Royal Commission
into Aged Care Quality and Safety

FINANCING AGED CARE

CONSULTATION PAPER 2

JUNE 2020

The Royal Commission into Aged Care Quality and Safety was established by Letters Patent on 8 October 2018. Replacement Letters Patent were issued on 6 December 2018, and amended on 13 September 2019.

The Honourable Tony Pagone QC and Ms Lynelle Briggs AO have been appointed as Royal Commissioners. They are required to provide a final report by 12 November 2020.

The Royal Commission releases consultation, research and background papers. This consultation paper has been issued by the Commissioners.

This paper was published on 24 June 2020.

ISBN 978-1-921091-18-6 (online)

Contents

Introduction

> We need to have a conversation with the Australian people about what we're doing with aged care, … for older people to stay at home, even though that's going to cost quite a bit more than residential care. Now, the cost of that would be substantial. What do we—what are we prepared to pay for and who pays for it? Those are the issues. Now, there are not snappy, easy answers to those questions, but we need a much more honest dialogue about that in the community.[1]
>
> **Ian Yates, Chief Executive Officer, COTA**

The aged care system needs a secure and sustainable source of funding now and into the future. Australians in need of aged care must have the certainty that their future is secure and that there will be the funds available to ensure that their need for quality aged care will be met when called upon. We must therefore have in place a secure, predictable and appropriate funding mechanism for those long term future needs.

The terms of reference of the Royal Commission into Aged Care Quality and Safety require us to inquire into and make recommendations on how the Australian Government and community can strengthen the system of aged care and can best deliver aged care in a sustainable way.[2] We are required not just to make recommendations about what aged care should be like in the future, but also about how any improvements we recommend should be paid for.

Our work so far has revealed that there are unacceptable and system-wide problems with aged care in Australia, that the aged care system requires fundamental reform, and that the reforms necessary to improve the quality and safety of aged will require a significant injection of additional funding. Questions then arise as to who should pay for the additional costs required to improve the aged care system and how any additional funding should be raised, managed and disbursed. It is important to our task that we identify for public responses the fundamental issues upon which will depend the security and sufficiency of aged care in Australia.

This discussion paper initially provides what we believe to be important background and context before a section entitled *Pressures on aged care financing*. The clearest evidence of the pressure which we identify upon the funding of aged care comes from demographic trends which will increase demand for aged care for years to come. But the improved quality necessary to meet community expectations will also require significant additional funding beyond that needed to address our ageing population. The precise amounts will not be clear until after the Australian Government has considered the detailed recommendations of the Royal Commission's Final Report.

In the section entitled *Challenges in aged care financing* we set the scene for our discussion by identifying some of the unique characteristics of aged care that shape our questions about how best to provide for our future aged care needs, how and when those funds should be collected, and how they might be managed.

Alternative approaches, drawing on Australian and international experience, are outlined in the section entitled *Alternative Approaches to aged care funding*, in which we outline some country-specific examples that could be considered.

The option of adapting the current aged care financing mechanisms in Australia is covered by the section entitled *Minimal Change*. Aged care is currently funded from general revenue collected from taxes, combined with private co-contributions to aged care service costs. These arrangements are flexible and provide a number of ways of meeting current and future aged care costs, including through general or earmarked taxation and increases to co-contributions, or some combination of these measures.

The section entitled *Social insurance models* considers possibilities for financing aged care through the introduction of a compulsory social insurance scheme. Australia already operates forms of social insurance for accident compensation and a number of compulsory schemes to provide for future needs such as compulsory contributions for superannuation, through the Superannuation Guarantee, and for health care through the Medicare Levy.[3] Social insurance approaches are common in other countries but are not currently used for aged care in Australia. Hypothecated funds, and public or private sector options, plus combinations of these, are outlined.

The section entitled *Private insurance and financial products* looks at private financing arrangements. Australia already has a number of well understood private financing mechanisms that are used in retirement income policy and health policy that could be adapted for use in aged care. These include superannuation, private insurance, gap cover and other financial products such as annuities and reverse mortgages.

The options are not all mutually exclusive and there is the potential to combine them, which is the focus of the section entitled *Combinations of financing mechanisms*. This could provide more choice and control for people as they age. Alternative financing arrangements could also be employed.

None of the options we consider for the future funding of aged care will necessarily generate additional money. However, we assume that additional funds will need to be found over and above that which is collected now, to provide high quality care. The structure and level of the additional funds, who bears the cost and when, and who benefits and when, will vary.

Each of the broad options, or any of the possible mixtures of options, will also require some degree of transition from the current system, even if it is only to reflect the need for a boost in funding. Hence, in the section entitled *Implementation and transition issues* we consider matters that could arise in any fundamental departure from the existing arrangements.

We have been asked to consider the sustainability of the aged care system and we will now reflect on the means for achieving that objective over coming months. Some of the options we canvass would see fundamental structural change to the way in which aged care is funded and secured in Australia. We are therefore seeking public input into the design of future arrangements for financing aged care services. Feedback on this paper will be an essential contribution to this process.

Background

Who pays for aged care?

At the moment, aged care is paid for through a mix of pay-as-you-go public funding, sourced through the general taxation system, private contributions in the form of means tested fees and co-payments for certain services, and public and private capital financing.

Australian public and private contributions to aged care have been estimated at about $27 billion in 2018–19.[4] This is not all that is spent on the care of older people. In 2015–16, Australia spent around $41.7 billion on the health care needs of older Australians, aged 65 years or over, and $46.4 billion on direct cash welfare payments, including the Age Pension, on top of the $23.0 billion it spent directly on aged care. Welfare related tax concessions worth $40.1 billion were also provided for older Australians.

The largest source of funding for the aged care system, by far, by the Australian Government's general tax collections.

About 75.4% of the annual cost of the aged care system in 2018–19 was sourced from taxpayers through the Australian Government, while 20.7% was paid directly by the recipients of age care through co-payments and means tested fees. A further 1.1% was paid by taxpayers through state and territory governments and 3.8% came from other sources.

Public, private and government providers also contribute significant capital to the aged care sector. Those investments are ultimately paid for over time by governments and care recipients, but in the absence of private investments in the sector, that capital would need be to found from elsewhere.

The table on the following page shows who currently pays for different aged care services.

Table 1: Summary of Government and private financing arrangements for aged care

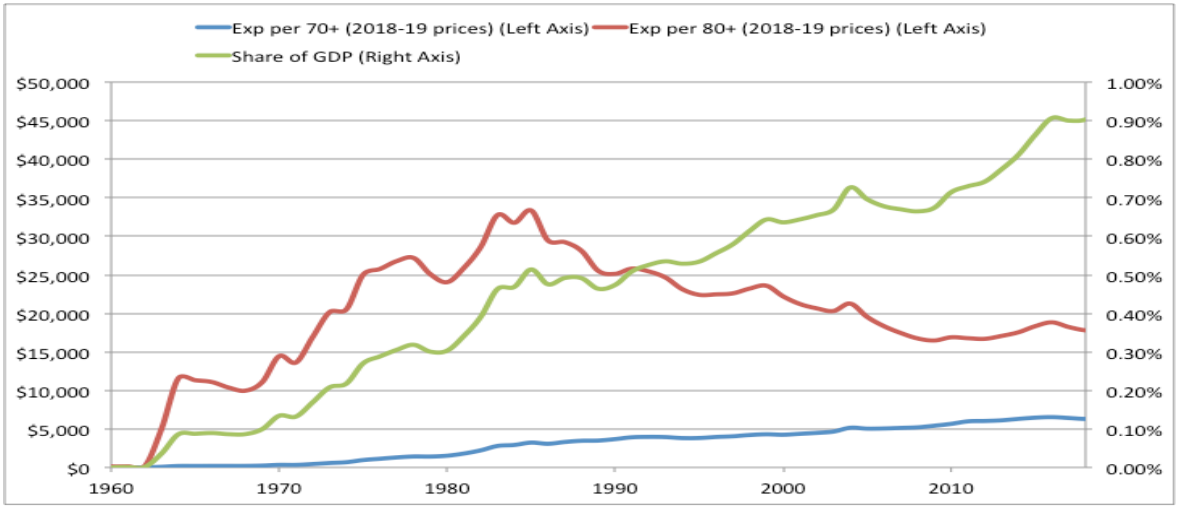
	Living in community— Commonwealth Home Support Programme and Home Care Packages	Living in aged care facility— Residential Aged Care
Accommodation and living expenses	Mainly a private expense. No government support through the aged care system. Australian Government support through Age Pension and Commonwealth Rent Assistance.	Mainly a private expense paid for by a combination of refundable accommodation deposit and/or daily accommodation payment and Basic Daily Fee. Australian Government support via Accommodation Supplement.
Domestic assistance and social support	Mainly funded by Australian Government through the aged care system, with some co-contributions and income testing in Home Care Packages Significant contribution by informal carers, mainly supported by Australian Government through the Carer Allowance and the Carer Payment	Mainly funded by Australian Government through the aged care system, with some co-contribution (means tested care fee). Some contribution by informal carers.
Personal care services		
Nursing	Mainly funded by Australian Government through the aged care system, with some co-contributions and income testing in Home Care Packages.	Mainly funded by Australian Government through the aged care system, with some co-contributions (means tested care fee).
Allied health	Partly funded by Australian government, and significantly funded by out-of-pocket expenses and private health insurance. Partly funded by Australian Government through the aged care system, with some co-contributions and income testing in Home Care Packages.	Mainly funded by Australian Government through the health care system with some co-contributions. Partly funded by Australian Government through the aged care system, with some co-contributions (means tested care fee) and additional fees.
Discretionary services	Additional supports can be purchased privately.	Higher standard of accommodation and improved or additional living expenditure and supports via Extra Service Fee and additional fees.

Australian Government funding

Contributions by Australian taxpayers to the cost of aged care have grown substantially over the last 60 years.

Figure 1 shows that the Government's share of spending on the three major aged care programs—Commonwealth Home Support Programme and its predecessors, Home Care Packages and Residential Aged Care. The chart shows that taxpayer contributions have grown from close to zero in the early 1960s to 0.3% of Gross Domestic Product (GDP) in 1978–9, 0.6% of GDP in 1998–9, and then close to 1.0% of GDP in 2018–19.

Figure 1: Australian Government expenditure on the three major aged care programs, 1959–60 to 2018–19 (per cent GDP and per person)



The chart shows that Australian Government spending has grown over the past 60 years, as the population has aged and care needs have increased, but it also shows that the average level of spending per head for people aged over 80 years, that is, the people with the highest needs, has fallen away since the early to mid-1980s.

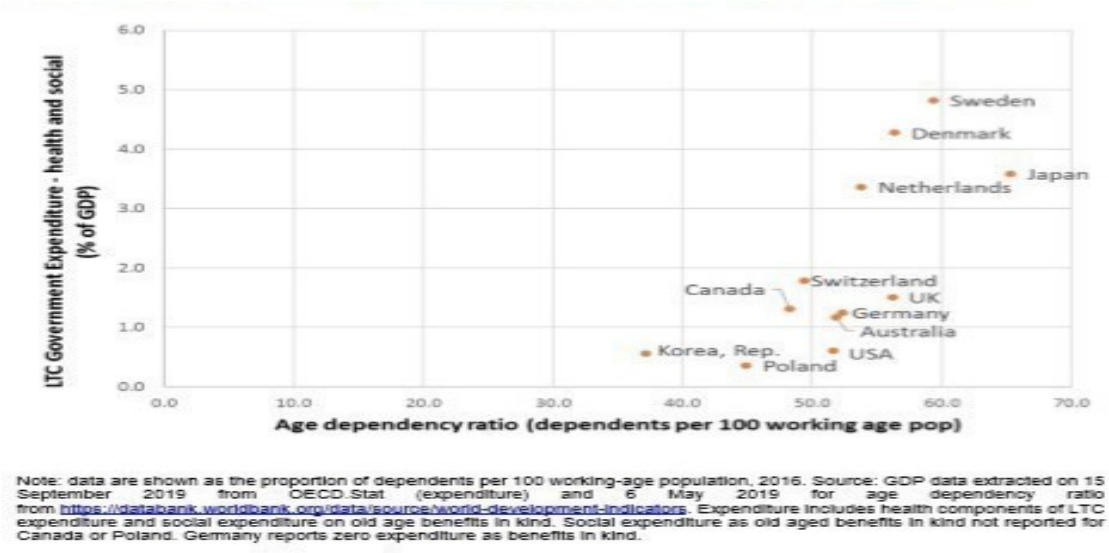
International comparisons

Spending by the Australian Government on aged care as a proportion of GDP is less than government spending in many other comparable countries.

Organisation for Economic Cooperation and Development countries spent about 1.6% on average on the long-term care of older people in 2015–16. Australia spent about 1.2% of Gross Domestic Product (GDP)—or 75% of the Organisation for Economic Cooperation and Development average.

A comparison of government spending on aged care is provided in Figure 2.

Figure 2: Long-term care expenditure (percentage of GDP) versus age dependency ratio, 2015.



Note: data are shown as the proportion of dependents per 100 working-age population. 2016. Source: GDP data extracted on 15 September 2019 from OECD.Stat (expenditure) and 6 May 2019 for age dependency ratio from https://databank.worldbank.org/data/source/world-development-indicators. Expenditure includes health components of LTC expenditure and social expenditure on old age benefits in kind. Social expenditure as old aged benefits in kind not reported for Canada or Poland. Germany reports zero expenditure as benefits in kind.

Source: S Dyer, M Valeri, N Arora, T Ross, M Winsall, D Tilden, M Crotty, *Review of International Systems for Long-Term Care of Older People*, 2019, p 45.

