Addressing Pressures on Aged Care Expenditure through an Aged Care Levy

January 2020

Anna L Howe PhD

CONTENTS

GLOSSARY 3

ABOUT THE AUTHOR 4

INTRODUCTION AND OVERVIEW 5

PART 1 The latest chapter in a long history 9
- 1.1 Towards a pillars approach to aged care funding 9
- 1.2 An absent option: Private insurance for aged care 14
- 1.3 The policy paradox 17
- 1.4 When will the next chapter be written? 18

PART 2 Interactions between aged care funding and the pillars of retirement incomes 20
- 2.1 Multiple but separate pillars 20
- 2.2 Home-ownership and housing assets as a 4th pillar 23
- 2.3 Payments for informal care 30
- 2.4 Medicare and NDIS levies 31
- 2.5 Where would another pillar of aged care funding fit? 33

PART 3 Trends in funding and use of residential aged care 34
- 3.1 Budget impacts of population ageing 34
- 3.2 Level and components of expenditure growth 36
- 3.3 Total expenditure growth 37
- 3.4 Shifts in shares of revenue from Commonwealth, resident and other sources 39
- 3.5 Demographic and dependency drivers of demand for care 41
- 3.6 Why is an ACL needed? 46

PART 4 Redirecting super tax expenditures to an Aged Care Levy 47
4.1 The problem: tax expenditures on superannuation 47
4.2 The solution: superannuation as the source of a third pillar of aged care funding 49
4.3 Affordability 50
4.3 Adequacy 52
4.4 Sustainability 54
4.5 Insurability 55
4.6 How would an ACL make a difference? 58

PART 5 Information, attitudes and behaviours in funding aged care 60
5.1 Informing policy development 60
5.2 Information 61
5.3 Attitudes towards paying for aged care 65
5.4 Behaviour and resources 67
5.5 Alternatives on offer 69
5.6 Who is contributing different views on policy options? 73

CONCLUSIONS 74
The when, where, why, how and who of an Aged Care Levy 74
Looking ahead through a wider policy lens 78

REFERENCES 80

GLOSSARY

ABS	Australian Bureau of Statistics
ACAR	Aged Care Approvals Round
ACFA	Aged Care Financing Authority
ACL	Aged Care Levy
ACSA	Aged and Community Services Australia (Peak body for aged care providers, mainly not-for-profit providers)
AHURI	Australian Housing and Urban Research Institute
AIHW	Australian Institute of Health and Welfare
ASFA	Association of Superannuation Funds of Australia Ltd.
ACAR	Aged Care Approvals Round
ACFI	Aged Care Funding Instrument, with three domains of care needs
ADL	Activities of Daily Living
BEH	Behaviour
CHC	Complex Health Care
CA	Carer Allowance
CCC	Core Care Component
CEPAR	Centre of Excellence in Population Ageing Research
CHSP	Commonwealth Home Support Program
CIPRs	Comprehensive Income Products in Retirement
CP	Carer Payment
CRA	Commonwealth Rent Assistance, paid to low income private renters
DAP/C	Daily Accommodation Payment/Contribution
CAM/SAM	Care Aggregated Module/Standard Aggregated Module
HACC	Home and Community Care program, preceded CHSP
HILDA	Household, Income and Labour Dynamics in Australia, longitudinal survey
LOS	Length of stay
MEW	Mortgage Equity Withdrawal
NDIS	National Disability Insurance Scheme
NSSS	National Seniors Social Survey
PBO	Parliamentary Budget Office
PC	Productivity Commission
PLS	Pensioner Loans Scheme
RAC/H	Residential Aged Care/Home
RAD/C	Refundable Accommodation Deposit/Contribution
RM	Reverse Mortgage
RUC	Resource Use Classification
SG	Superannuation Guarantee
SMSF	Self-Managed Superannuation Fund
STE	Social Tax Expenditure

ABOUT THE AUTHOR

Anna Howe completed her PhD at Monash University in Melbourne in 1982; the title of her thesis was 'Alternatives in systems of care of the aged: a geographic analysis', in which she made a comparison of provision and use of community care and nursing home care. She then held academic research and teaching positions in gerontology at the National Ageing Research Institute, affiliated with Melbourne University, and in health sciences at La Trobe University. Her research has involved major evaluations of many aspects of Australia's aged care system, including assessment, planning of residential and community care, interaction between acute and long term, service integrated housing, and financing.

Her policy work for the Australian Government includes advisor roles to Senate and House of Representatives inquiries, and from 1989-1993, she was Director of the Commonwealth Office for the Aged and Principal Policy Advisor of the Mid Term Review of the Aged Care Reform Strategy. Her research and policy work has contributed significantly to comprehensive restructuring of residential and community care services.

She has carried out numerous consultancies for Commonwealth, State and Local Governments, for major not-for-profit organisations including Alzheimer's Australia, and for profit providers. These projects have involved analysis of wide variety of demographic, financial and other quantitative data and qualitative material, and consultation with numerous stakeholders. Internationally, she has carried out consultancies with the OECD, the WHO, the UN, for AusAid in China, and for World Bank funded projects on the development of aged care services in Slovakia and Estonia.

She has served as a Commissioner of the Victorian Health Commission, a member of the Board of the Royal Melbourne Dental Hospital and of the Board of the Australian Institute of Health and Welfare, as well as a member of editorial boards of Australian and international journals. She has published over 140 papers and reports, in Australian and international refereed journals, in chapters in books and in major reports for Government.

Now retired, she maintains a close watching brief on developments in aged care policy in Australia. She has continued to make influential submissions to major inquiries, notably the 2011 Productivity Commission Inquiry into Caring for Older Australians and the current Royal Commission on Quality and Safety in Aged Care. As a Presidential Life Member of the Australian Association of Gerontology, she continues to contribute to activities of the ACT Division and national conferences of the AAG and the International Association of Gerontology and Geriatrics. In early 2019, she was appointed an Honorary Professor in the Department of Sociology, Macquarie University.

This paper has been developed over a number of years and thanks are due to many people who have provided comments on earlier iterations. Professor Elizabeth Ozanne, University of Melbourne, and Mr Mark Cooper-Stanbury, formerly at the Australian Institute of Health and Welfare, are thanked for their careful reading and feedback on drafts of this version.

Anna Louise HOWE
anna.howe@bigpond.com

INTRODUCTION AND OVERVIEW

Social insurance as an option for funding aged care in Australia

A recent and comprehensive review of almost 600 studies of long term care insurance by Eling and Ghavibazoo (2019) reaches the conclusion that:

Recent studies have taken both information asymmetry and sustainability problems into account and propose to embed long term care insurance costs in the notionally defined pension schemes as the optimal method of financing of LTC expenditures.

In Australia, this solution translates into an Aged Care Levy (ACL) applied to the earnings of superannuation funds that provide defined contribution pensions in retirement. An ACL would strengthen the aged funding system in three main ways: it would separate the cohorts that generate revenue from those on which expenditure occurs, it establishes a direct link between superannuation and aged care as a part of late retirement, and it diversifies funding streams for aged care. The features of an ACL as proposed in this paper are:

- It would be applied to the earnings of superannuation funds held by individuals aged 50 and over and with balances above a defined threshold;
- It would continue past retirement age to age 70 and apply to accumulation accounts and pension accounts until the balances fell below the defined threshold;
- It would support an additional pillar of aged care funding with the primary aim of relieving budget pressures rather than adding to funding, and current means testing of care and accommodation would remain.
- It would focus on residential care in the first instance and cover the cost of a common care component for all residents at a flat rate per diem, irrespective of length of stay, but coverage could be extended to Accommodation Supplements in residential care and home and community care following integration of the Commonwealth Home Support Program and the Home Care Program (packaged care).
- As a form of social insurance, it would complement the existing Medicare Levy and National Disability Insurance Levy, and the term Aged Care Levy is adopted for consistency with these schemes.

The idea of linking aged care funding to superannuation is not new. It was first mentioned of in formal policy debate in Australia in 1993 when the Report of the Mid-Term Review of the Aged Care Reform Strategy recommended:

Rec 6.1: That in order to contain public outlays on aged care while ensuring continued equity of access to services and protection of the capacity of older individuals to meet user contributions to the cost of services, consideration be given to the development of a method of financing aged care that includes a component drawn from superannuation contributions paid over the individual's working life. (Department of Health Housing Local Government and Community Development, 1993.)

That recommendation closely matched the *'three legged stool'* advanced around the same time in the US by Chen (1993, 1994). He proposed a social insurance model as an intra-generational transfer that would balance the intergenerational transfers already being made through social security and Medicare and would also reduce uncertainty and enhance sustainability. His model was based on trading off a small percentage of social security cash benefits for basic long term care coverage; at

that time, he estimated a 5% trade-off would pay for 22% of formal long term care costs. This model was later elaborated with private long term care insurance taking the place of social insurance (Chen, 2001). Chen points out that the trade-off concept is relevant to other industrialised nations which are experiencing continued greying of their populations, relative shrinkages of informal caregivers, declines in productivity growth and national savings and accumulating federal deficit and national debt: these considerations have all been relevant in varying degrees to Australia in the past and remain relevant currently.

The optimal proposal put forward by Eling and Ghavibazoo as above renews interest in social insurance for aged care in Australia as four conditions currently combine to present close to ideal conditions for introducing an ACL:

1. Compulsory superannuation is a form of defined contribution pension system that is generating growing pensions for a growing part of the growing retired population, who have contributed more as the Superannuation Guarantee has increased and accumulated balances over longer periods, a quadruple multiplier effect.
2. An ACL is highly compatible with levies already in place as major components of the health and social security systems by way of the Superannuation Guarantee (SG), the Medicare levy and the National Disability Insurance Scheme (NDIS) levy. Aged care has however yet to see reform of funding on a similar scale.
3. A demographic window of opportunity arises over the 10-15 years from 2020 as the entry of the Baby Boomers into retirement sees the proportion of the population aged 70 and over that is aged 85 and over decline to the early to mid-2030s, and marked pressures on the aged care system will not be experienced until after that time when this enlarged generation reaches their mid-80s, the age at which the likelihood of needing aged care escalates.
4. It would provide a more reliable means for direct funding of a part of aged care than the prospect of increasing user charges that depends on equity withdrawal or longevity insurance measures that aim to preserve income to late retirement but which, if successful, would only support a small part of aged care funding, and only indirectly.

Aims and scope of paper

Given this context, the broad aims of this paper are:

- to present a proposal for an ACL that expands on earlier discussions of aged care social insurance in the context of a number of recent policy debates and developments, and
- to consider the attributes of an ACL that make it a preferred option for strengthening the financing of aged care to meet future pressures.

The paper draws on the three frameworks set out by Eling and Ghavibazoo (2019) for evaluating long term care funding schemes:

- The financing framework follows Chen’s work to include public sector general funding, social security that provides both inter- and intra-generational models, and private sector insurance and out-of-pocket expenses.
- The demand framework covers economic factors, social and cultural factors, and structural factors that affect demand for long term care and hence demand for insurance cover.
- The insurability framework presents actuarial, market and social criteria that affect the predictability of use of long term care and likely supply of insurance products.

Criteria for assessing social insurance schemes arising from these frameworks are taken up through this paper together with other issues identified in local policy and research material.

Part 1 traces the discussion of social insurance as a third pillar of aged care funding in Australia from the early 1990s. Notwithstanding continuing concerns to control public outlays, changing policy contexts and priorities have seen policy measures to this end focus on the 'narrow band' solution of increasing user charges in line with expectations of an increasingly wealthy older population, in part due to the growth of superannuation. Policy has also been increasingly framed in terms of consumer choice in a deregulated and market based system. The fleeting experience of private insurance for aged care locally and its limited role in other countries is noted, but it is discounted as an option for further consideration. The policy paradox of why little has happened in the face of claims about increasing strains on government finances is addressed, noting that persisting concerns about sustainability have been flagged in the Terms of Reference of the Royal Commission into Aged Care Quality and Safety that commenced in October 2018. Part 1 concludes with some answers to the question 'When might social insurance come on to the policy agenda?'

Part 2 presents an account of interactions between the multi-pillar retirement income system and the aged care system that relies on just two pillars: a large one of government subsidies and a small one of user contributions. The centrality of the Age Pension in both systems stands out, notwithstanding the growth of superannuation. Home-ownership and cash benefits are also identified as 'shadow' pillars that need to be more fully recognised. An ACL is seen to be highly compatible with the SG within the retirement incomes system, and the Medicare and NDIS levies, although it would be applied in a different way to the latter levies. Part 2 concludes with some answers to the question 'Where would an ACL fit in with the pillars approach to retirement incomes policy?"

Part 3 begins with a short account of concerns about aggregate level of impacts of aged care funding on public outlays as presented in the four Intergenerational Reports published since 2012 and a recent report from the Parliamentary Budget Office. Detailed analyses of trends from 2012-13 are then presented for growth in total expenditure and in different care and accommodation components, and shifts in shares from Commonwealth, users and other sources. The steady rate of overall growth and the stability in the Commonwealth share, despite efforts to increase user charges, are projected to carry through forward estimates for the five years to 2022-23. Drivers of demand are examined with differential rates of growth of cohorts within the older population seen to present a window of opportunity for action over the 10-15 years to the mid 2030s, with demand moderating over this period before the large Baby Boom cohorts reach advanced old age thereafter. Part 3 concludes with answers to the question 'Why is an ACL needed?'

Part 4 examines the capacity of an ACL to contribute to strengthening aged care funding. The first contributions come from trade-offs that would make some correction to distortions arising from social tax expenditures associated with superannuation that have attracted growing policy attention with consequent rebalancing of inter- and intra-generational transfers. Further contributions are assessed in terms of the requisite features of a social insurance system: affordability, adequacy, sustainability and insurability. An ACL is not intended to cover all of aged care costs, but it has the capacity to make a worthwhile impact on covering a core care component as recommended in two recent reviews of the current funding instrument. Part 4 concludes with answers to the question 'How would an ACL work to provide a third pillar to strengthen aged care funding?'

Part 5 reviews a wide range of research on information, attitudes and behavior towards funding of aged care. The narratives from the perspectives of older people show that expectations of having to

meet at least some possible future costs of aged care are mixed with widespread uncertainties and limited planning about how these costs might be met. Emerging support for one or other means of making provision for these costs ahead of the time they arise is evident, with retirees willing to trade off some current income against future cost risks. Linking aged care funding to superannuation emerges as a preferred option that provides a direct contribution to aged care funding and avoids the considerable information barriers to adoption of other proposals which only provide indirectly for aged care. These preferred options diverge from policy proposals for longevity insurance products and reverse mortgages. Part 5 ends with some answers to the question 'Who is contributing different views on policy options?'

The Conclusions to the paper draw together the answers to the questions posed at the end of each part of the paper. Looking beyond these answers through a wider policy lens adds to the case for adding a new pillar of social insurance to funding of aged care. The potential for wider gains in social outcomes consistent with those realised by social insurance approaches in retirement incomes, health and disability calls for a similar big change in aged care funding.

PART 1 The latest chapter in a long history

1.1 Towards a pillars approach to aged care funding

Australia's aged care system relies on just two pillars of funding: a large one of government funding and a slender one of user payments, largely derived from transfers from the Age Pension and Veterans Pension. The large pillar has consistently funded around 75% of recurrent expenditure for the last four decades and the small one only 25%, with marginal shifts from public pension sources to private retirement incomes within this pillar. Changes to capital funding have similarly achieved limited shifts between public funding of accommodation for low wealth individuals and others drawing mainly on the sale of their home

This weak funding system contrasts with the widely recognised strength of Australia's 'three pillars' retirement income system. Calls for adding a third pillar to aged care funding that have been made for decades attract renewed interest in the context of growing debate about increasing intergenerational inequity stemming from social tax expenditures (STEs) associated with tax concessions applying to both superannuation contributions and incomes.

This Part reviews discussion of the need for a stronger system of aged care funding over four phases from the early 1990s to the present, with the level of attention to aged care insurance varying in relation to other options canvassed in each phase.

1.1.1 Changing policy contexts and priorities

Aged care policy under the Labor Government from 1983 to 1996 balanced principles of equity of access with targetting on the basis of assessed need, in line with the government's Social Justice Strategy (Hawke & Howe, 1991). The superannuation system that developed though this period balanced these social justice principles with economic policies of containing wage growth and future public expenditure on the Age Pension. The potential for a link between aged care funding and superannuation flagged in 1993 was not however pursued.

A shift in policy direction following the change of government in 1996 and the report of the National Commission of Audit (1996) placed a stronger focus on user contributions to aged care and from 2001, a series of changes in superannuation and tax policy set in train escalating STEs. A decade on, and after a change of government in 2007, the effects of these expenditures on distorting the purposes of the superannuation system away from supporting retirement incomes towards wealth creation began to attract attention. The next decade saw a series of measures taken to rein in STEs and other shortcomings of the superannuation system came under review. Throughout these deliberations, mentions of aged care funding were limited to expectations that increasing retirement incomes would enable older people to contribute more to the cost of their care.

A new Aged Care Act was passed in 1997, but the main impetus for developing aged care policy came later with the Productivity Commission inquiry commissioned by the Labor Government in April 2010 and reported in mid 2011. The resultant Living Longer Living Better package of measures was legislated in 2013 and largely continued after the change of government in September that year. Numerous changes have been made in a range of areas, but their intended or actual effects on expenditure have been marginal; examples include periodic adjustments to the Aged Care Funding Instrument that determines subsidies in residential care, and the introduction then withdrawal of the severe behaviour and dementia supplement. Some swings and roundabout effects generated by interaction between some of these measures have muted their impacts on expenditure.

More significant measures have been the expansion of community care packages in place of residential care, within the same overall budget commitment, and implementation of a new means test for residential care that takes account of both income and assets. Only this last measure has been directed to changing the mix of revenue.

The continuing expectation that user payments would contain public outlays culminated in the Aged Care Roadmap developed in 2015 by the Aged Care Sector Committee, an advisory body to the Minister. The Roadmap stated:

> *A fiscally sustainable aged care system requires consumers to contribute to their care costs where they can afford to do so. The increasing population of older people who are living longer necessitates an aged care system that is sustainable into the future. The system will need to continue to rely on consumers' contributions, as an increasing source of funding.*

The pervasive acceptance of this stance reflects the lack of discussion of other approaches to the revenue side of aged care funding, and sets the background against which current discussion are taking place as the expectation that rising retirement incomes from superannuation will increase capacity to pay is proving a very indirect and tenous link.

1.1.2 Early discussion of social insurance approaches in Australia

In 1993, the Report of the Mid-Term Review of the Aged Care Reform Strategy made probably the first mention of the need to link aged care funding to superannuation in formal policy debate in its recommendation:

Rec 6.1: That in order to contain public outlays on aged care while ensuring continued equity of access to services and protection of the capacity of older individuals to meet user contributions to the cost of services, consideration be given to the development of a method of financing aged care that includes a component drawn from superannuation contributions paid over the individual's working life.

The two stages of the Mid Term Review (Commonwealth Department of Health, Housing, Local Government and Community Services, 1991, 1993) furthered policy directions and program implementation for continuing expansion of community care vis-à-vis residential care through a coherent strategy that was in place from the mid-1980s to the mid-1990s. Little attention was given to revenue however and this recommendation was not acted on.

In 1998, McCallum and others (1998) advanced a social insurance approach in a discussion paper commissioned by the major Catholic aged care provider, Southern Cross Homes (NSW) Inc. These authors proposed a mandatory contributory scheme for all but the lowest 30% of income earners to ensure quality of later life, called the EQOLL model. The study flagged the need for further development to take account of changes in the older population in terms of financial independence, accumulation of assets and age-related dependency, and impending reform of the taxation system.

