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Royal Commission into Aged Care Quality and Safety: Invitation to respond to questions on financing aged care

I refer to your letter of 7 August in which you have provided a list of additional questions for my consideration. These follow discussions on 8 July 2020 and my Submission on Consultation Paper 2.

I have provided my responses to these additional questions in the attached. My responses are set against the background of the research projects I have led at UNSW Sydney in the School of Risk and Actuarial Studies and in the ARC Centre of Excellence in Population Ageing Research (CEPAR) which is referenced in my Submission on Consultation Paper 2. This focusses on long term care insurance, particularly actuarial modelling of the risks of functional disability, innovative design of retirement income products including long term care insurance as well as the actuarial analysis of equity release products.

These additional questions should be informed with a more detailed actuarial, demographic, and economic modelling of the alternative financing and insuring arrangements including actuarial quantification of risks and costs along with trends and uncertainty. This would allow a more detailed comparison based on measurable criteria.

A number of CEPAR research collaborators led by Associate Professor Jonathan Ziveyi (UNSW), with investigators, myself, Dr Yang Shen (UNSW), Associate Professor Jeromey temple (University of Melbourne), Professor Ermanno Pitacco (University of Trieste), currently have an Australian Research Council Discovery Grant application for 2021 on Forecasting and Financing Healthy Ageing and Aged Care in Australia, which, if successful, will consider modelling risks with individual level Australian data, the financing of aged care in Australia and the role of private market product innovations.

Without such research there is limited detailed actuarial modelling of these risks suitable to assess many of the questions raised in the Royal Commission Consultation Paper 2. Actuarial and demographic modelling techniques can be used to assess the costs of government provided aged care along with the design and costing of private insurance products including solvency capital requirements. They are also relevant in prudential supervision and assessing solvency of aged care providers.

The views in the attached are my personal view and, although social insurance is quite different to private insurance in financing aged care, with significant differences between the underlying actuarial basis of private insurance compared with social insurance, many of the underlying insurance principles apply to both.

Here is a summary of my responses for a possible approach to the Financing of Aged Care in Australia.

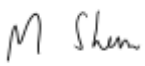
1. The financing of aged care in Australia should be based on an insurance model for the payments that are made to fund home support, home care and residential care. An Aged Care Insurance Agency could be established for determination and the payment of aged care benefits which would be from an Aged Care Levy, Government Budget allocations and co-contributions from individuals receiving benefits.

2. Payments could be based on the actual costs for aged care as charged by providers, who are subject to price reviews, quality standards and prudential regulation, or on defined levels of payment for different levels of limitations in Instrumental Activities of Daily Living (IADLs), for Home Support, and Activities of Daily Living (ADLs) for Home Care taking into account health status and functional disability along with cognitive decline.
3. For residential care, a separation of accommodation, living expenses and aged care would be required with individuals responsible for accommodation and living expenses. The defined levels of payment would be indexed to a measure of aged care cost inflation on an annual basis and reviewed every three to five years.
4. Public financing would meet a fixed percentage of the payments with co-contributions from individuals. The percentage of individual co-contributions could be for example 25% with 75% met by public financing. Co-contributions in this context refers to the co-payments for aged care services by individuals.
5. There would be a lifetime cap on co-contributions to limit the adverse impacts of very large aged care costs that could be considered catastrophic to an individual. This could be based on the current lifetime cap.
6. To determine the appropriate co-contribution percentage and the lifetime cap would require an actuarial assessment using estimated probabilities of requiring home support, aged care or residential care incorporating long term trends and uncertainty reflecting the impact relevant risk factors such as age, gender, and health status determine from individual longitudinal data for Australians.
7. The public financing would be based on that used for Medicare and the NDIS with an Aged Care Levy like the Medicare Levy along with government financing from Budget allocations. The Aged Care Levy would not cover the costs of the aged care financing system which would continue as a pay-as-you-go system. The percentage of the Aged Care Levy could be, for example 1.5%, but would be determined in conjunction with the actuarial assessment for the co-contributions and lifetime caps taking into account current and future levels of government financing for aged care which could be based on a Budget target GDP percentage committed to aged care support.
8. To allow for intergenerational equity the Aged Care Levy could be introduced over time starting with all taxpayers over 50 up to the age that payments for home support or age care commence. Then every ten years the age that the Aged Care Levy would apply would be reduced by 10 years. After ten years all taxpayers over age 40 would pay the Aged Care Levy, after 20 years all taxpayers over 30 would pay the Levy and after 30 years all taxpayers would pay the Aged Care Levy.
9. Benefit payments would not be separately means tested. The means tests used for the Age Pension would be used to determine the co-contribution that individuals make. Individuals on full Age Pension would pay no co-contribution with all benefits met from public financing, with the co-contribution increasing proportionally with the reduction in the portion of the Full Age Pension until then full co-contribution being met by self-funded retirees with no entitlement to Age Pension. This would be based on the entitlement to Age Pension at the time of payment of Aged Care Benefits.
10. With predetermined co-contributions along with caps, a government or private long-term care insurance product could be developed to cover these co-contributions with premiums payable from retirement age until time of payment of benefits.
11. Regulatory, taxation, and means-testing requirements should be supportive of the financing of individual co-contributions with innovative long-term care insurance and the financing of accommodation and living costs of residential care with equity release schemes. The government provide, as well as the Pension Loans Scheme, a long-term care insurance product for the co-contributions.

