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Inquiry into Caring for Older Australians
Productivity Commission
Canberra, ACT
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Thank you for the opportunity to make a submission to the Productivity Commission's Inquiry into Caring for Older Australians. I will discuss the relative merits of public and private insurance schemes for aged care and then lay out a research agenda that would support a more thorough examination of the reform options.

Much of the discussion of aged care reform involves differences in political philosophy with regards to the appropriate role of government. As such, it involves things that can neither be proved nor disproved. On the other hand, there are some issues that can be informed by rigorous quantitative analysis. It is on these issues that this submission focuses.

Specifically, there are a number of goals that the government might seek to advance in reforming its aged care system: reorienting the system so that care can be provided in the least restrictive setting; avoiding catastrophic out-of-pocket spending by beneficiaries; and being more efficient in targeting benefits to those most in need. Some of these goals are complementary and can be achieved together, while others speak to the strong preferences of users and their families. The government must decide which goals it chooses to maximize and undertake analysis to understand which reform options offer the greatest success at moving towards those goals.

I look forward to a lively debate around these topics and am happy to contribute to the future discussion in any way I can.

Yours sincerely,

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1. SHARING THE FINANCIAL BURDEN: THE RELATIVE MERITS OF PUBLIC AND PRIVATE INSURANCE

It goes without saying that the current system of financing aged care in Australia is unsustainable. In looking at reforms, one of the most important goals for the Commonwealth should be to treat aged care as a ***normal risk*** of living and of growing old. Mechanisms should be established so that people will know how they will pay for services should they need them rather than it being an unpleasant surprise. Among other things, this should include that the commitment of public resources is reliable and that the private share is not onerous. As cost of care often exceeds the resources of the average family, one of the great fears of the older person is that, without reliable funding, they will be a burden on their children. At a societal level, the future cost of care might very well exceed the willingness to pay of working-aged people.

The relative roles that the public and private sectors will play in the financing of aged care in Australia is at the centre of this discussion. This includes how to build on the existing aged care funding scheme and how the Commonwealth might introduce some form of public and/or private insurance option. The need to focus on insurance options stems from the fact that certain aspects of aged care represent a textbook case of an insurable event in that the probability of needing care is low and unpredictable while the cost of that care is high.[1]

Australia should be prepared to have in place strategies that anticipate the future demand for aged care and mechanisms to spread the financial risk of aged care over the ***widest possible population and over time***. Two issues are at play here. First, the cost of care should be spread over the largest group of people—i.e. the cost of care should not fall only on the people needing it thereby creating a financial catastrophe for the user. Second, the cost of care should be spread over time as the dependency ratios are shifting[2] and some level of pre-funding will be needed to even out the burden of paying for care into the future.

There are three distinct topics that merit investigation:

- First, what are the distributional consequences of using various public and private strategies. This includes looking at both the financing system (the "who pays") as well as how eligibility for services is determined (the "who benefits"). These analyses would be informed by the kind of simulation modeling that has been done previously in the U.S. [3]

[1] Residential care, particularly at the highest skill level, is especially relevant to this example. Of the 2.6 million Australians aged 65 and older in 2004, less than one-quarter or 562,000 were severely disabled. Over two-thirds or 382,000 of this group of severely disabled are living at home; the remainder are in care accommodation, largely nursing homes or other non-private dwellings. (Author's calculations based on ABS, 2004) At an average annual cost of about $57,000, residential care can be extremely burdensome to pay for. At present, about 70% of this is paid for by subsidies from the Australian Government ($48,550 for high care, $17,750 for low care). In 2006, about 68 percent of permanent residential aged care residents were classified as high level care; 32 percent low level care (Australia's Welfare 2007, AIHW, p. 124).

[2] Economic Implications of an Ageing Australia, Productivity Commission, 2005.

[3] Wiener, Hixon Illston and Hanley use a simulation model to examine a wide range of financing approaches to reforming aged care in the U.S. and the impacts they would have 25 years forward.

