Joint Submission to the Productivity Commission

Aged Care Association Australia and Deloitte

6 August 2010

Funding strategies for the Future

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Caring for Older Australians

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Dear Productivity Commission

Re: Caring for Older Australians Public Enquiry

We appreciate the opportunity to provide you with our collective views on certain of the issues which you have been asked to consider as part of your review of the Australian Aged Care system.

Please find attached our joint submission to be considered as part of your Caring for Older Australians Public Enquiry. Our submission is presented in 3 sections:

- Introduction
- Possible models to ensure sufficient savings are available to fund future aged care needs
- Strategies for effective funds' dispersal

We have also provided some further information in 2 appendices:

- additional research that we believe should be undertaken before final decisions are made
- a high level summary of the aged care funding model currently being used in Singapore

We hope that this submission is of benefit to you and would be pleased to address any queries that you might have with respect to it.

Yours sincerely

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1. Introduction

1.1 Changing demographics

1.1.1 While long term demographic projections contain an unavoidable element of uncertainty, it is widely accepted that the number of elderly people in the Australian population will rise rapidly in coming decades. Much of that increase will involve a rise in the number of people who are very elderly, including centenarians.

1.1.2 What is less certain is how the health status of that elderly and very elderly population will evolve over time. It is possible that advances in medical technology and in general population health will result in a postponement of morbidity and more broadly, of disability. On the other hand, it still seems likely that even with general improvements in population health, normal processes of senescence will result in substantial numbers experiencing frailty and a reduction in the ability to undertake activities of daily living. Even if the average health status of the elderly and very elderly population were to improve greatly relative to earlier decades, the sheer numbers surviving to very high age brackets would result in a very large increase in the population requiring care because of frailty or other conditions.

1.1.3 One aspect of this increase is a likely rise in the numbers requiring care for prolonged periods of time. To some extent, this simply reflects the increase in life expectancy, which, even with some compression of morbidity, is likely to translate into a lengthening time gap between the onset of conditions requiring care and death. Additionally, Australia is also likely to experience a significant increase in the prevalence of chronic diseases, with a particular likelihood of an increase in the prevalence of dementia (the incidence of which rises rapidly at higher age brackets) and of diabetes (and associated co-morbidities). Those chronic conditions give rise to enduring long term care needs, with care needs typically rising substantially with age.

1.1.4 The overall result is likely to be a rapidly growing population requiring care, but within which the level of care needed, and its duration, varies greatly (going from relatively low levels of care on an occasional basis, through to intense care for a period of 10 or more years).

1.1.5 At the same time, changes in family structure and more broadly in social structure will affect the availability of care and especially of informal care. While these changes are still poorly understood, relevant factors include a reduction in the number of children per family unit and rising female labour force participation rates, both of which tend to reduce the availability of informal carers. The changing multi-cultural background of the population will also influence the level of informal care provided and have an impact on the needs and requirements of the elderly in the future.

1.1.6 It is true that there are some trends that could reduce the incidence of widowhood, and hence increase the availability of informal care from a spouse or partner. These include reductions in the age gap between partners at the time of marriage (which decreases the number of years of widowhood because it diminishes the likelihood of husbands pre-deceasing wives), along with the reduction generally in the gender difference in life expectancy. However, even within a couple, as the spouse or partner ages, and he or she becomes frail and unable to cope with activities of daily living, the availability of informal care diminishes; and with fewer or no children to draw on, those couples must then rely on formal sources of care. At the same time, there is an increase in the numbers in the elderly and very elderly population who are divorced or have never married, and hence have less access to informal care.

1.1.7 Overall, therefore, the increase in the number of elderly Australians requiring care is likely to coincide with a reduction in the availability of informal care (both in absolute terms and relative to the size of the care-requiring population), increasing the expansion that must occur in the formal care sector if care needs are to be met.

