternative financing mechanisms than the Commission has taken to date. We provide examples with respect to efficiency and equity.

Economic efficiency as a criterion should in the first instance take account of the correction of the market failure which we have seen exists with respect to aged care insurance. Providing a risk-pooling mechanism for which there is no private market is an important contribution to economic efficiency. But in assessing which specific mechanisms might be deployed to this end, impacts beyond the aged care sector should be recognised. For example, as already noted, the financing choices can impact on informal care and labour force participation. If labour is more productively employed in the formal labour force rather than as informal carers, than greater socialisation of care provision can result in greater economic efficiency. Similarly, it is frequently observed that after retirement, people are reluctant to spend down their assets, and there is evidence that this is at least partly attributable to concerns about aged care costs and quality (Chomik and Yan 2019). If improved aged care can be relied upon, it would allow people to spend their resources securely in later life. Better consumption smoothing would improve the standard of living of older people, which raises overall welfare and is a component of efficiency in LTC provision.

Equity as a criterion can encompass equity within an age cohort / generation and equity across generations. The Commission has emphasised its concern with intergenerational equity. Intergenerational equity concerns in the context of social protection are generally associated with demographic transition. For example, this is the driver behind concerns about the sustainability of Pay-As-You-Go retirement pensions. In the context of aged care, intergenerational equity is probably less salient for two reasons:

- The aggregate government budget allocation is small. Even in countries such as Japan and Germany, the world's oldest large countries, long term care (LTC), funded through a pay as you go (PAYG) social insurance system, costs 1.5%-1.8% of GDP, compared with 9.4-10.1% of GDP for public pension expenditure.[3]
- Aged care is frequently seen as benefiting multiple generations. For example, it can bring relief and logistical manageability to children of care recipients in addition to the direct benefit to those needing care. Therefore, benefits, as well as costs, are spread across age cohorts. Intergenerational issues may be more important when transitioning between different financing systems and levels.

Whether funded out of general revenue or via social insurance, each system can include design features that improve its performance against these principles. While design features are discussed in the following sections, Table 1 summarises how principles for evaluating financing can apply to tax based versus social insurance based systems.

[3] https://www.oecd.org/els/health-systems/long-term-care.htm
https://www.oecd-ilibrary.org/social-issues-migration-health/pensions-at-a-glance-2019_b6d3dcfc-en

Table 1. Applying principles for evaluating financing

Principles	Tax financing	Social Insurance
Adequacy and timeliness	Capable of generating additional funding to provide adequate and timely care.	Capable of generating additional funding to provide adequate and timely care.
Economic efficiency	Tax financing allows for a broader and flexible funding base. Broader tax bases are generally more economically efficient and require lower rates on more people. Flexibility means could use more efficient tax instrument in case of need (e.g., by raising consumption tax). This efficiency is blunted in Australia which relies more heavily on labour income taxes.	Social insurance is based on a narrower funding base (e.g., from payroll for certain age groups). Narrower tax bases are generally less economically efficient and require higher rates on fewer people. This inefficiency is partly mitigated by (1) tax financing premia of low-income people, (2) co-financing premia with general taxes (e.g., as in Japan); and (3) by using taxable income rather than payroll as basis for premia calculation (which also allows contribution from older age groups).
Equity – vertical (progressive financial contribution from individuals based on ability to pay)	Inherits equity of existing tax system. Australian taxation is generally very progressive. While levies are proportional, they are based on thresholds below which no levy is paid.	Various parameters can be built into the system to increase progressivity (e.g., premia and co-payments in Japan are progressive).
Equity – horizontal (equal financial contribution from individuals with equal ability to pay)	Inherits equity of existing tax system. Horizontal equity blunted where tax system allows some to pursue tax-effective arrangements. Differential means testing rules may also introduce horizontal inequities (e.g., someone with a $1m house is treated differently to someone with $1m in financial assets).	Where social insurance relies on only narrowly defined forms of income, it may result in greater horizontal inequity (e.g., between those with labour versus capital income).
Equity – Intergenerational	Increasing tax for all taxpayers may introduce intergenerational inequity for those who fund existing and future services. This can be mitigated via different measures, such as (1) a long transition, (2) age-based rate of tax levy, or (3) greater means testing of assets of older beneficiaries of care. Perceptions of intergenerational inequity are offset by intergenerational solidarity. Community expectations of quality in aged care are high. Also, higher contribution to care of parent's generation relieves the children's generation from paying for it anyway via informal care.	Increasing new social insurance contribution for current employees may introduce intergenerational inequity where they have to fund both existing and future services. It is possible that some build-up of reserves is still possible before baby-boomers require care. Perceptions of intergenerational inequity are offset by intergenerational solidarity. Community expectations of quality in aged care are high. Also, higher contribution to care of parent's generation relieves the children's generation from paying for it anyway via informal care (e.g., this was the case in Japan and Germany).
Administrative efficacy	Using existing tax collection arrangements and infrastructure would be simpler and more administratively efficient.	May require new administrative infrastructure but there is no reason why cost would be excessive, since could collect premia via tax system.
Sustainability	Tax financing may be more variable because of budget cycle. By contrast, it could be more stable since relies on broader sources of revenue. Hypothecated levy and dedicated funding may perform the same function in terms of cost visibility as premia in social insurance. Hypothecated levy or dedicated financing may allow pre-funding. Pre-funding may allow reserve build-up as long as the population bulge of the demographic transition is below typical age of entry into long term care (i.e., another decade for baby boomers). It may be possible to build up a reserve without full pre-funding.	Social insurance financing may be less affected by political budget cycle. But it may be more variable if relying on a narrower base. This is because it could raise visibility of costs and justify increases to premia (e.g., as in Germany recently, though higher premia have not helped high out of pocket costs there). Pre-funding may allow reserve build-up as long as the population bulge of the demographic transition is below typical age of entry into long term care (i.e., another decade for baby boomers). It may be possible to build up a reserve without pre-funding.

