



## Think Tank—The Geneva Association : Providing and financing aged care in Australia

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On current demographic projections, the number of Australians aged 65 to 84 years will more than double and the number of people 85 years and over will more than quadruple by 2051. In an article from **The Geneva Association's** Health and Ageing Newsletter N° 23 (October 2010), Mr Henry Ergas, Senior Economic Advisor at Deloitte Economics Australia and Dr Francesco Paolucci, Research Fellow at the Australian Centre for Economic Research on Health at the Australian National University, say that as ageing occurs, the challenge of providing long-term care of and to the elderly will become of increasing importance.

Two facts are central to the current challenge of the changing demographics in Australia. The first is that older cohorts are living longer than ever before, with a corresponding rise in the numbers expected to live beyond the age of 70 and hence to be at material risk of requiring care. The second is that younger cohorts are having fewer children, which among other things, means they will have fewer voluntary carers to draw on when they reach old age.

These trends alone – the sheer increase in the numbers of the very old, especially relative to the potential population of carers – make large and sustained increases in the demand for aged care inevitable. Structure of demand for care However, the impacts on the structure of demand for care are also important, though more complex.

Demand for care is likely to shift from being a continuum that moves from home, into low-level residential care and then (often for only a short time) into high-level residential care, towards a pattern concentrated at the two ends of the spectrum.

At the same time, the temporal structure of care – ie the distribution of durations of care in the recipient population – is likely to change. Thus, long durations are likely to become more common in high-level care, as that care becomes less of an immediate antecedent to death.

Already, at all levels of frailty, residents with dementia remain in residential care for longer than other residents. Short stays will also remain common, and may become more so, both because of the greater prevalence of intermittent care and because many admissions continue to be as a result of acute events.

In the last three months of 2006, for example, 10.9% of discharges from high-level residential care occurred less than one month after admission and 12.2% of discharges occurred between one to three months after admission, with 70.0% and 69.8%, respectively, of these discharges being due to death. As a result, the distribution of durations of residential care, which already is bimodal, may become even more so, with a bunching of durations at the relatively short and relatively long ends of the duration spectrum. Total supply of care need to increase These changes in the level, structure and duration of demand will impose a significant adjustment burden on the aged care sector. The total supply of care will need to increase, with large absolute rises being required in the level of provision in each part of the aged care spectrum.

For example, for current ratios of places available to the aged population to be met in, say 2025, an absolute increase of 83,100 places would be required in low care (as compared to a total number of low care places of 86,000 in 2006-2007), with the corresponding increase in high care being of 87,400 places (as compared to a total number of high care places of 81,700 again in 2006-2007).

At the same time, the structure of supply will need to shift, with larger increases in community care on the one hand, and high-level residential care on the other. Supply side adjustments will also be impelled by changes in the costs of the different types of aged care. The resulting difficulties will be made all the more acute by the fact that the supply of the formal aged care workforce will also face considerable pressure as the share of the population requiring care increases. Providing for aged care costs in Australia Over the coming decades, funding aged care will place a growing burden on the community. Currently, 0.8% of Gross Domestic Product (GDP) goes on the provision of residential aged care and community care packages. Under current policies, public and private expenditure on aged care will more than double to 1.8% of GDP by 2049-2050.

Growth in spending on residential aged care is the main contributor to the increase (from 0.6% to 1.4% of GDP), although spending on community care also is projected to rise significantly (from 0.2% to 0.4% of GDP).

At the moment, the bulk of aged care funding is provided by the Commonwealth through consolidated revenue. Funding aged care in this way amounts to requiring current taxpayers, who are mainly in the labour force, to pay for the costs of caring for older Australians.

There is clearly a case based on social equity for the community to continue to fund the cost of long-term care for those older Australians who could not do so themselves. "Pay-as-you-go" system In a "pay-as-you-go" system, this redistribution occurs primarily through a shift in income from the working population to those who are retired. The extent of the inter-generational wealth transfer this entails should not be exaggerated.

An effect of Commonwealth funding of aged care is to protect the bequests made by long-term care recipients to their heirs. The exclusion of the family home from the assets tests used in determining eligibility for aged care subsidies is important in this respect, as the family home is the primary asset most older Australians own and are in a position to pass on.

As a result, the extent of the redistribution effected by the existing "pay-as-you-go" system depends on the degree to which the taxes used to cover current aged costs are correlated with the bequests that are being preserved. As that correlation seems likely to be quite high, the system may cause fewer intergenerational transfers than commonly thought. Means-testing This also means that an increase in the degree of means-testing of aged care assistance may not be as favourable to current taxpayers, in terms of their lifetime income position, as appears to be the case.

Greater means-testing of aged care assistance is effectively also a tax on asset accumulation during working life. This can reduce the incentive for lifetime savings, as well as distorting accumulation choices towards assets that escape the means-testing. These impacts need to be set against any efficiency enhancement that means-testing (or increased means-testing) may allow in terms of immediate reductions in tax burdens and associated tax wedges. Financial burden The financial burden aged care costs can impose on older Australians is already material. For example, some 25% of female and male part-pensioners with total income of A\$30,000 (US\$30,380) per annum and assessable assets of A\$160,000 who enter permanent residential low care will face an additional lifetime cost of more than A\$78,000 and A\$48,000 respectively (over and above the normal living costs they would have met if they had not entered residential aged care).