12. As far as possible aged care financing should be integrated with retirement income and health financing, including means testing and the level of the age pension. Consideration could be given to making age pension payments depend on age at payment with higher payments after age 85.

Please let me know if you require further information or wish to discuss the content of the attached responses.

Your sincerely



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ADDITIONAL QUESTIONS TO BE ADDRESSED

What must be publicly funded and financed?

1. What components of aged care require a financing arrangement that might require significant public participation (through, for example, social insurance or general revenue)? Is it appropriate to assume that:
a. the capital costs of residential care providers should continue to be recovered predominantly through interest-free accommodation deposits, or accommodation payments, directly levied on users (subject to a safety net arrangements for people in financial hardship);
b. daily living costs should continue to be directly levied on users;
c. the funding of personal care, clinical care and some allied health care needs arising due to ageing may require significant public financing arrangements?

Response:

Identifying the different costs of aged care to be financed is important since some of these costs, such as accommodation and living costs, need to be financed even when a retiree is healthy and able with no aged care needs through sources of retirement income. These sources include means tested age pensions, Medicare, private health insurance, superannuation products such as life annuities and account-based pensions, as well as personal savings including home equity.

To the extent that these aged care costs are additional to those that retirees face as a healthy and able individual in retirement, these will need to be financed or insured in the event that, through illness, disability or cognitive decline, they require aged care support through home support, home care, and residential care or nursing home care. Not all individuals will need aged care support, many may require home support as they age, fewer home care, and still fewer residential care. Costs are higher for increased levels of support and care.

Some retirees will remain healthy throughout life and others will require different levels of aged care support. As individuals age, they face the risks[1] and costs of requiring differing levels of aged care support and these risks increase with age. The risks vary not only with age but also by gender, with females on average living longer and spending more time on average requiring aged care. Many other risk factors also contribute to an individual's risk of requiring aged care, many of these also relate to the risk factors that impact longevity.

To the extent that accommodation and daily living costs are the same as those while an individual is healthy and able and funded from their retirement income resources, there is no need for additional financing for these costs. Where residential care accommodation or living costs are higher than an individual's accommodation and daily living costs when healthy and able, there is a need for additional financing. These accommodation and daily living costs while an individual is healthy and able, and funded from their retirement income resources, vary widely between individuals reflecting the wide variation in wealth including home equity of retirees. Different levels of accommodation and daily living costs will be expected if these living standards are to be reflected in residential aged care. Retirees on

[1] I use the word "risk" to refer to an actuarial estimated probability, usually quantified using actuarial models based on individual level longitudinal data. These probabilities are assumed to have systematic trends and to be stochastic with associated uncertainties. They vary with risk factors such as age, gender, marital status, and health status. I use the word "costs" to refer to the associated payments, or severity, which also have trends and uncertainty.

the lowest levels of income and with the lowest levels of wealth including home equity are likely to require public financing for these residential care costs.

In principle, residential costs and daily living costs should be met directly by users. If the basis for this is prespecified then individuals can arrange their finances in advance to cover the risk that they require residential care. The level of wealth and home equity of individuals in retirement varies widely in retirement. A significant proportion of retirees rely on age pensions under means testing requirements, very few hold longevity insurance products such as life annuities, most with superannuation assets use account based pensions to generate additional retirement income and not all own their own home. Without savings during a working life to fund aged care costs, many individuals will not be able to fund these costs from their own retirement savings at the ages when these costs are expected to be incurred. Many retirees who own their own home are “asset rich, cash flow poor” and can better fund residential care accommodation costs with access to an equity release financial product including the government Pension Loans Scheme.