The Figure shows that the percentage of GDP spent on aged care is highly variable as between countries. Greece and Portugal each spent less than 0.2% of GDP on the long-term care needs of their older citizens. By contrast, Denmark, Norway and Sweden each spent between 4.3% and 4.8% of GDP on these needs. Australia ranked 17th out of the 32 countries reporting data. The United States was in the bottom quartile, spending 0.6% of its GDP on the long-term care needs of older people, while Switzerland was in the top quartile, spending 1.8% of GDP on the long-term needs of older people.

Some of these differences can be explained in part by the different age profiles of the various countries. But as Figure 2 shows, even allowing for this factor, Australia is spending significantly less on the long-term care needs of its older citizens as compared with comparable countries with populations of a similar age structure.

Pressures on aged care financing

The overall cost of aged care will continue to grow over time due to the combined effects of demographic change, increasing costs of services and continuing expectations of improvements in the quality of services.

Although Australia currently has a relatively young population when compared with many other developed countries, its population is ageing and will continue to do so for the foreseeable future.[5] The Parliamentary Budget Office in 2019 projected that over the next decade, Australian Government spending on aged care will increase in real terms by 4.3% per annum and that aged care will be one of the faster growing program areas over that period, growing at more than twice the rate of all Government spending. By 2029–30, the Parliamentary Budget Office predicted that aged care will account for 5.4% of all Government expenditure.[6]

Population

The principal driver of the increasing cost of aged care is the increasing number of older people.

Older Australians are living longer and this trend is expected to continue. The average age for an Australian to enter residential aged care is 86 years. Over the last 40 years, the number of Australians aged 85 years and over increased significantly both in absolute terms and as a share of the Australian population—from 91,640 in 1978 (0.6% of the Australian population) to 503,685 in 2018 (2% of the Australian population). On current demographic projections, the number of Australians aged 85 years and over will continue to increase to more than 1.5 million in 2058 (3.7% of the Australian population).

While the projected increases are significant, the rates of increase in the absolute number of the Australian population aged 85 years or older, and in their share of the total population, will both be lower in the next 40 years than in the last 40 years. The share of the Australian population aged 85 years or older will increase by 83% in the next 40 years compared with 216% in the last 40 years.

An important issue to consider for future aged care financing is the proportion of the older population as compared with the population of traditional working age. This is important because a pay-as-you-go financing system requires working age people to fund the care of people in older age cohorts through taxation and government spending. There has been a significant decline over the last four decades in the ratio of the number of people of working age for every person aged 85 or older; from 101.4 people for every person aged 85 years or older in 1978 to 32.5 in 2018. By 2058, there will only be 14.6 people of traditional working age for every person aged 85 years or older.[7]

This means that while the proportions of older people are still growing, there will be proportionally fewer taxpayers for each older person needing aged care.

Additional information on the changing demographics that underpin future demand for aged care is provided in the Royal Commission's Background Paper 2: *Medium- and long-term pressures on the system: the changing demographics and dynamics of aged care*. This paper can be found at https://agedcare.royalcommission.gov.au/publications/Documents/background-paper-2.pdf.

Quality improvements

The aged care system will need additional funding in future years to deliver improvements in the quality and safety of care required to meet reasonable community expectations. This will be in addition to the funds required to support an increasing proportion of older people needing care.

In the Royal Commission's *Interim Report: Neglect,* published in October 2019, Commissioners Richard Tracey and Lynelle Briggs outlined the need for immediate action to:

- Provide more Home Care Packages to reduce the waiting list for higher level care at home
- Respond to the significant over-reliance on chemical restraint in aged care, including through the seventh Community Pharmacy Agreement
- Stop the flow of younger people with disability going into aged care, and expediting the process of getting those younger people who are already in aged care out.[8]

We will hear further evidence in coming months and are therefore still considering the precise form of the recommendations that we might make. However, it is already clear that significant reform is required to eliminate the lottery that exists as a result of variable waiting lists to provide additional certainty for Australians that their aged care needs will be met in a timely and affordable way.

Counsel Assisting have proposed a new approach to aged care programs in submissions to us that would have the effect of supporting people to stay in their homes for longer. They also proposed the employment of new care finders to support older people and their families to navigate a dauntingly complex and fragmented aged care program.

We have also found that the current system is not funded to provide enough staff members with the right qualifications to provide high quality care. At the same time, we have found that many care service providers are struggling to maintain their operations, especially in regional and remote areas.

Fixing these problems and providing sufficient funds to maintain continuing improvements in the aged care system will be expensive. The additional money needed to fix these problems will need to be found from somewhere.

Future financing requirements

We are not yet in a position to be able to say definitively what our final recommendations will be or the cost of implementing them. It is clear, however, that there is likely to be a significant gap between current funding levels and the expenditure required to meet the needs of a population with a higher proportion of older people, plus the implementation of substantial improvements in the quality and safety of care.

Costings of specific proposals to improve aged care are in preparation, but to provide an estimate of the impact, we are using a range of an additional 50% to 100% in the relevant expenditure base.

This does not mean that this will be the final cost of our recommendations. These broad parameters are intended rather to convey the scale of the funding challenges if we are to improve the quality and safety of aged care for a growing population of older people.

The challenge of meeting this funding gap may be compounded by the likelihood that the underlying economy will be more constrained, at least in the short to medium-term, than at

any time since the Australian Government began to make substantial financial contributions to aged care. On the other hand, the need to regrow the economy may provide opportunities for the provision of aged care and for putting its financing on a more secure and sustainable basis.

Challenges in aged care financing

The aged care needs of the population are long-term in nature. This makes it both essential and difficult to plan and to finance for their provision. There is a degree of certainty about some aspects of our long-term future: for example, the ageing of Baby Boomers, and the demographic "bulge" they present, has been clear for over 40 years. However, it is difficult to predict how long people will live on average, the level of support they will require, or for how long they will need support.

The cost of delivering aged care in the future is even more uncertain. Technologies, models for the delivery of care and social expectations about what constitutes acceptable levels of care will change over time in ways that are difficult or impossible to predict with any confidence today. The changes in response to the COVID-19 pandemic, such as telehealth consultations and virtual visits for family, are examples of rapid change in the delivery of health-related services that were not predicted only months prior to them becoming commonplace.

Long-term economic conditions, such as interest rates, unemployment rates and economic growth are also difficult to project. To deal with this uncertainty, long-term financing systems need to be flexible and adaptive whilst providing reasonable assurance that expected calls for benefits will be met.

Human beings are generally poor at assessing personal risks and in making long-term decisions.[9] This limits our ability to anticipate and plan for our long-term care needs. We tend to think that bad things can't happen to us and we put things off. As one of the witnesses to the Royal Commission, Sarah Holland-Batt, has written:

> While I am bereft for my father and the precarious, vulnerable state he is consigned to, I resist imagining myself in his place, even though I know intellectually it is possible the same things may happen to me.[10]

There is a natural tendency to shy away from the need to prepare for our future. Sarah Holland-Batt has described the 'magical fantasises' that keep at bay our fears of ageing.[11] We imagine that we won't need any care, that we will be cared for by family or loved ones, or that technology will spare us from the conditions that the elderly suffer from now. For many people, the demands of day-to-day living crowd out thoughts about the need to save for an uncertain future. For people who want to put funds aside for their long-term care needs, it can be difficult to know how much to save, creating the risk of either under- or over-providing for their care.

The uncertainties associated with financing future aged care costs raises such questions as whether the costs are best provided for by setting funds aside ahead of time or paying the costs when they arise. Both approaches have strengths and weaknesses. There are advantages in the simplicity and flexibility of pay-as-you-go arrangements, though they don't necessarily provide any assurance that adequate funds will be available in the future. Pre-funding may provide some assurance that funds will be available in the future, but pre-funded schemes are more complex to design and implement. In each case there is a need to ensure that there will be available at a future time the funds to meet expected future needs. The provision of funds to meet future needs is a task frequently undertaken by insurers of risk by insurance principles, actuarially calculated and prudentially regulated.

The two options we have mentioned also raise issues about who should pay for aged care: should people provide for their own aged care, or should each generation pay for the care of their elders? The issue of inter-generational transfers is complex. While (younger) working-age taxpayers are currently paying for the aged care of their older, mostly non-taxpaying parents and grandparents, they are enjoying the benefits of social and

economic infrastructure that was mostly paid for by previous generations. The younger working-age taxpayers also benefit from past expenditure which was made on their behalf, such as that made on their education and training, by their parents. Inter-generational transfers cut both ways and there is no easy solution to the question of which generation should pay for aged care.

Discussion—Pay-as-you-go or pre-funding

Aged care could be financed on a pay-as-you-go or on a pre-funded basis. Pay-as-you-go refers here to arrangements where finances are raised now to cover the costs of providing care each year for today's elderly. Pre-funding refers to schemes in which finances collected in a period are set aside to meet future aged care costs.

Pay-as-you-go is the simpler approach of the two. It depends upon funds being raised as and when they are needed. It provides flexibility for financing to be adjusted as needs change and avoids under- or over-funding. When applied to aged care, pay-as-you go schemes mean each generation effectively pays for the cost of the aged care of its elders. This is relatively straight-forward if the proportion of taxpayers to aged care recipients remains relatively stable over time. However, it can present challenges if a proportionally smaller working population has to raise the funds to pay for the care of a larger proportion of older people, as has been occurring in Australia and most advanced economies over the past twenty or thirty years and as is expected to continue for the foreseeable future.

While some might see this means of funding aged care as an obligation which a generation owes to its elders, others might question the fairness of this arrangement if older generations have benefited during their life from more benign economic conditions and have already accumulated significant wealth. There are no easy answers to this question.

Whatever might be one's views about fairness, there are also questions about the security of future pay-as-you-go funding. Future generations may be less comfortable about contributing to the growing cost of aged care, and circumstances could change such that governments may be less able to spend increasing amounts of money on aged care. There is, in other words, no guarantee in a pay-as-you-go system of funding that future governments will make available sufficient funds to meet fully the future needs: there are always competing demands for government/taxpayer funds and priorities may change over time or with changed circumstances. There is, however, flexibility for governments to change priorities at any time and direct more funds into aged care as needs change.

Pre-funding, in contrast, allows people to provide for their own future aged care costs. There are many different means of achieving this, including personal savings, investment in other assets, superannuation or other compulsory forms of saving, or insurance. Because future aged care costs are difficult to estimate, it is hard to know how much to collect in any given period, and pre-funding requires a much more complex infrastructure to maintain and manage the funds that have been collected to ensure that they are still available years into the future when they are needed. Complex actuarial assumptions are involved and governments will always be able to intervene and alter arrangements in unpredictable ways that can affect the level of pool funds available to meet long-term care requirements.

For the Australian aged care system, there would also be issues about how any transition from pay-as-you-go to pre-funding would be managed. People who are currently in aged care, or about to enter aged care, have relied on the reasonable assumption that as they contributed through their working lives to the cost of aged care for their elders, the next generation would pay for their care. However, a switch to pre-funding would require the working population to begin to contribute to the future costs of their own aged care while at the same time continuing to pay for the cost of care for the previous generation. Options to address this dilemma are canvassed in later sections of this report.

Reflecting on these and other issues almost 10 years ago, the Productivity Commission suggested that there was 'only a limited opportunity to develop policies that increase people's capacity to pay for their own aged care'.[12] This observation is of particular importance given the imminence of baby boomers who will begin entering their eighties.

The window to address this issue has narrowed further since that time and the transitional issues have as a consequence become more challenging.

A related issue is the extent to which the community considers that aged care is essentially either a private or a social responsibility. To the extent that elements of aged care are considered a private responsibility, it would follow that more of those costs should be funded directly through private contributions. To the extent that elements of aged care are considered a social responsibility, public financing of those components would be warranted. In practice, people can have different views about these issues. There is also a need to consider whether the community is looking for mechanisms to ensure that any future government will provide the quality of care we believe that Australians have a right to expect. Where the responsibility is private, there is still the need to consider whether incentives might need to be put in place to help overcome the natural biases that work against private provision for future aged care costs.

The issues are made even more complex by the fact that a country's financing arrangement for aged care needs to work in harmony with its traditions and values, its structures and systems of government and its general health and welfare financing arrangements. A scheme for financing long-term aged care can't be developed in isolation from the society in which it is intended to operate.

Questions

1. **To what extent should elements of aged care be funded by the individuals who benefit from the care that is provided, and to what extent should they be provided by the state?**

2. **To what extent should we prepare in advance for future aged care costs versus meeting the costs as they arise?**

3. **How are the long-term risks associated with aged care best managed?**

Alternative approaches to aged care financing

There are many different ways of financing aged care.

At present, the Australian aged care system is primarily financed through general pay-as-you-go taxation, supplemented by personal co-contributions determined by income and means tests and additional, voluntary self-funded contributions for extra services or supports.
Internationally, a wide variety of approaches is employed. The majority of Organisation for Economic Cooperation and Development countries fund aged care from taxes or social insurance while a much smaller number of countries incorporate private insurance in their aged care financing arrangements, and those arrangements are usually related to cover those excluded from public scheme.[13]

With some simplification for the purpose of making comparisons, the following table illustrates the range of approaches that have been employed by governments in other countries with ageing populations and advanced economies.

Table 2 Examples of international aged care financing arrangements

Type		Examples
Universal single system	Tax financed	Norway, Sweden, Denmark, Finland
	Social insurance	Germany, Japan, Korea, Netherlands, Luxembourg
Combination of financing methods	Multiple financing streams	Scotland, Italy, Czech Republic, Poland
	Income-related universal schemes	Ireland, Australia, Austria, France
	Mix or no benefit	Switzerland, New Zealand, Canada, Spain, Greece
Means-tested safety net system		United States, England

Source: https://cepar.edu.au/sites/default/files/Aged_care_in_Australia_Part_I.pdf

In practice, of course, the arrangements are not as simple as this. In many cases, what we have described as the principal system (for example social insurance in Japan or means-tested safety net system in England), will often also be complemented by other mechanisms (co-contributions in the case of Japan and financial products in England, for example). While Australian aged care is primarily financed through the general taxation system, individuals also make significant income related co-contributions. Additional information on the financing of aged care in other countries is provided in the Royal Commission's publication *Review of International Systems of International Systems for Long-term Care of Older People*. That paper can be found at https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-2-review-international-systems-long-term-care.pdf.