1.2 Financing future aged care

1.2.1 The issue then is how such an expansion could be financed. It is important to start by noting that current financing arrangements are not capable of supporting the expansion in supply that is needed. Currently aged care funding is financed from current tax payments. The changing demographics as outlined above will result in a significantly lower percentage of current tax payers to elderly requiring financing. It is also worth noting the substantial estimated intergenerational wealth transference generated from the sale of family homes and the question of whether this wealth should be applied to services for the elderly or simply continue to be a transfer from one generation to the next.

1.2.2 The most obvious problems arise from the inability to charge entry bonds into high care. This has made the availability of funding for expansion of the accommodation stock in high care dependent on the level of other, regulated, charges. The level of those charges has proven inadequate to finance that capacity expansion, with the problems then being exacerbated by the absence of geographical differentiation of accommodation charges in a way that would reflect differences in costs. As a result, a rising share of the growth in high places has occurred in the extra service segment (where bonds can be charged), but the decision to implement the policy cap on extra service places at local area level has now closed off that option in many of the places where capacity expansion is most needed.

1.2.3 The problems this creates are compounded by the differential trends in demand as between high and low care. The Aging in Place policy, as well as minimising the disruption to clients, has also allowed providers to cover at least some part of the common costs of high care places through entry bonds charged in low care. However, while low care continues to expand, it may not expand as rapidly as the required growth in high care places. As a result, the needed growth in high care places will not be able to be financed through bond payments in low care.

1.2.4 These constraints are likely to become ever more apparent as substantial parts of the current stock of residential care accommodation reach the end of their useful life. Replacing or renewing these premises will be made all the more financially challenging by rising regulatory and community expectations, which involve single bed wards (whereas 3 or 4 bed wards continue to account for a significant share of the existing stock). Altering existing 3 or 4 bed wards to single ward standard implies a material cost increase, which will simply not be viable at current and projected levels of the accommodation payments.

1.2.5 There are also issues of financial adequacy in community care. Transport costs have a major impact on the costs of providing community care; so also do staff costs. Both of these have been rising more rapidly than the community care payments and are likely to continue doing so. While there is some potential for new technology to reduce costs in community care (for instance, through improved remote monitoring), those reductions are not likely to be sufficient to offset other sources of cost increase, including rising levels of acuity in the population being served. As those cost pressures play themselves out, providers will have little choice but to reduce the hours of care they provide for each package.

1.2.6 The difficulties in this respect are accentuated by the very large gap between CACP and EACH payment levels. This gap means that allowed payments do not increase in line with acuity – rather, they remain largely constant before then experiencing a large rise. However, the trend in care provision is likely to be dominated by an 'aging in place' phenomenon, where recipients of care experience steadily rising acuity while remaining in a domiciliary care setting. The current payment structure is poorly suited for such an environment.

1.2.7 Further difficulties with the financing of community care are likely to arise from the move to consumer-directed care. This involves shifting some or all of budget control into the hands of the consumer, which can have many benefits. However, it also means that providers can no longer subsidise high cost to serve cases from low cost to serve cases. The result will be to erode the ability of providers to bridge the acuity gap noted above through cross-subsidisation within the pool of consumers.

1.2.8 Combined, these factors mean that meeting the growing demand for care will require a significant increase in the flow of funding to the sector. The question then is the appropriate balance in that increased funding as between consumer contributions and payments from the Commonwealth.

1.2.9 In principle, the primary financial role of the Commonwealth should be to finance care for those elderly Australians who are not in a position to themselves cover its costs. In that sense, the Commonwealth has, and must retain, a primary responsibility to ensure an adequate social safety net is in place. Conversely, those consumers who are in a position to cover their own care costs should do so, thus minimising the call on public expenditure and hence also minimising the need to impose distorting taxes so as to fund that expenditure.

1.2.10 The Government also has various secondary roles, including regulating the quality of care provided to the elderly and ensuring care is available across the states particularly in more remote and rural locations.