In 1999, Howe (1999) referenced Chen's 'three legged stool' model in arguing for adding a social insurance pillar. As well as achieving consistency with other major areas of social policy, the need for action was generated by instability and uncertainty resulting from an abrupt about-face on changes to user charges proposed by the Coalition government shortly after it came to office in 1996, prompted in part by the work of the National Commission of Audit (1996) that the incoming government had established to examine the role of government involvement in social policy areas. Very negative community response to the perceived forced sale of the family home fuelled political

opposition on all sides and in what was known as 'the nursing home debacle', the proposed extension of lump sum accommodation bonds to 'high care' Residential Aged Care Homes, formerly nursing homes, was abandoned and the option remained off the policy agenda for almost two decades.
The case for extending the pillars approach for retirement incomes and health care to aged care was elaborated by Howe and Sargeant (1999). Their modelling showed that a fully funded social insurance scheme that covered 10% of total annual capital funding and a standard base level of care at 50% of total care cost was estimated to be achievable at a cost of around 1.4% of national wages in 2008, falling to 1.08% from 2028. As well as strengthening aged care financing, it was seen to offer wider social policy benefits through:

- diversification away from heavy reliance on a single source of government current spending;
- making each generation more independent of other generations by replacing inter- with intra-generational transfers;
- separating the time at which contributions were paid from the time of need for services; and
- being more equitable than accommodation bonds that fell unduly on a small group and drew on a smaller income and asset base compared to national wages.

1.1.3 Policy deliberations

2004 Review of Pricing Arrangements in Residential Aged Care: the Hogan Review

The Terms of Reference for this Review included consideration of the long-term sustainability of the aged care industry and the need to facilitate equity of access for all Australians (Hogan, 2004). Although it did not make any recommendations on aged care insurance, the review presented two sets of information relevant to the debate on roles of private and social insurance:

1. Development of an Aged Care Dynamic Cohort Model, informed by international models, and presentation of a single outcome that looked at levels of individual (private) insurance, the income and assets of the elderly, and eligibility of individuals to access public funding.
2. A Background Paper on international perspectives on long term aged care (Cullen, 2004) described the experiences of six countries, three with social insurance schemes, Germany, Japan and Singapore, and the other three, the United Kingdom, Denmark and New Zealand, that rely on funding from taxation and user charges.

2010 The review of Australia's future tax system: the Henry Review

The report of this review chaired by Ken Henry (Treasury, 2010) stated three clear principles that guided its examination of the current responsibilities and possible reforms to funding of aged care as:

1. people with limited private means should be provided with assistance so they can receive an adequate level of care at no financial cost to them;
2. ensuring access to an adequate level of care irrespective of means is a 'public good'........ and should be funded by the community through general taxation; and
3. where people do have means, they should be charged for the services they receive, with individuals able to purchase a higher standard of service provided they pay the additional cost.

In discussing long-term sustainability of funding arrangements, the Henry Review noted that while measures to ensure recipients with sufficient means financed their own care costs would improve fiscal sustainability of aged care, several factors limited the scope for greater user funding through means tested user charges. These limiting factors included:

- While maturing of the superannuation system would see future cohorts of older people having larger assets balances at retirement, these assets would need to provide an adequate stream of income over a person's retirement, the duration of which was uncertain for individuals.
- The expected increase in average life expectancy was likely to add to this risk.
- The use of aged care services was particularly intensive for people aged 85 and upwards, after many have been retired for 20 years or more.

The solution to these problems was seen to lie in widening the availability of products that could insure against longevity risk and give greater certainty of income over a long retirement, but the comment that *'It is also possible that moves towards a universal levy on taxable income could be used to offset future fiscal risks of government financing aged care'* is noteworthy. The Review further observed that the uncertain and potentially high costs of aged care meant that many people would not be able to provide for care costs out of their savings, and that when insufficient provision for these costs resulted in inadequate access to care, the well-being of older Australians was significantly harmed. These observations led to the conclusion that: *The introduction of a compulsory insurance scheme should be considered as a way to deliver a funding source to ensure that all individuals can access an adequate standard of care.*

The Productivity Commission was at that time conducting its inquiry into how a National Disability Insurance Scheme could be established, not whether it should be, and the Henry Review proposed:

Recommendation 110: It is important for governments to determine what an adequate level of aged care should be, the necessary pricing and regulatory arrangements to deliver it, and the most sustainable funding arrangement to ensure access by those who cannot afford it. Given this, and noting that the Productivity Commission will be inquiring into the disability insurance scheme, its consideration of aged care should include the potential for insurance to play a role in helping to fund aged care as Australia's population ages.

2011 Productivity Commission Inquiry into Caring for Older Australians

The Productivity Commission assessed a number of options for voluntary and compulsory insurance, private and social insurance, and administration by a single or multiple insurers in the government or private sector. A number of international schemes were also outlined and a range of pros and cons expressed in submissions to the Inquiry were presented. Notwithstanding identification of a number of positive features of social insurance, it was seen to be little different to the current tax-payer funded system supplemented by a lifetime stop-loss mechanism (since implemented). The Inquiry also considered that contributions accumulated by those who had retired or were near retirement would be small relative to their potential drawdowns and that compulsory insurance would have limited scope to handle the bulge associated with ageing of the baby boomer cohorts. This conclusion was based on the assumption that contributions would only be made until retirement rather than continuing for another 10-15 years post retirement as is proposed for the ACL.

Instead, the Commission fell back on increased user contributions, through the extension of bonds to all residential aged care, changes to means testing for care subsidies and promotion of home equity release products as sources of increased user funds. Continuing reliance on user contributions did little to achieve the Commission's stated goal of widening the funding base and remains a 'narrow band' solution focused on a narrow class of assets of older home owners, namely their houses, and the narrow group of aged care users who do or could pay a bond.

The report of the Productivity Commission Inquiry addressed a number of the problems of aged care funding flagged in the Henry Review and some were remedied in measures taken under the Living Long Living Better reforms that followed the Inquiry. Perhaps most notably, from 2014, almost 20 years on from their abandonment, accommodation bonds became chargeable in former high care homes (nursing homes) as well as low care homes (hostels). The new arrangements, applied as Refundable Accommodation Deposits (RADs), were the last step on the long pathway that completed the integration of the formerly separate nursing home and hostels systems that began in 1997.

2011-2018 Other government reviews, but no focus on funding

The **Living Longer, Living Better Aged Care Reform Package** detailing the reforms initiated by the Labor government was released in April 2012 (Department of Health, 2012). Although largely in line with the 2011 report on the *Inquiry into Caring for Older Australians*, not all the recommendations made by the Productivity Commission were adopted and other measures were added. The reforms were formalised in the Aged Care (Living Longer Living Better) Act 2013 that was passed shortly before the 2013 election and included provision for a Legislated Review three years later.

The incoming coalition government continued the LLLB measures with only relatively minor changes, although not all measures have been advanced, the notable exceptions relating to workforce development. The **Legislated Review of the Aged Care Reforms** began in September 2016 when David Tune was appointed as the independent reviewer. The terms of reference of the Legislated Review focused on outcomes of the 2013 reforms, which were generally found to be successful (Tune, 2017), but funding was outside its Terms of Reference.

Beyond these three broad ranging reports, some 30 reports or discussion papers on aspects of aged care were released by Commonwealth government bodies after the Productivity Commission Inquiry report in mid-2011 to the establishment of the Royal Commission in late 2018. The most common issue was quality of care, examined in eight reports. Another four addressed dementia care, three focused on workforce development and eight addressed one or other different issue. Of the four that considered any aspect of funding, two dealt with instruments for determining dependency-based funding for residential care and two covered prudential and regulatory arrangements. None examined revenue and expenditure across the whole of the aged care system.

1.1.3 Current research contributions

Current research has seen renewed attention in three areas relevant to social insurance in general and an ACL in particular. The range of this work is noted briefly here and taken up in later parts of this paper. However, and notwithstanding the extensive reporting of expenditure on aged care by the Aged Care Financing Authority and the Productivity Commission, there has been very little investigation of the revenue side of the equation. Commenting on the lack of any clear account of funding sources for aged care, Piggott suggests options for increasing tax revenue by way of increasing the GST and the highest marginal tax rates (Piggott, 2016). Such measures would not direct funding specifically to aged care.

Accounts of the wealth of older Australians, including reports from the Grattan Institute and the Centre of Excellence in Population Ageing Research (CEPAR), show both the potential for implementing a social insurance scheme for aged care and its positive redistributive effects in the face of widening differences in wealth both between generations and within the present and future

older generations. The persisting gender differences that have been noted are especially relevant here given the greater propensity of very old women to use aged care services. The increasingly perverse role of STEs on superannuation contributions and income in contributing to both inter- and intra-generational inequity has been widely noted and scrutinised particularly in the generational accounting analyses of Spies-Butcher and Stebbing; this work is taken up in Part 4.

Surveys of older people's attitudes towards planning for ageing have been conducted primarily by National Seniors in conjunction with Challenger, and other surveys have investigated how older Australians are perceived in the community as deserving of public support. The more subjective and qualitative findings show some divergences from the quantitative analyses of wealth and income and generational transfers. Reports from the Aged Care Financing Authority (ACFA), the Association of Superannuation Funds of Australia (ASFA), and CEPAR show that there are also differences in expressed preferences for different options, actual behaviour and policy proposals to address the cost of aged care in future. This material is taken up in Part 5.

A range of interests that are extending discussion of retirement income policy to give more attention to aged care financing is seen in the participants in the Retirement Incomes Policy Dialogue held at ANU in December 2018. As well as academic researchers from CEPAR as the organising body, the Treasury, the Department of Finance, the Australian Prudential Regulatory Authority, the Office of the Australian Government Actuary and private sector businesses were represented. Regular contributions are also coming from ACFA within the Commonwealth Department of Health, ASFA is widening the scope of its activities, and National Seniors have brought the views of older Australians into the mix.

The prospect for renewed interest was signalled in the closing remarks made by Mike Orszag of Willis Towers Watson at the 2018 CEPAR Policy Dialogue. He asked why some areas of the retirement policy field have changed but others have not, and what lenses need to be looked through to see a different picture and wider vision. Flagging the need to look not only at income on reaching retirement but at expenditure through retirement, he called particular attention to spending differences over the course of retirement and between men and women, noting that persisting gender differences are unlikely to be solved by increasing retirement incomes alone. Recognising one of these differences is the greater use of aged care by women, he suggested that alternatives such as aged care insurance could be required to meet these cost, with provision of such insurance through superannuation a means to this end.

The most recent contribution to the debate comes from the Institute of Actuaries of Australia in a Green Paper *Options of an Improved and Integrated System of Retirement*, released in August 2019. One of the six priority areas identified for improving Australia's retirement system is the coordination of retirement, pension and aged care policies, with particular attention needed to addressing anomalies in tax concessions on superannuation and transfer of benefits late in life, and in aged care funding.

1.2 An absent option: Private insurance for aged care

Almost absent from policy discussion in Australia is any mention of a role for private insurance as an option for funding of aged care. Private insurance has been part of aged care financing only in two short and now distant periods (Howe 1986), and those experiences offer little prospect of a return.

1.2.1 Lessons from past experience

Prior to 1963, residents in nursing homes, often called convalescent homes, could only receive Commonwealth benefits for hospital care if they contributed to a private health insurance fund. Those without private insurance languished in long stay wards of public hospitals, or if needing less care, in private rest homes or lower cost boarding houses. Conditions imposed by funds often excluded many insured patients from full entitlements and these problems were resolved by the introduction of Nursing Home Benefits under the National Health Act in 1963, effectively removing the role of private insurance. A range of facilities were approved as nursing homes for receipt of the new Commonwealth nursing home benefits and various conditions imposed on their operation.

From 1977 to 1981, the Commonwealth required private health insurance funds to pay Nursing Home Benefits for privately insured care recipients in approved nursing homes and nursing home type patients in hospitals. This measure saw funds promote their cover, with rapid growth of claims soon reaching levels that strained the Commonwealth-backed reinsurance pool. The reinsurance arrangement ceased in 1981 and the full cost of nursing home benefits returned to the Commonwealth budget in a single year. The consequent surge in expenditure attracted the attention of the House of Representatives Standing Committee on Expenditure and triggered a sub-committee inquiry into accommodation and home care for the aged, chaired by McLeay (1982).

Following the election of the Labor Government in 1983, the McLeay Report recommendations formed the basis of the aged care reform strategy that continued in a number of stages to 1996. These reforms focused on addressing the dominance of spending on residential care by developing new program structures to expand community care. Expenditure increased especially in the early years, but no changes were made to underlying funding arrangements.

The one recommendation of the McLeay Inquiry that was not adopted was that responsibility be assigned to State governments. Instead, the Commonwealth took over the joint planning and cost-shared funding of community care, alongside its existing responsibilities for residential care. The transfer was completed some 35 years later at the end of 2018 when Victoria and Western Australia gave up their roles in what had been the cost shared Home and Community Care Program. If nothing else, this long time span provides some motivation for continuing the debate over social insurance for aged care as a worthwhile policy option.

1.2.2 Private insurance partnership prospects

The possibility of private aged care insurance taking a partnership role alongside public funding has been raised by Courbage (2011). Rather than private insurance being crowded out by public financing and informal family care, he argues that governments make a number of decisions that could foster complementary roles in joint public private partnership funding:

1. prioritising the type of risks that are to be publicly financed and leaving the rest to be privately insured or self-funded;
2. making explicit decisions about the permitted roles of private insurance;
3. influencing the structure of regulation of service delivery in ways that shape insurance roles, including reinsurance for private insurers; and
4. government can also take action to build partnerships, ranging from raising awareness of the risks of needing long term care to offering tax relief for premiums, and they can enter cost-sharing arrangements to cover different levels of dependency.

Despite these possibilities, private insurers, including private health insurance funds, have shown no interest in covering aged care in Australia since the early 1980s, and experience with private health insurance, including the private health insurance rebate, have curtailed government interest in any partnerships in aged care. The risk of similar adverse distribution consequences in attempting to develop private insurance for aged care is one of the many barriers identified by Hixon (2011) in her discussion of how the burden of aged care financing could be shared between public and private sources. She notes that as with health care, any shift to private financing does not imply that aged care should be left wholly to the market to distribute among purchasers, but that insurance is required to spread the costs and risks.

Considering the balance of who pays and who benefits, Hixon comments that the broad tax base of current arrangements in Australia spreads costs widely across care recipients and taxpayers without using insurance mechanisms, although the PAYG system does not spread costs over time and may give rise to intergenerational tensions. She argues that major changes would be required to address significant demand and supply side barriers, but without certainty of outcomes. Finding little prospect for private insurance, Hixon also flagged non-conventional methods of reverse mortgages and new life insurance products as means of expanding private provision; both have received subsequent attention and are taken up in Section 5.

The last word on the limited prospects for private aged care insurance in Australia can be taken from the final report of the Productivity Commission Inquiry (2011, Vol 2, p. 116-118). After canvassing a number of pros and cons of private, voluntary insurance, the Commission noted that the introduction of a lifetime stop-loss model where the Australian Government covered costs above a nominated cap would mean government took on the long risks that individuals and insurers are less willing to accept. It continued that while opening the way for private insurance for the more predictable costs of aged care would make it more affordable, issues of prudential regulation would arise and for this and other reasons, voluntary insurance was unlikely to provide an adequate funding mechanism for a large share of the population.

1.2.3 International experience with private long term care insurance

Australia is not alone in eschewing private aged care insurance. In an analysis of 31 OECD countries, Colombo (2011) found that private insurance accounted for an average of 0.9% of aged care funding overall. The majority of countries funded aged care from taxes or social insurance and only 12 had a small sliver of private insurance, usually related to coverage of those excluded from public schemes. Belgium was a marked outlier with close to 10% of funding coming from regional care insurance programs for which mandatory yearly contributions were paid; otherwise the private insurance part was highest in Germany but still under 2%. Although the data reported by Colombo is from around 2008, there is no evidence of a change in the picture over the last decade. In the US, private long term care insurance continues to attract only low take-up and experiences considerable churn as policy holders drop their cover. There has been little further development of social insurance beyond Germany, Austria, Japan and Israel where comprehensive schemes have been in place for almost three decades. The Netherlands and Luxembourg also have more limited social insurance schemes, and the only new scheme is that implemented in Korea.

Taken together, social insurance schemes and tax based system that they complement show considerable variation in relation to coverage and target populations, means-testing, program structures including interaction with health insurance and pension schemes, and types of services covered, reflecting differences in flanking health and social security systems in different countries.

Further, public spending on long term aged care across the OECD countries bears little relationship to the proportion of the population aged 65 and over, and Australia is notably one of the youngest OECD countries not only now but well into the future.

While international experience is pertinent to developing an ACL in Australia, a number of features of Australia's aged care and wider social security systems pose limits to transferring overseas policy and financing measures directly to the local context. International and local experience lead to the conclusion that private aged care insurance can be discounted as a likely option for an additional pillar of funding in Australia, on the part of both government and insurers. For all the above reasons, private aged care insurance is not considered further as a funding option in this paper.

1.3 The policy paradox

1.3.1 Are increasing consumer contributions necessary?

In its Aged Care Roadmap, the Aged Care Sector Committee (2016: 23) states that 'A fiscally sustainable aged care system requires consumers to contribute to their care costs where they can afford to do so. The increasing population of older people who are living longer necessitates an aged care system that is sustainable into the future. The system will need to continue to rely on consumers' contributions as an increasing source of funding.' This statement embodies the two sides of the policy paradox: a policy stance of austerity that contrasts with the actual experience of sustained economic growth, and expectations that individuals will be able to pay more while public resources shrink. At the same time, reliance on consumer contributions currently is an overstatement when it is recognised that the major part of these payments are transfer payments from the Age Pension, and prospects of increasing the share of consumer contributions outside the Age Pension are limited.

The framing of both the problem and the solution as an individualised consumer issue has been shaped by the rhetoric of austerity and individual over government responsibility that has persisted in policy since the 1996 Commission of Audit. This perspective has been influenced by policies of countries with very different and generally much poorer recent economic experiences compared to Australia. Sustained economic growth over close to three decades makes it difficult to specify the exact nature and real extent of growing strains on Australian government finances, or that aged care and population ageing are the causes of future strains that cannot be managed.

At the same time, it is precisely the strength of the Australian economy that is the foundation of increased wealth of older people, due to high earnings on compulsory superannuation balances and associated STEs. These conditions underpin the view that older people in future will be able and willing to contribute more to the cost of future care. These conditions are simultaneously the reason for insuring against such need in case they do not persist as the economy shows signs of weakening. Put simply, taking action in good times now can protect against bad times in future.

Yet despite positing increased user contributions as essential, making these contributions has been left to the point at which individuals take up formal services, by which time financial resources and decision-making capacities of many are diminished. While aiming to foster individual responsibility for future care costs, no options have been formulated for making consumer contributions in advance of such costs arising. Whatever resources older people have to pay for care at the time of taking up services, most often in their late 80s, those resources are a reduced funding base compared to the resources available in the decades before and early after retirement, both for individuals and in aggregate across the population.

Instead of relying on future retirement incomes boosted by superannuation and related STEs to be a growing source of funding of aged care, with a small proportion of the population paying a higher amount at a later time when they take up services, an ACL would see a higher proportion of the population paying a smaller contribution over a longer interval ahead of needing care. The main barrier to taking such a measure has been a policy stance that has favoured tax cuts and tax expenditures to advance private welfare over using tax revenue for public funding of welfare services that has been part of Australian policy thinking since the National Commission of Audit (1996).

1.3.2 Will she be right mate?

With proposals for a third pillar for aged care funding having been canvassed for 25 years without action, three main reasons for the lack of action can be put forward.

The first is the view that 'she'll be right mate': policy makers argue that the current system is working well both in terms of recurrent and capital funding, and that any pressures can be met by increasing user payments, including expansion of reverse mortgages or related schemes to draw on housing assets, or developing new products to ensure retirement income lasts through late old age and so be available to cover care costs. This policy vacuum has fostered a reluctance to consider any new funding options for fear of threatening or destabilising the current settled scene. Even if not all policy makers accept these scenarios, they have shown little propensity to question the premises prevailing in the political climate of the last two decades; their lack of protest perhaps comes from an awareness of actual continuing universalism and only residual cost sharing by way of user payments.