We stress that the different options set out in this paper are intended as illustrative examples to stimulate responses to inform our considerations and recommendations rather than being intended to be definitive or prescriptive. We seek to show how the different approaches might work, and how they might be arranged to achieve the objective of a secure and stable

financing stream for long-term care in Australia. We are aware that more detailed models need to be developed and costed but we are seeking feedback on the underlying issues and the broad direction of the models.

We consider a number of options under three broad approaches to financing aged care:

- minimal change, based on the continued adaptation of taxation methods and co-contributions
- social insurance models, involving mandatory contributions to dedicated pooled funds
- private insurance and other voluntary arrangements.

Each of these three approaches has advantages and disadvantages. Some achieve similar outcomes in different ways while others would, over time, lead to very different outcomes in terms of the ways in which aged care is delivered and who pays for it. It is also important to recognise that it is quite possible to have a range of different financing elements in an overall package of funding. Although a number of the approaches are expressed as alternatives to each other, it may be reasonable for one component of aged care to be financed in one way (for example, pre-funded and/or private) and another in an alternative way (pay-as-you-go and/or public).

One issue that distinguishes the alternative approaches is the scale of the implementation and transition adjustments that would be required. Any switch from a system that is primarily publicly funded on a compulsory pay-as-you-go basis to alternative schemes that have elements of pre-funding, private provision or opt-out arrangements, will have some complexity, and will raise issues about changing the existing balance affecting inter-generational fairness and equity. Policy makers will need to weigh carefully the establishment costs and distributional impacts of any change in financing arrangements and consider whether transitional arrangements are required. These issues will be considered in more detail in a later section of the paper but they should be kept in mind when considering the alternative options.

Minimal change

As noted in earlier sections of this paper, the existing framework for financing aged care relies on pay-as-you-go public funding sourced through the general taxation system, supported by private contributions in the form of co-payments for certain services, and public and private capital financing.[14]

General taxation

The taxation system provides finances for the social benefits enjoyed by Australians. This form of public financing has proven to be flexible in sourcing the funds to accommodate growth in Australian Government expenditure on aged care from close to zero, in the early 1960s, to roughly 1% of GDP by 2020.

The Australian Institute of Primary Care has suggested that public financing of programs which offer general benefits for the community, from revenue raised through payments that are progressive in nature, has been seen as an equitable and efficient way of financing necessary human services.[15]

Any significant increase in taxation of the dimensions canvassed in this paper would have significant economic consequences. Taxation and government charges provide governments with the means to provide goods and services, and redistribute income and wealth. However, the quality improvements to the aged care system that we consider necessary to meet reasonable community expectations would place an additional burden on taxpayers. To the extent that taxpayers or governments consider these demands to be unreasonable or unfair, the reliance on a single source of finance could jeopardise the quality improvements necessary to finance aged care into the future.

One of the limitations of general taxation in financing a long-term service such as aged care, is that taxation systems tend to operate on a pay-as-you-go basis. Financing of future aged care costs through pay-as-you-go taxation schemes are more susceptible to political change and competing public priorities than pre-funded schemes, and are therefore less secure than some pre-funded arrangements. Pay-as-you-go schemes are inherently short-term in their outlook. They provide no certainty about the availability of funding to meet needs into the future and also provide limited incentive for investments, for example, in maintaining a person's mobility, which may only have direct budget benefits many years in the future. On the other hand, the flexibility provided under a pay-as-you-go arrangement may enable funding to be expanded in response to population growth, unpredicted additional demand or a decision to enhance the quality of care.

Another important consideration regarding pay-as-you-go schemes is that of intergenerational transfers. Under a pay-as-you-go arrangement, where revenue is sourced through general taxation, aged care is paid for through transfers from people who are paying taxation (primarily the working age group) to the population receiving aged care benefits (some of whom may also be paying tax). A pre-funded scheme will, when fully operational, shifts more of the burden for the financing of aged care onto the generation that will consume the service. Pre-funding is more difficult to achieve in a taxation funded scheme, though not impossible, as we discuss in subsequent sections of this paper.

General taxation has proven to be resilient in financing the growth in aged care expenditures over the past 60 years and could be expected to continue to work effectively into the future. However, there are pressures on this arrangement and it is useful to canvass other approaches.

New 'earmarked' taxation

Aged care in Australia could potentially be financed through an earmarked aged care levy.

Governments in Australia occasionally earmark new taxes or levies for particular purposes. The nomination of specified purposes for the imposition of levies is sometimes seen as a way of encouraging public acceptance of those taxes.[16] Examples of these include the Medicare Levy, Temporary Budget Repair Levy, the Air Passenger Ticket Levy and the Passenger Movement Charge.

Tax levies in Australia may be hypothecated or non-hypothecated. Funds raised by a hypothecated levy are paid into a dedicated account within the Consolidated Revenue Fund, established for the specific purposes for which the tax is imposed and can only be used for those purposes. The funds cannot be used for any other purpose and any excess funds are rolled over from year to year.

Levies that are not hypothecated are also paid into Consolidated Revenue, but while the funds raised are notionally 'earmarked', the Australian Government is not legally obliged to spend those monies only on the purposes identified in the name of the levy. The monies raised through these levies can be directed to the notionally earmarked purpose, but they are also available to be spent on any other general purposes of the Government that might be approved by the Parliament and any excess revenue, beyond the specific needs identified by Government, may also be used for any other purposes approved by Parliament. If more funds are required to cover additional unexpected expenses, Parliament can appropriate a greater share of consolidated revenue to meet those needs, however long they may last.

The Medicare Levy is an example of a non-hypothecated levy. The Medicare Levy contributes to the costs of Australia's public health system and is collected in the same manner as income tax. The levy is a flat 2% of an individual's taxable income and is paid in addition to income tax. However, the funds raised by the Medicare Levy are far below the costs of the medical and pharmaceutical benefits provided through the Medicare system.

The National Disability Insurance Scheme provides an example of the use of hypothecated and non-hypothecated levies in funding social programs.

Example—Funding the National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) was intended to provide a secure revenue stream for disability services.[17]

The Productivity Commission noted that 'current funding for disability is subject to the vagaries of governments' budget cycles and proposed that the Australian Government should finance the entire costs of the scheme from general revenue, or a levy 'hypothecated to the full revenue needs of the NDIS'.[18] In the event, the financing of the scheme is different from the two main approaches proposed by the Productivity Commission.

The Commonwealth, State and Territory Governments participating in the scheme, jointly provide funding from a combination of sources but the scheme is neither fully funded nor hypothecated to the full revenue needs of the scheme.[19] Some funding for the scheme came from a redirection of existing funds.[20]

Additional funding for the scheme was raised through a July 2014 increase to the Medicare levy (from 1.5% to 2% of taxable income). These monies were directed to a special fund—the DisabilityCare Australia Fund. However, unlike the model proposed by the Productivity Commission, the increased Medicare levy was not designed to meet the full revenue needs of the scheme.

In the 2017–18 Budget, the Australian Government announced that it would provide additional funding for the scheme by increasing the Medicare levy from 2% to 2.5% from 1 July 2019. According to the 2017–18 budget papers, one-fifth of the revenue raised from the increased levy was to have been credited to an NDIS Savings Fund, a special account from which funds were to have been debited to help fund the scheme from July 2019.[21]

The Parliamentary Library Bills Digest noted at the time that '[g]iven revenue from the Medicare levy is not intended to meet the full cost of the NDIS, it may not provide the stable revenue stream originally envisaged by the [Productivity Commission]'.[22]

The Bills Digest continued that it is 'unusual to focus on 'fully-funding' a national program such as the NDIS' where other programs, such as the Age Pension, is funded as part of the ongoing costs of the Government's core business from the consolidated revenue fund.

The Government subsequently announced the Medicare Levy increase was no longer required due to an improved budget situation, including higher than expected tax receipts.[23]

The Government's contribution to the scheme continues to be sourced from monies repurposed Commonwealth programs that have been redirected to the NDIS and the July 2014 increase to the Medicare Levy. Any gap in funding which is not met by these sources 'must come from general budget revenue or borrowings.'[24] State contributions are funded from their own revenue sources.

It would be possible to link additional aged care financing requirements with the Medicare Levy or with a similarly constructed age care levy. However, as the Medicare Levy is not hypothecated, this would not necessarily guarantee that the additional funds raised would be spent on aged care. As a non-hypothecated tax, any additional funds collected would be directed to Consolidated Revenue and the Australian Government would continue to make separate decisions in the annual Budget about how much of the money would be directed to aged care. To ensure that a dedicated source of revenue was available for spending on aged care, the levy would need to be hypothecated.

Arguments can be advanced in support of hypothecated taxes:

- *Accountability and trust:* Since they are directed to a specific and identifiable fund, hypothecated taxes provide taxpayers with some assurance about how their taxes will be used, and the need for certainty and predictability is great in the provision of future benefits for older Australians.
- *Transparency:* Hypothecated taxes can educate people about the cost of particular services. Taxpayers can then make better informed decisions about the balance between tax burden and level of services provided.
- *Public support:* In some cases, hypothecation can generate public support for tax increases where the service set to benefit from the earmarked tax is perceived to merit it.[25]

The Australian Government has sometimes introduced narrowly-based hypothecated taxes to fund services provided exclusively to the contributing tax-payers or to support particular, temporary objectives.[26] However, governments are generally reluctant to apply broad-based hypothecated taxes. Governments have opposed the widespread adoption of hypothecated taxes on the grounds that spending priorities should not be determined by the way in which money is raised.[27] The Treasury has argued that earmarked tax revenues reduce the 'efficiency and effectiveness of government through impeding budget review and flexibility'.[28] Hypothecated taxes tie the hands of government, constraining the ways in which the government can allocate limited revenue between competing priorities and reducing the opportunities for governments to deal with economic cycles.[29] There is also a risk for the beneficiaries of a hypothecated fund that while revenues tied to a tax base, such as employment or incomes, might be buoyant during periods of economic prosperity, the same sources of revenue are likely to be suppressed during economic down-turns. This would mean that the level of finance available would depend on economic conditions rather than the specific needs of the program.

Example—An aged care hypothecated fund

In the aged care context, a hypothecated fund would allow the Government to set funds aside to be used solely for the purpose of funding the aged care needs of Australians.

This would provide a dedicated and transparent fund to cover expenditure on aged care. The funds could not easily be diverted for other purposes. However, if constructed as a fixed proportion of a broad-based tax (such as income tax), the money going into the fund would be dependent on the buoyancy of the economy and the levels of tax payments in any given year. In a poor year, the amount of money going into the fund may not meet the full costs of maintaining the aged care system and may need to be topped up.

Multiple variations on this option are available. A hypothecated fund could be used to collect payments to cover future age care costs. This option could be considered to be a form of social insurance and is expanded on in the next section of this paper.

The Australian Government could at some future point change the nature of the hypothecated fund or authorise other expenditures from the fund, but this would require an Act of Parliament. While a hypothecated fund is maintained separately from other government accounts, it is still subject to changes in political priorities and commitments.

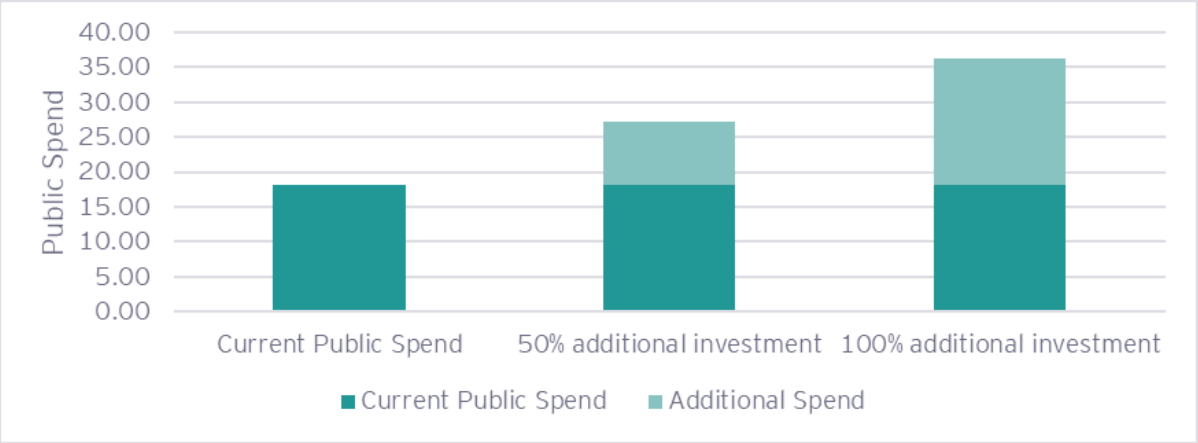
Earmarked or hypothecated taxes have drawbacks but could be employed as sources for financing aged care into the future, either individually or in combination with other measures.

How much extra taxation would be required to finance aged care?

To provide some context for the consideration of taxation options, we have had undertaken some preliminary analysis to illustrate the potential levels of taxation that would be required to finance future aged care costs.

This work suggests that if fully funded from personal income taxation and based on 2018–19 data, an additional 50% investment in care costs would initially require a 1 percentage point increase in personal income tax rates. An additional 100% investment in care costs would initially require a 2 percentage point increase in personal income tax rates. The relationship between changes in potential tax rates and the amount of financing available is illustrated in the chart below.