1.2.11 However, it also needs to be recognised that in practice, there are significant constraints on how much larger a share of aged care costs can be borne by elderly Australians without compromising equity of access (and/or on how rapidly a shift to greater consumer co-contributions can occur):

1.2.12 Many elderly Australians have limited assets and income, and a substantial share of what assets they own involve the family home. While that home can be sold at the time of entry into residential care, it may not be so readily sold if only one member of a couple is going into care. Moreover, domiciliary care provided in the family home obviously cannot be funded through the sale of that home, though there may be ways other than sale of unlocking the consumer's equity in his or her home. We note that many Australians who retire in the future will also have pools of superannuation available to them built up through the compulsory superannuation levy, though there are concerns that the amounts of super available to retirees will not fund their retirement needs let alone their aged care needs.

1.2.13 Unlike younger people, people needing aged care are almost never in a position to top up their income by working. As a result, they cannot compensate for shocks that reduce the value of their real income (such as an increase in aged care co-contributions) through a change in labour force status. This means they have significantly less ability to adjust to price shocks than do other sections of the community.

1.2.14 While care requirements generally will rise, the spread in care costs within the elderly and very elderly population will remain large, as some consumers may require relatively little and occasional care while others require intensive care over a very long period of time. The costs facing those at the upper end of that distribution are likely to substantially exceed the assets owned by most elderly Australians.

1.2.15 Given these constraints, ensuring that older Australians can help finance their care costs requires:

- *A carefully designed, long-term transition path, which will assist planning by consumers, care providers and care financiers (ie banks, super funds etc);*
- *Measures which can help consumers set aside and then access the financial resources they will require; and*
- *An approach that caters to the likely spread in care costs, i.e. that has an element in it of insurance and risk-pooling.*

1.2.16 There are a number of approaches which can meet these requirements. Assessing these alternatives requires a conceptual framework that can link back to the efficiency and equity objectives the Commission will want to achieve.

1.2.17 From an efficiency perspective, there can be benefits to approaches that ensure consumers accumulate the savings required to cover at least some part of care costs. In effect, to the extent to which those savings remain the property of the consumer (as in superannuation), mandated savings may not impose substantial distortion on labour market decisions (assuming consumers treat the savings as deferred income). Moreover, if consumers are using their own savings to finance care, moral hazard in care decisions may be reduced, which is likely to be especially important for domiciliary care.

1.2.18 However, if consumers are restricted in the use of those savings (for instance, if the savings can only be used to finance aged care), there is a distortion to consumption. Additionally, depending on the level of the required saving (and the scope for consumers to borrow against those savings), consumers may be forced to leave higher bequests than they would otherwise have chosen to do. This excess bequests distortion (and the associated reduction in life-time utility) is obviously especially large if the mandated savings level is set in line with average expected life time care costs while the distribution of those care costs is bimodal or in any event, highly skewed (so that many consumers will experience costs well below the mean, while some others will experience costs many times the median).

1.2.19 These considerations suggest that any mandated pre-savings (as in an 'aged care savings account' system) should be set to a level consistent with at most median expected costs. Higher costs would then need to be funded through some kind of insurance or risk pooling mechanism. That mechanism could either be determined through a distinct instrument (for instance, a levy on some part of the mandated pre-savings, which would then form part of a tontine), or using some broader instrument (for instance, as an adjunct to the Medicare Levy or even through PHI). There are obvious policy issues to be considered about whether it is preferable to make this insurance explicit (or simply provide it through the Commonwealth safety net arrangement), and if so, whether it should be mandatory (the risk being that if it is not, consumers may 'free ride' on to the Commonwealth safety net and additionally, there is a risk of adverse selection undermining the quality of the risk pool). To the extent to which the insurance was mandatory, there would then be issues about whether it should be community rated, whether a scheme along the lines of the Life Time Cover arrangements should be imposed, and about financing contributions to the scheme by low-income consumers. Any such scheme would also involve complex transition and scaling up issues.