The second reason is the continuing strength of the Australian economy which has meant that the crunch point forecast at various times in the past has not eventuated, and strains on the Commonwealth budget have stemmed more from policy decisions than underlying economic conditions. Rather than allaying concerns, continuing prosperity for the next 10 or even 20 years should be seen as providing the opportunity for strengthening aged care funding and improving annual budget outcomes. Worsening economic conditions would on the other hand be likely to reduce the very means that current policy rests on.

The third reason is that recent policy development has focused on the more immediate issues flagged in the 2017 Legislated Review. The issue of increasing individual choice through the implementation of Consumer Directed Care is essentially budget neutral, but consideration of moving from the Aged Care Funding Instrument (ACFI) to a new resource use classification for residential care funding has been driven in part by efforts to contain budget outlays. Continuing concerns over quality of care have also deflected attention from the revenue side of funding. Multiple shortcomings in the Oakden aged care facility in Adelaide prompted a Commonwealth inquiry into the national quality regulatory processes (Carnell & Paterson, 2017), and a Senate Inquiry that reported in early 2019 (Siewert, 2019). Notwithstanding major restructuring of quality assurance measures in line with recommendations of the Carnell and Paterson inquiry from mid-2018, media revelations of continuing cases of extremely poor care and abuse in late 2018 prompted the announcement of a Royal Commission into Aged Care Quality and Safety in October 2018. The Royal Commission was initially to report by April 2020 but its term has been extended to November 2020.

1.4 When will the next chapter be written?

Discussion of social insurance for aged care has been associated with major policy reviews over the last three decades, and the range of emerging interests points to renewed attention to the topic through two current opportunities.

The review of retirement incomes announced in mid-2019 in advance of the already legislated increase of the SG from 9.5% to 10% is the first opportunity. National Seniors were among the groups calling for inclusion of aged care funding, and while the Terms of Reference of the review do not mention aged care, the Consultation Paper released in November 2019 notes the need to take account of interactions between the retirement incomes and aged care funding systems (Treasury, 2019a). This review provides an opportunity for bridging the separate policy thinking about aged care funding and superannuation that has prevailed to date, and thereby widen the view of policy directions in both sectors.

The Royal Commission into Aged Care Quality and Safety provides the second opportunity as its terms of reference include *(f) how best to deliver aged care services in a sustainable way*. The breadth of the Commission's terms of reference overall invites thinking that goes well beyond the austerity view of government funding and immediate priorities that have left little space for canvassing alternative approaches to securing the long term sustainability of aged care funding. The only option that need not be on the table is private long term care insurance.

PART 2 Interactions between aged care funding and the pillars of retirement incomes

The three pillars of the retirement incomes system - the Age Pension, compulsory defined contribution pensions through superannuation, and private savings - each have a number of distinctive features and combine to form a system that has been labelled 'unique' by Chomik, Bateman and Yan (2018) in a detailed account of the current system and near future changes. The only defined interaction between these pillars and aged care funding is the setting of the Basic Daily Fee at 85% of the single rate Age Pension. While each of the other pillars contributes to aged care funding, the interactions are only loosely structured and different means tests apply to the Age Pension and the aged care means test that includes the former home in assets. Significant changes in retirement income arrangements over the last 30 years have not been matched by changes in aged care funding, a classic case of 'silo' policy making with very little cross program thinking until recently.

Two further 'shadow' pillars that play an important part in funding both retirement and aged care also need to be considered. The first is the use of housing assets that provide considerable security to home owners in retirement and are widely drawn on to fund the accommodation component of residential care. The second comprises not only unpaid, informal care provided by family and others but also cash benefits paid to a substantial proportion of these carers.

2.1 Multiple but separate pillars

The summary of the pillars of the retirement income and aged care systems in Table 2.1 shows that apart from the common element of the Age Pension, there are no other formally defined links. Interaction between the two systems is only loosely structured, and although superannuation is expected to enable users to pay a higher share of their care costs in the future, there is no provision to ensure this expectation will be realised.

2.1.1 The 1st pillar: Centrality of the Age Pension

The main pillar of both retirement incomes and aged care funding comes from government. In aged care funding, this very large pillar pays directly for care subsidies and Accommodation Supplements and indirectly for Basic Daily Fees through transfer payments of Age and Veterans Pensions.

The only formally defined link between retirement income and aged care funding is through the Age Pension (or Veterans Pension). Unusually among OECD countries, the Age Pension is funded from general revenue and is not a contributory scheme. The 2015-16 ABS survey of household income and wealth (ABS 2018b) shows that the Age Pension and other government pensions and allowances are central to older people's capacity to pay for aged care:

- They were the main source of income in 53% of households headed by a person aged 65-74, increasing to 74% at age 75 and over; the proportions receiving nil or less than 1% of income from these sources were 18% and 6% for the younger and older groups respectively.
- They accounted for more than 90% of gross income in one third and half of households in these age groups respectively, and between 50-90% in over another 20% of both groups.
- These age gradients suggest that the Age Pension is of even greater importance among those aged 85 and over now and is central to paying for aged care in the event of admission, and that it will continue to be so for some two decades even with increases in income from other sources in early retirement years.

As the source of the major part of user payments for aged care, the Age Pension should be regarded as a transfer payment rather than indicating users' capacity to pay from their own means. Limits to user contributions to care costs in both residential and community care are defined with reference to the Age Pension by setting an amount of income that individuals must retain. These limits ensure that individuals whose means exclude them from receiving a full or part pension pay no more than the equivalent amount from their income derived from other sources (with some exceptions for additional optional services that they choose to pay for). In residential care, the daily care fee paid by residents is set at 85% of the single rate Age Pension and paid from the Age Pension or the individual's other income, including from superannuation, on a means tested basis; the individual's own home has been included as an asset in the aged care means test only since July 2014 and the way in which it is valued interacts with accommodation payments for RACH.

Table 2.1: Interaction between retirement income pillars and aged care funding

Retirement Income	Aged Care Funding
1. Age Pension/Veterans Pension	1. Government funding 1a. Basic Daily Fee set at 85% of the Age Pension, paid largely by transfer payments from pension income, or from other income by those with higher means. 1b. Care subsidies and supplements, means tested but substantially covered by government.
2. Superannuation	2. Contributions to 2a. Basic Daily Fee by those who receive only part or no Age Pension 2b. Payment of means tested care fees and optional Additional Services fees 2c. Means tested accommodation payments as RAD/Cs or DAP/Cs (see 4a below).
3. Other income from savings, continued earnings, family contributions etc.	3. As for superannuation income
4. Home-ownership excluded from Age Pension means test. Commonwealth Rent Assistance (CRA) paid to low income renters.	4. Realisation of housing assets by home owners to meet accommodation charges, subject to combined means test on income and assets, including former home. 4a. Means test for Accommodation Charges includes both income and assets, including the value of the former home, capped at $170,000. Accommodation Charges paid as a lump sum Refundable Accommodation Deposit (RAD) and/or Daily Accommodation Payment (DAP) or RA and DA Contributions. Mainly funded by realisation of housing assets. Prices set by providers under Commonwealth Guidelines. 4b. Accommodation Supplement paid by Commonwealth for low means residents, substitutes for CRA for eligible residents. Amount set by Commonwealth linked to DAPs.
5. Carer Payment paid to informal carers under Age Pension age who leave work due to caring responsibilities, means tested.	5. Carer Allowance paid to informal carers in recognition of caregiving role, eligibility is means tested for carer and care recipient, and for care recipient disability and hours of care provided by carer.

2.1.2 The 2nd pillar: The Superannuation Guarantee and defined contribution pensions

The centrality of the Age Pension in Australia's social security system is evident in almost a century passing before a second, universal pillar was formally established when the 1986 National Wage Case saw those working under industrial relations rulings, or awards, trade off a lower immediate

wage increase for increased income in retirement. Under what came to be known as The Accord, the national wage increase was held to 3% with the goal of curbing wage inflation, and a further 3% contribution was paid as a mandatory contribution to superannuation. The awards-based contribution was replaced by the Superannuation Guarantee (SG) in 1992, extending coverage from 64% to the total workforce excepting those with low monthly earnings. Periodic increases in the SG lifted it to 9.5% of gross salary and it is legislated to rise in number of gradual steps to 12% by 2025. Paid by employers into the employee's nominated superannuation fund, the contributions are effectively wages foregone.

The SG functions as a defined contribution pension scheme and has a number of distinctive features:

1. While the SG is mandatory, superannuation funds are not run by government but as private and not-for-profit business operating under extensive government regulation. This arrangement is one of the forms of public-private partnership noted by Courbage (2011).
2. Favourable tax treatment of contributions and eventual retirement income have made superannuation a highly favoured means of saving. The growing cost and inequities of STEs to the Commonwealth budget became one of the major factors prompting reviews of the superannuation system since 2008 and are discussed further in Section 4.1.
3. Superannuation makes no specific provision for aged care and income from superannuation is not currently differentiated from other non-pension sources in user payments for aged care as few of those receiving any services are as yet in receipt of significant superannuation income. Its future role may also be limited by the low preservation age for accessing superannuation which ranges from 55 for those born before July 1960 up to 60 for those born after July 1964. Withdrawal of lump sums will also have an impact; while not major overall, this impact is uneven across the population entering retirement.

Relying on individual super to fund a greater part of aged care in the near future faces three significant limitations that are identified in ASFA's analyses of super accounts balances by age and gender and over time (ASFA, 2019a, 2017, 2015b, 2014). There are major and persisting differences between the population groups most likely to have higher super incomes and those mostly likely to need aged care, namely relatively younger retired men and relatively older women, especially those who had broken participation in the paid workforce.

1. Coverage remains far from complete, notwithstanding the spread of super. In 2015-16, at age 60-64, one in 5 men and one in 3 had no superannuation or a nil balance. The picture is more positive for those aged 30-34, where coverage reaches 89% and 83% for men and women.
2. Balances vary markedly between men and women. In 2015-16, for those with superannuation at age 60-64, the average balance for men was around $270,700 and $157,000 for women. While more than double the average balances in 2005-06, the gender difference persisted. ASFA notes that most of the gender differences are due to a significant minority of men with large balances and that median balance were much lower than averages, at $110,000 for men and only $36,000 for women at age 60-64. Recent decreases in the gender discrepancy could also be due to more men with low balances reaching retirement as much as to increasing balances for women.
3. Questions arise about how well super incomes at retirement will last the distance to the time that need for aged care arises, mostly after age 80. The low balances of the majority of women around retirement age in 2015-16 means there is little prospect that many will have any balance remaining in 15-20 years when they reach their 80s. Increases in coverage and in super balances at retirement for the 30-34 cohort will only be realised over many years, with this younger cohort

reaching their mid-80s only after 2050. Even with later retirement and later entry to care tracking in line with increasing life expectancy, and increases in individual retirement incomes over that time, it is unlikely that most will have much capacity to contribute to the costs of their aged care.

2.1.3 The 3rd pillar: Private savings outside superannuation

Private savings are the third pillar of retirement incomes. Favourable tax treatment of contributions to and eventual income streams from superannuation have resulted in some crowding out other forms of savings, but have substantially increased the level of national savings and will generate higher retirement incomes for most of the population at the same time as reducing reliance on the tax funded Age Pension, one of the main original intentions of the SG. Private savings and other income outside superannuation currently account for only a small share of user contributions to aged care costs and cannot realistically be seen as likely to increase in future.

2.2 Home-ownership and housing assets as a 4th pillar

In addition to these monetary pillars, home-ownership constitutes a fourth pillar of security in old age in Australia and is widely drawn on by home owners in paying for the accommodation component of aged care. Examination of home-ownership and living arrangements as detailed in Table 2.2 indicates that this pillar may not be as solid at older ages as it appears across the total population aged 65 and over. It should be noted that tenure in Table 2.2 refers to the tenure of the dwelling in which the older person was enumerated at the Census and that not all those in owner occupied dwellings are necessarily the owner.

2.2.1 Trends over time and with advancing age

Home-ownership is high for older households

Some fluctuations in home-ownership in late middle age observed in the wake of the 2008 Global Financial Crisis appear to have been related to delays in achieving full ownership more than dropping out altogether. Prior to the GFC, it appears that rising house prices and low interest rates led some to increase their mortgage to ‘up-size’ in late middle age with a view to either using lump sum withdrawals from superannuation to pay off mortgages outstanding at retirement, or selling the house to reap greater tax free capital gains to finance downsizing and possibly final contributions to super.

This interpretation is supported by the analysis of trends in mortgage equity withdrawal (MEW) over the decade 2001-2010 reported by Ong and others (2013) who distinguished flexible mortgage products that can be drawn on and repaid at any age from reverse mortgages that can be used only by older people and not repaid until the property is sold. Using HILDA data, they found that the proportion of households using the former products peaked at just on one third for those aged 45-54 in 2007-08 and fluctuated around half as many among those 55-64, but was much lower at around 5-7% for those aged 65 and over. These authors observe that those in pre-retirement age bands seem to view housing wealth as a resource that can be dipped into by adding to their mortgage without moving, although increasing housing costs. In contrast, *in-situ* MEWs are rarely used by older age groups for whom downsizing and selling-up become much more common ways of drawing on housing assets and also reducing housing costs. The primary home accounted for about 65% of the assets of both downsizers and those who sold up, but the total value of assets among the latter group was only about half that held by downsizers.

Delays in achieving full ownership by the time of retirement due to faltering household finances and super balances in the wake of the GFC appear to have been overcome. ABS Household Survey data for 2015-16 (ABS, 2018b) show that ownership among households headed by a person aged 65 and over has recovered. Some 71% of these households with a head aged 65-74 and 82% of those aged 75 and over were owners without a mortgage; adding another 12% and 5% for owners with a mortgage for the two age groups brings ownership to around 85% overall.

The recent AHURI report on mortgage stress among those aged 55 and over confirms the recovery of ownership at age 65 and over, albeit with the share who hold mortgages after age 65 increasing from under 4% to over 8% from 2001 to 2016 (Ong et al., 2019). Whether this level of ownership is sustained into the future depends on how the coming cohort of retirees are able to manage their housing and superannuation wealth, with marked changes and increasing heterogeneity evident in the pre-retirement group aged 55-64 over same period. A key finding was that, using HILDA data, outright ownership fell from 68% to 45% of households with a head aged 55-64 and mortgagors increased from 18% to 36%, with the balance of renters increasing from 14% to 19%.

Detailed analysis of differences between these owners and mortgagors showed complex interactions between household characteristics, borrowing behaviour and mortgage repayment risks relative to income and wealth. Drawing on superannuation was noted as one strategy for mortgage repayments, with evidence of inverse relationships in balancing superannuation savings and property wealth. A number of particular risks identified for those experiencing higher levels of mortgage stress point to greater volatility in home-ownership and superannuation savings among those reaching retirement and that changes in the housing market, wider economic shocks and changes in family and personal circumstances could have potentially large negative impacts. Any wobbling of the housing pillar due to failure to achieve home-ownership will have long term implications for well-being through retirement and eventual ability to pay for aged care accommodation as well as need for housing assistance in earlier years of retirement.

But changes occur with advancing age

In contrast to the picture of a high level of home-ownership across the population aged 65 and over, only around half of all residents entering RACH pay the full cost of their accommodation. This difference arises in part from comparing figures on tenure on the part of households headed by older people with Census data on individuals. As well as identifying older individuals living in dwellings owned by others, with or without a mortgage, or in other tenures, the Census data also includes those living in non-private dwellings (NPDs). Different types of tenure and living arrangements in private dwellings as well as NPDs are detailed in Table 2.2.

Older people living in owner occupied housing are not necessarily the owner; this is especially likely for those living in multiple family or other household arrangements where the house is owned by a younger family member. The differences over the age range do not stem primarily from cohort changes in homeownership early in retirement which has been relatively stable for decades, but are instead the result of compounding interactions between housing tenure and changes in living arrangements that are in part related to dependency and so have greater impacts at more advanced ages. The diversity of tenure and living arrangements overall, and differences over the age range, point to considerable dynamism in housing in late old age that is masked in broad statistics on home-ownership.

Those admitted to RACH are drawn unevenly between homeowners/purchasers and those in other tenures; having achieved home-ownership compared to being a long term renter persists as the greatest divide in well-being as Australians enter retirement and progress to advanced ages at which care needs rise. No single shift can be identified to account for the increase in those living in RACH from age 85, a fourfold increase to over 16% compared to 4% at age 74-84. Rather, a multiplicity of effects contribute to four main shifts.

1. The protective effect of home-ownership is evident; the proportion in fully owner occupied dwellings at age 85 and over is around 20% lower than at ages 65 to 84 (51% compared to ~65%), whereas the difference is close to 40% for renters (8% compared to ~12%). The smaller drop in home-ownership reflects the decreasing share of couple owners being offset by the increasing share of single owners, mostly due to widowhood, and also most of the couples or singles with mortgages achieving full ownership.
2. Multiple person living arrangements are mainly with family members but include other non-related people. More detailed ABS data (not included in Table 2.2) show that just over half are couples or a single parent living as a family with a child (53%), or with another related person such as a sibling (18%); only a small proportion lived with unrelated persons or in group households (10%). The high proportion not stating tenure (19%), twice as high as for the total population aged 65 and over in private dwellings (9%), suggests various forms of shared tenure and occupancy, including between generations. There may also be some uncertainty as to who was the actual owner of the dwelling on the part of the individual completing the Census for the household. Full ownership remains remarkably stable across the age range for these living arrangements at around 12%, and the proportion with mortgages almost halves, from 5.6% to only 3.1%; this decline may be due to discharge of mortgages by younger owners who then achieve full ownership. The overall stability may also mask changes in living arrangements over the age range, such as shifts from younger individuals living in dwellings owned by older family members to older people moving to live in dwellings owned by younger family members. To the extent that restructuring of tenure and living arrangements over the age range has involved redistribution of assets at some point, not all older individuals may retain housing assets sufficient to pay the full cost of their aged care accommodation. The proportion who do not pay for RACH accommodation is also reduced by others remaining in the house having ‘protected person’ status, that is, having been a long term caregiver whose means do not exceed the Age Pension means test.
3. Increases in the remaining types of tenure over the age range reflect different choices available to those with and without assets. Although a small share overall, the proportion in life leasehold tenures or ‘other’ tenures doubles over the age range, most noticeably from age 65-74 to 75-84. These tenures are likely to include leaseholds in retirement villages and social housing as these self-contained dwellings are enumerated as private dwellings, as are self-contained dwellings in public housing. Noting that village residents may also own their unit, this figures does not capture all who have moved to a retirement village, with most of such moves likely to be made by those who have had assets to realise.
4. NPDs are defined on the basis of shared living arrangements and common amenities such as kitchens, not by ownership. The increase in the proportion living in NPDs at age 85 and over is the most marked shift in tenure over the age range, reflecting declining ability to maintain private living arrangements whether due to financial and/or dependency reasons. About two thirds of those living in NPDs are residents in RACH, with only very small numbers in long stay hospitals. Almost one in two older Australians are now likely to enter RAC over their lifetime and half of

these admissions occur at age 85 and over; the dynamics of use of RAC are detailed in Part 4.5. The proportion living in 'other NPDs' also increases markedly at age 85 and over to account for one third of those in NPDs, a significant but often overlooked minority who have very limited housing options.