3. Definitional elements of tax financing versus social insurance

In our assessment, the community requires '***social assurance***' that adequate aged care services will be available when needed, which inevitably involves some public pooling of risk. This can in principle be funded by general revenue, hypothecated (or ear-marked) taxes, or through an explicit social insurance scheme which tracks entitlements. Different elements of aged care can draw on different financing mechanisms. In practice, there is no pure universally tax financed system and no pure public provision of actuarially balanced insurance but rather a continuum between them.

One response to the question about what specifically characterises social insurance would be that it is an attempt to generate a more explicit contract between government (or independent entity created by government) and the contributor. The contract may be explicit and understood by the public as a set of promises, but it is still only an assurance of benefits and is subject to change. While contributions and

benefits in social security are clear, contracts are not watertight and can change over time (e.g., increases in eligibility age) and may require public subsidy.

4. Potential models for better tax financing or social insurance for Australian aged care

Assuming that social assurance of adequate aged care is of essence here, an important question is whether such assurance requires a formal social insurance system for its delivery and what form this takes. We briefly outline what we see as possible designs for a Social Security system, and a simple approach to transition, and then consider a re-vamped tax-based system.

Setting up a social insurance system of financing

Financing a social insurance structure for aged care would require stipulating:

- A contribution base
- A contribution rate
- A defined population who would be mandated to contribute
- A mechanism for managing reserves.

Perhaps the best base is taxable income, although labour income is a common and possible alternative. These bases are already valued for taxation purposes. The population would be defined around age, and contributions could be made mandatory only above some income threshold. A surcharge on current income could be progressive with income (using existing thresholds) and could vary with age. Confined to aged care financing, the rate is likely to be quite low. For example, assuming a rate in the order of 1%, the effective increase in marginal tax rates would be unlikely to be salient with households. Behavioural adjustment is therefore likely to be minor.

A ***pay-as-you-go*** model would begin delivering adequate financial support immediately. If we assume a demographic and technological equilibrium, the rates could in principle be set such that no reserves would accumulate. In practice, if such a system were implemented in the next few years, it is likely that, assuming the rate is set at an actuarially approximate level, reserves would build. This will occur because the relatively more numerous baby boom generation will be paying premiums to cover a relatively smaller population of beneficiaries who were born in the decades prior to 1946. Intergenerational, or at least inter-cohort equity will be served if these reserves are accumulated, and then subsequently disbursed as the baby boom generation reaches advanced age.

A ***pre-funded*** model would see a much slower generation of aged care funding, with existing or reformed tax-based funding carrying the weight of government support for aged care for some time, and the build-up of a much larger pre-funded asset accumulation. Pre-funding in this context is problematic. Generally, pre-funded social protection models work successfully when the benefit is certain, as it is with the Australian Superannuation Guarantee. Here the benefits are far in the future and subject to considerable uncertainty.

Superannuation pre-funding shows that a large pool of funding is at risk of political interference. It may also be difficult to generate public support for a pre-funded system of social insurance that generates a large reserve for uncertain future needs. We are not aware of pre-funded models of this kind existing anywhere for aged care (though some pre-funded operating reserves exist in Germany and Luxembourg). Therefore, while intergenerational equity could be protected with an appropriately designed pre-funded model that absorbs demographic variability over time, we do not see full pre-funding as a viable option for financing aged care. We will consider only the PAYG social insurance model from here on.

Social Insurance can be supported by tax finances for those not meeting minimum contributor requirements, and co-pay requirements for various services can also be a part of this model. Such co-payments could continue to be means tested.