- Relatedly, what is the potential demand or market for private insurance and how might it be configured to wrap around the existing public benefit?
- Third, what are the non-conventional methods that might be used to fund the private share of aged care needs?

a. Distributional consequences of various systems

An explicit understanding of who benefits from a particular aged-care system and who pays for that system helps policymakers make informed decisions about the direction of reform. It is clear that, to be consistent with current Australian policies on health and aged care, the burden of paying for care should not fall only on those needing care; rather it should be spread across the widest population. For example, ***if*** the average annual cost of residential aged care is $57,000,[4] a large proportion of older Australians would become impoverished if they had to shoulder the burden themselves. Depending on their pensioner status and level of assets they own, the current resident contribution toward this care can be quite significant perhaps as much as 60%.[4] With general revenue funding, current aged care programs in Australia have a broad revenue base and spread the financial burden widely across people. However, there are two drawbacks associated with this kind of ***pay-as-you-go*** public funding.

First, general revenue funding is less reliable than a dedicated funding stream as it is contingent on the Commonwealth's other spending priorities. Competing with aged care programs for general revenues are a broad set of programs running from education to transportation to environmental protection. Second, this funding mechanism does not allow for spreading the financing burden ***over* time.** As the population ages and has an increasing demand for aged care services, these demands will take up a larger and larger proportion of general revenues or will require an increase in taxes. These burdens will fall more heavily on the younger working population. In contrast, a social insurance scheme dedicated to aged care would allow for pre-funding of services by building up a trust fund for future needs.

Continuing the principle of ***universal*** access to services, regardless of ability to pay, is a popular strategy and tends to garner enthusiastic public support[5], particularly in contrast to welfare-related or income-tested programs. However, realistically, access is never completely universal; rather, access can be limited in

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Sharing the Burden: Strategies for Public and Private Long-term Care Insurance. (1994) The Brookings Institution: Washington, DC.

[4]Author's calculation is based on average annual public subsidy ($40,100) divided by the percentage paid by the Australian Government (approximately 70%) and is simply a rough calculation. The annual cost in high care is much greater than in low care. By way of illustration, BlueCare estimated an income of about $73,000 from a high care resident (between 17% and 59% coming from the resident) in written submission to the Senate Finance and Public Administration Committee in 2008. See table 2 http://www.aph.gov.au/Senate/committee/fapa_ctte/aged_care/submissions/sub18.pdf

[5] S. Wilson, G. Meagher, and T. Breusch, "Where to for the welfare state?" in Australian Social Attitude: The First Report (September 2005). UNSW Press. S. Wilson "The voters are getting restless, and government policy is yet to soothe them" in the Sydney Morning Herald, May 3, 2004.

a number of different ways---through explicit budgetary constraints or by limits on the number of funded services available such as the planning ratios used currently. Who then receives services can be targeted to those most in need of care or those least able to pay for care. Each of these strategies for limiting public expenditures has different distributional consequences that need to be understood to adequately assess them against each other. In particular, a better understanding of the income and asset position of current and future aged care service users would inform decisions about the consequences of limiting public expenditures by shifting more responsibility to users.

b. Potential role for private insurance

In addition to looking at the public versus private mix of financing responsibilities, it is also important to examine how the private responsibility might be reconfigured. Currently, the private responsibility is born in three ways: first, by the significant sacrifices of family and friends providing informal care; second, through private spending on formal services; and third, through the cost-sharing imposed by public programs.

There is, of course, some limit to how much additional burden can be shifted to individual users, their family and friends. Again, this question would be informed by a better understanding of financial status of users and their current levels of out-of-pocket spending. Avoiding catastrophic levels of out-of-pocket spending certainly is an important reform goal. Australian society uses private insurance to protect against loss from catastrophic events such as automobile accidents, home fires, and early death. Insurance against the potentially devastating costs of aged care has yet to be introduced. And, in effect, aged care insurance would be a logical next piece to the insurance portfolio that includes life insurance and total and permanent disablement insurance and/or trauma insurance.

Understanding the potential role of private insurance is necessary here. As with public insurance, private insurance offers a method to spread the cost of aged care across a larger group of people and over time. However, there are significant demand and supply barriers to private aged care insurance. [6] These include, on the demand side: affordability, and lack of awareness of the risk and cost of aged care.