Table 2.2: Tenure and living arrangements, by age group for population aged 65 and over, 2016 Census

Age Group	**65-74**		**75-84**		**85+**		**Total**	
Private Dwellings	No.	%	No.	%	No.	%	No.	%
Owner-occupied[1] Without mortgage		64.4		65.8		51.0		63.0
Couple only	778,387	40.4	378,778	36.2	76,210	16.5	1,233,582	35.9
Single	227,748	11.8	189,862	18.1	105,329	22.9	522,969	15.2
Multiple family /other[2]	232,983	12.1	119,601	11.4	53,210	11.6	405,818	11.8
With mortgage		13.2		6.4		4.1		9.9
Couple only	115,772	6.0	19,716	1.9	2,228	0.5	137,743	4.0
Single	30,805	1.6	7,931	0.8	2,115	0.5	40,853	1.2
Multiple family /other[1]	106,998	5.6	39,230	3.7	14,311	3.1	160,548	4.7
Total Owner & Mortgage		77.5		72.1		55.0		72.9
Other tenures		21.2		22.5		20.4		21.5
Renter	253,528	13.2	119,587	11.4	37,497	8.1	410,637	12.0
Life time tenure	14,602	0.8	22,835	2.2	12,491	2.7	49,931	1.5
Other tenure type	6,846	0.4	6,474	0.6	3,660	0.8	16,981	0.5
Not stated	129,633	6.7	86,670	8.3	40,456	8.8	256,774	7.5
Total Private Dwellings	1,897,302	98.5	990,684	94.3	347,507	75.4	3,235,493	
Non-Private Dwellings		1.5		5.7		24.6		5.8
RACH (incl Hospitals)	14,634	0.8	38,008	3.6	77,343	16.8	129,989	3.8
Other NPD	13,568	0.7	18,061	1.7	35,725	7.8	67,356	2.0
Total Non-Private Dwellings	28,202	1.5	56,069	5.7	113,068	24.6	197,345	5.8
Total	1,925,504	100.0	1,046,753	100.0	460,575	100.0	3,433,032	100.0

Source: ABS, 2017d, Table 6 and 7. Totals in Table 2.2 combine ABS categories and may differ very slightly from totals in ABS data due to small random adjustments to protect confidentiality of data.

Notes: 1. Older persons enumerated in owner occupied dwellings may not necessarily be the owner of the dwelling.
2. Multiple family/other = total of living arrangements of one family households of couple or single parents with child/ren, multiple family households, those living with unrelated people in family or group households, and other non-classifiable households.

While most of these changes are small, even this limited account of housing dynamics shows how their combined effect reduces the proportion of very old people with readily realisable housing assets at the point when the need for admission to RAC arises. At age 85 and over, just over 1 in 2 remain living in owner-occupied housing, compared to around 3 out of 4 at younger ages. The dynamics of housing tenure and living arrangements involve many more shifts than just home owners selling their house and moving to RACH and some are associated with financial and other risks. The variety of circumstance that can deplete assets reported by Ong et al. (2013) include older owners borrowing against their housing assets to give financial assistance to younger family members, breakdown in informal agreements for accommodation and care, and divorce on the part of younger or older individuals sharing housing and/or care-giving, and in extreme cases, financial and emotional abuse.

Even among better-off owners who downsize, transaction costs and reductions in the Age Pension and other benefits due to increases in assets outside their own home can erode wealth. These intervening changes in living arrangements and tenures, and especially moves to other tenures and NPDs warrant much close examination. In addition to renters without housing assets, changes among those who enter retirement as home owners provide some explanations as to why only around half of those admitted to RACH are able to meet the full cost of their accommodation. The broad pillar of homeownership in early retirement narrows considerably as ageing advances.

The extent and variety of changes in household composition and assets across the older age range is made more evident in a finer grained analysis by Wu and others (2014) that traced changes over an 8 year period using a Centrelink database of over 10,000 Age Pension recipients. The background against which these changes played out showed wide variations at the outset:

- for single households at age 60-64, whether owners or non-owners, household consumption ranged from around $12,000 for those in the lowest asset quintile to almost three times as much for the highest asset quintile;
- for couple households at age 60-64, household consumption of under $20,000 for the lowest asset quintile was half that for those in the highest asset quintile; and
- consumption was markedly lower for non-owner couples compared to owners and at older compared to younger ages.

These figures reflect both base incomes largely reliant on the Age Pension and the wide range of income and assets, especially in non-assessable owner-occupied housing, before exclusion from any Age Pension income. These different starting points were greater than changes over time and persisted across age groups. Detailed analysis found change was most pronounced early and late in retirement compared to age 70-79, and greater for singles compared to couples, with compounding effects apparent, the most marked declines in ownership and assets occurring for widowed and divorced individuals at all ages, and at age 80 and over. While most held on to their assets, non-homeowners in the lowest quintile are far less able to meet accommodation costs in RACH compared to home owners in the same quintile let alone compared to those in the highest quintile, and taking account of the likely commensurate range in housing assets that are not counted as assessable assets for the Age Pension. Again, the average picture of high home-ownership belies wide variations and changes in circumstances.

Recent research conducted by the Australian Housing and Urban Research Institute (James et al., 2019) reported differences between the three age groups 55-64, 65-74 and 75 and over in both actual changes and aspirations for moves that would improve housing satisfaction. Looking 5-10 years ahead, the proportion who thought their current housing would not meet their aspirations or were uncertain was 30% for the youngest age group and dropped to around 20% at age 75 and over, possibly reflecting more already having made moves to housing that suited them better. The study also found that one third of the 55-64 year olds had an adult child living in their household. The need for a more dynamic view of the diversity of housing over the older range is again evident.

2.2.2 Use of assets to pay for accommodation

Sale of the house by those who are home owners is the main source of funds to pay for the means tested accommodation component of residential care by those whose means exceed the combined income and assets test, currently around half of all admitted to care. From 2014, these residents could opt to pay a lump sum Refundable Accommodation Deposits on admission, a Daily Accommodation

Payment, or a combination of a RAD and DAP. Rather than the new aged care means test resulting in more opting to pay a RAD, ACFA (2018a) observes that decisions are shaped by other factors such as the cost of the DAP which is linked to interest that would be earned on a RAD, their expected length of stay, and personal finances and other circumstances.

The account of payment options exercised by residents who pay fully for their accommodation and those who are partly or fully supported by the Accommodation Supplement in ACFA (2019, Chart 7.5) shows that among the former non-supported residents, the proportion paying a full RAD has fallen slightly over the last three years, the proportion paying fully by a DAP has increased and the balance who paid a combined RAD/DAP remained stable. Although short term so far, the trend away from RADs suggests that those who have to pay for their accommodation are becoming less willing to realise their housing assets and that it may be necessary to revise expectations about this source of user payments. As well as changes in the housing market noted by ACFA as a cause of the shift, more highly dependent residents may be more aware that their stay may be a matter of months rather than years and they and their families may be electing not to sell the former home. Residents have one month to decide how to pay for their accommodation, and if they opt for a RAD, have 6 months to pay. In the light of analysis of AIHW data on people leaving care in 2018 that shows 27% of those admitted for permanent care left within 6 months, mostly due to death, and 40% within a year, the decision to pay a DAP may be financially sensible and avoid the complications of selling a house in stressful circumstances.

2.2.3 The Accommodation Supplement

Those who cannot pay a RAD or DAP in full or in part receive a Commonwealth Accommodation Supplement and may pay part of the cost as a Refundable Accommodation Contribution or Daily Accommodation Contribution.

Over the decade to 2017-18, the proportion of new permanent residents classified as eligible for an Accommodation Supplement increased steadily from 35% in 2008-09 to 40%, while the proportion of permanent resident bed days occupied by supported residents fluctuated from year to year from a low of 38% to a high of 46% (Productivity Commission, 2019, Table 14A.21). This trend over a 10 year period runs counter to the view that residents in RACH have been increasingly able to pay a larger share of the costs and does not suggest change in the future. As well as reflecting the low means of very old women who make up the majority of residents, it appears that increases in life expectancy and associated increases in age at admission may be outdistancing any increases in incomes and assets early in retirement.

ACFA (2019, Chart 7.5) shows that 4 out of 5 supported residents pay only a DAC, made up largely of the Accommodation Supplement; of the remainder, most pay a combination RA/DA Contribution and only a small share pay a RA Contribution, presumably a low one or possibly paid by a third party. When the proportions of all residents paying by different options are applied to the share of bed days occupied by supported and non-supported residents, 46% and 54% respectively in 2017-18, just over 25% of all residents paid fully by a RAD (including under 3% paying a RA Contribution), just under 20% paid a combination of RAD/C and DAP/C (mostly DAP/C), and over half paid only a DAP/C. The proportion paying a RAD initially increased after the introduction of the combined means test from July 2014 and the extension of RADs to former high care RACH, but soon fell back towards its earlier level. While only a short term view, the last 3 years do not suggest marked future change is likely in either the balance of supported and non-supported residents or the share of the latter paying fully by a RAD.

The Accommodation Supplement is a form of social protection as defined by the OECD (Muir, 2017) as payments that ensure that all people who need aged care services can afford them, reducing the financial impact of paying for formal services, and compensating for the opportunity cost of providing informal care. The Commonwealth requires RACH to admit 40% of residents eligible to receive the Supplement in order to receive it at the maximum rate. This incentive to admit low means residents has resulted in a high proportion of RACH admitting these residents and generally avoided a division between RACH along wealth lines, notwithstanding variations associated with the socio-economic status of the RACH location. In 2015-16, just on 2 out of 3 RACH exceeded the 40% benchmark, 15% fluctuated around it and only 23% never exceeded it (ACFA, 2017b). While the ‘40% rule’ ensures a spread of supported resident across RACH, the last group that admit fewer supported residents will have a larger share of those paying fully by RADs. The resultant concentration of capital flows to these providers will be greater to the extent that they also charge higher RADs.

2.2.4 Sustainability of capital funding

These recent outcomes suggests that user payments for accommodation may not grow as a source of capital funding as much as has been anticipated from continuing high RAD payments by an increasing proportion of residents. Instead, the capital income base may be narrowing. At the same time, three indicators show growth and confidence in the industry and allay concerns about the need for additional capital funding beyond that becoming available under current policy settings.

1. ACFA reports provider interest in securing new bed approvals through the Aged Care Approvals Round (ACAR) by comparing applications to the number of places advertised for allocation. In the 2018-19 ACAR, the 13,500 places advertised attracted applications for almost three times as many places; the ratio of applications to advertised places of 2.8:1 was however lower than in the 2016-17 ACAR when there were 3.5 applications for each of 10,000 places advertised. No ACAR was held in 2017-18, but as at mid-2018, there were 31,600 places provisionally allocated and under development to become operational over the next 3-4 years (ACFA, 2018).
2. The *Aged Care Sustainability Report 2016* released by the consulting firm RSM (2016) included figures from a survey of 200 providers that showed only 3% expected to exit the industry, 66% expected to stay at their current level of operation, and 31% expected to grow; mostly through expansion of existing services or new development and only 15% through acquisition of existing beds.
3. The 2017-18 *Report on the Operation of the Aged Care Act 1997* reported that 20% of RACH completed building work and another 15% had new or upgrading building work underway, figures consistent with previous years allowing for some fluctuations from year to year, and a steady proportion were planning building work.

ACFA (2019) reports that capital expenditure growth has slowed in the last two years compared to the four years 2012-13 to 2015-16, noting provider reasons for delaying investment due to depressed returns and policy and regulatory uncertainty. Over the longer term, marked periodic variations in capital development are evident and this recent downturn cannot be taken as indicating a continuing trend or a shortage of capital funding. As at June 2018, providers held a total of $27.5bn in RADs, compared to total expenditure of $4.9bn on building work completed or underway in the year. Notwithstanding the apparent health of capital funding and the central role of RADs in securing further investment finance, the Institute of Actuaries (2019) is critical of RADs as the foundation of capital funding of RACH, arguing that long term investment in property assets should be funded from long term loans from informed lenders and not from short term loans from vulnerable residents.

2.3 Payments for informal care

2.3.1 Current cash benefits paid to carers

It is widely recognised that informal care from family and others plays a critical role in aged care by supporting frail older people to remain living in their own home or with relatives. However, rather than casting informal care as being 'unpaid' and without government support and remaining a 'shadow' pillar of funding, two cash payments paid to carers warrant recognition. The need for this recognition is all the greater because the availability of cash benefits has been largely overlooked in discussions of aged care funding in Australia. The reason for this neglect appears to be that these benefits are quite separate from the aged care system administered by the Department of Health as they are part of the income support system for all age groups, administered by the Department of Human Services and both paid through Centrelink, but under policy oversight of the Commonwealth Department of Social Services.

The Carer Payment (CP) is an income benefit paid to compensate those who are unable to work due to care-giving responsibilities but who are not eligible for the Age Pension or other income support; the amount of the Carer Payment is equivalent to the Age Pension, with CP recipients moving to the Age Pension on reaching age eligibility.

The Carer Allowance (CA) is a cash benefit paid to carers who meet eligibility criteria based on assessment of the carer's role in terms of the type and level of care provided, and the level of disability of the person they care for, and is differentiated for those caring for younger individuals (under age 16) and adults.

Carers may receive both CP and CA and both are means tested; although unlikely to exclude many as most carers have low incomes, means testing does make for consistency with other benefits for income support and for formal services. Spending of CA is discretionary and not tied to receipt of or payment for services. Although the amount of CA paid to the individual is modest, total expenditure on CA is substantial in relation to the aged care budget and take-up is high among the eligible population:

- Department of Social Security Demographic Data show that the 268,466 people caring for a person aged 65 and over receiving CA as at June 30, 2018 accounted for 43% of all recipients of CA (Adult).
- Assuming they accounted for the same share of the $1.7bn spent of CA (Adult) in 2017-18, this expenditure of $731m is equivalent to 30% of the $2.36bn spent on the Commonwealth Home Support Program in 2017-18 (including the remaining Home and Community Care program in Victoria and Western Australia at the time) (ACFA, 2019).
- The 2015 survey of disability, ageing and carers reported some 206,000 people aged 65 and over received informal care for self-care (ABS, 2015) and as providing and receiving such care can be taken as approximating the eligibility criteria for CA, this figure indicates that take-up is high among the eligible population. A much larger number, some 867,000, received informal care for a wider array of personal and instrumental activities of daily living, but much of this help would not qualify for CA.

Australian policy has justifiably given considerable attention to supporting carers with services, notably respite care, as well as through cash benefits. Attention to carers has however tended to obscure the situation of those without any family or others who are willing and able to help. Yet it is precisely this group who are most likely to turn to formal services and especially residential care.

Whether this group would prefer or benefit more from cash payments as an option in Consumer Directed Care in community care is not apparent, but debate over this option is a further reason for recognition of existing cash benefits.

2.3.2 Insurance and cash payments

Cash payments are commonly associated with social insurance schemes and individualisation of care. Medicare funds providers to deliver services at standard rates, and in the NDIS, individualised funding pays for services, with the cost of the overall package determined in line with care plans; cash payments are available only under particular conditions where formal services are not available. The issue of cash payments has nonetheless been a theme in discussions of aged care insurance in Australia over time as it has been seen by some as a mechanism for paying cash benefits. A related question is whether cash payments would be made to clients only for reimbursement of the cost of formal services or include payments to family and other informal carers. The relationship is not so simple as insurance schemes do not automatically mean cash payments, nor is insurance a necessary precondition for cash payments. Rather, international experience shows four relationships:

1. Most OECD countries have neither an aged care insurance scheme nor make cash payments.
2. Of the few countries that have insurance schemes and make cash payments, Germany leads the way; cash payments are not tied to spending on formal services but are paid at a discounted rate on the assumption that informal care is less costly than equivalent formal services, including informal carers being able to use the cash payment to purchase low wage help.
3. Japan in contrast has a longstanding insurance scheme but does not make cash payments; one grounds for not doing so was that cash payments were seen as binding women to traditional caring roles and subverting the purpose of social insurance in fostering growth of formal services.
4. Other countries without insurance systems make cash payments, but there are major differences between the two notable examples of Direct Payments in the UK and the CA in Australia. Direct Payments are paid to those who have had care needs formally assessed and a Personal Budget determined, and cash is paid in lieu of services to those who opt for Direct Payment; but take up of self-managed cash benefits among older people is low compared to take up of direct services. While CA is subject to detailed assessment of eligibility, this is independent of assessment of need for care services and CA can be received alongside formal services. While both CA and service charges are means-tested, CA is seen primarily as a recognition of carer roles and not as a means of paying for services.

2.4 Medicare and NDIS levies

Finally, some interactions between the Medicare and NDIS levies and aged care funding warrant note as they relate to an ACL. There are a number of similarities in the current circumstances of pressures on aged care funding and those surrounding the introduction of the Medicare levy in 1974 and much later, the NDIS levy, legislated in 2013 and implemented from 2014.

- The Medicare levy was introduced to cover those unable to afford private health insurance and so achieve universal access to free primary care and public hospital care for all Australians by expanding the population covered. It continues to fund only a relatively small share of total health funding, the major part of which comes from general revenue.
- The NDIS levy similarly added to existing funding of disability services from general revenue to address chronic under-funding across the population with disabilities and to provide a more adequate level and range of services.

- Both Medicare and the NDIS are seen as having elements of social insurance as both schemes cover the total population against adverse risks and the levies count as premiums. But neither pays for all care, and other accident and injury insurance schemes continue alongside the social insurance provided by the two broad schemes.
- The NDIS provides valuable lessons in taking the long view in policy development. The national inquiry into compensation and rehabilitation, chaired Woodhouse and Meares, reported in mid-1974 and legislation to establish a national scheme was passed by the House of Representatives. It was before the Senate on November 11, 1975, the day of the dismissal of the Whitlam government. It was almost 40 years before the issue returned to the policy agenda and concerted and bi-partisan political commitment saw it through. Over this interval, residential and community care services for younger people with disabilities went in different directions. In 1985, nursing homes catering for younger people were transferred from the Commonwealth aged care program to become a State responsibility under the accommodation component of the Commonwealth, States and Territories Disability Agreement. At the same time, in order to gain States agreement to the new cost-shared HACC program that brought together a number of previously separate State and cost-shared programs serving older people, State community care programs for the younger client group were also brought into HACC.

The aged care system is much more established than the disability system was at the time of the introduction of the NDIS, and it is not proposed that an ACL would take over all funding but that it would cover a defined part of care costs alongside continuing pillars of funding from general revenue and user payments. The main purpose of the ACL would thus be similar to the combined Medicare/NDIS levy, that is, to support tax-based funding for health and disability services. Like Medicare and the NDIS, and ACL would be a Pay-As-You-Go scheme, but in the event that revenue from the ACL in the early years exceeded expenditure on the component of aged care it was intended to fund, the surplus could carry over from year to year, and the option of setting up a specific fund to manage such surpluses could be considered.

Finally, access to services funded by an ACL would be based on types of services and not age, noting that there is only very limited overlap in age of eligibility for and receipt of disability and aged care services. Those entering the NDIS before age 65 can continue to receive disability services as they age, but new entry ceases at age 65. Planning for aged care services is based on the population aged 70 and over, but access to aged care services is not based on age and individuals under age 70 can access aged care services in the community and residential care subject to assessment of need. Thus, while those aged 65 and over cannot access NDIS services anew, younger people receiving NDIS services can transfer to aged care services if changes in their care needs make aged care services more appropriate, for example with the onset of age-related conditions such as dementia. These eligibility conditions means that only small proportions of users of aged care programs are under age 65: 2% in the Commonwealth Home Support Program and 3% in Home Care Packages, and of the 5% of residents in RACH under age 65, half were aged 60-64 and only 0.4% were under age 50.

An ACL would complement both the Medicare and NDIS levies by covering the long term care needs of older people which neither of the existing levies provide for.