Transition issues are appropriately dealt with at this point. Concerns about intergenerational equity when transitioning to higher contribution levels can be addressed by different age-based contribution rates. For example, in the near term, a 1.5% of income contribution rate may be levied on those aged 60 and over, with a 1% levy on cohorts aged 40-60, and a zero contribution rate for younger taxpayers. (The necessary rates will be determined by the revenue requirement – these are simply illustrative.) For example, Japan imposes a contribution rate on those aged 40 and above but premiums paid by those aged 65+ are set by local governments and may differ.

Improving the tax-based system of aged care financing

Bringing greater funding into aged care to raise the level of adequacy could involve two strategies: greater contributions from care recipients via alternate means testing arrangements and higher hypothecated or earmarked taxes, which also vary by age.

Means testing has been the key approach to socialising risks in Australia, where benefits are based on needs not rights. Means testing is used in aged care but its application can be characterised as imperfectly integrated with other social protection domains such as retirement income. Also, the taper rates, scope of included assets, and caps result in what may be an insubstantial contribution from those that have greater means.

Schedules of how fees differ with income or assets are illustrated in the appendix. They show for example, how a residential care recipient with $70,000 in income can be expected to pay about $19,000 in basic daily fees and about $21,000 in accommodation fees (unless otherwise negotiated) but would make no contribution to their means tested nursing and personal care fees. Raising the rate of contributions as income increases may allow a greater contribution to care costs, though few singles or couples have over $70,000 or $140,000 in income, respectively (about 9% of households aged 65+ in 2017-18, based on authors' analysis of the Survey of Income and Housing, SIH 2017-18).

The main source of private funds, largely shielded from the means test, is in the home. Currently, only about $170,000 of the family home is counted, yet 80% of older households have a home worth more than that (based on SIH 2017-18 data). In addition, the rate at which overall assets are counted in the asset test increases at a shallow rate (i.e., 1% and 2% past the first and second thresholds), which underestimate the person's ability to pay.

The home could be counted without forcing a sale via an existing publicly-administered mechanism: the Pension Loan Scheme. The scheme funds a reverse mortgage that is typically repaid following the sale of a house for a deceased estate. The scheme could similarly also allow a proportion of home equity to pay for an older homeowner's care while protecting the rights and potential inheritance of a 'protected person'. Figures in the Appendix illustrate the rate of fees if half or all of the home were included in the asset test.

While there is social value in insuring the population against catastrophic out of pocket costs of aged care, the existing annual and/or lifetime caps could be revised upward to increase private contributions of those with greater ability to pay. Without detailed administrative data on existing aged care payments and assessed resources of care recipients it is difficult to say what would be the fiscal and distributional effects of any changes.

Another option is to investigate the extent to which higher Additional and Extra Fees can be used to cross-subsidise aged care, or even allowing the basic daily fee to vary with income and assets or operate in different bands as do price-regulated accommodation charges.

It is unlikely that means testing changes or cross-subsidising from other fees would be able to raise large amounts of funds while allowing for social risk pooling to continue to take place. If a case were made for greater funding, bringing more funding into aged care would require either a redirection of existing budgets or new earmarked taxes.

A hypothecated tax for aged care would achieve comparable levels of funding to that which could be raised via premia in a social insurance model but do so by way of the existing tax-benefit system. It is likely that a tax linked to an increased level of quality in aged care would be acceptable to the public. The tax rate could be a single rate across income range and age or could be a set of rates, varying as indicated with the contribution rate for the social insurance model depicted above.

Oversight of reserves

The introduction of earmarked taxes can be expected to result in an accumulation of reserves because of demographic disequilibrium. Any reserves that are accumulated should be prudently and professionally managed. Australia has some experience of the professional management of publicly held reserves, through its development and administration of the Future Fund. As a matter of practice, aged care-earmarked reserves generated by a hypothecated tax with demographic disequilibrium may well be placed under the Future Fund's governance, in a separate account. Governance and investment principles for the management of public investment funds are explained in Mitchell et al (2008).

The role of private insurance

As indicated in above, private long term care insurance has not achieved much penetration anywhere for reasons laid out above. Sometimes it is characterised as a 'residual market'. There is a question as to whether it has any role at all to play in the types of aged care financing arrangements outlined above.

One possible role for the private market would be to provide insurance for those wishing to obtain residential care costs services above a basic threshold. That is, covering additional and extra service fees. There would be some moral hazard in this contract - the type and value of service sought may be higher with insurance than without - but nevertheless, additional service payments up to some cap, and possibly after some initial period of residence, may be insurable at acceptable rates.

One relevant product type that may have application in this context is a retirement insurance product combining longevity and aged care insurance. This is the only aged care -relevant product to show signs of increased market share in the US in recent times. It exploits the natural hedge between longevity and aged care risk. Encouragement of this type of product in the market may yield some efficiency gains, since its deployment at some scale would support consumption smoothing through active retirement as well as coverage of supplementary aged care costs. Michael Sherris describes these 'combo' products in his submission (Sherris 2020).