Similarly, 25% of female and male self-funded retirees with total income of A\$60,000 per annum and assessable assets of A\$280,000 who enter permanent residential low care will face an additional lifetime cost of more than A\$153,000 and A\$94,000 respectively. If they choose to receive permanent residential care on an extra service basis, then 25% of women and men with this level of wealth will face an additional lifetime cost of more than A\$257,000 and A\$157,000 respectively. These are clearly substantial amounts, even relative to average (much less median) wealth levels. Pressure to move to "user pays" Despite those increases, it is likely that the Australian arrangements are still at the relatively redistributive end of the international spectrum, and that pressures for a further move to "user pays" will persist, regardless of which political party is in office.

This is most obviously because the burden on taxpayers and on the Commonwealth budget associated with the existing arrangements seems likely to increase sharply over time.

While aged care funding currently consumes about 3% of Commonwealth revenues, by 2046-2047, Commonwealth expenditure on aged care is projected to grow (on current policy settings) to about 9% of Commonwealth revenues (assuming revenues remain at their long-term average of about 22% of GDP).

As noted above, the Intergenerational Report 2010 projects that Commonwealth aged care expenditure will increase from 0.8% of GDP, currently, to 1.8% of GDP by 2049-2050. This is lower in absolute terms than the projected increase in health costs, from 4% of GDP to 7.1% of GDP, and on the age pension, which is projected to increase from 2.7% of GDP to 3.9% of GDP.

However, the rate of growth in expenditure is the highest in aged care. The pressures to reduce this growth, and to see more of the costs borne by beneficiaries, are therefore likely to become progressively greater. This raises the question of whether a further increase in the co-payment rate is feasible, much less desirable.

An immediate constraint on placing a greater share of the cost of long-term care directly on beneficiaries is the income available to older Australians. It may be that markets would respond to an increased co-payment rate for aged care through the further development of financial products that allow consumers to convert relatively illiquid assets into current income (e.g. reverse mortgages).

Another option would be to introduce a targeted element of pre-payment into the funding of aged care: that is, some mechanism by which future beneficiaries could set aside the amount needed to cover some or all of the care costs they were ultimately likely to incur. Pre-paying long-term care The risk with “pay-as-you-go” approaches is that they can prevent sufficient savings from occurring now to allow future burdens to be met without an unjustifiably large sacrifice to consumption. The question then is whether some form of pre-payment for long-term care costs is feasible and what form such pre-payment could most efficiently take.

As the risk of incurring long-term care costs is significantly, though not entirely, a function of longevity, and the longer one lives, the greater the likelihood of needing aged care and for longer, pre-payment for the cost of long-term care involves a substantial element of insurance against longevity risk (ie insurance against longevity risk). Superannuation vs insurers Traditionally, insurance against the risks associated with longevity was provided by superannuation schemes. These schemes amounted to buying an annuity, which provided an income stream for life in retirement.

The move from such defined benefit schemes to defined contribution schemes has, somewhat paradoxically, removed this form of longevity insurance just as population ageing makes longevity risk a matter of greater concern. Moreover, annuities generally have high loadings and low rates of voluntary take-up.

It is of course possible for public policy to seek to incite greater annuitization – indeed, there are jurisdictions (such as the UK and Germany) where some degree of annuitization of retirement savings is mandatory. However, even were that to occur, it seems unlikely that the amount of those annuities could realistically provide for long-term care costs – much less do so efficiently.

Rather, it would seem more efficient to allow the risk to be pooled through some form of insurance targeted at long-term care. The question, however, is the extent to which the risk of long-term care possesses the characteristics required for a risk to be insurable.

Prima facie, there is no obvious reason why it should not be possible for private insurance markets to offer insurance against long-term care costs. Also insurance products aimed at covering long-term care costs exist in a number of countries. However, experience in Australia and overseas suggests that the widespread development and take-up of these products encounters substantial difficulties. May not be an attractive market for insurers

Three factors seem to be involved: • Complexities involved in devising and properly pricing long-term care insurance products, for example because the need for care depends to a considerable extent on the health of the potential recipient's partner. • Voluntary markets for long-term care are most likely to be affordable for younger consumers, but those younger consumers are unlikely to be much concerned about long-term care, especially if they discount the future at hyperbolic rates. • Purely voluntary markets are likely to be constrained by the Commonwealth assurance to a universal and high-quality safety net services (ie public insurance). As a result, it is not apparent that voluntary demand for long-term care insurance would be sufficient to make this an attractive market for insurers. Going forward Internationally there would appear to be a general consensus that the ageing of the population will drive the need for reform in long-term care.

Any reform of long-term care in the Australian context needs to balance the needs of social policy – for example, ensuring equity of access, including in geographic regions not normally amenable to market forces, and addressing the information asymmetries inherent to health markets and especially prevalent in the voluntary markets for long-term care insurance – with those of fiscal policy, while providing greater scope for competition, service differentiation and innovation than current arrangements permit.

Experience to date is not encouraging as regards the development of efficient, voluntary forms of pre-payment for long-term care.

Superannuation alone is unlikely to be sufficient, at least in the relatively near term, for the vast majority of Australians. Annuities might provide a means of procuring some additional coverage against longevity risk, but the market for suitable annuities products is not well developed.

Moreover, seeking to cover the risk associated with long-term care costs through annuities alone would likely imply inefficiently high-level of bequests. Finally, as the most direct form of cover – voluntary long-term care insurance – has not proved effective, the introduction of universal mandatory coverage with consumer choice of plan and (risk- and income-related) subsidies represents a viable and efficient option in the long term.