2.5 Where would another pillar of aged care funding fit?

An ACL on earnings of super funds would not only add a third pillar to aged care funding but closer interaction with the retirement income system would see the whole add up to more than the sum of the parts of both by bringing together what to date have been separate pillars in policy thinking and in practice. The restructuring of the pillars of aged care funding would see:

1. The large pillar of government funding would be divided into separate shares of care costs covered by the ACL and from general revenue.
2. The Age Pension would remain central to both aged care funding and retirement incomes and its roles would be unaffected by an ACL applied over a time interval over late working life and early retirement, and well ahead of entry to care. It would not affect transfer payments from the Age Pension towards the Basic Daily Fee in aged care which is governed by means testing for the Age Pension, applied at the time of using care services.
3. An ACL would establish a direct link with the second pillar of superannuation in the retirement incomes system and would strengthen the role of super in providing for lifetime needs in retirement. By extending to super earnings in the early years of retirement, an ACL would bridge the gap between cessation of contributions to super on retirement, for most by their mid to late 60s, and take up of aged care services in their 80s. It would be much more reliable than the slender pillar of other income that will be even smaller for most by advanced old age; even with increases in super and other retirement incomes across the older population in general, few of the much more selected population who come to use aged care, especially very older women, will have sufficient non-pension incomes to make substantial user payments.
4. The pillar of home-ownership has been found to be not as strong as it appears. Although a solid base for most at the time of retirement, it is considerably eroded by changes in tenure and living arrangements associated with advancing age by the time of admission to residential care. These changes explain why although more than 3 out of 4 are home owners at retirement, only one in two are able to pay for their aged care accommodation some 15 to 20 years later. The ACL would not affect current arrangements of user payments for accommodation, but it could cover government funding of the Accommodation Supplement.
5. An ACL would leave Carer Payments and Carer Allowance as they are. CA especially moderates the need for cash payments in Australia, and an ACL would not automatically provide for cash payments which would instead rest on consumer directed options available through different service delivery programs.
6. An ACL is highly compatible with the SG and the Medicare and NDIS levies that fund part of those service systems. This compatibility is likely to extend to acceptance of social insurance as a way of sharing risks in Australian social policy, with user contributions playing a residual role.

PART 3 Trends in funding and use of residential aged care

Concerns over Commonwealth spending trends driven by ageing of the Australian population have been expressed in the four Intergenerational Reports published from 2007 to 2015. These reports together with a recent analysis from the Parliamentary Budget Office show that aged care expenditure is growing faster than Age Pension outlays, and projections show continuation of this difference. Within aged care spending, residential care accounts for the major share, and analysis of components of this funding show that it is proving difficult to control outlays on care funding and to increase the share of funding from residents.

3.1 Budget impacts of population ageing

While the pillars of the retirement income system are only loosely linked to streams of aged care revenue, concerns about the balance between the cost of the Age Pension and aged care have arisen at an aggregate level. The main pressures for controlling both expenditures stem from projected impacts of population ageing on the Commonwealth budget.

3.1.1 The Intergenerational Reports

Demographic impacts on Commonwealth spending have been the main focus of the four Intergenerational Reports published in 2002, 2007, 2010 and 2015. Table 2.3 traces actual spending and projected spending as a proportion of GDP across these Reports; the uneven intervals between the second and third IGR have made for varying intervals of 5 and 10 year projections, but comparisons can be made by reading diagonally across the cells in the table. Three observations can be made:

1. As can be expected, the 5 and 10 year projections correspond more closely than the 20-40 year projections. The greatest divergence is evident between the 30 and 40 year projections presented in the 2007 and from 2040 in the 2015 IGR. The explanation is seen in the 2015 IGR comparison of projections under previous policy, as in the 2010 IGR, and proposed policy that takes account of measures in the 2014-15 Budget to control aged care expenditures, mainly by limiting the rate of growth of the Commonwealth Home Support Program.

Table 3.1: Commonwealth aged care expenditure as share of GDP, actual and projected, Intergenerational Reports, 2002-2015 (actual baseline figures in bold)

IGR \ Year	01-02	06-07	09-10	11-12	14-15	16-17	19-20	21-22	24-25	26-27	29-30	31-32	34-35	36-37	39-40	41-42	44-45	46-47	49-50	54-55
First 2002	**0.7**	0.7		0.8				1.0				1.4				1.8				
Second 2007		**0.8**		0.9		1.0				1.2				1.6		1.8		2.0		
Third 2010			**0.8**		0.8		0.9				1.2				1.6				1.8	
Fourth 2015					**0.9**				1.1				1.3				1.4			1.7

2. While all IGRs identify growth of the aged population as the main, and highly predictable, driver of spending, this divergence highlights the impact of policy change. The last projected outcome will only be realised if policy settings as at 2014-15 remain constant for the next four decades and economic conditions that determine the size of GDP are stable, neither of which are likely.

3. With actual outcomes in line with projections to date, none of the IGR projections have given rise to major immediate concern and short term action, but nor have they given rise to consideration of longer term action to address the increases projected from the early to mid-2030s.

3.1.2 The Parliamentary Budget Office

A wider view of the impact of ageing on the Commonwealth budget is given in the recent report of the Parliamentary Budget Office (2019). Released just ahead of the 2019-20 Commonwealth budget, this report examines the ageing-related effects on both revenues and spending and the impacts across a range of areas of outlays over the decade to 2028-29. It identifies a number of specific effects of the maturing of the superannuation system on the composition of the tax base: the legislated increase in the SG is seen as likely to lower real wage increases as earnings are shifted into superannuation, and revenue growth is expected to weaken as more superannuation accounts move from the accumulation phase into the retirement phase with tax free incomes. The further question raised is whether the net budget effect of higher superannuation incomes on lowering Age Pension expenditure will be offset by higher tax concessions associated with superannuation.

The PBO report noted spending on the Age Pension at $45 billion in 2017-18 compared to $18 billion on aged care, giving a ratio of 2.5:1. This figure continues the shift noted in the Mid Term Review of the Aged Care Reform Strategy from 8:1 in 1980-81 to 4:1 by 1990-91 (Department of Health, Housing, Local Government and Community Services, 1993, p. 92), and can be attributed to the greater control of outlays on the Age Pension compared to aged care. Growth of pension expenditure has been moderated by the increase in the age of eligibility, especially for women, indexation to wages, and a decrease in take up of the full compared to part Age Pension associated with the growth of superannuation. Further, in differentiating the uneven growth of cohorts within the total population aged 65 and over, the PBO notes that growth in expenditure on the Age Pension peaks in the next decade while aged care expenditure will lag behind and not peak until the 2030s. The window of opportunity that arises from the growth of superannuation ahead of the growth of demand for aged care, and its implications for an ACL, are taken up in Section 3.4.

In contrast, while wages account for a large part of the cost of aged care and subsidies are indexed to wages, other factors have driven greater increases in aged care expenditure ahead of budgeted growth. The cost increases that ACFA (2017a) identifies as compounding volume increases in recent years have been in effect over the longer term. Control of provision in line with the population aged 70 and over has limited volume growth since the 1980s, but demand appears to be falling as the younger cohorts in this target population have increased more rapidly than the older cohorts; this balance will reverse from the early 2030s as the baby boomers reach advanced old age.

Costs have however grown twice as fast as volume alone due to escalation of claims on the three needs-based funding instruments used over the period. Each of these instruments has seen an upwards shift in dependency ratings, and currently 50% of residents are classified at the highest funding level. Only part of this upward movement can be attributed to real changes in resident profiles and an element of gaming has been recognised in calls for a revised funding assessment instrument to be less susceptible to gaming, more transparent and more reliable (Applied Aged Care Solutions Pty Ltd, 2017). Measures to limit claims growth have only recently been introduced. Finally, the major part of costs fall to the Commonwealth and user payments have not come to contribute a larger share.

The various factors have somewhat different impacts on the Age Pension and aged care costs, and the trends in expenditure are to a substantial part the consequence of past policy decisions. It follows that alternative decisions could lead to different outcomes over the medium to longer term.

3.2 Level and components of expenditure growth

Notwithstanding continued policy efforts by all Commonwealth governments to shift the balance of spending in favour of community care, the share of funding going to residential care has remained at around 80% of public outlays on aged care since the reforms made by Labor from the mid-1980s. It has proved similarly difficult to increase the share of costs met by residents of RACH compared to government. Accordingly, this Part examines funding of residential aged care, focusing on recurrent expenditure. Accommodation Supplements paid for low income residents and DAP/DACs are included, but not RAD payments as the Commonwealth requires RAD payments to be reserved for capital funding.

3.2.1 Control of growth through the planning framework

The planning framework gives the Commonwealth effective control over growth of the volume of provision at the same time as ensuring RACH places are distributed in relation to the target population - the population aged 70 years and over and the Indigenous population aged 50-69 - and the consequent growth of provision in line with the ratio set in relation to this target population. These trends are detailed in Table 3.1. The total population aged 70 and over increased by 16% between the 2011 Census and 2016 Census, with annual increases rising in the later years as the Baby Boomers reached their 70s. The share of the total population aged 70 and over increased from 9.7% in 2011 to 10.7% in 2016. The Indigenous population aged 50-69 adds marginally to the total aged 70 and over and is unevenly distributed geographically.

Annual growth of RACH places rose more slowly than the population aged 70 and over, from around 1% to 3.5%. The changes in growth rates reflect places approved in ACARs up to 5 years previously coming into operation and the declining target ratio. Notwithstanding the increase in the absolute number of places in the last two years, the ratio is already below the target set for mid-2022 of 78 places per 1000 of the target population (population aged 70 and over and the Indigenous population aged 50-69). This target ratio is the outcome of successive adjustments made since the initial ratio of 100 beds per 1000/70+ and in the balance of residential and community care packages which have been included from the mid-1990s. The total provision ratio for 2022 is set at 125 places per 1000, divided between 78 residential, 45 community care packages and 2 short term restorative care.

Table 3.2: Population aged 70 years and older and residential aged care places, 2011-2018

As at June 30	2011	2012	2013	2014	2015	2016	2017	2018
Population 70 yrs and over[1]	2,133,651	2,191,816	2,250,702	2,324,028	2,397,925	2,479,178	*2,597,370*	*2,707,318*
% annual growth	-	2.7	2.7	3.3	3.2	3.4	4.8	4.2
Operational Places[2]	182,302	184,570	186,278	189,283	192,370	195,825	200,689	207,142
% annual growth		1.1	0.9	1.6	1.6	1.8	2.5	3.2
Achieved ratio per 1000 aged 70 and over [3]	85.8	84.4	84.5	82.6	81.1	79.7	77.9	76.5

Source: 1. Estimated resident population, as at June 30, ABS (2019) *Australian Demographic Statistics, March 2019*. ABS Catalogue 3101.0 DO 002_201903.

2. Productivity Commission (2019) *Report on Government Services*. Table A14.14.

3. Note that the ratio per 1000 aged 70 and over is marginally higher than the ratio per 1000 target population, which includes Indigenous Australians aged 50-69, and Transition Care Beds, which at June 30, 2018, was 74.4.

The impact of the planning ratios illustrates the effectiveness of controls exercised consistently over a long period in bringing about major change in the aged care system. The target population that has been in place since planning ratios were formalised as an outcome of the 1986 Nursing Homes and Hostels Review is however coming under question. The 70 years and over population is now seen to be out of step with the much older population that uses RAC but the Commonwealth has yet to address calls for the base population to be raised to age 75 and over, and adjust the base for the Indigenous population, currently those aged 50-69, to 55-74. Adjustment to take account of improvements in life expectancy at older ages, including among the Indigenous population, over the last four decades is now well overdue, and rather than just recalculation of a ratio based on current provision, trends in age-specific rates of admission need to be taken into account.

3.2.2 Price increases driving expenditure growth

The Aged Care Financing Authority released its 7th Annual Report in July 2019. Table 3.2 presents details from the last six ACFA reports covering the years 2012-13 to 2017-18. Data are taken from the report for the relevant year, noting that some minor differences between year to year figures are due to changes in provider reporting and ACFA classification of revenue, as noted in Table 3.2. Although every 1% of revenue represented $180 million in 2017-18, many of these minor differences in small revenue categories have little impact on broader patterns of revenue flows.

The rate of increase in spending consistently exceeded growth of the target population and residential care places over the period, and in its 5th Annual Report, ACFA (2017) identified three drivers of expenditure growth:

1. Some 30% of growth was due to volume increases associated with growth of provision in line with planning targets, with the declining target ratio offsetting the increase in the target population.
2. The major driver was price increase which accounted for about 70% of the increase; this price increase has occurred over a period of very limited growth in staff wages and has been driven by price increases associated with the increasing proportion of residents for whom the highest levels of care benefits were claimed and increases in benefit levels.
3. A small share was due to interaction of price and volume increases.

3.3 Total expenditure growth

3.3.1 Trends 2012-13 to 2017-18

Total revenue paid to residential aged care providers increased from $13.9bn in 2012-13 to $18.1bn in 2017-18, the bottom line in Table 3.3. Growth peaked at 8.6% from 2015-16 to 2016-17, but has since dropped back to well below rates of increase in earlier years. The changes from year to year do not conform to increases in provision but reflect the stronger influences of policy measures taken to control different revenue streams, some with swings and roundabouts effects and some with compounding effects.

1. The substantial increase in revenue from **care subsidies based on the Aged Care Assessment Instrument (ACFI)** to 2014-15 reflects changes in claiming on the part of providers. Growth then fell over the next two years as elements of the ACFI were adjusted and controls imposed in the following years saw growth fall, especially in the latest two years.
2. The high growth of **respite and other care supplements** in 2013-14 is due to changes in subsidies from that date. The cost blow out following the introduction of the Severe Behaviour

and Dementia Supplement led to its subsequent withdrawal, and the Payroll Supplement was also withdrawn from 2014-15. The recent recovery is associated with increased use of residential respite care.

3. The rate of growth of revenue from the **Basic Daily Fee** has fallen steadily over the whole period, in line with low increases in the Age and Veterans Pensions.
4. The marked increases in **Means Tested Care Fees** from 2014-15 continuing through 2015-16 reflect the introduction of the combined aged care means test that included income and assets. Once this change was phased in, growth of these revenue streams has fallen over the last two years.
5. **Extra Services or Additional Service fees** show some marked fluctuations. The decline over 2013-14 to 2015-16 can be attributed to higher means residents switching to paying means tested care fees following the introduction of the combined means test and policy changes in the treatment of election to pay that fee rather than extra or additional service fees, but these shifts then reversed. As well as the range of additional services increasing from 2016-17, ACFA notes some changes in provider reporting of these fees.
6. The combined means test generated flow-on increases in **Accommodation Supplements and Daily Accommodation Payments** to 2015-16, but this growth has since abated.
7. Revenue from **other income** has fluctuated markedly from year to year, in part due to the level of different government grants varying from year to year and changes in reporting.

Table 3.3: Residential Aged Care Revenue 2012-13 to 2017-18

Year	2012-13 $m	2013-14 $m	% inc 12/13 - 13/14	2014-15 $m	% inc 13/14 - 14/15	2015-16 $m	% inc 14/15 - 15/16	2016-17 $m	% inc 15/16 - 16/17	2017-18 $m	% inc 16/17 - 17/18
ACFA Source Table (1)	3rd, T7.2	3rd, T7.2		4th, T7.2		5th, T9.3 (2)		6th, T9.4(3)		7th, T6.9	
Care Subsidies											
ACFI	7,483.1	7,917.2	5.8	9,146.8	15.5	9,961.9	9.0	10,741.7	7.8	10,812.3	0.7
Respite and other care supplements	805.0	981.7	22.0	453.4	-53.8	360.5	-20.5	390.7	8.4	431.4	10.4
Fees											
Basic Daily Care Fee	2,692.5	2,855.8	6.1	2,986.3	4.6	3,088.9	3.4	3,186.7	3.3	3,253.4	2.1
Means tested care fees	326.0	314.2	-3.6	373.6	18.9	456.0	22.1	468.9	2.8	504.0	7.5
Extra Services Fees and Additional Services Fees	179.3	194.8	8.6	183.1	-6.0	146.9	-19.8	218.7	48.8	264.7	21.0
Accommodation											
Accom. Supplement	769.6	762.4	-0.9	827.6	8.6	971.6	17.4	929.7	-4.3	1,008.1	8.4
Daily Accom. Payment paid by residents (excl RAD)	514.4	643.5	25.1	680.7	5.8	850.8	25.0	778.4	-8.5	781.0	0.3
Other revenue											
Other income	1,191.0	1,156.5	-2.9	1,158.6	0.2	1,335.2	15.2	980.0	-26.6	1,011.4	-2.9
Total	**13,960.9**	**14,826.1**	**6.1**	**15,810.1**	**6.6**	**17,171.8**	**8.6**	**17,756.5**	**3.4**	**18,066.3**	**1.7**

Source: Aged Care Financing Authority, *Report on the Funding and Financing of the Aged Care Sector*, annual 2012-13 (2014) to 2017-18 (2019).

Notes: 1. Figures for each year taken from ACFA Annual Report covering corresponding year.
2. ACFI revenue in 2014-15 is total less adjustment for means tested and other optional care fees as detailed by ACFA.
3. Extra Services Fees from 2016-17 includes Additional Services Fees, both paid by the resident by on discretionary basis.

Rather than achieving significant control of expenditure at aggregate level, the main effect of the short term changes in smaller revenue flows has been instability for providers and uncertainties for residents. Aged and Community Services Australia expressed these concerns in its submission to the Department of Health Aged Care Legislated Review (ACSA, 2016), citing modelling it had commissioned as showing an 11% cut in subsidies flowing from adjustments to the Complex Health Care domain of the ACFI, and claiming potential negative effects on admission of the most dependent individuals.

3.3.2 Forward estimates

The last forward estimates for residential care expenditure were presented in the 2017-18 Budget Statements, and have since been combined with estimates for home care packages. Table 3.4 details figures from Budget Statements for 2017-18 and 2019-20, to 2022-23. Expenditure specifically on residential care has been estimated from the 2019-20 total figures as the same share as in the 2017-18 estimates, then declining marginally year-on-year in line with the planned growth of care packages. These Forward Estimates do not include expenditure on the Commonwealth Home Support Program.

Annual increases in the order of 5-6% continue the level of growth from the earlier years seen in Table 3.3, except for the lower growth projected for 2020-21. One explanation for this fall is that there was no Aged Care Approvals Round in 2017-18 and a lower number of residential care places will thus become operational 3-4 years later.

Table 3.4: Forward estimates for residential care expenditure, 2016-17 to 2022-23

Year	2015-16	2016-17	2017-18	2019-20	2020-21	2021-22	2022-23
From 2017-18 Budget Statements (Treasury, 2018)							
Total		12,612,400	13,396,445	14,351,886	15,528,076	16,525,050	
Home Care Packages		1,726,419	1,967,122	2,293,311	2,656,893	2,971,024	
RACH		10,885,981	11,429,323	12,058,575	12,871,183	13,554,026	
RACH share %		86.3	85.3	84.0	82.9	82.0	(81.0)
% annual inc. in RACH expenditure			5.0	5.5	6.7	5.3	
From 2019-20 Budget Statements (Treasury, 2019b)							
Total			14,927,939	16,084,128	16,902,230	18,156,957	19,458,112
Est RACH at % as above			12,735,934	13,514,019	14,010,216	14,892,534	15,566,490
% annual inc. in RACH expenditure				6.1	3.7	6.3	4.5

3.4 Shifts in shares of revenue from Commonwealth, resident and other sources

The shares of revenue from different sources set out in Table 3.4 are regrouped into direct and indirect Commonwealth funding and revenue from residents and other sources in Table 3.5. Notwithstanding measures aimed at increasing the share of revenue coming from residents, there have been marginal declines in the last two years from the peak of 20% in 2015-16.

3.4.1 Commonwealth sources

Commonwealth payments have remained steady at around 80% of all revenue over the period, dominated by direct care funding through the ACFI and indirect funding through transfer payments from the Age and other pensions for the Basic Daily Fee.

1. **Direct Commonwealth revenue from ACFI care subsidies** accounts for by far the major share of all revenue, increasing marginally from 2014-15 when the share from **respite and other supplements** fell. Taken together, Commonwealth care subsidies have been steady at around 60% over the whole six years.
2. Commonwealth payments for the **Accommodation Supplement** remained steady at around 5.5% of revenue over the six years. Some of this stability is due to interaction with DAPs, and sees the supplement continue as a significant part of Commonwealth funding.
3. The share coming from indirect Commonwealth revenue for the **Basic Daily Fee** dropped slightly from 2014-15. The estimate of a constant 2/3 share of Basic Daily Fees coming from transfer payments may over-estimate the Commonwealth share, but shifts in shares paid by residents suggest that any difference would be small.
4. **Other revenue** coming from government through viability supplements, grants and other specific payments has been estimated at 30% of this revenue stream on the basis of ACFA figures, with capital grants included in this stream. This share has fluctuated around 2%.