Which direction to take?

In thinking about these alternatives, we begin with the observation that Australian social policy is distinct from that of most OECD nations in adopting a needs based, rather than a rights based, approach to social protection. Examples include the Age Pension, which is available to all eligible residents regardless of

work history – it is a non-contributory scheme, available to all, subject to means. Unemployment benefits are similar: in most OECD countries, social security contributions entitle contributors to unemployment insurance, regardless of means. By contrast, Australians receive unemployment benefits if they need them, on a non-contributory basis. For example, if the unemployed person's partner earns enough, no benefits are paid. These Australian social protection policies are not 'entitlements', predicated upon a contribution history. But they are there if needed. In all cases, these still constitute a form of social risk pooling.

Moving from these precedents to a full, rights based, social insurance scheme is a significant departure from past policy design. The social insurance model for long term care has proved successful thus far in countries such as Germany and Japan. But in those countries, social protection in general is embedded in an established social insurance regime and is still subsidised by general revenue.

It is also the case that while OECD type social security systems such as the US Social Security Administration do guarantee payments contingent upon contribution history, these can be altered in various ways by government policy. As noted previously, the most obvious example is increasing access age, but other policy interventions – such as changing indexation or survivor benefits – can also be utilised. Further, these systems can themselves become unsustainable, and when that occurs, it provides a further opportunity for rights to be eroded. So setting up a social insurance system does not guarantee sustainable delivery of aged care financing into the future.

There is of course the same kind of risk with a system based on general revenue. The 2014 Australian budget proposed a switch of indexation of the Age Pension from increasing in line with the greater of wages and prices to prices only. Had it been enacted it would have eroded Age Pension benefits considerably over the long term. No system offers guarantees.

A possible middle ground would be to develop a hypothecated tax for aged care. Most economists regard hypothecation as a bad idea, primarily because if a tax is actually to be designated as the primary revenue generator for a public service, then then there is no guarantee that the revenue flow from the stipulated tax will match the outlay requirements of the service. Nevertheless, it is increasingly conceded that public support for taxation is more likely if its purpose is clearly flagged. Definitionally, revenues from such a tax would be immediately available.

Assume for the moment that the best tax base for financing government contributions to aged care is the income tax. Then an additional (hypothecated) tax, an aged care levy (ACL), could be legislated to increase the marginal tax rate of income tax payers. The tax rate could be a single rate across income range and age or could be a set of rates, varying as indicated with the contribution rate for a social insurance mode. An increasing rate with taxable income would benefit progressivity. In the near term, an additional levy on older (60+) individuals would support intergenerational equity.

Securing delivery of aged care services of acceptable quality will be critically related to governance structure, along with transparency around finance sources. Whatever the financing mechanism, appropriate governance will be essential. It will include the capacity to effectively place public pressure on government to provide enough funding to deliver on agreed criteria. It is to the question of governance that we now turn.

5. Potential management for better tax financing or new social insurance arrangements

Current governance in the Australian aged care sector comprises three independent bodies – the Aged Care Quality and Safety Commission (ACQSC), the Aged Care Finance Authority (ACFA), and the Aged Care Pricing Commissioner (ACPC). Essentially there are two functions that require independent

oversight. First, there is a need for stronger oversight of the quality of services (as it relates to inputs such as staffing or buildings, processes such as governance, or outcomes such as fall rates and client satisfaction). Second, there is a need for better information on the costs and prices of services for a given level of quality. Existing entities may need an enhanced remit and resources to allow them to provide advice to government that integrates information about necessary inputs with the costing of such services, thereby clarifying revenue requirements that in turn inform the setting of levies and means tested co-payments, which are channelled into a dedicated fund. The provision of information on quality and inputs could be independent of the costing and pricing of them and reside in separate authorities. Reserves from the aged care fund could be managed via the Future Fund.

The advice should be formalised and regular to deliver a similar degree of certainty of funding as a formal social insurance scheme, without departing radically from the Australian approach to social protection. But there are two risks to this approach. The first is that the cost and pricing authority could be captured by industry; this could be partly overcome by having government and community representatives well represented in its membership. The second is that the government of the day will ignore or distort the advice. We believe these risks will be present whatever the financing mechanism chosen.

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Appendix

Existing fee structures in aged care – means tested co-payments to universal public care insurance

The bulk of funding of aged care in Australia is tax financed. Private contributions to aged care providers are not insignificant. For example, in 2018-19, recipients of home support services, home care, and residential care contributed $252 million, $107 million, $4.8 billion, respectively (ACFA 2020, available here).

Private contributions to care can be characterised as means tested co-payments to universal public care insurance. That is, government contracts independent care providers for services and adjusts payment based on care need and user contributions. The types and levels of fees are summarised in figures, below.