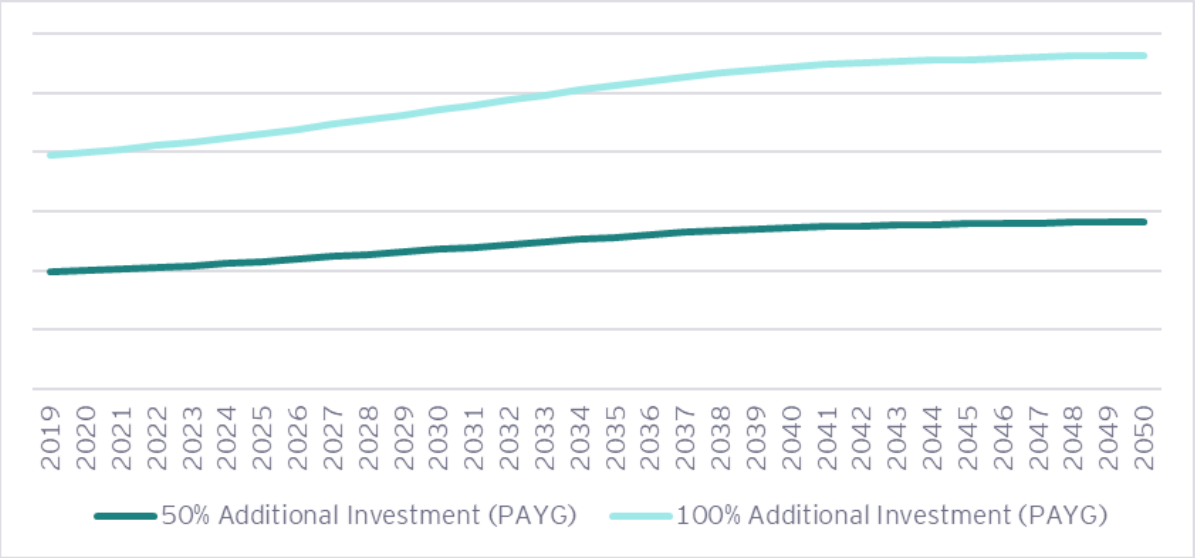
Figure 3: Public spend on aged care services for 2018–19 based on increased personal income taxation scenarios in $billions



Early modelling by those advising us suggests that an additional financing requirement equivalent to 50% or 100% of the current level of spending on aged care would require a further upward shift in the average income tax rate over time. This is because aged care costs are likely to rise faster than the income tax base.

The need for an increase in the average income tax rate to meet the additional funding requirements over time is illustrated in the following chart.

Figure 4: Illustration of increased personal income tax rates over time for 50% and 100% additional investment in aged care



Note: This illustration is dependent on a number of key assumptions regarding future population, aged care need and costs, and personal income. It is illustrative only at this stage and refinements could also include allowing for potential behavioural responses to higher tax rates.

Continued heavy reliance on taxpayer funding for aged care, whether through general taxation, hypothecated taxation or earmarked taxation, would place an increasing cost on taxpayers. Over the longer term, this could have effects upon after tax income, and might have consequences for the willingness of taxpayers to continue to fund improvements in the quality of aged care services.

Co-contributions / means testing

As described in the section of this paper entitled *Who pays for aged care*, at present, many aged care recipients make significant direct and indirect contributions to care they receive.

Overall, at present, care recipients currently contribute between 20% and 25% of the costs of aged care.

Recipients of Home Care Packages currently pay an average of $30 per week towards the cost of their services. People in residential aged care currently pay an average of $502 per week towards the cost of the services that they receive, including ordinary costs of living.

In addition, many aged care residents contribute significant amounts to the cost of their care in the form of Refundable Accommodation Deposits. In 2019, those deposits were worth a total of $30.2 billion.[30]

There is, nevertheless, some scope for looking at the potential for care recipients to make greater contributions to the cost of their care, where they can afford to do so. At the moment, base level home care services are available with no mandatory charge for everyone, regardless of their capacity to pay. Initial studies undertaken on our behalf suggest a preparedness to contribute more to meeting the cost of higher quality aged care, including through increased co-contributions.

Aged care recipients could be encouraged to make greater co-contributions to the costs of their care by refining existing means or asset testing arrangements. This would result in care recipients in the present contributing a greater share of the wealth built over their working lives to the cost of their aged care. It would contribute to achieving an intergenerational balance in financing the additional funding of aged care which we anticipate will result from the adoption of our recommendations.

There are, at present, no arrangements for formal means testing for the Commonwealth Home Support Programme. The contribution made by the recipients of these services represents only a very small proportion of the cost of the care they receive.

People in receipt of Home Care Packages are subject to an income test but not to an assets test. Moreover, the income test for Home Care Packages has different, and lower, annual limits on the level of the means tested fees that an older person can be asked to pay as compared with residential aged care. Again, as a consequence of the current arrangements, all older people who are sufficiently frail are entitled to a considerable subsidy of their care costs, no matter how wealthy they might be.

People in residential aged are subject to both an assets and an income test which encourages individuals who can afford to do so to make greater contributions to the costs of their care. However, there are annual and lifetime limits on the level of the means tested fees that an older person can be asked to pay, so that all older people, no matter how wealthy, are entitled to a considerable subsidy of their care costs. Most, if not all, of the value of the person's home is currently excluded from the aged care means test. The home is entirely excluded if it continues to be occupied by a dependent of an older person receiving residential aged care. However, unlike the Age Pension arrangements, most of the value of the person's home continues to be excluded from the aged care means test, even when the older person and their dependants are no longer living in the home. In the major metropolitan housing markets, there is a very significant difference between the market value of many homes and the upper limits considered as part of the current aged care assets test.

One option could be to lift the current threshold on the value of assets included in the assets test. Another would be to provide for the possibility of reverse mortgage equity drawdowns for very high value homes.

Initial studies, conducted on our behalf, of the preparedness to pay for the cost of aged care suggest that some further contributions could be made from additional payments by aged care recipients, but that this source of finance alone would need to be complemented by other measures to meet the prospective funding gap.

While we do not yet have a settled view on whether the Australian Government should change the existing means test arrangements, we are aware of a range of options that could be considered should there be community interest in pursuing this issue. We would be interested in views on options that should be considered for allowing those with the means to contribute more to the cost of their care to do so.

Questions

4. **Does an approach based on a mix of taxpayer funding and co-contributions provide an appropriate basis for financing Australia's aged care needs into the future?**

5. **What are the advantages and disadvantages of a levy to fund aged care?**

6. **If a levy were to be introduced, should it be hypothecated or non-hypothecated?**

7. **If there were an aged care levy, should the levy be based on personal income tax or on a broader tax base?**

8. **Should older Australians be asked to contribute more to the cost of their care if they have the capacity to pay? How would this be best achieved?**

9. **Should the current residential aged care means test on the family home be tightened to ensure that taxpayer funds are directed to the most needy?**

Social insurance models

Social insurance is one possible mechanism for financing social welfare programmes. It is perhaps most well-known for covering pensions, unemployment and sometimes health care, but social insurance programs for aged care also exist. By social insurance, we are referring to compulsory contributions to a dedicated, pooled fund which is used to finance the aged care costs of a defined group of individuals.

The mandatory element in social insurance schemes allows long-term risks to be pooled across a large group. By sharing the risks, the overall costs of providing for long-term care are reduced and costs are reduced for everyone. Compulsory insurance also reduces the cost of 'adverse selection', which arises when the insured knows more about their own risk than the insurer and chooses to purchase or skip paying for insurance because they are sicker or healthier than the average.

A number of countries, including Germany, Japan, the Republic of Korea, and the Netherlands and Luxembourg, finance some part of their aged system through social insurance.[31] Since care regimes are so country-specific, the associated social insurance regimes, where they exist, also vary significantly. For example, schemes may operate on a pay-as-you-go or pre-funded basis, and may be publicly or privately delivered.

The potential for a social insurance scheme covering aged care was considered by the Productivity Commission in 2011. The Productivity Commission concluded that "the opportunity to smooth the higher costs associated with the bulge of baby boomers has largely passed." [32] The Productivity Commission argued that a social insurance scheme would not be an improvement over the current system of financing from general taxation revenue as long as the current system was complemented by higher contributions from individuals with a capacity to pay and a lifetime cap on care costs.[33] The Productivity Commission recommended a comprehensive means test for care recipients' co-contributions based on the Age Pension income test, and an assets test applied to the relevant share of a person's assets which are excluded from the Age Pension means test, including the principal residence.[34] In the event, some changes in this direction were made, though they did not go as far as the Productivity Commission recommended.

In a recent publication, the World Health Organisation has pointed to the difficulties being experienced by countries with ageing populations in seeking to finance health care through employment related contributions and premiums. It concluded that:

> "De-linking entitlements from the payment of contributions and instead relying more on general taxation to fund health is critical both for equitable financing and access to care, as well as for sustainability."[35]

Nevertheless, we consider that this is a potential option for long-term financing of the aged system, and that the issues surrounding the security of current financing arrangements have not gone away since the Productivity Commission reported in 2011.

We see a number of benefits in a social insurance model for the provision of aged care which are not found in the current Australian system of funding primarily from consolidated revenue. First, that there would be created funds to meet expected costs based upon insurance principles actuarially calculated. There are many components of aged care and many risks involved some of which can be left to private choice and private funding (perhaps some accommodation choices) whilst others can be pooled into common social insurance funds. The price of social insurance (in other words, the annual premium) would be fixed by an independent authority applying insurance principles actuarially calculated to secure sufficient funds over time to provide expected benefits to meet expected needs. Secondly that the funds would not be susceptible to change by government from other competing

public priorities over time or otherwise susceptible to political influence. There would, when fully operational, rather be the funds available in one or more public or private insurer (prudentially regulated) to provide those insured benefits to which older Australians are entitled as of right. The funds could be collected by direct levy or compulsory obligation to contribute to a fund (subject to any top up required to be made by government to meet the needs of those unable to contribute directly).

Hypothecated pre-funded levy

The option canvassed in the previous section of a hypothecated levy used to pre-fund aged care costs, in which the funds are maintained in a pooled trust, or reserved account, could be considered to be a form of social insurance.

Funds collected though this levy could be held and managed by the Future Fund, or another public fund manager, subject to appropriate drawing rights and legislation being established.

The levy could be applied to a number of different tax bases.

The Henry Review of Australia's tax system suggested that, in general, tax revenue should be raised from one of the broad tax bases of income, consumption and land, rather than from a narrowly based charge.[36] The Review observed that the broader the tax base, the lower the share of that base needed to raise a given amount of revenue and the lower the efficiency costs of doing so.[37]

Given the universal eligibility of access and broad social benefits of aged care in Australia, the simplest approach would be to apply the levy to personal incomes, like the Medicare levy. The rate of the levy though would need to be varied from time to time to reflect estimates of the long-term cost of aged care.

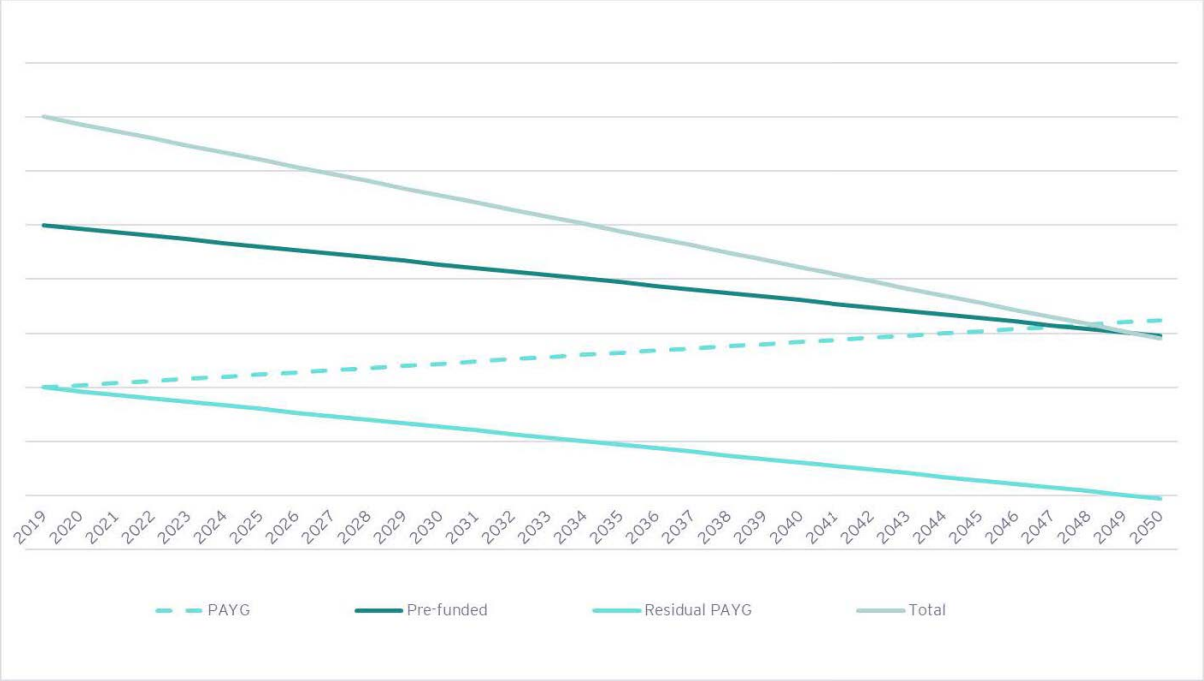
There are many variations on how these arrangements could be constructed.

A hypothecated fund could cover the future aged care costs for taxpayers aged, say, 25 to 65 years. Funds would accumulate for many years until those taxpayers draw down on the accumulation to pay for their aged care costs. At the same time, aged care costs for the existing cohort of recipients would be met via general revenue, in line with current arrangements. This does mean that the taxpayers aged 25 to 65 years will be paying both for the care of their elders as well as for their own care. Future working generations will only pay for their own care once this transition is complete.