Table 3.5: Share of revenue from government, residents and other sources

Revenue stream	% of total 2012-13	% of total 2013-14	% of total 2014-15	% of total 2015-16	% of total 2016-17	% of total 2017-18
Direct Commonwealth						
Care Subsidies						
ACFI	53.6	53.4	57.9	58.0	60.5	59.8
Respite and other care supplements	5.8	6.6	2.9	2.1	2.2	2.4
Accom. Supplement	5.5	5.1	5.2	5.7	5.2	5.6
Indirect Commonwealth						
Basic Daily Fee (total)	19.2	19.3	18.9	18.0	17.9	18.0
66% Basic Daily Fee est. as Age/other Pension transfers	12.6	12.9	12.6	12.0	12.0	12.0
Other revenue	8.5	7.8	7.3	7.8	5.9	5.6
Est 30% from govt.	2.6	2.3	2.2	2.3	1.6	1.7
Total paid by Government incl. transfers from Age & Other Pensions	**80.1**	**80.3**	**80.8**	**80.0**	**81.4**	**81.5**
Resident and other						
Means tested and optional fees						
33% Basic Daily Fee est. paid by resident	6.4	6.4	6.3	6.0	5.9	6.0
Means tested care fees	2.3	2.1	2.4	2.7	3.0	2.8
Extra Services Fees and Additional Services Fees	1.3	1.3	1.2	0.9	1.2	1.5
DAP/ C (excl RAD)	3.7	4.3	4.3	5.0	4.4	4.3
Other revenue est. 70% from providers	5.9	5.5	5.1	5.5	3.9	3.9
Total paid by residents/other sources	**19.9**	**19.7**	**19.2**	**20.1**	**18.4**	**18.5**

Source: Derived from Table 3.2. Sub-totals may not add exactly due to rounding.

3.4.2 Resident and other incomes shares

The shares of the separate streams within the total of around 20% of revenue from residents and other sources have fluctuated marginally rather than showing any clear trends.

1. The share of the **Basic Daily Care Fee** paid by residents from non-pension income is the largest component, estimated at 6%, with a smaller and steady share from **Means Tested Care Fees**; both show minor but irregular increases from 2014-15 and together accounted for a steady share of total revenue over the full 6 years.
2. The share coming from **DAPs** has fluctuated around 4 -5% and has steadily tracked below the share from the Accommodation Supplement. The steady shares from Means Tested Care Fees and DAPs supports the estimate of non-pension income accounting for a constant 33% of Basic Daily Care Fees.
3. **Other sources of non-government revenue**, estimated at 70% of other revenue on the basis of the value of interest, donations and fundraising, sale and revaluation of assets accounted for around 6% of total revenue until a fall in the last two years, possibly due to lower interest rates.

Efforts to increase the share of revenue paid by residents have yielded little growth in their share of revenue over the last six years. While the long term impact of the combined means test from 2014-15 has yet to be seen, expectations that future RACH residents will be wealthier and so able to contribute more towards the cost of their care need to be tempered by three considerations:

1. As discussed in Part 2, the largest group of residents are women aged 80 years and over who have low incomes, and many also have low assets. There is little prospects that these individuals will have much higher means in the foreseeable future, or that they will be able to make them last longer before entering residential aged care at increasingly older ages.
2. The combined means test aimed to achieve more consistency in payment for care and accommodation between asset-rich but income-poor residents, who exhausted their assets by paying a high RAD but then did not pay for their care, and income-rich but asset poor residents, who paid for their care but not for their accommodation. The impact of these changes is moderated by the introduction of annual and lifetime caps on user fees at $25,000 and $60,000 respectively. The proportion of residents likely to reach these caps is small due to both separation from residential care in less than a year, mostly by death, and the run-down of assets and incomes over longer stays. Those with long stays do however account for a disproportional share of occupied bed days, and reaching the lifetime cap will again limit the share of residents who will be required to contribute more to the cost of their care over time.
3. Interaction between increases in DAP/Cs paid by residents in new and upgraded homes and Accommodation Supplements paid by the Commonwealth to supported residents in these homes sees a ratcheting effect that has outweighed any impact of higher DAPs at least in the short term.

3.5 Demographic and dependency drivers of demand for care

Rather than facing immediate and high increases in demand for care due to population ageing, demographic trends point to slower growth over the next 10-15 years before an upswing from after 2030. As well as differential growth of the 70-84 years cohort compared to the 85 years and over cohort, associated changes in dependency affecting patterns of use of residential care also need to be taken into account. These differences suggest that the near to mid-term time frame to the mid-2030s needs to be distinguished within the longer term view, such as the 40 year projections to 2058 presented by Cullen (2019).

3.5.1 Differential growth of older cohorts

While the growth of the older population numerically and as a proportion of the population aged 65 and over is widely recognised, closer examination of trends for different cohorts at middle age, older and advanced age shows uneven growth over the next three decades, as set out in Table 3.6. The very old population is projected to increase by close to 40% over the decade from 2020, then by nearly 50% from 2030 to 2040 as the Baby Boomers reach their mid-80, but the rate of increase then halves to just on 25% from 2040 to 2050. The actual changes are smoother than the decade by decade figures suggest, but it is this uneven growth that presents opportunities for taking action ahead of the peak growth in the oldest cohorts.

With reference to an ACL, the three cohorts broadly define the contributors aged 50-69, a transition group aged between 70-84, a proportion of whom become beneficiaries, and the beneficiary group aged 85 and over, with this age group accounting for most beneficiaries. More specifically, around 210,000 places in RACH in 2020 equate to just 3.2% of the 50-69 age group. Differences in rates of growth of the three cohorts are much more pronounced and give a more dramatic view of change than shifts in shares of the total population aged 50. Even after a fall in its share from 2020 to 2030, the contributor cohort underpinning an ACL remains large and stable over the longer term. Assuming a constant ratio of provision of 78 beds per 1000 aged 70 and over to 2050, some 412,000 places then equate to 4.5% of the 50-69 age group.

Table 3.6 Projected cohorts aged 50-69, 70-84 and 85 and over, 2020-2050

Cohort / Decade to	Contributor 50-69	Transition 70-84	Beneficiary 85 and over	Total 50 +
Jun-2020	6,460,494	2,384,162	517,228	9,361,884
Jun-2030	7,013,649	3,221,067	719,494	10,954,210
Jun-2040	8,005,496	3,697,516	1,070,781	12,773,793
Jun-2050	9,251,299	3,945,663	1,334,172	14,531,134
Age group as share of pop. aged 50+				
Jun-2020	69.0	25.5	5.5	100.0
Jun-2030	64.0	29.4	6.6	100.0
Jun-2040	62.7	28.9	8.4	100.0
Jun-2050	63.7	27.2	9.2	100.0
% increase over decade				
2020-2030	8.6	35.1	39.1	17.0
2030-2040	14.1	14.8	48.8	16.6
2040-2050	15.6	6.7	24.6	13.8

Source: ABS 2018a. *Population Projections, Australia, 2017 (base) – 2050.* Series B. Catalogue No. 3222.0

3.5.2 The demographic window of opportunity

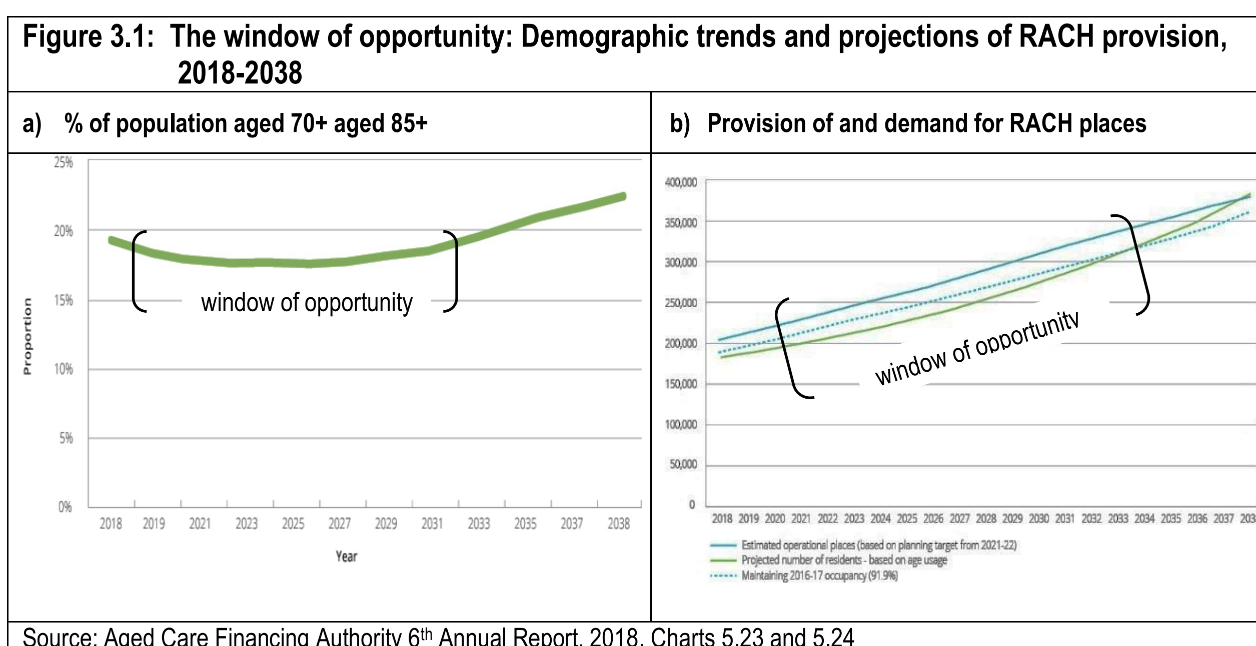
These patterns of differential cohort growth present a window of opportunity for making adjustments in planning and funding of aged care services ahead of the increase in demand that will occur when the baby boom cohort, now just entering their 70s, move into advanced old age, over 85.

The proportion of the 70 and over population that is aged 85 and over has been used by ACFA to present a picture of demand in each of its annual reports from 2015 to 2019. Charts 5.23 and 5.24

from the 2018 report are reproduced below with the 'window of opportunity' superimposed. From just under 20% of the 70+ population aged 85 and over in 2018, the proportion dips slightly to the mid-2020s and then climbs steadily to reach this level again around 2030s. Beyond the period shown in Figure 3.1, the older cohort continues to increase to peak at around 27% in 2047. The trend then plateaus through to 2056, followed by a slight decline to steady at just above 25% (ABS, 2018c).

ACFA goes on to demonstrate that the projected number of residents needing care in RACH using constant age specific rates of use falls below the estimated operational places based on maintaining the planning target of 78 places per 1000 aged 70 and over from 2021-22 and maintaining current occupancy at 92%. The projected number of residents does not reach the number of places until after 2035. Increases in longevity associated with declining rates of chronic disease and impairment could see this point of convergence pushed further into the future.

Figure 3.1: The window of opportunity: Demographic trends and projections of RACH provision, 2018-2038



Source: Aged Care Financing Authority 6th Annual Report, 2018. Charts 5.23 and 5.24

These recent demographic trends and projections of provision point to a window of opportunity over the next 10-15 years for adjusting planning and funding of aged care. These adjustments include increasing the age base for planning from 70 and over to 75 and over, basing planning on age-specific rates of use rather than a flat rate for the total target population, and revising planning time intervals and targets in line with population trends. The possibility of over-provision in the short term followed by under-provision in the longer term also needs to take account in the lead time for approval and construction of new RACH.

The most significant feature of this graph is that it shows that it is not too late to take action on an ACL. Indeed it highlights the imperative to establish a third pillar of funding in the near future to strengthen the system ahead of 'peak ageing' from the mid to late 2030s.

3.5.3 Life expectancy and dependency drivers of demand

As well as the uneven size of the cohorts entering older age, increasing life expectancy at older ages is identified as a prime factor underlying changes in demand for aged care over time. Several indicators in Table 3.7 show three outcomes that suggest that demand is being moderated with the

'younging' of the older population and associated falling levels of dependency and that this pattern will only change when the older population grows older, that is, when the proportion aged 85 and older increases.

1. Life expectancy at age 70 increased by 1.7 years for men and 1.1 years for women from 2001-03 to 2013-15; the 6 month increase for men at age 85 exceeds the further gain of 3 months for women, showing some convergence in later life expectancy.
2. Data from the four ABS *Surveys of Disability, Ageing and Carers* from 2003 to 2015 show that these increases in life expectancy do not appear to be associated with increasing levels of disability but rather that rates of severe and profound activity limitation across all older age groups fell steadily over the period, for men and women.
3. AIHW (2017) has also reported that healthy life expectancy, the remaining years of life expected to be free of disability, increased steadily from 2003 to 2015.

Table 3.7: Changes in life expectancy and activity limitation at older ages, 2003 to 2013-15

A. Age-specific life expectancy at 70 and 85	2001-03		2013-15		Increase 2001-2003 to 2013-15
	M	F	M	F	
LE at age 70 - years	13.9	16.9	15.6	18.0	3.0 yrs > 2.4 yrs
LE at age 85 - years	5.6	6.9	6.2	7.2	1.3 yr > 1.0 yr
B. Persons with severe or profound activity limitation	2001 %	2009 %	2012 %	2015 %	% change 2003-2015
Age 70–74	14.6	14.0	12.4	11.6	- 20.6
75–79	20.3	17.7	18.3	15.9	- 21.7
80–84	35.2	28.0	29.7	28.8	- 18.2
85–89	50.8	46.9	45.8	41.6	- 18.1
90 and over	74.2	70.3	66.9	63.4	- 14.6
Total all ages	6.3	5.8	6.1	5.8	- 7.9
Total all ages, age standardised	6.2	5.5	5.8	5.4	- 12.9

Source: A. Australian Bureau of Statistics, *Life Tables*. 3302.0.55.001, 2001-03 and 2013-15.
B. Australian Bureau of Statistics, *2015 Disability, Ageing and Carers, Australia: Summary of Findings.* 44300DO020. Table 2.3.

The effects of these trends in life expectancy and dependency on use of residential care also have to be seen against the background of the decline in the ratio of provision per 1000 population aged 70 and over as shown in Table 3.8A. While the decline in the ratio of about 1 bed per 1000 per year has been widely attributed to increasing provision of community care, especially community care packages, several other indicators suggest that it has also been accommodated in part by underlying changes in the population that have resulted in reduced demand. This explanation is supported by a number of indicators as set out in Table 3.8B.

1. Age-specific rates of use of RACH per 1000 in each age group have fallen across all age groups, consistent with the decrease in rates of severe and profound activity limitation noted above. Rates of RACH residence are low until age 85, but the large fall in the 80-84 age group is significant given the size of this population group.
2. The increase in the proportion of admissions aged 85 and over reflects a steady increase in age at admission as a corollary of falling age-specific rates of use and the demographic trends noted above.

3. In contrast to these marked trends, turnover has shown only a slight and uneven increase. Turnover of around 33% from 2009 to 2016 remains consistent with that reported in an earlier analysis which found turnover was steady at around 32% over the period 1999 to 2006 (Andrews-Hall S, Howe A & Robinson A, 2007). Rather than increasing as could be expected if residents were markedly more dependent, the stability of turnover results from the interaction of declining age specific rates of admission and the declining ratio of bed provision.
4. RACH occupancy has fallen from a peak of 97% in 2003-04 to just over 90% in 2017-18. Against the decline in the provision ratio, the explanation for the fall in this indicator of demand has to draw on the interaction of increasing life expectancy, falling rates of dependency and increased provision of community care together, with a marginal effect of the Short Term Transitional Care Program that is part of the residential care program. The impact of the most recent Restorative Care Program, based in the community, is likely to be similarly marginal at the population level, although both these programs can have important benefits for individuals.

Table 3.8: Indicators of changes in aged care provision and use, 2008-2018

Year to June 30	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	% change 2008-18
A. Changes in residential aged care provision (1)												
Beds per 1000 aged 70 yrs and over	87.3	86.9	86.8	85.8	84.4	84.5	82.6	81.1	79.7	77.9	75.9	13.0
B. Changes in use of residential aged care (2)												
Age-specific rates of use of RACH, per 1000 population (2,3)												
70-74	13.0	12.8	12.9	12.8	12.7	12.5	12.4	12.0	11.8	11.8	11.8	-9.3
75-79	32.3	31.5	31.0	30.2	29.2	29.2	28.6	27.6	27.3	27.1	26.4	-18.3
80-84	78.5	76.8	75.5	74.4	72.3	71.3	70.9	67.7	65.7	64.6	63.4	-19.2
85+	235.5	229.6	229.7	225.9	218.9	224.4	223.6	215.4	213.9	211.4	208.8	-11.3
% of adms 85 yrs and over (4)	47.8	48.5	48.2	50.2	51.1	51.6	52.7	53.3	53.9	53.3	52.7	+10.2
Turnover (5)	33.0	33.7	33.6	34.7	34.8	35.5	35.1	35.7	35.4	35.4	34.8	+5.4

Sources: (1) Productivity Commission (2017) Report on Government Services. Table 14A.14
(2) Data for 2008-09 to 2010-11 from AIHW *Residential and Community Care Statistical Overviews*, 2010-11, Table 6.6.
(3) Data for 2011-12 to 2017-18 from Productivity Commission, annual, Report on Government Services
(4) Data 2008 to 2011 as for (2), 2012 to 2018 from www.GEN-agedata.gov.au, People using aged care.
(5) Turnover calculated as separations of permanent residents, excluding separations to other residential care, per year per 100 permanent residents as at June 30 each year. Data as for (4), using www.GEN-agecaredata.gov.au, People leaving aged care

While rates of severe and profound core activity limitations have been falling across the older population, it is more difficult to establish trends in dependency among those admitted to RACH. The account of resident dependency presented by Cullen (2019) shows that the introduction of the Resident Classification Scale in 1998 saw an increase then decline over the first two years, followed by a very gradual increase from 2000 to 2008. The introduction of the ACFI from 2008 then saw four separate trends: a steady increase to around 2011, flattening from 2011-2014, a short steep increase over 2015 then a further flattening. These short term shifts cannot be linked to any evident abrupt

changes in the population from which residents are drawn and contrast with the stability of other indicators of use of RACH. Instead, the initial change can be associated with the shift from funding split approximately 50/50 between the flat rate Standard Aggregated Module and the dependency based Care Aggregated Module under the RCS, to all funding being based on dependency. Changes in provider claiming behaviour to maximise income in turn prompted adjustments in the ACFI to control Commonwealth outlays (Applied Aged Care Solutions, 2017).

Taken together with demographic trends, drivers of demand in terms of trends in longevity, dependency and use of residential care make for a ‘steady state’ in the aged care system: flows into the system are limited by selection of admissions from the very oldest cohorts near the end of life, and by bed provision, and outward flows are set by separations, largely by death. Increases in life expectancy have so far brought less rather than more disability but this trend is likely to abate as the oldest cohorts increase and the age structure of the 70 years and over population shifts upwards from the mid-2030s. It follows that longer term changes will depend on underlying demographic and dependency trends as much as program changes.

3.6 Why is an ACL needed?

Aged care funding is set to increase in coming decades, and regardless of whether these increases will place undue pressure on the national budget or not, the analysis of funding trends shows four reasons why an ACL is needed.