With home support services, providers can ask for a private contribution to services, capped at the cost of the service.

Private contributions to home care come in two parts. First, a basic daily fee can be charged, capped at 17.5% of the single age pension. Most charge part, or all, of this amount. Second, an income-tested care fee can be charged for those who are effectively part-pensioners or self-funded retirees. This fee is capped annually at about $5,400 for part-pensioners and $10,800 for self-funded retirees, with a lifetime cap for everyone of about $65,000 across home care and residential care. This addresses the tail end of costs. Based on analysis of exits in residential care data, 58% people who die in residential care spend under two years in the care home (Authors' analysis of GEN Aged Care Data).

Contributions to residential accommodation and care are subject to an asset- and income-based means test. All residents pay a basic daily fee, capped at 85% of the single basic age pension. A person with assets above about $50,000 or income above about the full pension pays a contribution towards their accommodation.

Schema of current charging arrangements

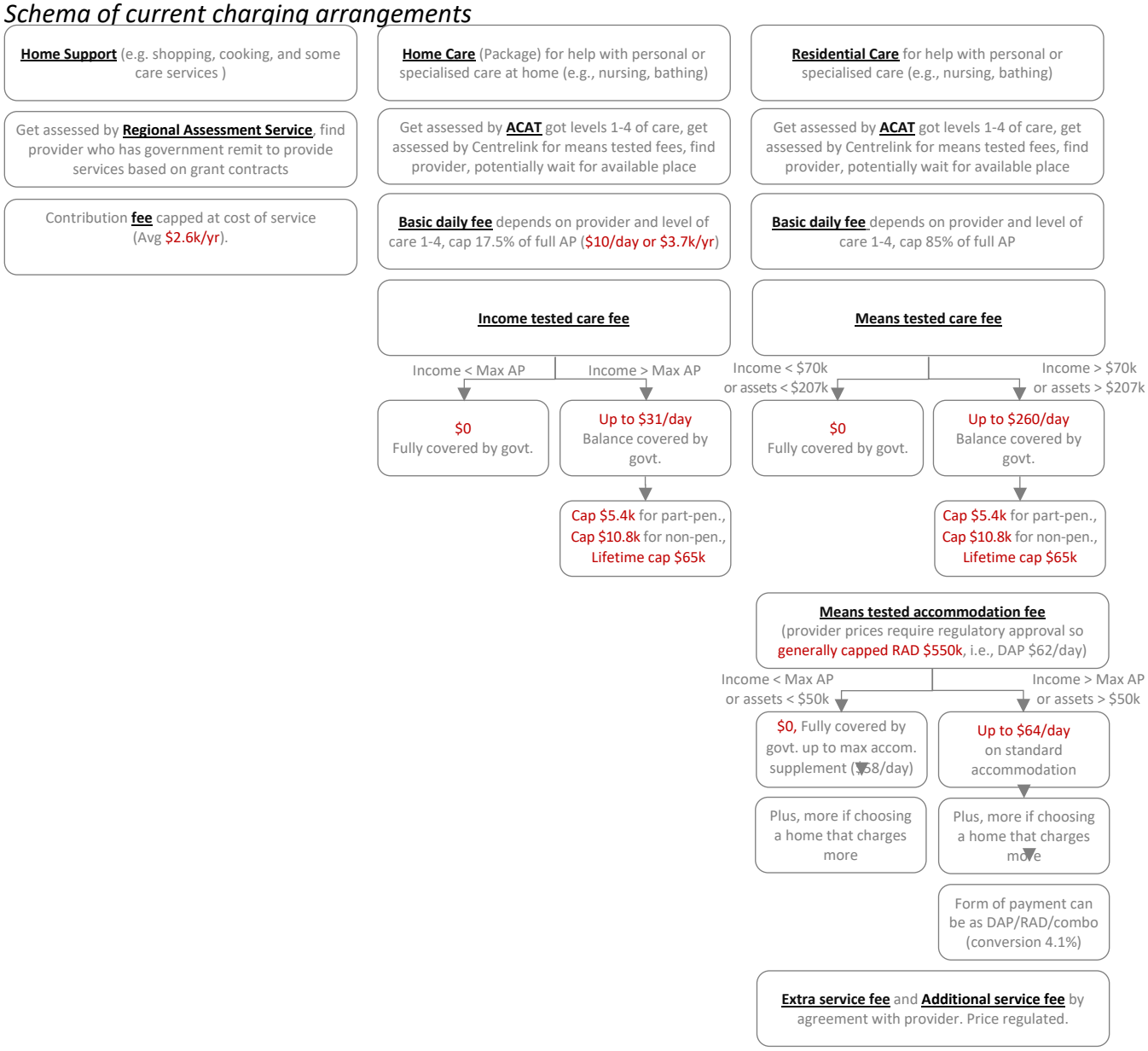
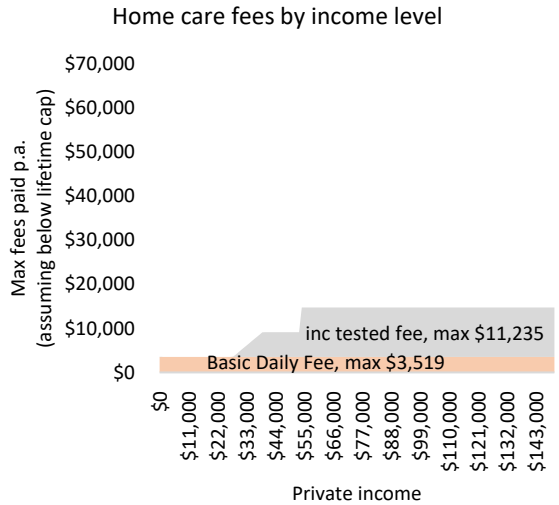
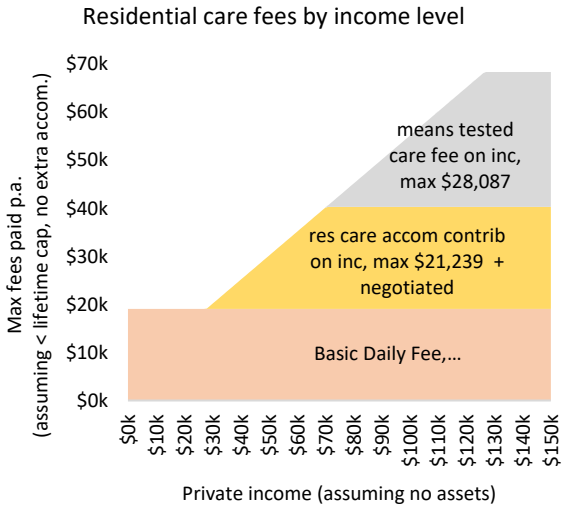
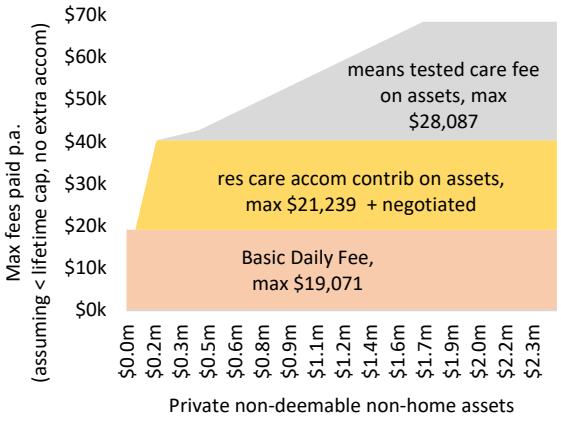