1.2.20 Set against this background, this submission outlines some approaches that may be worth considering.

2 Possible models to ensure sufficient savings are available to fund future aged care needs

We believe that the options outlined below are not necessarily mutually exclusive and a combination of these ideas could be considered.

2.1 Use of Superannuation or other long term saving products

2.1.1 Our first conceptual idea is to open up superannuation or other long term saving products e.g. savings account, long term care insurance. This would require a system whereby care and services would be separated from accommodation and each funded differently which would provide flexibility for both the provider and the resident.

2.1.1.1 Residents' individual superannuation funds would be used to pay for care and services, whereas the cost of capital would be funded by the superannuation industry as a whole. We believe that incentives would be required for this to occur (possibly tax incentives) or government legislation to ensure minimum investment % of the funds into the industry.

2.1.1.2 The system would operate under a similar funding model to that used to fund private medical insurance.

2.1.1.3 At a particular age (e.g. 40-45) a portion of superannuation contributions would be set aside for aged care needs.

2.1.1.4 If these funds were not all used to provide for a person's aged care needs, then either the entire balance would be forfeited to the larger fund or alternatively, the employer portion would remain in the fund and the voluntary contributions would be released to the family.

2.1.2 The operator would benefit through user pays for care and services and should benefit from gaining access to capital. The model would be similar to a private hospital, with options based care and services, therefore the operator would be able to fund debt from loans out of superannuation funds.

2.1.3 This model could potentially lead to a reduction in the government burden for care cost if used as an incentive for younger ageing and wellness. It also moves the burden of funding to the consumer through superannuation payments during their working life, although the government would still be required to provide a safety net level of funding and would still have a vital role in ensuring that quality of service was maintained. As the funds increased over time, this requirement could possibly reduce the government's funding burden if the option of accumulating unused funds was adopted. The government could make a mandatory increase in the superannuation levy to reduce their burden or it could be voluntary only for levels of care above base levels.

2.1.4 This model could also have further benefits if the superannuation system was opened up to allow children to contribute for the aged care needs of their parents.

2.2 User (resident) pays system

2.2.1 Our second conceptual idea is also based on separating the care and accommodation aspects of aged care and then allowing the resident to pay for the care and accommodation based on the quality of the service provided.

2.2.1.1 As opposed to the current system where the basic level of service is underpinned by the resident, under the resident pays system, the basic level of service would be underpinned by some level of government support.

2.2.1.2 The monthly retention of the accommodation bond would need to be changed from a cap to a floor arrangement and could be used by the resident to fund care and accommodation.

2.2.1.3 As an ancillary matter, we also considered that across the board investment in the industry (i.e. investment across all levels of service and accommodation) would only occur if a number of the regulatory burdens on the industry were removed.

2.2.2 This should allow the operator to derive a reasonable rate of return and provide greater transparency in charging. It would result in the removal of regulatory burdens which create inefficiencies and would result in an increased ability to attract capital market funding.

2.2.3 This model would ensure that the government could focus regulation on the level and quality of care and would involve the provision of a safety net for basic care for those who cannot afford it and a guarantee in the case of 'resident default'.

2.2.4 This would benefit the resident through greater transparency in charging and the ability to choose service and accommodation levels to their liking (but also their affordability). It would also result in access to better quality facilities and care given greater investment by the industry.

2.2.5 This model could result in the wealth and income of family being used to fund the resident care and accommodation needs of their parents/grandparents although we note that the removal of the government funded place may create some initial uncertainty in funding and prompt a pull back on bank lending guidelines which would need to be addressed.

2.3 Use of insurance products

2.3.1 Our third conceptual model involves the use of different forms of insurance to fund aged care e.g. Public (e.g. Medicare), Private, and /or Social.

2.3.1.1 In our view, insurance would not be for base level aged care needs. This is a method whereby the costs of care above base level would be prepaid for users of the aged care system.