First, insurance must be purchased at younger ages to be broadly affordable and this is at a time when families have many competing demands on their incomes such as mortgages and children's educations. Additionally, if bought at a younger age, it is important that the policy has sufficient inflation protection, and provisions for policy lapse. All of these add to the cost of the policy. If people wait until they are older to purchase private insurance, it

[6] For a thorough discussion of the potential of private insurance, see Wiener J. and Hixon-Illston, L. "Private insurance options for long-term care financing" in Community Care: New Agendas amd Challenges from the UK and Overseas, D Challis, B Davies, and K Traske, editors (British Society of Gerontology Press).

become prohibitively expensive – particularly as the elderly, despite improvements in financial status, are still relatively modest in their resources.

The second key issue confronting private insurance is an information barrier: few people understand the lifetime risk of needing aged care (particularly nursing home care), the cost associated with needing care, or how those costs are borne currently. The fee structure for care and accommodation in residential aged care is far from straightforward and varies by level of care needs, pension status, assets, and facility guidelines. So, while older Australians are confident today that they will not become impoverished if they need care, as financial pressure increases in the future, and changes becomes inevitable, that confidence may erode.

On the supply side, private insurers worry about moral hazard (or the increase use of services that results when people have to pay less for a service because they have insurance). This is especially true with services in the community that are inherently more desirable than residential care. Estimating the levels of moral hazard for home care and residential care should be done carefully as it has implications for setting premiums, contributions, or funding levels depending on whether one is designing a private or public insurance benefit. Here, Australia can learn from the induced demand experiences of other countries that have public and private long-term care insurance schemes such as Japan and the U.S. Given that most disabled people in the community do not use formal services, there is a potential for vastly increased use of services by the large number of persons who would "medically" qualify for benefits. For private insurance, unforeseen changes not only in utilization (from both moral hazard and adverse selection), but in disability, mortality, and rate of return on financial reserves, can dramatically alter the viability of a policy.

To the extent that private insurance is intended to result in savings to public programs by shifting spending from public to private sources, it is important that we understand who the purchasers of private insurance are and how they are distributed across the income and asset categories. Realistically speaking, expectations for **voluntary** (note emphasis) private insurance should be fairly modest because of the demand and supply barriers discussed above. A little more than one-third of all Australians have life insurance much of this associated with superannuation funds; less than one-quarter have disability insurance[7]. As a starting point for establishing parameters around the potential market for private aged care insurance, it is reasonable to expect that the market penetration is unlikely to exceed that of these other products. Similarly, it is reasonable to assume that characteristics of private aged care insurance purchasers might be more similar to those currently purchasing total and permanent disablement (TPD) insurance than life insurance because the decision to purchase life insurance is so closely linked to superannuation funds and is made at a group rather than individual level.

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[7] Data from the 2003-04 Household Expenditures Survey (Australian Bureau of Statistics) as found in Buchmueller, T.P., Fiebig, D.G., Jones, G. & Savage, E.J. 'Advantageous selection in Private Health Insurance in Australia' presented at the *7th European Conference on Health Economics*, University of Rome Tor Vergata, July 2008.

In addition, it would be important to construct a private insurance product that does not undermine the integrity of the public system but rather complements it. There are numerous examples from Australia and elsewhere of private insurance producing unintended negative consequences on the public system.[8] Furthermore, we need to better understand how the public and private strategies interact and how government might help make private insurance more attractive and affordable; say, for example, by offering re-insurance mechanisms, by offering tax advantages for purchase, or by allowing for some asset protection in exchange for purchase. Again, the distributional consequences of these government positions (who benefits from tax advantages and asset protection?) as well as examining the relative merits of using these strategies versus directly providing public insurance are needed.