Illustration of fees by income and assets

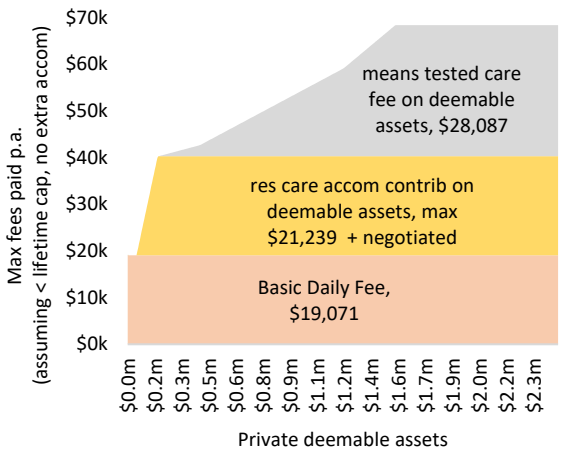




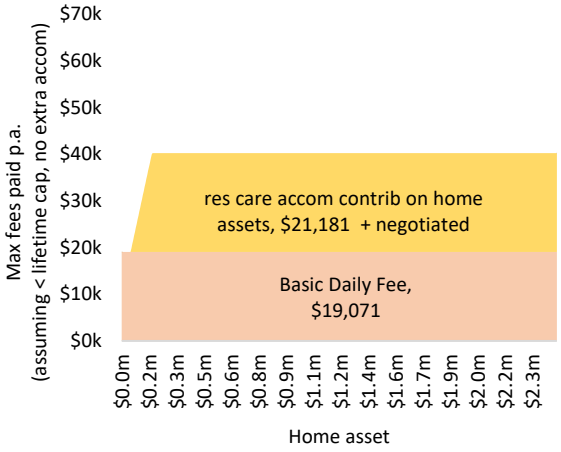
Residential care fees by non-income-producing non-deemable non-home asset level (i.e., excess RAD)