Public financing of aged care already plays a significant role in aged care support not unlike the role of public financing for retirement income. In Australia, the age pension is considered a “safety-net” that provides retirement income for those who do not have sufficient superannuation or other savings to fund their needs. Means testing for both income and assets is used to determine the extent to which individuals are entitled to part or all the age pension which is a relatively modest level of income. With the increase in superannuation savings from the superannuation guarantee individuals will have increased resources to finance their retirement and will rely less on the age pension. Although without longevity products such as life annuities, individuals are more likely to have run down their retirement savings by the ages that they are most likely to require higher levels of care. Without their own resources to finance these aged care costs then public financing is critical.

For these reasons, significant public participation in financing aged care will be required. Individuals will in general not have their own saving to finance aged care costs, and they will be on average older and have run down their own retirement savings when they will require the financing. Those who own their own home are more capable of financing residential accommodation care costs with the benefit of equity release financial products.

Design principles

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

Response:

The principles of equity; economic efficiency and timeliness; administrative efficiency and simplicity; stability and sustainability, are important considerations in the design of long-term financing of aged care. These issues require balance and judgement since it is unlikely that any long-term financing arrangement can be designed to meet all these criteria. How these criteria are quantified and compared for differing long term financing arrangements needs careful consideration and analysis along with actuarial modelling of risks and costs as well as methods of funding. A thorough literature review of how these criteria are measured and the extent to which existing long term financing arrangements in other countries meet these criteria would be useful to inform this question.

How these design principles apply will depend on the financing methods used. For example, a social insurance-based system would rely on different principles to a system where individuals are expected to finance their own care needs from their own resources with an increased reliance on private insurance products. Issues of equity would be quite different for these, as would issues of efficiency, adverse selection and the need for safety-net funding.

Fundamental to any long term financing arrangements is the recognition that aged care is a risk that all individuals face in retirement but not all individuals will need aged care and the level of aged care support will vary amongst individuals depending on the levels of their health status, disability, and cognitive decline. Aged care risk also interacts with longevity risk. Individuals who live longer will, on average, face different aged care risks to those with higher mortality risk.

Risk pooling is fundamental to financing of aged care since it provides for a more efficient use of resources from an individual perspective. Without risk pooling, individuals would have to self-insure the risks with precautionary savings that would significantly exceed the expected costs involved. Risk pooling replaces this high level of precautionary savings for individuals with an average cost. This average cost would influence premiums in a private insurance aged care product.

For a social insurance scheme pooling produces a more reliable stream of future expenditures on aged care, that can be more efficiently financed since the future obligations in the scheme would be less volatile, although still subject to systematic factors such as the impact of improvements in health, the impact of technical and medical innovations as well as the impact of aged care cost inflation. These systematic factors are not well managed by individuals and should be managed through public financing.

Compulsory risk pooling ensures that all individuals participate in the pool. If this was through a government social insurance scheme, then issues of adverse selection would not arise. The scheme would rely on actuarial solidarity where individuals with differing risks participate in the pool, with no option for individuals with risks that are lower than average from opting out of the scheme, assuming contributions to such a scheme were not risk based.

Although risk pooling is an efficient way of financing these risks, there are aspects of aged care risks that are less effectively managed through risk pooling. These are systematic factors including trends in risks and costs of aged care. For aged care risks there are systematic changes arising from improvements in health and longevity that impact all individuals to a greater or lesser extent. There will also be systematic impact on aged care costs arising from inflation including medical inflation as well as wage inflation in the health care sector. These must be factored into the long-term financing of aged care. The uncertainty around these trends is also critical. The higher the uncertainty the higher the need for a mechanism to manage these systematic factors and the more important public financing.

Compulsory and universal coverage also ensures the risk pool is as large as possible and increases the potential of benefits of economies of scale in the administration and operation of the long-term financing arrangements. The extent of these will largely be an empirical issue that could be considered based on the experience of compulsory and universal coverage long term financing arrangements in other countries. There is a balance also involved here since there can be diseconomies of scale beyond a certain pool size from administrative inefficiencies.