2.3.1.2 The system would be deregulated and the Government would provide a minimum underwritten level of accommodation ("e.g. 4-bed ward services") and services / care with existing co-payment arrangements. On top of that insurance would provide funds for levels of accommodation and food above base levels (and possibly care above base levels).

2.3.2 This model would encourage a deregulated environment with opportunities for product differentiation. Government would still be responsible for base care.

2.3.3 Insurance products could be acquired by individuals and used either by the individual or their carers/relatives. The method is cheaper for individuals than the alternative of pure savings schemes where everyone has to save enough to meet the costs even if they end up not using the system.

2.3.4 In order to ensure that the pool of funds was sufficiently large, the government could make the scheme mandatory or make it an opt out scheme or incentivise individuals in a way akin to the current private health insurance arrangements.

2.4 Use of capital markets for funding requirements

2.4.1 Our fourth conceptual idea involves the wider use of capital markets for funding requirements. Current bonding and debt arrangements lack flexibility and are a limited source of capital so Aged Care businesses will need to attract other sources of capital.

2.4.1.1 Capital market funding would include:

- *Superannuation funds*
- *Stock markets*
- *Private capital*
- *Private Health funds*

2.4.1.2 The funding of accommodation costs (capital markets / superannuation / private capital) should be separated from the funding of care costs (supported by government) to allow a greater diversity in the mix of the accommodation.

2.4.1.3 The current level of regulations would need to be reduced to make the industry more attractive for investment. The cap on the rate of return would need to be lifted to make it attractive to the capital markets. In our view we believe that the capital markets would need a 15% pre-tax rate of return as a minimum in order to proceed with additional investment. The rate of return could be assisted by reducing the tax burden on aged care businesses – i.e. State/ Federal, direct and indirect taxes. Owners could also get relief through a "negative gearing" type model.

2.4.2 The Government would still need to provide a safety net for base levels of accommodation and base this on individual or family means tests. However as the levels of investment and return increased over time this might reduce. The government would still be required to fund care under this model.

2.4.3 This would result in increased access to funding for operators and improved margins, and thus more investment.

2.4.4 Residents would benefit through access to more diverse accommodation as well as more choice.

3 Strategies for Effective funds dispersal

3.1 The Current position

3.1.1 The key components of funding for care recipients are:

- *Care & Personal Services*
- *Accommodation and Hotel Services*

3.1.2 Currently Government provides approximately 80% of aged care funding

3.1.3 Means tests and regulations discriminate for and against many care recipients in accessing their care and accommodation needs. Numerous anomalies, inconsistencies and imbalances have grown out of a system focused on management of demand for aged care, services and accommodation within the government appropriation system. This is entirely understandable as good Government must be held accountable for its expenditure. However, what we now have is a system where Government is the price setter, price taker and price controller with complex regulation and controls to protect its interest in the process.

3.1.4 Some of the many examples of distortions arising from this system that impact access for Care Recipients are: Discrimination on bonds for High Care residents, arbitrary and inappropriate concessional resident ratios applied nationally, an inadequate mechanism for indexation of subsidies, inappropriate rural and remote subsidy, discrimination in means testing mechanisms, inappropriate and discriminatory limitations and exclusions on extra services, and restriction or effective elimination of additional services.

3.1.5 The current rigid and inflexible system exists in a changing environment and where higher and more complex levels of care will be required by many and where Care Recipients will seek more choice over their care needs than the current one size fits all model.

3.2 A Suitable Pricing Mechanism.

3.2.1 To implement a funds disbursement mechanism that will be suitable for meeting emerging changes in demand and in the scope and range of services, the Industry and Government will both need a more responsive method to ensure the above key components are priced accordingly.

3.2.2 What is needed is an independent mechanism for calculating an appropriate economic cost of care & personal services and levels of hotel and accommodation services. The task of undertaking this cost assessment should be allocated to an independent Authority or Commission (ie consider the possibility that that function be undertaken by the new Hospital Pricing Authority) for the ongoing evaluation, calculation and administration of this cost mechanism.