1. The scale of expenditure growth warrants a stronger funding system than is in place at present. The main objective of an ACL is to inject a new stream of revenue into the aged care budget to relieve whatever pressures do arise, not to increasing the total amount of funding available for aged care other than in line with the growth of super assets. It would smooth the impact of ‘good times’ and ‘bad times’ on government capacity to meet costs of care at any one time by spreading revenue and expenditure more widely between different cohorts.
2. The overall stability of past and projected growth demonstrates very limited margins for reducing Commonwealth outlays or for markedly increasing revenue from user payments. Efforts to control government outlays have instead resulted in short term instability; it remains to be seen whether declines in the most recent years can be sustained.
3. Attempts to decrease the share of revenue from government sources and increase revenue from user payments have so far yielded little result, in part because of links between government and user sources that set limits to the Basic Daily Fee and DAPs. Instead of nibbling away at smaller revenue flows, a major new flow of funding is needed to complement government sources. An ACL provides this revenue and would have a large and lasting effect compared to small changes that appear to be soon countered by other measures.
4. The window of opportunity identified in demographic trends over the next three decades presents a strong reason for action in the short term to prepare for the longer term. The proportion of the population aged 50-69, the contributor cohort at the base of an ACL, remains a large and stable share of the total aged 50 and over after a decline over the decade 2020-30; this decline is partly offset by an increase in the transition cohort that grows most over the coming decade, and the user cohort only exceeds its current share after 2030. The aged care system has also been in a steady state over the last two decades, resulting from interactions between increases in life expectancy, falling dependency rates and changes in provision and use of residential care. Maintaining a steady state over coming decades needs to be supported by a steady funding system which would be substantially enhanced by an ACL.

PART 4 Redirecting super tax expenditures to an Aged Care Levy

As well addressing some of the uncertainties and inequities of relying on increased retirement incomes from superannuation, boosted by tax concessions, to fund more of the cost of aged care, an ACL on superfund earnings can be assessed in terms of a range of criteria relevant to combining social insurance with tax-based funding and user payments. The trade-offs argued by Chen (1994, 2001) that arise in the current Australian social policy context include an increase in generational self-sufficiency for a decrease in inter-generational transfers, paying for social insurance instead of direct public funding, and an increase in protection for a reduction in risk. A first assessment of an ACL is also made against the criteria of affordability, adequacy, sustainability and insurability identified in the work of Eling and Ghavibazoo (2019).

4.1 The problem: tax expenditures on superannuation

4.1.1 Distortion of the purpose of superannuation

One of the first to raise the issue of tax advantages for superannuation distorting its purpose from increasing income in retirement above Age Pension level to being a vehicle for building wealth was Borowski (2008). He presented retirement income policy as a 'slippery fish' on which government has had a stronger grip at some periods than others, with policy decisions that loosened the grip having both intended and unintended consequences. A fairly firm grip was exercised by the Hawke-Keating governments which reformed the 'non-system' that was in place to the early 1980s with the introduction of the SG to achieve near universal coverage. The system became more slippery through the Howard government's measures that first weakened the link between work and superannuation as the vehicle for replacing earnings in retirement, and from the 2006 Budget, reduced tax on contributions and abolished tax on benefits received by those aged 60 and over.

The implications of these last changes that Borowski foresaw - opening up of opportunities for tax minimisation and avoidance, accentuation of pre-existing inequities, the nurturance of inter-generational inequities, contest about whether older workers would be encouraged to stay in the workforce, blurring of the role of the Age Pension, and deleterious future effects on the public purse - have all come to pass, to a greater or lesser extent, sooner or later. Although not specifically mentioned, the last impact includes the capacity of government to meet future costs of aged care.

A wider view of the scale of social tax expenditures (STEs) associated with superannuation has been presented by Stebbing and Spies-Butcher (2010) to demonstrate the development of a dual welfare state in Australia. Alongside a first tier of progressive welfare benefits paid to well defined target groups, a second tier of STEs has extended welfare to higher income earners excluded from income-targeted benefits and reversed progressivity. The two tiers are exemplified by rent assistance to low income renters and first home owner grants that assist those with the means to save a deposit to achieve home-ownership. They identify three drivers of STEs as fiscal austerity, the privatisation agenda of neo-liberalism and the rise of 'aspirational' politics that interact to result in a dual welfare state that provides publicly funded support to different groups using different instruments.

Turning attention to perceived fiscal pressures associated with population ageing, Spies-Butcher and Stebbing (2011) focus on the growth of STEs associated with tax concessions for superannuation contributions and benefits aimed at increasing private savings. Rather than realising the policy goal of reducing public expenditure on the Age Pension, they cite Treasury projections to 2050 that show very modest offsets and identify other negative outcomes in terms of increasing inequity and greater exposure to market risk. They also point to the prospect of growing STEs linked to private assets

held in owner-occupied housing and investment property. With two major reviews that reported in 2009, the Harmer review of pensions and the Henry review of the taxation system, failing to generate action to deal with the tensions between conflicting policy objectives, the deficiencies stemming from STEs were set to increase in a political climate that continued to favour deregulation and private savings over reform of institutional arrangements.

4.1.2 Exchange value of housing assets

As well as superannuation STEs, the role of housing assets in retirement policies is amplified in the generational accounting analyses developed by Stebbing and Spies-Butcher (2016). Adding to the cost of revenue forgone though superannuation STEs which equalled the cost of the Age Pension by 2011-12, this research shows that growing divergence in rates of homeownership between younger and older generations is exacerbating intergenerational inequity in asset accumulation. This shift is reinforced by inheritance and policy settings that favour asset-based welfare through reduced taxation on wealth.

In their most recent account, Spies-Butcher and Stebbing (2019) apply the generational accounting approach to contest the framing of policies of austerity in debates about sustainability of public expenditures in the face of population ageing. The international view of permanent austerity has been fostered in Australia through the Inter-Generational Reports which mobilised the case for continued fiscal restraint as projected surpluses would eventually give way to sizeable and growing deficits. The IGR reasoning is however limited by asymmetric consideration of spending and continuing tax cuts to the neglect of tax expenditures, and the exclusion of housing wealth and inheritance. Growing recognition of STEs in Treasury lead to measures to bring some control over superannuation tax concessions for those with higher super savings, but housing STEs have not been touched.

ASFA (2015) has pointed out that STEs on superannuation that accrue to high-net-worth individuals are less than they gain from negative gearing, capital gains on investment property and exemptions of the family home. These tax arrangements need to be addressed, but any returns from changes to property related STEs would likely go to general revenue as hypothecation of revenue streams to specific areas of expenditure is rare. In contrast, the lifetime role of super makes it more feasible to tie revenue from recovery of STEs on superannuation to an ACL to support aged care.

The generational accounting approach also sets the framework in which the value of housing assets shifts from utility to exchange for purchasing alternative accommodation, in retirement villages or other forms of downsizing, or in RACH. The 2014 reform to the aged care means test stands as a rare case of attempting to increase revenue and to draw on private wealth alongside public accommodation supplements to provide the infrastructure in which heavily subsidised care is delivered.

4.1.3 Wealth of older Australians

Policies that rest on the expectation that older people will be able to meet more of the cost of their future aged care need to be tested against the evidence that incomes are increasing across all groups in the older population and that they are and will be lasting longer.

Three reports from the Grattan Institute have been effective in demonstrating that incomes and wealth of older Australians are rising and that age-based tax breaks have played a role alongside housing in contributing to this wealth. Daley, Coates and Young (2016) show the intergenerational inequities that have resulted from policies that give most retirees ‘more than enough’ money in retirement:

- Those whose high incomes exclude them from the Age Pension enjoyed much higher replacement rates compared to those reliant on the Age Pension.
- At the same time as having rising incomes, the proportion of those aged 65 and over who are paying income tax has halved over the last 20 years to around 15%, largely due to tax free superannuation incomes.
- Seniors are the only age group to be paying less tax than they did 20 years ago, apart from those under 25, many of whom are engaged in higher education and hence have low incomes.
- Many seniors are paying less tax than younger people with the same income.
- Many benefit from other concessions, notably higher private health insurance rebates for seniors, even if they are not paying the Medicare levy which is applied to taxable income.

Two considerations of costs of aged care facing retirees in the future are noted by Daley and Coates (2018). They identify concerns about future health and aged care costs as a reason for precautionary savings in retirement, and see use of housing assets to pay for aged care accommodation serving as a de-facto guaranteed bequest since the RAD is returned to the estate when the resident dies.

Against the picture of increasing wealth, Hetherington and Smith (2017) show that gender differences in superannuation balances accumulated by women and men over their working lives are due not only to broken workforce participation and lower earnings but to policy decisions such as the withdrawal of the Low Income Superannuation Tax Offset, high marginal tax rates on second income earners, and the lack of SG on a range of family benefits. ASFA (2017) has also drawn attention to the significant disparity in the retirement incomes for men and women; among those aged 60-64 in 2015-16, men held almost two thirds of total super account balances and women a little over one third, pointing to persisting differences in their retirement years ahead.

4.2 The solution: superannuation as the source of a third pillar of aged care funding

Reforms to the retirement incomes system have addressed some of the shortcomings in superannuation raised in recent debates and reviews, but have only begun to address the macro-level concerns of growing inter and intra-generational inequity generated by tax concessions on earnings within superannuation funds and eventual incomes, or the cost of aged care to government.

4.2.1 Rebalancing intergenerational transfers with an intra-generational transfer

An ACL on super fund earnings and applying to balances held by retirees as well as by the working population aged 50 and over would bridge the gap that currently exists between tax payer cohorts who contribute to the cost of aged care, the retiree cohorts who pay little tax, and the much older beneficiary cohorts as identified in Part 3. A wide spread of recovery of tax advantages that have already been enjoyed and continue to be enjoyed achieves some rebalancing of intergenerational transfers by trading off a small reduction in retirement incomes for better-off current and future retirees against taxes paid by younger and less wealthy tax payers that fund aged care. This trade-off would address intergenerational inequity arising from the substantial tax benefits already accrued by those who have retired or will do so shortly relative to those of younger working age who are at an earlier phase of building up their super.

This rebalancing also moves towards self-sufficiency of each generation's contribution to the cost of future care and achieves an intra-generational transfer with trade-offs between wealthier and less wealthy individuals within older cohorts. In particular, there would be a transfer from relatively well-superannuated younger men to poorly superannuated older women. An ACL would also smooth the life-time risks of having to pay for aged care for individuals and cohorts; in particular, it would even

out risks arising from variations in economic conditions over individual's working lives, the timing of their retirement, and the timing of their need for aged care. This risk-spreading would in turn protect against changes in policy of the kind that have seen increased charges for individuals at the time of entry to aged care who have had no means of preparing for these costs during their working life.

There is also a time trade-off as the funds realised through an ACL would benefit those who will require aged care in the relatively short term: those who will be affected by a minor reduction in post-retirement incomes are also those who will benefit soonest. Having each cohort contribute more over the pre-retirement and early years of retirement at young-old ages also trades off risk pooling with leaving individuals to face the risk of having to pay very close to the end of their life.

There is little evidence of intergenerational conflict in Australia. Rebalancing of intergenerational transfers towards a greater degree of intra-generational self-sufficiency could moderate the likelihood of such conflict arising in future and rebuild the intergenerational contract in line with changes in the distribution of wealth between and within generations.

4.2.2 Catching the rising tide of superannuation

This restructuring of inter and intra-generational transfers counters the three grounds advanced by the Productivity Commission (2011) for rejecting aged care insurance:

1. It was argued that older Australians needing aged care services have generally had the opportunity to purchase a home and to accumulate other wealth such as retirement savings and therefore have the capacity to contribute to the costs of their care. While this argument holds for the older population overall, it is far less valid for the selective group who are most likely to actually use aged care, namely women aged 80 and over. With a 20 year interval between retirement at 65 and needing aged care at 85 or older, it remains to be seen how well those with more assets and incomes are able to make them last over longer periods of retirement in more volatile economic conditions.
2. The Commission saw co-contributions paid by older individuals as achieving a measure of intergenerational equity by reducing the burden on younger taxpayers. However, as the figures presented above show, user payments are a small share of expenditure on care and a much greater part comes from general revenue, especially when transfer payments by way of the Age and Veterans Pensions are included, and remains a transfer from younger to older generations.
3. In comparing a compulsory social insurance scheme to the current funding from pay-as-you-go taxation, both paid for by the working age population, the Commission argued that as the baby-boomers are already moving into retirement, their capacity to contribute to an insurance pool was limited. Rather than 'missing the boat' however, an ACL extending beyond retirement age would 'catch the boat' on a rising tide of superannuation as the baby boomers move into retirement.

4.3 Affordability

4.3.1 Estimating revenue

A first estimate of the revenue that could be generated by a levy on superannuation fund earnings can be made using super statistics from ASFA (2019a). As at May 2019, superfunds held assets of $2.783bn, up from $2.324bn at August 2017, and including unfunded public sector funds. The estimates presented in Table 4.1 draw on these figures and are based on earnings on 50% of total

assets, in line with half the total assets being held by people aged 50 and over and who have accumulated greater balances in their super funds.

These assumption are supported by available data. A paper prepared by Treasury (2012) showed that 50% of the concessions on super earnings accrued to those in the top two deciles of taxable incomes, and 20% accrued to the top 5%, observing this distribution reflected the concessional tax rate of 15% on super earnings compared to the marginal tax rates of 35% or higher that these high income earners would otherwise pay. ASFA (2015b) similarly reports that of funds in super account balances in 2013-14, 67% was held by those aged 50-74, and the major part of this amount, fully 61%, held by just 11% of the population in this age range with high balances, defined as over $100,000. ASFA statistics also show that setting fund earnings at 5% provides a low figure compared to actual investment returns ranging from 6.5% to close to 10% over 1 to 35 year periods to June 2018.

Table 4.1: Estimates of Aged Care Levy revenue at 1.5% and 5% of earnings of superannuation funds

Year	A. Treasury 2008 asset forecast $bn	B. Estimated assets held by population 50+ at 50% of total assets $bn	C. Est. earnings on B at 5% $bn	D. Levy at 1.5% of earnings $bn	E. Levy at 5% of earnings $bn
2020	2,815.00	1,407.50	70.4	1.1	3.5
2025	3,830.00	1,915.00	95.8	1.4	4.8
2030	5,075.00	2,537.50	126.9	1.9	6.3
2035	6,650.00	3,325.00	166.3	2.5	8.3
2040	8,645.00	4,322.50	216.1	3.2	10.8

Source: Estimated from Treasury asset forecasts in ASFA (2019)

4.3.2 Revenue outcomes

An annual return of 5% on 50% of total assets would generate $70.4bn per annum in 2020 (Col. C). A low levy set at 1.5% of these earnings would earn $1.1bn (Col. D) and a high levy set at 5% would yield $3.5bn (Col E). The latter sum amounts to 32% of direct Commonwealth expenditure of $11.24bn on ACFI subsidies and care supplements in 2017-18, and 28% of $12.25bn when the Accommodation Supplement is included. This amount far exceeds the $1.3bn currently paid by users in means tested care fees and DAPs, or that is likely to be generated from users in the future. The assumptions underlying these estimates mean that these outcomes are conservative.

A tax rate of 20% on earnings of super accumulation accounts, comprising a 5% levy added to the current 15% tax, is still well below the marginal tax rates paid by medium to high income earners, and a 5% levy is not a major impost on those paying no tax on earnings of substantial balances in pension accounts. An ACL applied to both accumulation and pension accounts would avoid transfer from the former to the latter, noting that any such transfer would see more funds subject to draw-down requirements and be in line with the purpose of super to provide income in retirement rather than accumulation for other purposes such as estate and inheritance transfers. Higher drawdowns would however reduce the capacity of super to last through to late old age. The impact of lump sum withdrawals on aggregate assets held in super has not been taken into account, but it would be possible to factor in an ACL payable on these amounts had they remained in super to age 70.

Although related to actual returns experience and comparable levies for Medicare and the NDIS, the selection of rates used in this estimate for superfund earnings and levies is essentially arbitrary.

Interestingly, they are broadly in line with Chen's early proposal for a social insurance scheme for aged care in the US in which he estimated that a 5% trade-off of social security income would generate funds sufficient to cover 22% of the cost of long term care (Chen 1994). Further, in the event that revenue exceeded expenditure and the possibility of setting aside a part of ACL revenue for future funding arose, a new agency could be established to manage future funding, along the lines of the Long-Term Care Trust Fund proposed by Chen (2004) to operate in the same manner as trust funds already operate in the US Social Security and Medicare systems.

4.3 Adequacy

4.3.1 Coverage of a worthwhile share of costs

Adequacy concerns the sufficiency of funds to cover a reasonable part of the cost of aged care and so make the implementation of new arrangements worthwhile. Assessment of adequacy is assisted by the separation of recurrent revenue for care from capital and accommodation revenue into government sources and user payments. This separation is much clearer in Australia than in many other countries, and enables identification of indirect government funding by way of transfer payments from the Age Pension and other pensions, as above. Previous discussions of social insurance for aged care in Australia have focused on coverage of accommodation funding paid by government by way of the Accommodation Supplement for low means residents. This component accounted for $1bn, or 11% of all direct Commonwealth outlays in 2017-18, and as shown above, would be covered by a levy of 1.5%.

The major and persisting feature of total aged care funding is the overwhelming dominance of ACFI care subsidies paid by government for dependency based funding for permanent residents. ACFI funding has accounted for just on $2 out of every $3 of total aged care spending by government and residents over the last 6 years, and at just on $10.8bn in 2017-18, accounted for fully 88% of direct Commonwealth funding. The relativity of this care cost compared to accommodation costs, whether met by government or by residents, points to the greater scope for strengthening the funding system by having an ACL that covers part of the cost of care. A levy set at 5% that generated $3.5bn would cover close to one third of total care funding and so would have a worthwhile impact of Commonwealth funding.

4.3.2 A common care component

The possibility of funding a defined part of care costs at a flat rate arises from a 2017 review of the ACFI by Applied Aged Care Solutions Pty Ltd (2017) and the final report on a new system based on resource use classes (RUCs) prepared by the Australian Health Services Research Institute (AHSRI, 2019). Both proposed that all residents should receive a base level of care funding and the term Core Care Component (CCC) is used here to cover both the ACFI and AHSRI options, to avoid confusion with the Basic Daily Fee and to distinguish it from variable levels of individual dependency based funding; it also avoids connotations of minimum funding or that it is the base on which further levels of variable funding would be set.

ACFI Review with base level funding

Currently, the ACFI provides different amounts of funding for three domains of care need, Activities of Daily Living (ADL), Behaviour (BEH) and Complex Health Care (CHC), with four levels of funding in each domain (nil, low, medium and high). The design of the ACFI recognised that ADL limitations accounted for the major part of care needs and that the BEH and CHC domains covered care needs over and above ADL related needs. Funding for the three domains reflects this design

with ADL accounting for the major share of ACFI funding; at the time of the ACFI Review, low ADL funding of $36 a day compared to $16.25 for CHC and $8.25 for BEH and high funding was $108.92, $66.82, and $35.66 respectively. Funding for a resident rated low on all three domains was thus $60 per day and $211 if rated High on all domains, with ADL accounting for 60% and 52% of these amounts respectively.

While the combinations of ACFI ratings generate 64 separate levels of funding, the distribution of the residents is very uneven across these levels. By mid-2016, 33% of permanent residents were rated high on all three domains, a very marked increase from under 4% at mid-2009. Conversely, the share of all residents in ACFI categories grouped as Low Care (formerly provided in hostels) fell from 25% in 2008-09 to 4.2% in 2015-16. The ACFI Review proposed a base minimum level of care funding at the Low rate for ADL. As at June 2018, this was $36.65 a day or $13,377 a year. Paid for the 180,100 permanent residents as at that date, this funding would have cost just on $2.41bn per annum, accounting for 22% of total ACFI benefits paid that year.

AN-ACC and a base care tariff

The development of a new Australian National Aged Care Classification (AN-ACC) by AHSRI similarly proposed a base care tariff in conjunction with 13 classes of variable care funding (McNamee et al., 2019; Eagar et al., 2019). The base tariff would be paid per diem at six levels that take account of a mix of resident characteristics in terms of Indigenous status and homelessness, and facility characteristics of size under 30 places located in the two most remote categories, 7 and 6, under the Modified Monash Model. Only a small minority of residents are in these categories and the great majority are in a single category of ‘all other homes’. The base care tariff would see the removal of the Homeless Supplement, paid for some 1,500 residents at June 30, 2018, and the Viability Supplement paid at an average of $8,600 per resident in 2017-18 to homes in very remote and remote regions.