Finally, it is worth noting there is some evidence from the U.S., where there is about 2 decades of experience, that having private long-term care coverage enabled claimants to exercise their preference for alternatives to nursing home care. [9] So, in terms of rebalancing the system towards more care at home, there may be things we can learn from how benefits are structured under a private insurance scheme.

c. <u>Non-conventional methods to fund the private share of aged care services</u>

If, eventually, a greater share of aged care expenses is to be borne by individuals, there are non-conventional methods that should be explored by the Commonwealth. Generally, the idea is to identify creative ways to draw down resources from a person's wealth portfolio. When a particular asset is widespread (e.g. housing), there is great interest in the potential uses of it to fund care in later life. It would be fruitful for the Commonwealth to explore how the home, typically a family's most valuable asset, could be used as a vehicle for financing the private share of aged care services. Housing wealth in Australia represents about half of total private assets.[10] Some earlier research has been

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[8] For example, private health insurance in Australia has not produced the sort of savings in the Medicare system it was expected to produce, especially in consideration of the revenue losses from incentives to purchase. Lu, M. & Savage, EJ, 2006, "Do financial incentives for supplementary private health insurance reduce pressure on the public system? Evidence from Australia." CHERE Working Paper 2006/11. Sydney. Sundararajan, V., Brown, K., Henderson, T. & Hindle, D. (2004), "Effects of increased private health insurance on hospital utilisation in Victoria," *Australian Health Review*, vol. 28, no. 3 (December), pp. 320-329.
Similarly, Medicare supplemental insurance ("Medigap") policies in the U.S. are used to pay for the legitimate cost-sharing requirements of Medicare services but with the unintended consequence of undermining the cost controlling functions of copayments and deductibles. W. Scanlon "Medigap: Current Policies Contain coverage Gaps, Undermine cost control Incentives" Testimony before the Committee on Ways and Means, U.S. House of Representatives. Lemieux, J., Chovan, T., and K. Heath. "Medigap Coverage and Medicare Spending: A Second Look" *Health Affairs* (March/April 2008)

[9] Doty, P., Cohen, M., Miller, J. and X. Shi. "Private Long-term Care Insurance: Value to Claimants and Implications for Long-term Care Financing," *The Gerontologist* (March 2010)

[10] Creighton, J., Jin, H., Piggott, J. and E. Valdez. "Longevity Insurance: A Missing Market," *Journal of Economic Literature* (September 2005).

done to investigate what parameters would make reverse mortgage mechanisms a viable commercial option in this regard.[11]

Two other examples of non-conventional methods to fund aged care rely on insurance products: one involves conversion of life insurance into early benefits, the other development of longevity insurance. The first requires that a life insurance have a cash value (so-called "permanent life insurance" policies) that could be used to pay the costs of aged care services under certain conditions. As permanent life insurance policies are no longer available in Australia and only about one-third of Australians even have term life insurance, the current potential for this is limited.

Longevity insurance, on the other hand, takes a slightly different tack and instead of making premature death the insurable risk, it is structured around long life or, more specifically, the risk of outliving your savings. This strategy reflects the movement away from defined benefit to defined contribution annuities and offers flexibility in that benefits not used for aged care services can be used for other expenses in old age.[12]

2. GETTING FROM HERE TO THERE: A RESEARCH AGENDA FOR PUBLIC AND PRIVATE AGED CARE INSURANCE

There are three distinct parts to the research agenda that could evolve from the discussion above. The last two of these recommendations are things that should relatively easy to accomplish. The recommended research agenda includes:

- Developing simulation modeling capabilities

The discussion above suggests that a research agenda for reforming the aged care financing system must include developing simulation modeling capabilities to subjectively analyze the distributional consequences ("who pays, who benefits"), and the impact on individual out-of-pocket spending of various public and private insurance strategies and their impact on ***future*** financing.

As discussed above, there is at least one simulation model, the Brookings-ICF Long-Term Care Financing Model, that could serve as a template for Australia. Briefly[13], this model takes a representative population data base, then simulates income, labor force activity, family structure and assets in each year in future. Next, the Model simulates disability of the elderly (entry, level, recovery),

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[11] Mitchell, O.S. and J. Piggott "Unlocking Housing Equity in Japan. *Journal of Japanese and International Economies* (December 2004)

[12] Mitchell, O.S., Piggott, J., Sherris, M., and S. Yow "Financial Innovation for an Aging World" Pension Research Council, The Wharton School of Business, University of Pennsylvania Working Paper 2006-11.