3.2.3 This can then serve to be the price setter, whereby Government as purchaser, can determine the level of services it will fund and to who it will fund into the aged care system.

3.2.4 It can also be the price setting mechanism for care recipients in choosing the services they wish to access and the type or quality of accommodation and hotel services they procure.

3.2.5 Government will then have a much simpler task ahead of it, deciding which services/accommodation it purchases and which is left to the Care Recipient to fund.

3.3 Effective disbursement of aged care funding

3.3.1 So, how then to disperse aged care funding effectively? How do we convert the savings of care recipients to disbursements to Care Providers and how does Government facilitate a disbursement structure efficiently and effectively?

3.3.2 Recipients are currently converting their savings, much of which is in their family home, to buy their aged care accommodation through payment of bonds/charges. The wealth in the family home has been enhanced by Government tax treatment, which applies an exemption on the principal family residence.

3.3.2.1 Savings Options

3.3.2.1.1 Introduction of a supplementary national aged care savings scheme could be made through the extension of the superannuation guarantee scheme to generate a pool of funds preserved for procuring health and aged care services for all citizens older than seventy five years.

3.3.2.2 Insurance

3.3.2.2.1 Health Savings Accounts - Government approved tax effective savings accounts that are preserved for health and aged care service funding above an agreed age e.g. seventy five years

3.3.2.3 Long Term Care Insurance

3.3.2.3.1 Government approve a tax effective long term care insurance product that could be offered through the Private Insurance Industry or through general insurers.

3.3.2.4 Private Health Insurance

3.3.2.4.1 PHI providers are either obligated or provided with incentives to expand their product offering to include a range of aged care specific services and products that could be delivered in either the home or residential care.

3.3.2.5 Public Insurance

3.3.2.5.1 Medicare be required to extend the range of options that it would offer customers to cover long term care and home based service provision

3.3.3 Having established a Price setting Authority, and a price for the components of care, personal services, hotel services and accommodation, Government can then select the level it will fund and the components it will support for all or some of these, for different classes or levels of Care Recipients.

3.3.3.1 The Recipients can then access their savings, to fund the balance of care , services and accommodation or access one of the long term funding options outlined above

3.3.3.2 Government would be obligated to provide a substantial safety net for the complete service and accommodation offering for anyone not in a position to contribute to their hotel, accommodation or care services.

3.3.3.3 The options above other than the Medicare extension all have relatively long lead times to generate a sufficiently large enough pool to be self sustaining. It would be necessary therefore for the Government to provide substantial bridging support during the transition phase during the pool creation period.

Appendix A

Possible areas for additional research

1 How large is the funding gap today? Can it be reasonably quantified? What does it look like today – split between residential care and care in the home? How would it change if funding models change?
2 Superannuation modelling – what impact would an additional 1% of super saving have on the funding gap? What preserved component would be necessary to fund aged care needs?
3 What are the likely impacts of deregulation on investment / funding?
4 Models used in other countries (eg Singapore, Netherlands and the USA)? What can be cherry picked?
5 Private health company involvement / products
6 What sort of tax or other incentives would work for capital providers?
7 Current rates of return?
8 What impact would reducing the tax burden on the industry have on investment?

Appendix B

An overview of Singapore's funding schemes for the aged

B.1 Overview

Funding for the needs of aged people in Singaporean society has been formalised in a number of financial schemes. These provide firstly for the compulsory accumulation of savings throughout a person's working life, then for the orderly disbursement of these savings throughout retirement.

Alongside the retirement savings scheme is a separate medical savings scheme Medishield, which allows the health costs at older ages to be funded by savings made earlier in life.

Integrated with the compulsory savings schemes are voluntary insurance schemes covering hospitalisation costs and severe disability; and also home financing arrangements.

The overall impact is that the options faced by aged people in Singapore are greater because of the degree of savings required during working age.