In respect of equity of aged care financing arrangements, social insurance does not have the need for fair pricing and is less impacted by adverse selection than market based private insurance. There is the issue of intergenerational equity for pay-as-you-go financing arrangements where there are substantial

demographic changes in fertility, immigration, or longevity, as highlighted by the current baby boomers entering retirement. Intergenerational equity is a complex issue and needs to be assessed by considering prospective costs and benefits for differing generations rather than using cross sectional point in time comparisons. Home equity and bequests are important factors in assessing intergenerational equity, especially given the role that home equity plays in financing aged care needs both for residential care costs as well as living costs using equity release products.

Whatever long-term financing arrangements are adopted, the sustainability of these agreements from an actuarial perspective, is important. This requires an actuarial assessment of the risks and costs for individuals, consideration of the amount of financing required and how this is funded in terms of contributions, premiums for private insurance or taxation. This assessment should also consider intergenerational equity using forward-looking actuarial projection, valuation, and funding methods. This should include comparisons between pre-funding and pay-as-you-go funding for public financing. Pre-funding is generally required where individuals contribute to finance co-contributions towards aged care costs. For individual financing arrangements based on private insurance markets to be effective, they need to be integrated with retirement income and health financing. Taxation and means testing arrangements for aged care should be integrated with the taxation and means testing used for retirement incomes and government age pensions.

3. Would some form of social insurance scheme to fully finance (or materially contribute to financing) the aged care funding requirements you identify in response to question 1 meet the principles you identify in response to question 2? Which (if any) of those principles might be better promoted by:
a. an appropriately designed social insurance scheme;
compared with other available forms of financing, such as:
b. financing from general revenue; and/or
c. financing by a material contribution from a user pays system, augmented by any available private insurance products?

Response:

A form of social insurance scheme to finance aged care funding is needed since the risks are inherently insurable and compulsory and universal coverage ensures that the risks and costs are efficiently insured. There are a wide range of differing approaches to the long-term financing of aged care adopted in differing countries. This suggests that there is no long-term financing arrangement that dominates others. Social insurance schemes that have well defined benefits, well defined methods for ensuring funding is sufficient to meet benefits and that reflect social and political factors will have an important role.

In the Australian context there are related insurance schemes for health costs through Medicare and for disability through the NDIS. A form of aged care insurance reflecting the approach used for the NDIS should be considered.

Definitional elements of social insurance

4. How should ‘social insurance scheme’ be defined? What are the indispensable core elements (if any) of social insurance, and what other elements might social insurance have? For example, is the following description accurate?
• The scheme is established by government, and its benefits and financing are prescribed by statute.

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

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

Response:

This definition covers the main aspects of a social insurance scheme. I make the following comments:

- The scheme should be established by government with well-defined benefits and financing, and these benefits and financing should be prescribed by statute.
- The program should be partially financed by contributions (which could be through taxes, a specific Levy, or premiums) from or on behalf of participants. Contributions would need to be supplemented by government income to ensure the scheme met its obligations. If there were accumulated reserves, then these should be used to contribute to the financing of the scheme.
- The scheme should be compulsory for the whole population.
- The scheme should have some form of means testing but this could be based on the means testing used for age pensions to make administration of the scheme simpler and to integrate the scheme with social security for age pensions.
- If tax levies or similar imposts are used to contribute to financing of social insurance, they should be hypothecated under law to the insurance scheme.
- It would be essential that for an insurance-based scheme that actuarial methods and insurance principles are applied to review the scheme, estimate long run benefits, value the benefits and income and assess the scheme funding.
- If most financing of the scheme is from government budget allocations, then there is no direct need for accumulation of reserves in an insurance fund or pool. There is a stronger case for Individual contributions to be accumulated as reserves in an insurance fund or pool.

Potential models for social insurance for Australian aged care

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

Response:

The components of a social insurance scheme for the financing of aged care funding requirements in Australia would be the following:

- The financing of aged care in Australia should be based on an insurance model for the payments that are made to fund home support, home care and residential care. An Aged Care Insurance Agency could be established for determination and the payment of aged care benefits which would be from an Aged Care Levy, Government Budget allocations and co-contributions from individuals receiving benefits.
- Payments could be based on the actual costs for aged care as charged by providers, who are subject to price reviews, quality standards and prudential regulation, or on defined levels of payment for different levels of limitations in Instrumental Activities of Daily Living (IADLs), for Home Support, and Activities of Daily Living (ADLs) for Home Care taking into account health status and functional disability along with cognitive decline.
- For residential care, a separation of accommodation, living expenses and aged care would be required with individuals responsible for accommodation and living expenses. The defined levels of payment would be indexed to a measure of aged care cost inflation on an annual basis and reviewed every three to five years.
- Public financing would meet a fixed percentage of the payments with co-contributions from individuals. The percentage of individual co-contributions could be for example 25% with 75% met by public financing. Co-contributions in this context refers to the co-payments for aged care services by individuals.
- There would be a lifetime cap on co-contributions to limit the adverse impacts of very large aged care costs that could be considered catastrophic to an individual. This could be based on the current lifetime cap.
- To determine the appropriate co-contribution percentage and the lifetime cap would require an actuarial assessment using estimated probabilities of requiring home support, aged care or residential care incorporating long term trends and uncertainty reflecting the impact relevant risk factors such as age, gender, and health status determine from individual longitudinal data for Australians.
- The public financing would be based on that used for Medicare and the NDIS with an Aged Care Levy like the Medicare Levy along with government financing from Budget allocations. The Aged Care Levy would not cover the costs of the aged care financing system which would continue as a pay-as-you-go system. The percentage of the Aged Care Levy could be, for example 1.5%, but would be determined in conjunction with the actuarial assessment for the co-contributions and lifetime caps taking into account current and future levels of government financing for aged care which could be based on a Budget target GDP percentage committed to aged care support.
- To allow for intergenerational equity the Aged Care Levy could be introduced over time starting with all taxpayers over 50 up to the age that payments for home support or age care commence. Then every ten years the age that the Aged Care Levy would apply would be reduced by 10 years. After ten years all taxpayers over age 40 would pay the Aged Care Levy, after 20 years all taxpayers over 30 would pay the Levy and after 30 years all taxpayers would pay the Aged Care Levy.
- Benefit payments would not be means tested. The means tests used for the Age Pension would be used to determine the co-contribution that individuals make. Individuals on full Age Pension would pay no co-contribution with all benefits met from public financing, with the co-contribution increasing proportionally with the reduction in the portion of the Full Age Pension until then full co-contribution being met by self-funded retirees with no entitlement to Age Pension. This would be based on the entitlement to Age Pension at the time of payment of Aged Care Benefits.
- With predetermined co-contributions along with caps, a government or private long-term care insurance product could be developed to cover these co-contributions with premiums payable from retirement age until time of payment of benefits.
- Regulatory, taxation, and means-testing requirements should be supportive of the financing of individual co-contributions with innovative long-term care insurance and the financing of

accommodation and living costs of residential care with equity release schemes. The government provide, as well as the Pension Loans Scheme a long-term care insurance product for the co-contributions.

- As far as possible aged care financing should be integrated with retirement income and health financing including means testing and the level of the age pension. Consideration could be given to making age pension payments depend on age at payment with higher payments after age 85.

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

a. static equity issues that would arise, for example those that might arise depending on the premium structures and rates of the particular scheme;
b. intra-generational equity issues that would arise;
c. intergenerational equity issues that would arise;
d. aspects of such a scheme that appear likely to be efficient by comparison with other financing approaches; and
e. aspects such a scheme that appear likely to be inefficient compared with other financing approaches.

Response:

The scheme proposed in Question 5 would formalise and reflect current aged care financing and financing methods used for other insurance based universal schemes such as Medicare and more importantly the NDIS. It should be integrated with retirement incomes including means testing of the age pension.

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

Response:

To address intergenerational issues the phasing in of the social insurance scheme is required. To some extent in the Australian context, the Baby Boomer generation has already entered retirement and it is not possible to fund any additional intergenerational costs in advance. Introducing a formal co-contribution with insurance based aged care benefits, along with an Aged Care Levy that is phased in, has the potential to balance intergenerational issues. The extent that this is balanced could only be assessed using detailed actuarial, demographic, and economic modelling of any proposed social insurance scheme and its financing.

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

Response:

Given that most of the financing would be from government funding with define obligations and co-contributions, there would be no formal accumulation of reserves in the scheme. The government could use a sovereign fund to accumulate budget surpluses to meet unexpected future aged care benefits. Given the current budget status and the impact of COVID19 the accumulation of reserves in the short to medium term is unlikely to a consideration.

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

Response:

Reinsurance is appropriate for systematic risks that arise from trends in risks and costs that are only able to be forecast with uncertainty. Reinsurance would spread these risks internationally and offset the risks from trends in longevity and functional disability with other insurance related risks such as life insurance. The risks could also be spread across different ages that will experience different trends in mortality and disability using a reinsurance mechanism. Securitization of the risks could also be used to pool the risks with uncorrelated financial market risks thus providing more efficient risk pooling beyond the Aged Care Insurance Scheme.