Early modelling, conducted on our behalf, suggests that the required contribution rate to meet 50% and 100% increases in the funding requirement would be significantly higher than the PAYG rates. The contribution rate would be highest for the initial cohort, as they have the least time on average to fund fully their own costs before payments would be required. Each successive younger generation would have a much lower rate, so the blended rate for the pre-funded scheme would progressively drop. In the meantime, pay-as-you-go contributions would continue to be required for the costs of older people who had not contributed to the hypothecated pre-funded levy. The contribution rate would reduce over time as pre-funded participants commence being paid from the funded scheme and current older people pass away.

Under this option, the total contribution would be expected to come down over time as the hypothecated fund commences paying some of the total aged care costs, until there is no residual payment to be made from general revenue. This effect is shown in the following chart.

Figure 5: Illustrative interaction between pre-funded and residual PAYG arrangements in additional personal income tax rate (note it would take longer than 30 years for the Residual PAYG to fall away altogether)

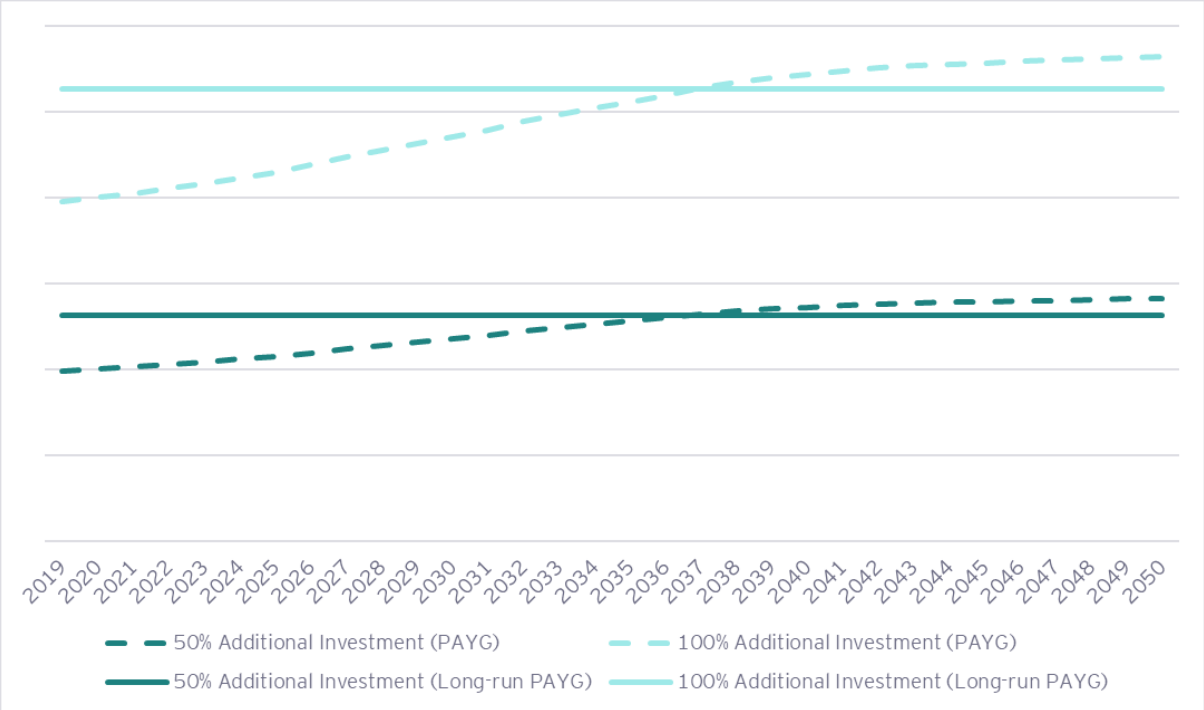


The pre-funded line is the levy for full pre-funding. The residual pay-as-you-go is the adjusted contribution from general revenue (the dotted line marked PAYG is the unadjusted contribution). The total is what will be required from taxpayers, as a combination of their contribution to the hypothecated fund (pre-funded) and their contribution to general revenue to cover the costs for those not covered by the pre-funded scheme (residual pay as-you-go).

All of these rates are dependent on long-term assumptions, in particular economic assumptions around GDP growth, cost increases and investment returns. We have assumed that the aged care hypothecated fund would be established in such a way as to allow for investment of the accumulated monies by an appropriate body to generate a long-term rate of return. Alternatively, the hypothecated fund could be used to collect actuarially assessed payments to cover both current and future aged care costs. This spreads the cost of care for everyone across several generations.

Early modelling undertaken on our behalf suggests that the required contributions to meet 50% and 100% increases in the funding requirement for this scenario might be of the order illustrated in the following chart—the fixed contribution rates would effectively be a long run average of the pay-as-you-go costs (shown in the dotted lines).

Figure 6: Illustration of long-run personal income tax rates over time to support PAYG levy expressed for 50% and 100% Additional Investment in aged care



As a hypothecated arrangement, the monies collected through this levy could only be spent on aged care costs as defined in legislation. This option would provide more transparency than the current approach to funding aged care through the taxation system because contributors would know exactly how much they were paying for aged care every year and would have certainty about how the monies would be used. This might provide a greater level of reassurance around the availability of funds to meet the cost of future aged care needs. However, there could be a risk that the funds in any particular period might not meet the actual costs of aged care in the same period. If this were the case, Government would need to top up the fund to meet the actual costs incurred or meet those costs from general revenue.

While the hypothecated fund would provide some measure of assurance around future aged care funding, government could at some future point pass legislation to change the nature of the hypothecated fund or authorise other expenditures from the fund. While a hypothecated fund would be maintained separately from other government accounts, it would still be subject to changes in political priorities and commitments.

Public aged care contributory scheme

A public aged care contributory scheme could be developed to raise funds to cover aged care costs currently funded by government. These sorts of arrangements exist in a number of countries.

Japan, for example, finances its aged care costs in part through a social insurance scheme that has been in operation for approximately 20 years.

Example—Long-term Care Insurance in Japan

Aged care in Japan is funded through a combination of a compulsory social insurance scheme, taxation revenue and co-payments.

Public mandatory insurance was introduced through the Long-Term Care Insurance Act. All people aged 65 years and over are insured under the long-term care insurance system, which covers both home and residential care. Long-term care services funded under the insurance system are provided when people aged 65 years and over require care or when people aged 40–64 years develop aging-related disease. Everyone receives the same level of service, regardless of income. Benefits are in-kind and do not include cash benefits or other direct benefits for family caregivers;

In an attempt better to integrate the long-term care system and the health system, a care manager is assigned to each user of long-term care who establishes a care plan with the user and their family to integrate required medical and welfare services. Excess demand for institutional care has been met by new types of housing; and the line between institutional and community care in Japan is now less distinct.

The majority of home care service providers are private. Residential services are predominately public or non-profit, as private residential services are only partly covered by long-term-care insurance.

The long-term care Insurance is financed by 50% from general taxes and 50% from premiums of the insured. All users pay a co-payment of 10%, regardless of income. In 2015, a co-payment of 20% was introduced for people above a certain income level. This was increased to 30% in 2018.

In residential care in Japan, staff-to-resident ratios are mandated at 1:3 but there is no regulation around the mix of staffing qualifications. Long-term care workers are certified in Japan and there are financial incentives for providers who offer ongoing training. Mandated training, including an examination, is required for certified care workers and home helpers. Community care workers do not require examined qualifications but are required to complete 130 hours of training.

Municipal governments are responsible for the accreditation and licensing of long-term care facilities and conduct quality assurance through inspections. Staffing and physical requirements must be met to gain accreditation. Annual reports must be submitted to the governor and results are publicly reported online. There are three complaint processes for clients and families; through a care manager, directly to the provider or through the long-term care insurer.

There are financial incentives for providers that exceed requirements on a number of criteria including rehabilitation outcomes for care recipients, numbers of staff with particular expertise (e.g. nutritionists) and comprehensive care planning.

The Japanese scheme is delivered through municipal governments and operates in conjunction with health insurance arrangements that cover some aged care related costs.[38]

The Japanese aged care social insurance scheme provides an example of an arrangement that has operated with success in combination with a number of financing elements that are also employed in Australia, including funding from general revenue and co-contributions. It illustrates the potential to provide funding for aged care through a social insurance scheme.

Who would be covered and who would contribute?

All people currently entitled to receive Australian Government funded aged care would be covered.

Contributions should, in principle, be paid by all Australians who may benefit by being covered provided that they have the means to contribute. Contributions, however, could be limited to some specific age range, for example, ages 25 to 65 years, when people generally have more ability to save, or could be across a broader base. This is similar to current arrangements and could be compared with the entitlement for the Australian Age Pension, which is not directly linked to the level of contributions that people have made over their lifetime, but does have some basic requirements (e.g. length of residence in Australia) for eligibility.

It's not uncommon internationally to limit benefits from social insurance schemes only to those who have contributed, or to link benefits to the amount contributed or contribution period. For example, in some pension social insurance schemes, partial benefits are payable in proportion to the number of years that a participant was able to contribute. However, in the case of aged care, this would mean that a sizeable proportion of the population, including parents who have left the workforce to care for children or the elderly, immigrants and some indigenous people, might be deprived of the aged care available to other Australians. We do not consider that this approach would be acceptable to the Australian community as a basis for determining eligibility for the full range of aged care services that should be available to older Australians, or that it would be consistent with our position in this Royal Commission on universal access to aged care for all Australians.

Arrangements would need to be developed to ensure that all Australian were able to participate in the scheme and able to benefit from the universal provision of aged care. Further comments on this issue are provided in the following sections.

How would those contributions be defined and collected?

Contributions could be obtained in a number of ways. For example, they could be paid by employers based on wages, in a similar way to the current Superannuation Guarantee levy, or by individual payment to approved funds. They could be paid by workers based on taxable income, like the Medicare Levy. There are other possibilities, such as payment by corporations, but wage or income-based arrangements or payment of a premium to an approved fund, have the advantage of familiarity and understanding in the community.

These arrangements would leave some members of the community unable to make regular contributions to such a scheme. This would include people unable to work, those working on a part time or casual basis whose income did not meet a defined threshold, and those temporarily out of the workforce due, for example, to study, caring responsibilities or other reasons.

To cover the financing costs for the groups not able to contribute regularly to the scheme, the government could either apply higher contribution rates for those able to contribute or it could 'top up' the payment from time to time to make up for any shortfalls against the funds required to support universal coverage.

What would the financing basis be and implications for the contribution rate?

A scheme for social insurance could operate on a pay-as-you-go or pre-funded basis. Either option invokes many of the issues canvassed in earlier sections of this paper around the

inherent uncertainty of forecasting long-term care needs, the security of provisions for future aged care costs and inter-generational issues.

Many social insurance schemes operate on 'long-run' pay-as-you-go principles, or 'uniform pay-as-you-go', which in many respects produce similar results to pre-funding as they allow for variations in the size of different generations and economic conditions over time.

A fully pre-funded scheme would imply setting a contribution rate such that contributors would accumulate sufficient funds to meet their own aged care costs in the future. This could be defined cohort by cohort, for example the current working population aged say 25 to 65 years, to use our previous example, could commence contributing and build up entitlements to benefits when they need them. In one possible scenario, only those aged 25 years would be considered to have built up full entitlement by aged 65 years. In that case, those aged 65 years, contributing for only one year, would have a very small entitlement built up and other arrangements, such as top-up funding from the government, would be required to fund the bulk of their costs, as would apply for everyone aged 41 to 64 years who had built up a partial entitlement. Subsequent generations—those currently aged 24 years or younger—would fully fund their own benefits over the contributory period of aged 25 to 65 years. But this is only one of a number of scenarios that could be developed and has the disadvantages of complexity and some arbitrariness. It would be simpler for the compulsory obligation to fall upon all taxpayers, or all taxpayers over an age (say, 25), with transitional arrangements.

A 'long-run' pay-as-you-go scheme would have a different objective. It would start paying benefits immediately and would set a contribution rate to be stable over the very long run. That is, based on long run assumptions about benefits, contributions, investment returns and costs, which depend on views about many of the uncertainties described in the section around aged care need and economic conditions, a constant, actuarially-sound contribution rate could be determined. This would need to be periodically reviewed, perhaps every three to five years, and adjusted if needed. Bounds could be set on the level of surplus or deficit permissible over time, which would further increase the stability of the long-run rate.

In many respects, this would be indistinguishable from a fully funded scheme, except that each cohort is not expected directly to fund its own entitlements; instead the pooling is across all cohorts. In that regard, it is similar to traditional defined benefit superannuation schemes, where the employer contribution rate is set on long-run assumptions about the benefits, contributions, investment returns and costs for all employees, including those who have already retired and those, in some cases, yet to join the scheme.

What institutional arrangements need to be considered?

A move to compulsory social insurance would have implications for the institutional and governance arrangements around the collection, management and disbursement of any funds. A social insurance scheme would need to be subject to the same planning, regulation and cost control as currently applies to long-term care programs for the aged.

For the entity, or entities, acting as the social insurer, several roles and responsibilities would need be developed, including underwriting, claims management, investment management and prudential regulation. The contribution rate for social insurance will also require the development of assumptions including claim termination rates, claim inception rates, mortality in deferment, lapse rate, average claim sizes and economic growth. Many of these functions are, of course routinely performed by insurance companies which are themselves already prudentially supervised.

In one scenario of a social insurance scheme, the funds collected under the scheme could be managed by a for-purpose entity established by government or could be managed under mandate by professional funds management firms to maximise the benefits associated with the significant funds to be invested. For example, the NZ Accident Compensation

Corporation uses an investment management team who continually review the asset allocation and manage the investment portfolio to gain better risk-adjusted returns.