B.2 Retirement savings and disbursement

The Central Provident Fund Board (CPFB) is the government institution that collects and manages retirement savings funds for all citizens and permanent residents. CPFB recently celebrated its 55th anniversary, and the Singapore retirement savings system has been in operation for that long.

At March 2010 membership was 3.31million people, with members' balances totalling SGD172 billion (about AUD143billion)

Contributions to the CPFB are made primarily by employers, with contributions combined for retirement and medical savings. Contributions for retirement are around 28% of earnings. These reduce for the lowest incomes, and also for people at older ages particularly above age 60. The combined retirement and medical savings (see B.3 below) contribution rate is often quoted at around 35%.

At retirement members receive a regular payment from their retirement funds, although until 2009 those payments were not designed to last throughout a person's life. This has been recently been redesigned, and from 2013 people reaching age 55 will place their funds into a compulsory longevity insurance scheme ("CPF LIFE scheme"). This scheme pools the longevity risk among all members, and so can ensure that all members receive an income throughout life.

Members are also able to access these retirement funds in order to buy a home.

B.3 Medical savings

The compulsory Medical Savings Scheme "Medisave" is also operated by the CPFB, under the sponsorship of the Ministry of Health. Contributions are made by employers and are generally in the range 7% - 9% of earnings. This is reduced for those on lower incomes. The higher rates of 8%-9% apply to older people, with 7% applying at the younger ages.

Medisave funds can be used to pay for health treatments in hospital, and also for a defined set of treatments out of hospital. They can be used for family and dependants of the contributor.

To ensure that there is likely to be sufficient funds for a person's medical needs in their retirement, there is a Medisave Minimum Sum requirement of $34,500 that must be retained in the fund at withdrawal age.

Medisave funds can also be used to pay insurance premiums for the health and ageing insurance schemes sponsored by the government (see B.4 below).

The increasing cost of health care with increased age is a clear motivator for the existence of this scheme.

B.4 Insurance Schemes

Long term Care – Eldershield

Eldershield is a severe disability income scheme that pays income benefits on a person's inability to perform 3 or more Activities of Daily Living (ADLs). The range of ADLs is similar to those measured under Australia's ACFI aged care funding regime, although not identical.

Standard benefits and premiums are specified by the Ministry of Health ("MoH") and confirmed following a tender process with insurers. These benefit levels are set by MoH against an understanding of the out-of-pocket costs for home care after allowing for government subsidies of this service.

These standard benefits and premiums are enforced by two devices. The first is the ability of MoH to allow premiums to be paid out of Medisave – if a product does not meet the requirements, premiums cannot be paid from Medisave. The second is the allocation of new members – all people turning age 40 are "allocated" to a participating insurer who then offers membership of the standard scheme. Take up rates are very high, with over 750,000 members currently in the scheme – a high proportion of the eligible population.

The insurance risk is carried by private sector life insurers, who each offer the standard scheme benefits and premiums that result from a formal tender proves carried out by the Ministry of Health.

In addition to the standard benefits, those insurers who participate in the standard scheme are also authorised to offer supplementary improved benefits, again with the premiums being paid out of Medisave.

Health – Medishield

Medishield is a health insurance scheme offering hospital payouts that enable people to receive standard ward hospital treatment without financial embarrassment. Premiums are paid out of Medisave. As with Eldershield, private insurers are authorised to offer supplementary insurance benefits.

Unlike Eldershield, insurance risk for the basic scheme is carried by the Central Provident Fund through its Medishield Fund.

Insurance premiums are age-related, but for older people are kept affordable by two devices:

- Premiums are payable of of Medisave, meaning that a person can save through their lifetime for the health costs at old age
- For people over age 70 who joined Medishield before age 60 there is a (non-guaranteed) system of premium discounts.

Members are able to pay Medishield premiums on behalf of other family members and dependants, providing another route to pre-funded support for older people.