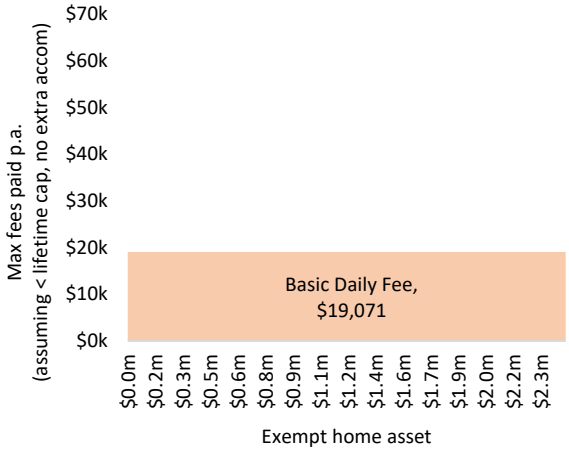
Residential care fees by deemable asset level (i.e., financial assets)



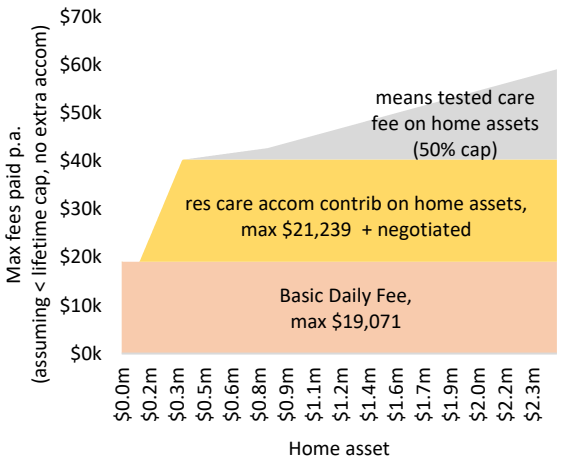
Residential care fees by home asset level (i.e., unless occupied by protected person)



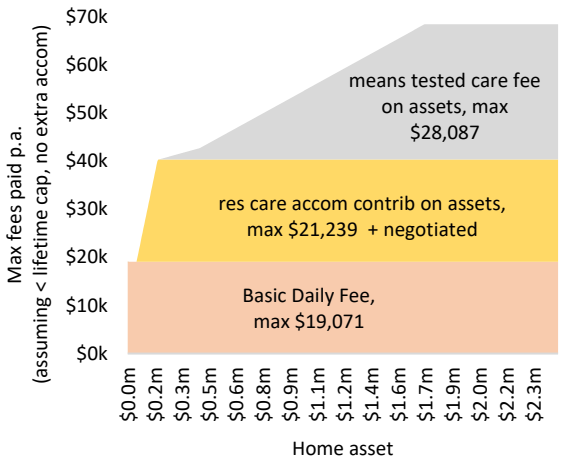
Residential care fees by home asset level (i.e., occupied by protected person)



Residential care fees by home asset level (if 50% of asset were counted)



Residential care fees by home asset level (if 100% of asset were counted)



The Commission's 'Aged care financing: Further questions', issued 29 July 2020

What must be publicly funded and financed?

1. What components of aged care require a financing arrangement that might require significant public participation (through, for example, social insurance or general revenue)? Is it appropriate to assume that:

a. the capital costs of residential care providers should continue to be recovered predominantly through interest-free accommodation deposits, or accommodation payments, directly levied on users (subject to a safety net arrangements for people in financial hardship);

b. daily living costs should continue to be directly levied on users;

c. the funding of personal care, clinical care and some allied health care needs arising due to ageing may require significant public financing arrangements?

Design principles

2. Outline the principles that you consider should underlie the design of long-term financing arrangements for the future aged care system. Without limiting the matters you may wish to address, please refer to and describe those you mentioned to us during our recent teleconference on 15 July 2020: equity; economic efficiency and timeliness; administrative efficiency and simplicity; stability and sustainability. With regard to equity, please elaborate on the various facets of equity as a design principle, including both equity at a point in time and intergenerational equity.

3. Would some form of social insurance scheme to fully finance (or materially contribute to financing) the aged care funding requirements you identify in response to question 1 meet the principles you identify in response to question 2? Which (if any) of those principles might be better promoted by:

a. an appropriately designed social insurance scheme;

compared with other available forms of financing, such as:

b. financing from general revenue; and/or

c. financing by a material contribution from a user pays system, augmented by any available private insurance products?

Definitional elements of social insurance

4. How should 'social insurance scheme' be defined? What are the indispensable core elements (if any) of social insurance, and what other elements might social insurance have? For example, is the following description accurate?