Arrangements for the payment of aged care costs would need to be defined. At present, residential aged care providers are paid directly by the Department of Health in respect of assessed costs of care provision. Home care providers currently receive package funds in advance and draw down on these. Under the pay-as-you-go options, this would mean that funds would be collected by the social insurance and paid to providers. Under the pre-funded option there would be a period during which both the social insurer and the Australian Government would have responsibility for costs. Hence, arrangements for payments to providers would need to be developed. One possibility would be for the social insurer immediately to take full responsibility for all payments to providers and seek reimbursement from the Australian Government for that component.

Institutional arrangements for oversight of the delivery of benefits through the new scheme would also need to be developed. There would be a question as to whether oversight and governance of the aged care system required a new entity at arms-length from government, or whether those functions could remain with the Department of Health. The same desire for confidence and certainty in future funding allocations that may lead some people to think that a social insurance scheme needs to be set up outside the government's normal financing arrangements might lead to some expectation that the funds collected by the scheme were not subject to day to day Ministerial control or direction, but that the delivery of the benefits to be provided by payments should be amenable to government supervision. The Government would also need to consider arrangements for setting standards for aged care and establishing prices for aged care based on sound insurance principles.

For social insurance schemes established in other areas, there have been set up specialised, for-purpose agency, such as the National Disability Insurance Agency, Transport Accident Commission in Victoria, or the Accident Compensation Commission in New Zealand.

Example—New Zealand's Accident Compensation Corporation

The Accident Compensation Corporation is an example of a fully-funded approach to a social insurance scheme in New Zealand which provides accidental injury cover to all residents and visitors.[39] The corporation had 1.98 million new registered claims in 2019, 25 branches across New Zealand, $44 billion investment portfolio and 3538 temporary and permanent staff members.[40] The scheme is primarily funded through investment income and receives funding from levies from government and levies from employees, employers and motorists.[41]

The key intended outcomes of the corporation are injury prevention, rehabilitation, and sustainable levy setting and collection, investment management and claims management.[42] The actuarial team calculates levy rates based on claims, health care costs and investment returns in each year. Any rate changes are formally documented through a proposal and are submitted for a public consultation process. After submissions have been reviewed, the Government Minister for the corporation reviews the recommended rate and may seek advice from the Ministry of Business Innovation and Development. Cabinet will then finalise levy rates and applies them for the following year.[43]

The corporation also has a key focus on improving the financial sustainability of the scheme through:

- carefully considering the costs of the services offered through the scheme to achieve the best client outcomes
- managing cost and liability growth
- decision-making which encourages a 'today for tomorrow' mindset. This appears to have the perspective of a funded approach.
- maintaining investment performance above benchmarks
- risk management and appropriate government embedded across the organisation.[44]

Consideration would need to be given to the relationship between the Australian Government and Department of Health, other aged care functions, such as planning, market oversight and pricing and the aged care social insurance body. Other bodies with similar functions, such as the National Disability Insurance Agency, Victorian Transport Accident Commission, Victorian WorkCover, and the NZ Accident Compensation Corporation have significant roles in market oversight, pricing, case management and quality assurance on behalf of their clients.

Estimating the levy

As a rough guide, the average contribution rate might be expected to be around the same as the pre-funded or 'long-run' pay-as-you-go hypothecated arrangements discussed above.

Private aged care contributory scheme

A variation of the social insurance model would allow individuals to have a choice of private insurers. This is somewhat like the way Compulsory Third Party insurance operates in many States today, and in a broad sense is analogous to superannuation guarantee obligations although a social insurance model for aged care would not have payments into individual accounts.[45]

Many aspects of the scheme would be similar to the public model. As in the public model, all people currently entitled to receive government funded aged care would be covered by the scheme. Contributions made by those who can contribute would be mandatory.

In the same manner as the public contributory scheme described above, the scheme is pre-funded, meaning that the premiums paid by each generation during their working lives are used to cover that generation's claims. This minimises the need for intergenerational transfers for long-term care. However, there would be some key differences:

- Contributions would now be directed to their selected insurer, in a similar way as people currently direct their superannuation guarantee levy contributions to the super fund of their choice
- For those who can only contribute for some periods or not at all, government would need to put alternative arrangements in place, which could including paying the equivalent premium to a selected insurer or levying a higher contribution rate on contributing members to make up the gap.

Providing choice of insurer can be seen as a way of providing additional choice and competition that stimulates improved performance and lower overall cost. Competitive improvements might occur in a number of ways. For example, insurers could compete for business from insureds on the basis of their record in providing high quality and safe aged care services to those who they insure. For this reason, and to obtain the best value use of their insurance pools, insurers would be expected to demand innovation, high quality services and low costs from providers, and they might establish panels of preferred providers.

These sorts of advantages would be significant in addressing one of the major weaknesses of the present system, which is the information and market power asymmetries that currently exist between aged care providers and people seeking aged care services.

What would be the funding basis?

A privately managed scheme would normally operate on a pre-funded basis. As described above, that would mean a considerable transition period would be required during which contributions would be paid before benefits would be paid for those contributors.

Government would continue to pay for the unfunded proportion of aged care costs for those people who had only been able to contribute to the scheme for a short time. Alternatively, government could transfer a lump sum to the insurer that is intended to cover those costs, and they could be fully covered by the insurer for that person.

Example—Singapore

Long-term care in Singapore is considered to be a collective responsibility of society. Long-term care needs are financed through a combination of government contributions, community assistance, personal and family savings and insurance. Whilst Singapore's national expenditure has increased four-fold between 2011 and 2016, the role of insurance is relatively small. This is primarily due to a younger cohort of policyholders whose claims will only be realised when they are older.

ElderShield is Singapore's basic long-term care insurance scheme which provides $300 to $400 per month for up five or six years for those with severe disabilities. ElderShield Supplements can also be purchased which provide additional benefits. Key features of ElderShield are:

- The scheme is designed by the Government; however, it was administered by private insurers based on the features and parameters defined by the Ministry of Health. Policyholders are randomly assigned to one of the eligible private insurers and have a three-month period to switch insurer if they would like.
- All Singaporeans with a MediSave Account are automatically enrolled at 40 years of age, however may choose to opt out of the scheme. MediSave is a national medical savings schemes which enables individuals to set aside a portion of their income to pay for the future health care needs of themselves or approved dependents.
- Whilst those with a pre-existing illness are covered, individuals with a pre-existing disability are not eligible.
- In 2017, premiums were $175/year for males and $218/year for females, payable from the ages of 40 to 65 years.
- Premiums cease once a successful claim is made and can be fully payable through MediSave.
- A total of 15,600 policyholders have claimed through ElderShield since 2002, of whom 6300 are still actively claiming.
- The scheme is pre-funded meaning that the premiums paid by each generation during their working lives are used to cover that generation's claims. This minimises the need for intergenerational transfers for long-term care.

The ElderShield scheme has faced challenges in financing long-term care including:

- Significant Opt-Out Rates—when ElderShield was first-introduced the opt-out rate was 38%, however this has steadily dropped to 15% in 2006.
- Alternative Sources of Funding—demand for ElderShield may reduce due to viable alternative sources of funding such as state subsidies or public insurance.
- Supply-Side Issues—insurers face significant uncertainty in the long-term care market which is compounded by factors such as information asymmetry, adverse selection and moral hazard.
- Affordability—ElderShield benefits have been criticised for being inadequate to meet increasing service costs which result in high out-of-pocket costs.
- Perverse Financial Incentives—there are potential perverse incentives for individuals to seek hospitalisation for their long-term care needs rather than services within the community. In particular, this could impact middle-income families who receive significantly less subsidies than lower-income groups.

ElderShield is in the process of being replaced by ElderCare, a public scheme with longer term coverage.

Who would set the contribution rate, and with what objective?

There are several options available on how rates may be set including market forces. The underlying principle, however, must be that the same high quality standard of aged care should be available to all Australians. An independent authority would seem best placed to determine the benefits that must be available to older Australians as of right, and the price that may be paid for those benefits. The role of the body setting the price, in accordance with insurance principles actuarially calculated, is to determine the aggregate level of funding for the provision of aged care.

An independent authority should estimate lifetime costs for the cohort of actual and potential aged care recipients; that is, the actuarially calculated estimated costs of meeting the expected obligations. That cost would be reflected in the premium to be paid. The experience in other countries is that insurers will compete for business (that is, to attract funds through insurance premia) even though both the price and the obligations to be paid are fixed. The choice of insurance companies, and the ability to change insurers, promote competition on additional benefits not covered by the social insurance contract.

What policy and institutional arrangements need to be considered?

As private insurers, the Aged Care Insurance providers would be regulated by the Australian Prudential Regulation Authority and would be subject to all the prudential, supervisory and reporting arrangements currently in place for insurers in Australia. They would be required to hold prudential capital that gives confidence in their ability to pay claims when they fall due, even in the very long-term.

The introduction of competitive private insurers could stimulate innovation in aged care service delivery. However, it could introduce some new risks for consumers and government. There are questions for example about the balance of benefits and risks for consumers in the commercial arrangements that a private insurer might enter with aged service providers or in the level of flexibility that might be available to an insurer in relation to setting of premiums.

In setting up a privately delivered social insurance scheme for aged care, the government may need to consider whether changes to the existing regulatory arrangements are required to support the operation of private insurers and to protect the interests of consumers. It is assumed that government would continue to set aged care standards and to regulate compliance with those standards, though over time the aged care insurers could be expected to take an increasing interest in the performance of aged care providers, as they have done in other countries where social insurance arrangements operate. There may also be, as we have said, a need for an independent price regulator to ensure that the prices of aged care services are established on sound insurance principles.

Other details around the operation of the scheme would need to be resolved, including how a person might ‘switch’ insurers, in the same way that people can transfer their super funds from one provider to another.

Estimating the contribution rate

As a rough guide, the average contribution rate should be around the same as the fully public scheme, either pre-funded or ‘long-run’ pay-as-you-go. It might be a little higher because of the explicit capital requirements for example, but that might be more than offset by different assumptions on administrative costs and investment returns.

Questions

10. Should there be an hypothecated levy for aged care?

11. What transition arrangements would need to be in place to implement a long-term pre-funded financing arrangement?

12. Would a compulsory social insurance scheme for aged care provide more certainty about the availability of financing for future aged care needs?

13. If there were a social insurance scheme, should this be provided through a government provider or should there be a competitive market for social insurers?

14. What regulatory arrangements would need to be developed to govern the behaviour of aged care insurers and protect the interests of consumers?

Private insurance and financial products

This section of the paper addresses a spectrum of private insurance options spanning a fully private insurance model, a top-up model of 'gap' insurance, and the contribution of other private financial products.

Various forms of private long-term care insurance exist in different forms around the world. Countries where some products exist include France, the United States, Germany, Israel and Spain.[46]

While private aged care insurance schemes exist, they are uncommon and they do not provide wide coverage. Australia is not alone in eschewing private aged care insurance. A 2011 study found that across 31 Organisation for Economic Cooperation and Development countries, private insurance accounted for an average of only 0.9 per cent of aged care funding overall.[47]

One reason for considering private provision is that it potentially empowers individuals to take matters more into their own hands, rather than relying on current and future governments. The other key reason is that it potentially attracts additional levels of funding from those with means, allowing government to target more of its funding contribution to basic levels of provision. This helps achieve our expectation of high-quality care for all while increasing the scope for those with means to purchase additional services.

Private aged care insurance

It would be possible to develop a fully private insurance option to cover all, or part of, future aged care costs. This could take various forms and insurers could provide benefits—cash payouts or benefits-in-kind.

The Organisation for Economic Cooperation and Development presented the two main views on the potential for private long-term care insurance to form part of the aged care financing landscape: 'For some, this could leverage new financial resources…thereby alleviating future potential pressure for governments… For others, it could represent a less efficient and more costly way…relative to public pooling'.[48] It is worth noting that the Organisation for Economic Cooperation and Development explicitly compares private insurance to a public (or social) insurance mechanism.

A fully private and voluntary aged care insurance scheme could operate as an alternative to social insurances arrangements outlined previously, or in combination with them, for example, as an opt-out alternative to social insurance.

Given the challenges in financing higher quality care for a growing population of older people, some individuals may feel more attracted to the security that a private insurance policy may offer, as these funds would not be subject to the fluctuations of budget cycles and changing political priorities that normally apply to taxpayer funded programs. The viability of a large private insurance market would, however, depend on sufficient numbers of people taking up the product to allow pooling and risk sharing.

Example—France

France has been relatively successful in implementing private long-term care insurance. In that country, this insurance generally features:

- a lifetime level premium which depends on the age of entry. Individuals usually purchase insurance between the ages of 40 and 70 years.
- non-guaranteed premiums, which mean they can be changed at the discretion of the insurer.
- a State assessment, and an established need for support with a number of activities of daily living, to access benefits.
- fixed benefits, tiered according to an individual's partial or total dependency and generally paid in cash on a monthly basis.

Durand and Taleyson (2003) analysed the reasons for the success of the long-term care insurance product in France, identifying main features, the first being a favourable environment. With media support, there was rapidly growing awareness in the general public of the increasing cost of aged care along with a realisation that the State was not in a position to fully fund this increase. This created demand. However, sustained effort by insurance companies to develop and promote the product was required. The creation of benefit eligibility criteria linked to the need for rather than the consumption of services. Further and crucially, the criteria are linked to the State's assessment of need. The benefit is in the form of a pre-determined cash amount, more like life insurance, rather than indemnification of incurred expenses, more like health insurance. This leads to simplified administration.

By contrast, there is no recent tradition of private aged care insurance in Australia and Australian insurers have not shown any great interest in offering aged care insurance products.