Potential management arrangements

10. What are the most appropriate options for institutional arrangements for the management of a social insurance scheme of the kind descried in response to questions 5–9? For example:
a. Should one entity be responsible for determining premiums, and paying out funding (benefits), or other aspects of management of such a scheme?
b. Should that entity be government-controlled and owned, or private?
c. What might be the benefits or risks of a social insurance scheme where funds management functions and/or other scheme management functions, are placed in the hands of private insurance providers? In particular:
i. In what ways could private insurance providers be used effectively to manage social insurance?
ii. Would a tax rebate model resembling the approach to private health insurance be appropriate? What adaptations would be appropriate?
iii. Or would a direct requirement to obtain insurance (with an option to obtain it from a private provider) be appropriate, similar to the process for vehicle registration in New South Wales?
iv. Would private insurance providers be likely to have advantages over government in effective funds management?
v. Might an arrangement of this kind lead to innovative product offerings in conjunction with aged care providers?
d. What regulatory arrangements might be required, and what functions might appropriately be regulated?

Response:

Based on my response to Question 5 I would have the following views:

a. One entity, an Aged Care Insurance Agency, should be responsible for determining premiums, and paying out funding (benefits), along with other aspects of management of the scheme.
b. Given that most of the financing will come from Government budget the entity should be a government-controlled and owned Agency.

c. The scheme should operate on a pay-as-you-go basis with co-contributions and an aged care levy so that there would be no accumulation of reserves, no need for outsourcing funds management functions and/or other scheme management functions, to private fund managers or insurance providers.
    a. Private insurance providers could be used to cover the co-contributions that individuals pay through long-term care insurance or other innovative products that combine retirement income with longevity insurance and long-term care insurance.
    b. The taxation treatment, along with the means testing treatment, of any private insurance products should be consistent with the treatment of other retirement income products.
    c. In respect of the individual co-contribution to the benefit payments, a direct requirement to obtain insurance (with an option to obtain it from a private provider) could be considered. Individuals should have the option of self-insuring this risk since these products may not be affordable by less wealthy and less healthy individuals and the frictional costs, such as underwriting and adverse selection, of these long term care insurance products could substantially reduce the effectiveness of risk pooling for these aged care risks.
    d. It is quite likely that a government insurer provider would have advantages over private insurance providers since they would not need to meet the costs of solvency, profit margins and it could have a larger pool size resulting in economies of scale.
    e. A co-contribution to benefits of around 25% which reflected the means testing used for the age pension should mean that innovative long-term care insurance products that incorporated retirement income needs for wealthier and healthier individuals at retirement could result in innovative product offering in conjunction with aged care providers

d. The regulatory arrangements for insurers offering long term care insurance as well as longevity insurance products should be conducive to ensuring these products are attractive to individuals. The insurer should be subject prudential regulation through APRA in the same way as life insurers and health insurers are. Taxation and means testing regulations should also be consistent with the treatment of retirement products in superannuation funds.

Potential models for transition

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

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

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

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

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

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

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

ii. Significant co-payments (increased over the current levels of co-payments) apply to ongoing support/care at home and to residential care for the next 30 years, but they decline incrementally over time, as the financing they represent are replaced by the hypothecated fund referred to in point (i).
iii. Safety net provisions apply - government will cover the quantum of co-payments for older people in financial hardship.

Response:

- Given my response to Question 5 the transition arrangements could be to phase the introduction of the Aged Care Levy over time starting with, for example, all taxpayers over 50 up to the age that payments for home support or age care commence. Then every ten years the age that the Aged Care Levy would apply would be reduced by 10 years. After ten years all taxpayers over age 40 would pay the Aged Care Levy, after 20 years all taxpayers over 30 would pay the Levy and after 30 years all taxpayers would pay the Aged Care Levy.
- Intergenerational equity could be assessed for the arrangements that I cover in my response to Questions 5 and the specific design features of the scheme including the phasing in over time of a co-contribution, the Aged Care Levy, a budgeted contribution of government financing based on percentage of GDP, could be considered with actuarial, demographic and economic modelling. It is important to recognise that a major issue with intergenerational equity is the Baby Boomer generation, and this generation has moved into retirement so there is little opportunity other than through co-contributions and limited payment of an Aged Care Levy until benefit commences for those retirees paying income taxation. This must be balanced and assessed.