- The scheme is established by government, and its benefits and financing are prescribed by statute.
- The program is at least partially financed by contributions (e.g. taxes or premiums) from or on behalf of participants, and contributions may be supplemented by government income from other sources. Investment income from accumulated reserves may also be used to finance the scheme.
- The scheme is generally compulsory for a defined population, or the contributions are set at a level such that the majority of that defined population actually do participate.
- Lack of means testing and strict eligibility criteria are defining features of comprehensive social insurance.
- To the extent that tax levies and similar imposts may be used to contribute to financing of social insurance, they may, but need not, be hypothecated under law to the insurance scheme.
- Actuarial methods and insurance principles may be applied to estimate periodic imposts on the scheme in payments of benefits, and to determine required premiums.
- Significant accumulation of reserves in an insurance fund or pool may, but need not, be a feature.

Please comment on whether you agree with the above definition or suggest an alternative, or additional or different potential elements.

Potential models for social insurance for Australian aged care

5. What would be the key components of a social insurance scheme most appropriately adapted for the financing of the aged care funding requirements you identify in response to question 1 in Australia? Please describe the model you think might be most appropriate.

6. What would be the strengths and weaknesses of a social insurance scheme for aged care in Australia which has the key components you identify in response to question 5? Please include consideration of a scheme of that kind against the principles you have outlined in response to question 1, and in particular please identify any:

a. static equity issues that would arise, for example those that might arise depending on the premium structures and rates of the particular scheme;

b. intra-generational equity issues that would arise;

c. intergenerational equity issues that would arise;

d. aspects of such a scheme that appear likely to be efficient by comparison with other financing approaches; and

e. aspects such a scheme that appear likely to be inefficient compared with other financing approaches.

7. To the extent that it appears likely that intergenerational issues may arise under a social insurance scheme along the lines you describe in questions 5 and 6, are there any optional measures that may be adopted for them to be managed or offset?

8. In what circumstances might it be appropriate to plan the accumulation of reserves to meet or contribute to 'intergenerational' financing requirements, that is, the financing requirements of aged care in years that are somewhat distant in the future? How could the planned accumulation of reserves be managed most appropriately under a social insurance model of the kind described in response to questions 5–7?

9. In what circumstances might re-insurance be appropriate in the context of a social insurance model of the kind described in response to questions 5–8?

Potential management arrangements

10. What are the most appropriate options for institutional arrangements for the management of a social insurance scheme of the kind descried in response to questions 5–9? For example:

a. Should one entity be responsible for determining premiums, and paying out funding (benefits), or other aspects of management of such a scheme?

b. Should that entity be government-controlled and owned, or private?

c. What might be the benefits or risks of a social insurance scheme where funds management functions and/or other scheme management functions, are placed in the hands of private insurance providers? In particular:

i. In what ways could private insurance providers be used effectively to manage social insurance?

ii. Would a tax rebate model resembling the approach to private health insurance be appropriate? What adaptations would be appropriate?

iii. Or would a direct requirement to obtain insurance (with an option to obtain it from a private provider) be appropriate, similar to the process for vehicle registration in New South Wales?

iv. Would private insurance providers be likely to have advantages over government in effective funds management?

v. Might an arrangement of this kind lead to innovative product offerings in conjunction with aged care providers?

d. What regulatory arrangements might be required, and what functions might appropriately be regulated?

Potential models for transition

11. If the Australian Government and Parliament were to decide to implement a social insurance scheme along the lines described in response to questions 5–10:

a. What principles should inform the design of appropriate implementation and/or transition mechanisms to achieve change from the present financing arrangements to that kind of scheme?

b. In light of those principles, what options are there for appropriate implementation and what transition mechanisms might be appropriate to achieve its successful implementation?

c. What are the strengths and weaknesses of any different implementation/transition options?

d. If a model of social insurance that involved the accumulation of reserves to meet liabilities some distance in the future were to be preferred are there any arrangements that might ameliorate equity issues that could arise? Please be as specific as you can, if there are any such arrangements.

e. In the case of a social insurance scheme that depends on building a significant reserve by which future aged care needs would be partially funded by present contributors of premiums of working age, might it be appropriate to attempt to mitigate intergenerational inequities by adopting a transitional mechanism setting off contributions imputed to particular age cohorts against liability to pay user contributions by those cohorts? For example:

i. Taxpayers aged, for example, between 35–65 years, earning above a particular taxable income bracket, pay a tax levy into a hypothecated fund that is intended to pay a contribution toward the aged care costs (as defined in response to question 1) of that same cohort over the age of 65.

ii. Significant co-payments (increased over the current levels of co-payments) apply to ongoing support/care at home and to residential care for the next 30 years, but they decline incrementally over time, as the financing they represent are replaced by the hypothecated fund referred to in point (i).

iii. Safety net provisions apply - government will cover the quantum of co-payments for older people in financial hardship.