Those who take out cover would pay a premium to an insurer. The coverage offered could be a reimbursement of costs incurred, as is the case in some Israeli and United States products, or the benefits could be a fixed amount, as in France. People would be able to start claiming costs once the insurer had assessed them as meeting some threshold of need.

When applying for insurance, there would usually be an underwriting process, whereby insurers select people they are prepared to cover, and the cost. Premiums could decrease for those seeking cover earlier in their lives and conversely increase for those seeking cover later. Similarly, higher premiums could apply to those who are less healthy, or be reduced for those who are healthier. Generally, premiums would be paid for a lengthy term, and in some cases, a lifetime. This would make the burden of payment less onerous for policy holders and provide the added benefit of enabling funds to accumulate money for the payment of claims. Premium rates may or may not be guaranteed. The premium loading required to offer such a guarantee could be relatively costly.

For those who might normally be asked to pay a very high premium, or even be excluded by a standard approach to medical underwriting—on the grounds that they represent a high risk of costly claims—risk-equalisation arrangements of the kind used in private health insurance would be an option to share these costs across the industry, particularly if the Australian Government mandated that applicants could not be declined.

In regard to the uncertainties we have described before and the very long-term nature of the risk, the general solution in Australia is for premium rates to be adjustable. If the insurer starts to experience heavy losses, premiums can be increased for everyone. This can create a 'death spiral' in that those who believe they are at low risk relinquish their policy, leaving those at poorer risk in the pool, resulting in further premium increases. Another approach

might be to seek re-insurance to stop the losses, either on the commercial market or from government, although this will come at a cost. Finally, the insurer's financial capital, as determined by the Australian Prudential Regulation Authority, is intended to be sufficient to ensure that all claims due can be paid, even under very adverse circumstances.

For people who choose to purchase cover when they are older, say at retirement or later, they might use a lump sum, from their super or other asset liquidation, to give themselves peace of mind. In the United Kingdom, products exist that allow a person to use a lump sum to buy an annuity to pay for aged care costs as they enter residential aged care. These arrangements are known as 'immediate needs annuities'. Novel insurance products that pay an income stream in retirement and which then pay an additional regular amount to meet any aged care costs, known as 'life care annuities' could be developed, noting that lifetime annuities have not been a feature of the Australian market for several decades. In general, annuity markets are only fully effective where people are compelled to convert their lump sum into an income product. Such arrangements would change the Australian aged care funding and finance landscape significantly.

Overall, international experience of private long-term care insurance has not been very successful; for example, in the United States, a number of insurers have withdrawn from providing long-term care insurance altogether due to poor experience. Given a choice, people often prefer to face the risk themselves and meet costs from their own resources rather than taking out insurance. The experience of private insurance products in the United Kingdom and the United States suggests that without government intervention to underwrite aged care insurance products, a combination of medical exclusions and the premiums required to cover these risks prevent anything but a limited take-up of the products.

Long-term aged care risks are insurable, and other markets show that the design issues are manageable, although it would require product characteristics that have not been common in Australia for many decades, such as risk sharing arrangements.

Even if a market did exist and take up was significant, the key challenge would be the question of how to cover the aged care costs of those who chose not to take out insurance and subsequently could not afford to meet the costs themselves by drawing on savings, assets or other sources of funding. A government safety net would be required. At the same time, that safety net would need to be accessible only after most of people's means had been exhausted. The community would need to feel comfortable with such a position to ensure that the safety net did not become the default position, which would be highly detrimental to the development of a private insurance market.

Many countries have private long-term care insurance as part of a combination of financing options. Israel is presented as a case study as just one such example of a mixed system.

Example—Israel

Long-term care expenditure in Israel was estimated to be approximately 1.2% of GDP in 2015. This is financed through various mechanisms including national funding (through the long-term care law), state funding, private insurers and individuals. In 2015, 60% of the population had some form of private long-term care insurance which covered approximately 11% of the costs associated with long-term care. These financial products are purchased primarily through three mechanisms:

- Individual Private Voluntary Insurance—individuals purchase insurance at their own discretion and select the extent and duration of coverage appropriate for them. Premiums for these insurance policies depend on the nature of coverage and level of personal risk.
- Group Private Insurance—these products are purchased by organisations such as employers and workers unions. Policies are generally limited in duration and coverage is generally cancelled when an insured member leaves the group. Premiums depend on the group's average risk.
- Health Fund Insurance—this refers to long-term care insurance policies which are sold through health funds. The fund acts as the policy owner and is responsible for choosing the insurance provider and managing negotiations.

Whilst long-term care private insurance is common across Israel, there are challenges facing the scheme including:

- Moral hazard—individuals may choose not to purchase private insurance in the belief that the government will ensure their welfare if they require long-term care.
- Adverse selection—insurance premiums are determined based on an individual's risk. Individuals have a better understanding of their risks than the insurance. As such, those who buy private long-term care insurance may be more likely to make a claim.
- High premiums—the uncertainty associated with long-term care contributes to relatively high premiums.
- Narrow insurance base—low-income individuals may not be able to afford private insurance premiums, whilst high-income individuals may prefer to bear the costs associated with care when it occurs rather than purchase insurance.
- Market risks—to meet the costs of long-term care in the future, there is a significant accumulation of funds which is exposed to capital market risks.
- Selective insurance—insurers are not required to accept all applicants. As such, those most requiring insurance such as the elderly and those with a disability are usually left without protection.
- Restrictions—there is generally a predefined ceiling on insurance benefits.
- Compromised coverage continuity—individuals may be left without cover if they leave a group plan (e.g. retirement or resignation) or if the group's long-term care insurance is not renewed.

Private aged care gap cover

There may be some scope in the future for private gap insurance to cover extra aged care expenses of a private nature, such as board and accommodation, and optional extras, that may be incurred on top of the care costs that would generally be expected to be met through the taxation system or a social insurance scheme. This scope would increase if means-testing thresholds and current caps were raised so that there was more private co-contribution expected from those of greater means.

Australians are familiar with the use of private insurance to complement the basic health care provided by Medicare. Currently, 44% of the population holds private health hospital insurance. Products can be purchased for hospital or general treatment coverage, and most often for bundles that cover both. These products provide access to nicer rooms, certain private hospitals, and effectively allow patients timely access to many surgical procedures. The same idea can be readily extended to the costs of aged care, particularly if the components of aged care are unbundled.

Private cover for aged care would differ from private health insurance in some important respects. Where the premium paid for private health insurance covers the cost of claims arising in that year, private long-term care insurance is a much more long-term product. Premiums would be paid for many years in advance of potential claims for long-term care costs. For the most part, it would have many of the features of the private insurance products described above, and so would be targeted at a very particular segment of the market that chose to purchase it, for example to protect their assets for their inheritors.

Tax deductions for long-term investments in aged care

The extension of tax deductible donations to the aged care sector could provide one way of encouraging wealthier individuals to provide additional contributions to the expenditure required for aged care services and potentially make additional funding available to expand the number of age care places and improve the quality of services.

Australian tax laws allow certain entities to be eligible for Deductible Gift Recipient endorsement.[49] School building funds are a recognised category of Deductible Gift Recipient within Division 30 of the Income Tax Assessment Act 1997. Each type of Deductible Gift Recipient has some special rules that apply to it, but they all fit within the same scheme and, unless specifically named within the Deductible Gift Recipient tables, each fund has to apply for endorsement.

Some aged care facilities are already registered as Deductible Gift Recipients. However, the practice does not appear to be widely employed and there is no distinct aged care category of Deductible Gift Recipient within the Income Tax Assessment Act. An aged care category could be created within the Deductible Gift Recipient table that deals with hospitals and health research.

Example—School Building Funds

In the education sector, donations to school building funds are eligible for a tax deduction where the fund has been approved as a Deductible Gift Recipient and no material benefit is received by the donor (Australian Taxation Office, 2020).

Donations to school building funds can significantly increase the funds available to schools and enable fees to be lower than otherwise (Wilkinson & Denniss, 2004). However, payments to school building funds as an alternative to an increase in individual school fees is not considered tax deductible. As at November 2016, there were 4850 school or college building funds approved as Deductible Gift Recipients.

Strict rules currently apply to the definition of contributions that are tax deductible. The money provided must be a gift, in that it is a voluntary transfer without any benefit passing to the donor.[50] Any direct, material benefit would render the donor ineligible for the deduction because it would not long qualify as a gift.

For example, under the current provisions, for an aged care building fund, any donation which procured a reduction in aged care fees, preferential access to the facility or other direct benefits would disqualify the donor from claiming a tax deduction for the contribution.

Based on the example of school building funds, it is likely that to benefit from Deductible Gift Recipient status, an aged care facility would need to be a public fund established and maintained solely for providing money for the acquisition, construction or maintenance of a building used, or to be used, as an aged care facility by:

a) a government; or

b) a public authority; or

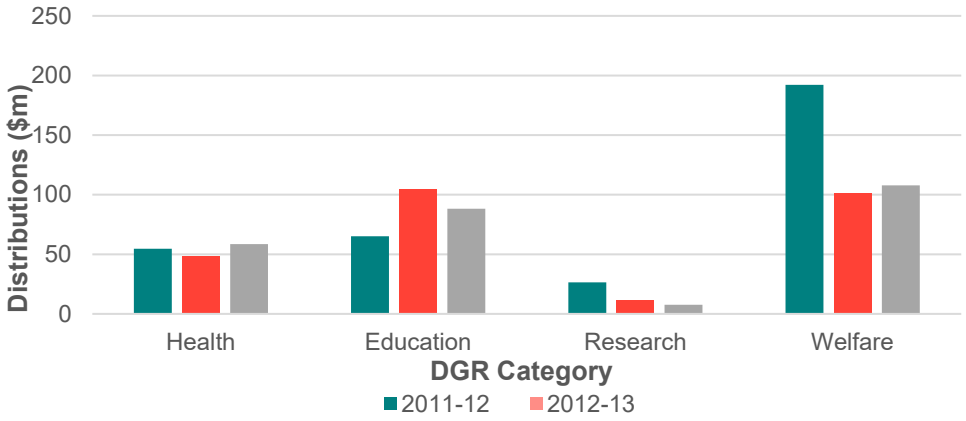
c) a society or association which is carried on otherwise than for the purposes of profit or gain to the individual members of the society or association; or

d) an entity which has been approved by the Aged Care Quality and Safety Commission to be an approved provider for the purposes of the *Aged Care Act 1997*.

In 2013–14, total distributions made to Deductible Gift Recipients over all categories totalled $0.4 billion. Figure 7 below illustrates the magnitude of donations to Deductible Gift Recipients from private sources across a range of sectors (McGregor-Lowndes & Crittall, 2017).

It may be desirable, however, to modify these rules to encourage contributions of capital to aged care facilities. Donations to facilities by donors with relatives in the facility should not disqualify the donation from tax deductibility as long as the amount donated is received by the facility without conditions as to use or entitlement to repayment or use in reducing or defraying costs of any resident.

Figure 7: Tax deductible donations by category (as defined in the Income Tax Assessment Act 1997)



Although donations are unlikely to provide a complete solution to the financing of aged care, individual donations could make a significant difference to the quality of care provided in particular services.

To fund an additional $5 billion investment in aged care, we would need commitments of approximately 25 times the total amount currently raised through all categories of Deductible Gift Recipients. This would cost approximate $2.5 billion in revenue foregone for the Australian Government.

At best, this option is only likely to form a small part of any long-term solution to the problems of future aged care finances.

Additional funding could potentially be attracted to the sector if the government were to legislate to protects the "gift" status of contributions to the aged care sector, on the basis that any benefits that might be derived by a donor would be short term in nature while the gifted capital would be retained in the sector to benefit other aged care recipients for years into the future. Further modelling would be required to assess the likely benefits of such a change for the aged care sector and the potential flow-on impacts to other sectors and government tax receipts.

Questions

15. Should private insurance be adopted to finance the Australian aged care sector?

16. How should the risks of private insurance be managed?

17. What additional specific regulatory mechanisms around private insurance arrangements might be required to protect the interests of consumers?

18. Is there value in considering private "gap" insurance for certain aspects of aged care?

19. Should tax deductible gift arrangements be extended or modified for aged care?

Combinations of financing mechanisms

While the discussion so far has largely presented different approaches for financing aged care as discrete options that are expressed as alternatives to one another, it would be possible, and may even be preferable, to apply some of these approaches in combination.

As we have described earlier, the current arrangements for financing aged care in Australia represent a mix of public and private financing, though the system relies heavily on public finance through the pay-as-you-go tax system. Other countries also employ mixed systems of financing. Japan finances its aged care through a form of social insurance, supplemented by budget contributions from general revenue and private co-contributions, while England and Wales provide a means-tested safety net system funded through the taxation system.

Aged care typically involves a mix of services, ranging from home care services, personal services, nursing and allied health support, board and accommodation, and sub-acute care. These services have different characteristics and involve a different mix of public and private benefits. Some might be considered to be in the nature of private goods, such as hairdressing or home cleaning, that the community would expect individuals to pay for while others, such as wound management or medication, are more akin to health services which Australians typically see as universal entitlements.

It may be quite reasonable for one component of aged care to be funded in one way, for example, pre-funded and/or private, and another in another way, such as pay-as-you-go and/or public.

It would be possible to design an aged care financing system that uses a combination of several of the specific mechanisms discussed above to a greater or lesser extent, for example:

- general revenue—including higher income tax to provide for higher quality care
- social insurance paid for by an employment-related levy
- higher co-contributions which could optionally be covered by private insurance and or financial products
- donations—incentivised by offering tax deductions.

Each of these mechanisms could be used to finance different components of aged care costs.

For example, it would be possible to construct an aged care system in which different financing mechanisms are applied to the different elements of aged care as follows:

- daily living supports—privately funded
- nursing and allied health supports—funded through the taxation system and co-payments as in the health system
- board and accommodation—personally funded, perhaps supplemented by optional private insurance
- personal care—funded through general taxation, a dedicated levy, social insurance or private insurance, with co-payments, or a combination of these measures.