[13] For a more comprehensive description of the Model, see Kennell, D., Alexcih, L., Wiener, J., and R. Hanley, "Brookings-ICF Long-Term Care Financing Model Assumption" (Washington, DC.: Lewin-VHI, May 1991).

utilization of long-term care services (both institutional and non-institutional), sources and levels of payments (public programs and private financing).

Among other things, the results that can be derived from this Model include total and new public and private spending, as well as average out-of-pocket spending. Out-of-pocket spending calculations are done in both absolute and relative terms so that we know how well each option performs in targeting those who would otherwise have incurred catastrophic out-of-pocket costs. For private options, the Model also calculates savings to public programs.

- Understanding the characteristics of current private insurance purchasers

In order to put parameters around the potential market for private aged care insurance, a thorough examination of the income and asset position of current purchasers of private life insurance, total and permanent disablement insurance, and trauma insurance is needed. A good start would be to link the income and household net worth data with expenditures on insurance from ABS's Household Expenditures Survey (HES). This could potentially provide useful information on purchasers. It is worth repeating that ***currently*** these insurance products are not broadly purchased. Recall: only 23% of Australians own disability insurance policies and only 35% have life insurance. It is even harder to envision a need to purchase aged care insurance, if it were available, unless it offered preferential treatment in admission to residential care or enhanced services or accommodation. The merit in this discussion is looking towards the future and the expectation that the current system is unsustainable.

Similarly, it would also be useful to understand the characteristics and decisions of ***non-purchasers***.[14] Are they systematically different from purchasers? What factors have led to them not purchasing—e.g. universal aged pensions and other government programs, the role of mandatory superannuation contributions, etc. Related to this would be a public opinion component to the research agenda where Australians' attitudes and opinions about retirement planning and aged care were solicited including their understandings about the potential lifetime risk of needing care (particularly residential care) and how they believe they will pay for it.

- Understanding the financial position and out-of-pocket spending of current users of aged care services

In the context of understanding how much additional financial burden can realistically be transferred onto users of aged care services, one could link the HES to information about participation in public aged care programs in the

[14] E.g. LifePlans, Inc. (August 2004) "A Demographic and Attitudinal Profile of Non-Buyers of the Federal Long-Term Care Insurance Program." Curry, L., Robison, J. Shugrue, N., Keenan, P. and M. Kapp "Individual Decision-making in the Non-purchase of Private Long-term Care Insurance" *The Gerontologist* (2009)

community (HACC, CACP, EACH, etc.). This would provide vital information in the discussion of how much current users still need to spend out- of- pocket to remain in their homes and what sort of a burden this represents. Unfortunately, the same cannot currently be done with users of residential aged care services as residents of non-private dwellings are excluded from the HES.

Without surveying the population in residential aged care in a systematic fashion, the calculation of resident contributions towards care and accommodation is far from straightforward and varies by pensioner status, assets and facility practice. An understanding of the current out-of-pocket spending relative to income and assets for current users of residential aged care is too important an issue to not bring to the forefront of data collection efforts in the future.

It is worth remarking here that the important and nuanced policy discussion around separating housing from service costs is very relevant in this discussion of shifting costs from public to private sources and is, unfortunately, beyond the scope of this submission. It is also a primary consideration when attempting to rebalance the system towards more care in less restrictive settings.

CONCLUSING REMARKS

It goes without saying that the current system of financing aged care in Australia is unsustainable. Indeed, it might be said that the universal access to the public aged pension and disability support are likewise unsustainable for much the same reason. That is to say, while all these programs successfully spread the risk of longevity, disability, and need for aged care over the largest group of people, they do not spread that risk over time and allow for some level of pre-funding. As strictly pay-as-you-go programs, and with shifting dependency ratios, the tax burden is likely to reach levels that working Australians are unwilling and unable to pay. An examination of out-of-pocket spending by current users is likely to show that shifting this burden from public to private schemes without mechanisms for spreading the risk over time is equally untenable. The relative lack of interest or unwillingness to buy various other insurance products (life, disability, etc.) that provide benefits in later years needs to be better understood as public and private insurance both must be at the center of reform strategies.

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