As the discussion of options in previous section of this paper illustrated, the use of alternative financing options, in combination with one another, could help in attracting funds into the sector and contribute to a more flexible aged care system that was better able to respond to a broader range of needs and long-term care preferences. The combination of financing

options could also form part of a transition from the current taxpayer funded system to an alternative long-term social insurance arrangement.

Questions

20. Should Australia continue with a mixed approach to financing aged care?

21. Is there a case for developing different financing arrangements for different elements of aged care?

22. Are there opportunities to adopt new financing arrangements in combination with existing arrangements?

23. What would be the best mix of financing schemes for aged care?

Implementation and transition issues

Implementation of any new financing arrangements for aged care would be complex. The options outlined in this paper would involve different implementation and transition challenges. Some would be much easier to implement than others. For some, it would be necessary to develop a wholly new institutional architecture to oversee the delivery of aged care and new regulatory arrangements to govern the operation of funds outside the government's own accounts. Depending on the option, the government and the private sector would need to develop new products and possibly new businesses to collect, manage and disburse the funds that are required to provide for future aged care costs.

New methods for collecting and managing such vast sums of money would have implications for the day-to-day consumption, and saving and investment decisions by contributors. They would also have broad implications for financial and other sectors of the economy.

Some of the options would take many years to achieve their desired benefits. Transition to the new financing arrangements would need to be very carefully managed, not just because of the complexity of developing new arrangements but because of the need to avoid any disruption in the availability of funds to ensure high quality care through the transition period.

The discussion of the options in earlier chapters has attempted to identify and address some of these issues. A number of approaches have been suggested that might provide for a smoother transition to a new, longer-term financing scheme. Transition might also be managed by adopting some of these options in combination with others. However, while some preliminary work has been undertaken by those assisting us, much more detailed developmental and modelling work would need to be undertaken to establish the feasibility, practicality and benefits that might reasonably be expected from any of these options, if there is interest from the community in pursuing them.

Questions

24. What would be the best way of financing an immediate improvement in quality for aged care services?

25. What transition requirements or dependencies need to be considered when considering changes to long-term aged care financing?

Conclusion

The current system in Australia has provided for simplicity, flexibility and relative equity for the financing of aged care. However, there are pressures on the system driven by population trends and the need to invest more to improve the quality and safety of care.

This paper has canvassed a number of options for alternative approaches to financing aged care, many of which are employed in other countries.

Each of the options has strengths and weaknesses. Some, such as mandatory contributory schemes or gap insurance, are familiar to Australians, at least in concept, because they are applied in other areas. Others, such as the purchase of annuities to cover aged care costs or the use of private insurance companies to collect, manage and disburse payments to aged care providers, would be less familiar.

None of this of course is an argument against changing the current arrangements if a new financing scheme would contribute to higher quality care for older Australians. The costs of any change, including the substantial implementation and transition costs and risks, will need to be weighed up against the expected benefits.

We understand that responses to many of the issues raised in this paper will be grounded in strongly held social values and preferences. There will be a range of views on the questions we pose, and there will not always be simple solutions. This is an important debate and we encourage the Australian community to engage in this conversation in the interests of improving the quality and safety of care for older Australians.

Next steps

We invite submissions on the issues raised in this paper about the future financing of the aged care system.

We understand that the options presented in the paper have only been sketched out in the broadest terms and that our modelling is very preliminary. We hope that we have provided enough information to enable the community to see the broad directions that are possible and to stimulate comment and feedback. Subject to the feedback we receive, it is our intention to specify a smaller set of options in more detail and undertake further modelling to inform the recommendations we provide to government in our Final Report.

The main sections of this paper set out questions for consideration. These are not the only questions that could be asked and while we hope that contributions will address at least some of these questions, we also invite general comment and observations about aged care financing.

Submissions on the issues raised in this paper will be accepted until close of business on **Tuesday, 4 August 2020**.

Submissions should be sent to FinanceOptions@royalcommission.gov.au

We anticipate that these submissions will be published on our website. However, the Royal Commission reserves the right to not publish submissions, or to redact information in submissions, before publication.

If your submission is of a more general nature, or relates to other concerns, then please go to our Submissions page on the Royal Commission's website and follow the instructions for making a submission.

If you have already made a submission to the Royal Commission that includes a discussion on financing the aged care system, you do not need to repeat that submission. However, you may wish to draw our attention to that submission via the email address above.

Endnotes

[1] Transcript, Adelaide Hearing 1, Ian Yates, 11 February 2019 at T60.1–7.
[2] Letters Patent dated 6 December 2018, paragraphs (d) and (f).
[3] The Transport Accident Compensation Scheme in Victoria and the Compulsory Motor Vehicle Third Party insurance in New South Wales are examples.
[4] This is not all that is spent on the care of older people. In 2015–16, Australia spent around $41.7 billion on the health care needs of older Australians, aged 65 years or over, and $46.4 billion on direct cash welfare payments, including the Age Pension, on top of the $23.0 billion it spent directly on aged care. Welfare related tax concessions worth $40.1 billion were also provided for older Australians.
[5] Australian Bureau of Statistics, *Population by age and sex, Australia, states and territories*, cat. 3101.0, 2016, https://www.abs.gov.au/AUSSTATS/abs@.nsf/Previousproducts/3101.0Feature%20Article1Jun%202016, viewed 18 June 2020; Australian Government, *Intergeneration Report Australia in 2055*, 2015, pp 9–10, https://treasury.gov.au/sites/default/files/2019–03/2015_IGR.pdf, viewed 18 June 2020; H Kendig, P McDonald, and J Piggott, *Population Ageing and Australia's Future*, 2016, chapter 4, http://press-files.anu.edu.au/downloads/press/n2121/html/ch04.xhtml?referer=&page=11#, viewed 18 June 2020.
[6] Parliamentary Budget Office. (2019). *2019–20 Medium-term fiscal projections.* Canberra: Australian Parliament.
[7] Royal Commission into Aged Care Quality and Safety, *Medium– and Long– Term Pressures on the System: The Changing Demographics and Dynamics of Aged Care, p 5.*
[8] Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect*, 2019, Volume 1, p 10.
[9] D Kahneman, *Thinking Fast and Slow*, Farrar, Straus and Giroux, 2011.
[10] S Holland-Batt, "Magical thinking and the aged-care crisis", *Griffith Review 68: Getting On*, p 30.
[11] Ibid, p 32.
[12] Productivity Commission, *Caring for Older Australians Inquiry Report*, 2011, Vol 2, p 5.
[13] F Colombo, A Llena-Nozal, J Mercier and F Tjadens, *Help wanted? Providing and paying for long-term care* OECD Health Policy Studies. OECD Publishing, Paris, 2011.
[14] Pay-as-you-go essentially means that expenditure in any given year is more or less sourced from revenue raised in the same, or a closely proximate period. Pay-as-you-go financing for aged care can be distinguished from pre-funded arrangements in which the revenue raised in any given year is based on actuarial calculations of the long-term cost of providing care for the current taxpaying population.
[15] Australian Institute for Primary Care (1999) cited in *Options for Financing Long-Term Care for older people in Australia: A discussion paper* prepared by Jan Webster, Webster Associates Pty Ltd for the National Aged Care Alliance, January 2002, p 14.
[16] A Weier, *Legal Definition of Taxation Terms*, Paper presented to the 50th Annual Conference of the Australian Agricultural and Resource Economics Society (AARES) Conference, Sydney, 8–10 February 2006, p 5
[17] L Buckmaster, *The National Disability Insurance Scheme: a quick guide*, Parliamentary Library, 3 March 2017, p 4.
[18] Productivity Commission, *Disability care and support—volume 1, Report, 54,* Canberra, 2011, p 3 and 85 in L Buckmaster, T*he National Disability Insurance Scheme: a quick guide, Research Paper Series, 2016–17,* 3 March 2017, p 4.
[19] L Buckmaster and A Dunkley, *National Disability Insurance Scheme, 'Fully funding' the NDIS, Budget Review 2017–18 Index*, Parliamentary Library, May 2017, https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201718/NDIS#_ftn7, viewed 18 June 2020.
[20] Ibid.
[21] Australian Government, Budget strategy and outlook: budget paper no. 1: 2017–18, pp 3-8-3-10
[22] P Hawkins, A Dunkley and H Ferguson, Medicare Levy Amendment (National Disability Insurance Scheme Funding) Bill 2017 [and] related Bills, Parliamentary Library, 24 October 2017, p 8.
[23] Ibid, p 7.

[24] The Hon Dan Tehan MP, *Media release: A fully funded NDIS,* 26 April 2018; S Borys and H Belot, 'Medicare levy turnaround 'a win for all', Scott Morrison claims, as disability sector presses for detail, ABC News, 26 April 2018, https://www.abc.net.au/news/2018–04–26/disability-advocates-cautious-new-ndis-funding/9697114 viewed 18 June 2020.

[25] O Doetinchem, *Hypothecation of tax revenue for health*, World Health Organisation, Geneva, 2011.

[26] K Henry, *Australia's future tax system*, Report to the Treasurer, Part 2, vol 2, December 2009, p 333. Examples of the former include a number of agricultural levies. These levies are used to fund what the Henry Review refers to as club goods. 'Club goods' are a special type of non-rivalrous, but excludable good which can often be provided in markets. The Henry Review notes that Governments can assist in the provision of club goods by allowing the imposition of compulsory fees on certain groups, with the rate set by the beneficiaries from the spending. A recent example of the latter is the Dairy Adjustment Levy, imposed on milk sales by processors to retailers on a cents per litre basis to fund structural adjustment in the dairy industry. The levy ceased to operate in February 2009.

[27] A. Seely, *Hypothecated taxes*, House of Commons Library, 2011. p 1.

[28] Treasury 1996, cited in S Hatfield Dodds, "Practical issues in the design of environmental taxes in Australia", paper presented to the Australian New Zealand Ecological Economics Society National Conference Grounding the Paradigm, Griffith University, Brisbane, 5-7 July 1999, p 4.

[29] O Doetinchem, *Hypothecation of tax revenue for health*, World Health Organisation, Geneva, 2011.

[30] Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020, p 10.

[31] Royal Commission into Aged Care Quality and Safety, *Research Paper 2—Review of International Systems of Long-term Care of Older People,* 24 January 2020, p 72; Productivity Commission, *Caring for Older Australians*, Volume 2, 2011, p 122.

[32] Productivity Commission, *Caring for Older Australians*, Volume 2, 2011, p 121.

[33] Ibid, pp 126–128.

[34] Ibid, pp 91–92

[35] J Cylus, T Roubal, P Ong, S Barber, *Sustainable health financing with an ageing population,* World Health Organisation, 2019, pp 8–9.

[36] K Henry, *Australia's future tax system*, Report to the Treasurer, Part 2, vol 2, December 2009, p 335.

[37] Ibid.

[38] This case -study makes heavy use of information provided in the Commission's publication Review of International Systems of International Systems for Long-term Care of Older People, 2020. https://agedcare.royalcommission.gov.au/publications/Documents/research-paper-2-review-international-systems-long-term-care.pdf).

[39] Accident Compensation Corporation, *Who we are—what we do,* New Zealand Government, 12 June 2020, https://www.acc.co.nz/about-us/who-we-are/what-we-do/ viewed 19 June 2020; Accident Compensation Corporation, *Who we are—our history,* New Zealand Government, 12 December 2018 https://www.acc.co.nz/about-us/who-we-are/our-history/ viewed 19 June 2020

[40] Accident Compensation Corporation, *Supporting the Kiwi way of life, Annual Report 2019,* New Zealand Government, pp 3 and 50.

[41] Accident Compensation Corporation, *Supporting the Kiwi way of life, Annual Report 2019,* New Zealand Government, p 4; Accident Compensation Corporation, *Newsroom,* New Zealand Government, https://www.acc.co.nz/newsroom/about-us/ viewed 19 June 2020.

[42] Accident Compensation Corporation, *Supporting the Kiwi way of life, Annual Report 2019,* New Zealand Government, p 21.

[43] Accident Compensation Corporation, *How levies work—the levy setting process,* New Zealand Government, 12 December 2018, https://www.acc.co.nz/about-us/how-levies-work/the-levy-setting-process/ viewed 19 June 2020.

[44] Accident Compensation Corporation, *Supporting the Kiwi way of life, Annual Report 2019,* New Zealand Government, pp 48–49.

[45] In New South Wales, a person seeking to register a motor vehicle may choose their compulsory third party personal injury insurance insurer. This process is administered through the chosen insurer notifying a central body (Roads and Maritime) of a current insurance policy, as a condition of registration or re-registration of the relevant vehicle.

[46] Royal Commission into Aged Care Quality and Safety, *Research Paper 2—Review of International Systems of Long-term Care of Older People,* 24 January 2020, pp 21, 29, 73; Organisation for Economic Co-operation and Development, *Help Wanted? Providing and Paying for Long-Term Care: Chapter 8 Private Long-term Care Insurance: A Niche or a "Big Tent",* 2011, pp 248 and 253, http://www.oecd.org/els/health-systems/47884985.pdf, viewed 18 June 2020; Kol Zchut, *Private Long-Term Care Insurance,* https://www.kolzchut.org.il/en/Private_Long-Term_Care_Insurance, viewed 18 June 2020.

[47] F Colombo, A Llena-Nozal, J Mercier & F Tjadens. *Help wanted? Providing and paying for long-term care.* OECD Health Policy Studies. OECD Publishing, Paris, 2011.

[48] Ibid, p 247.

[49] Division 30 of the *Income Tax Assessment Act 1997* (ITAA 1997).

[50] *Leary v Federal Commissioner of Taxation* 80 ATC 4438 at 4454 per Deane J,