AHSRI also proposed a one-off adjustment payment to cover a settling in period up to 16 weeks for residents admitted for the first time, at a flat rate substantially higher than the base care tariff which it included. The variable care funding would only come into effect after the settling in period. The base care tariff is designed to cover the elements of care that all residents receive equally or that are shared, such as group social activities. AHSRI proposed the base daily tariff at 50% of the total cost of care, so it would account for $5.2bn of the $11.2bn of direct Commonwealth funding for ACFI benefits and care supplements in 2017-18.

4.3.3 Applicability of an ACL to a Core Care Component

A CCC funded by a 5% ACL would fall between the two cost estimates made by the ACFI Review and AHSRI. Funding of $3.5bn would cover more than the 22% proposed ACFI base level of care and less than the 50% proposed by AHSRI. Covering around one third of care costs in a CCC is evidently feasible and adequate to have a worthwhile impact on Commonwealth funding. Several further aspects of separating funding of a CCC from variable dependency based funding warrant further comment:

1. Setting a CCC intermediate between the ACFI and AHSRI levels reinforces provision of care in response to a combination of ADL limitations rather than splitting costs into more specific areas of care. Both the ACFI Review and the AHSRI proposals argue for recognition of such care that is common to most residents and/or provided on a shared basis such as through group therapies.

2. A CCC would be associated with a recalibration and simplification of the ACFI or the adoption of the 13 class scheme proposed by AHSRI as both consolidate care over the low dependency range and provide more differentiation over the dependency range, spreading residents more widely across all categories.
3. Covering a CCC as a set share of funding reduces the share that is exposed to a risk of gaming engendered by tying funding to specific aspects of care; the experience of the short-lived but expensive Dementia and Severe Behaviour Supplement is salutary here.
4. Funding a CCC at a flat rate would also prompt efficiency in delivery of these services, but also give providers considerable flexibility in how this third of funding was spent. It would allow cost-effectiveness to be assessed across providers, and quality of care to be related to value for money.
5. A CCC would fit well with respite care and RAC places funded through Multi-Purpose Services and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program as it would provide more certainty about the base level of funding that would be received.
6. Splitting care costs into a CCC and a variable care component is in some ways similar to the Standard Aggregated Module (SAM) and Care Aggregated Module (CAM) in place under the Resident Classification Scale until 2008. Total funding was divided approximately 50/50 between SAM and CAM, and allowing for resident fees for daily living costs recouped by the Commonwealth then accounting for around 20% of total funding, the balance of SAM accounted for some 30%.
7. A CCC funded by an ACL would enhance transparency and integrity of funding overall by clarifying the different sources of funding to be applied to different costs areas, to the benefit of residents, providers, government and taxpayers generally.

4.4 Sustainability

4.4.1 Growth of superannuation

Sustainability of an ACL is supported by the increase in aggregate superannuation assets which gains from a quadruple multiplier effect of:

1. the large cohorts reaching their 50s and then moving into retirement over the next three decades,
2. more of whom have super,
3. more of whom have more super, and
4. more of whom are staying in the workforce for longer, extending the time over which super balances are accumulated.

Looking to the future, superannuation assets are projected to increase substantially. ASFA (2019a) reports Treasury forecasts of an increase of $1,000bn in just five years from 2020-2025 to reach $3,830bn, and then more than double to reach $8,645bn by 2040. This growth in the volume of assets and their spread across diverse asset classes means that over the long term, linking an ACL to superannuation has the capacity to even out fluctuations in annual budget conditions and also across cohorts reaching very old ages.

Trends in workforce participation seen in ABS surveys of retirement and retirement intentions for 2016-17 and a decade earlier, 2006-07 (ABS, 2017), confirm increases in superannuation coverage and duration of contributions will contribute to sustainability:

- Of those aged 45 and over in 2017 who had already retired from the labour force, 74% of men had contributed to superannuation as had 58% of women; the respective figures for 2006-07 were 67% and 41%.
- Retired men had also contributed for longer than women, with 59% having contributed for 20 years or more whereas only 38% of retired women had contributed for as long; again, both figures had increased over the 51% and 21% a decade earlier.
- While individual super balances of these retirees will not all be substantial, more will have super and more will have contributed for longer, boosting aggregate assets.

4.4.2 Trends in age at retirement and intentions

Higher ages at retirement also contribute to sustainability. The same ABS surveys suggest that increases in age of retirement over the last decade are set to continue.

- In 2006-07, 80% of men and over 90% of women had retired by age 65, but by 2016-17, these proportions had fallen to 71% and 85%.
- Conversely, intended age of retirement among those aged 45 and over who were still in the workforce increased: over the decade, the proportion intending to retire between age 60 and 64 dropped from 33% to 23%.
- The proportion nominating retirement under age 60 more than halved, from 18% to 7%.
- The 50% nominating retirement between 65 and 69 age was a marked increase over the 38% intending to retire at this age in 2006-07, and by 2016-17, almost twice as many intended to work to age 70 or older, 20%, compared to 11% in 2006-07.

At both dates, more women intended to retire at younger ages than men, but the most marked change overall was the drop in the proportion of women intending to retire before age 60, from 25% to only 8%. These trends most likely reflect women retiring at the same age as older spouses and the increase in age of eligibility for the Age Pension for women. Factors shaping retirement decisions appear to be converging for men and women:

- Reaching the age of eligibility for an age or service pension remained steady as the main influence for men and women at around 12% at both dates
- The greatest change was the halving of reasons associated with poor health and physical ability, from 40% to 20% for both men and women.
- Financial security remained unchanged as a reason for men, but fell for women, but the other factors that became more important are unclear.

While setting the ages for starting and ending the interval over which the levy would apply is a matter for consideration, extended workforce participation and increased life expectancy mean that the ACL would be paid over a 25 year interval on average. Further life expectancy at age 50 is now 36 years for women, and 32 for men, to just on age 86 and age 82 respectively (ABS, 2018). Starting at age 50 would also be equitable in relation to the 6% of the population who die between age 15 and 50 (ABS, 2017b) and who are likely to be disadvantaged in many areas of well-being.

4.5 Insurability

The risk of needing aged care and the cost has been identified by Hudson (1993) as intermediate between the higher and more predictable probability of retirement and the lower but less predictable risk of needing high cost health care. He argues that the interaction of probability and cost makes aged care suitable for social insurance in the same way that Social Security, Medicare and Medicaid

provide social insurance for the risks of retirement and health care in the US. The main risks to be taken into account in considering insurability are the predictability of lifetime probability of using residential care and length of stay.

4.5.1 Lifetime probability of using permanent residential care

An increase in the lifetime probability of using permanent residential care at age 65 over the decade 1997-98 to 2007-08 was reported in a technical paper prepared for the Productivity Commission by the Department of Health and Ageing (2011). The increase for men, from 31% to 37% was greater than for women, 51% to 54%, and while probability of admission was higher at all ages for men at the later date, there was little difference for women up to age 95. Figures at two time points however do not necessarily indicate continuing trends, as figures to 2012-14 show in Table 4.2.

Rather than a clear trend of increasing likelihood, lifetime probability of admission showed considerable stability over the three dates for four of the groups (in bold). Among the other four, increasing probabilities for men at age 65 and 75 in the earlier interval stabilised, but for women, some instability was evident, with an increase at age 85 over the later interval and a decline at age 95 over the first interval then stabilising. Analysis of annual data and for a longer time period would clarify whether these figures were fluctuations over time or indicative of sustained trends.

Table 4.2: Lifetime probability of using permanent residential aged care, 1997-98, 2007-08 [(1)] and 2012-14 [(2)]

	Probability at age	1997-98	2007-08	2012-14
Men	65	31	37	38
	75	36	42	42
	85	**45**	**46**	**45**
	95	**37**	**40**	**40**
Women	65	**51**	**54**	**52**
	75	**56**	**56**	**55**
	85	62	60	68
	95	57	42	45

Source: 1. Department of Health (2011) and 2. ACFA (2017).
Note: 2012-14 figures are read from graphs but are sufficiently precise to show any marked changes

The probabilities of using RACH are the product of complex interactions between need, predisposing and enabling factors, all of which can change over time. Among the need factors, rising life expectancy combined with declining rates of severe and profound impairment have seen declining age specific rates of admission. Rising life expectancy for men has seen increasing probability of admission but still below rates for women. Among predisposing factors, cohort differences in family formation and hence availability of informal support in later life that affect the likelihood of admission have received less attention, and it is unclear whether increasing survival of both partners in couples will have equally protective effects for both men and women.

Among the enabling factors that make admission easier or more difficult, bed supply sets limits to probability of admission once turnover is taken into account. Vacancy rates also have an effect, with current vacancy rates in the order of 10% suggesting that bed supply is not restricting admission. Historically, a high proportion of RACH admissions occurred on discharge from acute care, and these patterns and use of post-acute care need to be taken into account. While older patients generally have longer hospital stays than younger patients, continuing reductions associated with advances in

medical care can be expected, leaving dementia even more prominent in RACH. Another set of enabling factors are the availability of alternatives to RACH, including home and community care, residential respite care, post-acute restorative care and possible protective effects of adjustments in housing such as moves to retirement villages. Although each of these factors may have only marginal effects, their compounding effects could be considerable over time. Sufficient high quality long term data bases are available for modelling.

4.5.2 Length of stay (LOS)

Contrary to expectations that LOS would be reduced by pre-admission assessment and if residents were more dependent and admitted closer to the end of their life, it is the stability of LOS of separated residents that stands out. Average stay has declined only very marginally from 3.3 years in 2003 to just under 3 years in 2019 (ACFA, 2019a). As well as being driven by increasing age at entry and an increasing proportion of men being admitted, most of the decline occurred from 2003-2011, suggesting that the steeper decline in the earlier years was due to the exit of residents admitted through the late 1990s when higher bed provision, especially in low care hostels, likely saw admission of more residents who were less dependent and then had longer stays.

The median stay of 1.6 years is about half the average (Cullen 2019). Of the 50% who leave within this time, ACFA (2019a) shows that around 15% have left within one month of admission, and fully 33% have left within a year. Only minor fluctuations are evident in these figures over the 14 years to 2018. At the same time, 10% had stays approaching 6 years or more in 2017-18; it is this small group with long stays that skews the average and makes it much longer compared to the median LOS.

An ACL that pays for a CCC at a flat rate per resident avoids having to make decisions about several aspects of use of care that confound other possible systems.

1. By covering all residents regardless of whether they are at the beginning of a short stay or near the end of long stay, a CCC throughout all residents' stays avoids having to decide on covering only one or other part of a stay, such as the early stay for all residents or stays beyond a certain duration for those who have longer stays.
2. Rather than having to determine a level of dependency and intensity of care need at which funding from the ACL would become available, adoption of a CCC defines the cost point at which the variable care component of funding would start.
3. Paying an ACL at a flat rate for a CCC at around one third of total funding, and allowing for around 20% of funding from Basic Daily Fees, would limit the share of total funding that is dependency based and at risk of gaming on ratings.

Length of stay and turnover remain important for access as one resident staying for 6 years accounts for the same bed day use as 12 residents each staying for only 6 months. The tail of long stay residents is a persisting feature of use of RACH and appears to have defied all efforts to limit admission to those in greatest need of care because of high dependency, and who would be expected to have shorter stays. Nor can the long stay group be attributed to residents with dementia as the proportion of people admitted to permanent RAC with a diagnosis of dementia has consistently been around 43-45% over the last decade, and there are only small differences in the proportion of residents with or without a diagnosis of dementia remaining in care over time (ACFA, 2019).

Two particular aspects of length of stay need to be better understood. The first is the difference between those who have short stays and the small group of long stayers who account for a disproportionate share of total bed days and cost, and that persists notwithstanding pre-admission

assessment and increasing provision of community care and other interventions aimed at forestalling unnecessary admission. Better identification and provision of alternative care for even a proportion of this group have the potential to free up access for others. The second area is the impact of changing movements between acute hospital care and RACH, driven largely by changes in acute care. Despite concerns about this interface, little data has been released for almost a decade.

4.6 How would an ACL make a difference?

An ACL would make a difference at both the general level of generational transfers and the specific level of aged care funding.

At the general level, intergenerational accounting analyses show how an ACL could rebalance inter- and intra-generational transfers that currently flow through STEs on superannuation and housing.

1. An ACL would begin to redress the distortion of the purpose of superannuation by directing a part of the STEs on super contributions and incomes to provide for aged care as a common part of late life.
2. It would reduce current intergenerational transfers by substituting for a part of tax funding of aged care by younger working age tax payers and reducing STEs paid by these cohorts through tax concessions to late middle aged and early retiree groups. This shift would increase generational self-sufficiency; although not a forward funded system, an ACL would see the latter cohorts contribute relatively more to the cost of aged care for the very old generation, and increase greater intra-generational equity through transfers from early to late retirement, from higher to lower income older people, and especially between men and women. In the event that revenue from contributors exceeded expenditure, a new trust fund agency could be established to manage such a surplus for future funding.
3. Further understanding of the scope for these transfers requires accounts of the wealth of the total older population, whether taken as aged 60, 65 or 70 and over, to be supplemented with more fine grained investigations to show cohort differences in income and assets, especially housing assets. Cross-sectional and longitudinal research is needed to provide a clearer account of changes that come about over the 15-20 years from entry to retirement to entry to aged care, and the processes contributing to these changes. The role for an ACL will be supported to the extent that such investigations confirm that not all people will be better off on retirement and even more so at advanced old age, and moderate optimistic expectations of how far very old individuals will be able to meet a larger share of the cost of their care from their own resources.

Focusing specifically on aged care funding, assessment on four criteria finds that an ACL would make positive contributions.

1. An ACL is affordable; a 5% levy on the earnings of 50% of aggregate assets held in superannuation by the population aged 50 and over with high balances would generate revenue sufficient to cover some 30% of recurrent government funding for the care component of residential care.
2. An ACL is adequate in terms of contributing a worthwhile share of aged care funding; allocation to a defined core care component funded at a flat rate, in line with current proposals, would bring other advantages in testing value for money and greater control over spending.
3. Sustainability comes from a quadruple multiplier effect that supports strong growth in aggregate superannuation assets; an ACL collected through smaller contributions from a larger share of the

population, over a longer time, is more sustainable than user charges of varying but uncertain amounts, collected from a small share of the population over a short period in late old age when savings and incomes of many individuals are likely to have been diminished by the vicissitudes of advancing age.

4. An ACL would cover an insurable risk based on the predictability of admission to residential care and length of stay. These two risks are known now, and these and other parameters can be further modelled with extensive, high quality data already available over many years.

Finally, while the proposal for an ACL put forward here has focused on residential care, it could be extended to community care. The simplest approach would be to allocate a share of funds from the ACL to a single community care program, integrating the current Commonwealth Home Support Program and Home Care Packages, as is being considered by the Royal Commission (Smith, 2018). Alternatively, if funding of care packages continues to be aligned in some way to residential care, with different levels of funding allocated to individual recipients, a core care component could be defined for community care.

PART 5 Information, attitudes and behaviours in funding aged care

5.1 Informing policy development

Discussion of information, attitudes and behaviours towards funding aged care is linked to similar concerns associated with decision-making about superannuation and retirement planning more generally, and research has begun to explore this overlap in recent years. Expectations on the part of government and individuals that care recipients will have to meet more of the cost of their care have prompted a number of investigations into how older people are planning for this eventuality and especially the information they need to make sound decisions. Survey material widens the range of information and by bringing the voice of older people into the mix is especially important in showing preferences for and likely acceptability of various policy options.

Major reports based on recent, large scale surveys that provide a wide range of information on how older Australians are planning (or not planning) for financing their retirement, sometimes including aged care, come from five sources across consumer and industry bodies as well as academic research.

1. ***National Seniors Australia*** has released two reports based on the large scale National Seniors Social Survey conducted in conjunction with Challenger (National Seniors & Challenger, 2019, 2017). Wave 6 conducted in 2017 and wave 7 conducted in early 2018 are referred to as NSSS2017 and NSSS2018 below. Each collected data from just on 5,500 members of National Seniors aged 50 years and over and these large samples are generally representative of the wider population aged 50 and over except that home-owners are over-represented and renters are underrepresented. Three other reports focusing on particular aspects of retirement and aged care have also analysed NSSS data (McCallum, Maccora & Rees, 2018; Rees, Maccora & McCallum, 2018; Rees & McCallum, 2017).

2. ***COTA Australia*** included questions on planning for ageing in its survey of a nationally representative sample of just over 2,500 people aged 50 and over in 2018 (Council on the Ageing, 2018). The wide age range makes for very different time horizons to the time of needing aged care for the youngest respondents compared to the oldest.

3. ***CEPAR*** has published three Working Papers examining options for design and purchasing aged care insurance since 2015, co-authored by 8 CEPAR researchers: Shao, Sherris & Fong (2015), Wu, Bateman, Stevens & Thorp (2017) and Shao, Chen & Sherris (2017). While essentially considering private insurance, all have relevance to social insurance schemes and point to ways in which an ACL could address limitations of private schemes.

4. ***The Association of Superannuation Funds of Australia (ASFA)*** has issued three reports that raise issues of relevance to aged care funding (ASFA 2019b, 2017, 2015b). These three reports include findings from surveys of over 1,000 fund members that investigated views of the roles that super fund providers could play in financing aged care.

5. ***The Aged Care Financing Authority*** was commissioned by the Minister to undertake a consultation project and on-line consumer survey in 2018 to inform government responses to concerns over older Australians' planning for financing their aged care (ACFA, 2018b). Of the total 1,506 respondents, half were not currently using any services, but the others had

overlapping experience of accessing formal services for themselves or their spouse/partner, receiving informal care or being carers, and all the latter shares were higher than in the total aged population.

Many findings across all these reports are broadly consistent, and taken together, they show asymmetries between widely expressed concerns about uncertainties of advancing age and more limited identification of acceptable solutions to actual and expected problems. Interpretation of the findings needs to take account of:

- differences between actual behaviour reported in some studies and expected behaviour reported in others;
- the wide age ranges included in different studies, so the need for aged care was far more distant for some respondents than others; and
- reporting only for total respondents with no breakdowns by smaller age groups, and cases of lack of clarity as to whether results refer to total samples or only particular sub-groups, for example, those receiving care and among the latter, not differentiating care from formal services and informal sources.

The areas of common findings nonetheless show that some major themes dominate, including the current and expected continuing centrality of the Age Pension as a source of retirement income and in funding aged care. Among the wide range of other lesser issues canvassed, some provide grounds for clear policy directions; explorations of the potential market for aged care insurance in one form or another, and whether though public or private providers, indicate an emerging interest in and willingness to use insurance as a means of providing for the costs of aged care.

5.2 Information

5.2.1 'My risk' of needing care

The most basic information asymmetry in individuals' thinking about funding their aged care is the very limited capacity to estimate the likelihood of needing care, especially costly residential care. This asymmetry arises in part because the proportion of the older population in care at any one time is far lower than the likelihood of admission over a lifetime. Early work in the US (Kastenbaum & Candy, 1973) flagged the 4% fallacy, based on only 4% of those aged 65 and over being in nursing homes. This fallacy was debunked in Australia many years ago (Howe, 1982), but as only some 8% of the population aged 70 and over are in RACH currently, the fallacy persists in the common view that only a minority of older people use residential care. Hoping they will not be among this minority, respondents to various surveys persistently underestimate their likelihood of ever needing residential care. This assessment however fails to take account of the marked changes in the proportion using RAC at increasingly older ages, or the likelihood of entry over remaining lifetime as age advances.

In contrast to actual increases in life expectancy and the stability in probability of admission to aged care noted in Part 4, three other asymmetries relating to need for care have been reported.

1. Individuals have tended to underestimate their life expectancy, especially at younger and middle ages, with some expressing the view that they will not live long enough to need aged care.
2. They also underestimate the age at which they expect to use aged care. The ACFA consumer survey (2018) found that those not already using services showed poor capacity to anticipate need: fully 2 out of 3 of those aged 60-64 expected to use services within 3-5 years, most well

before they were 70 and markedly higher than actual probabilities, but there was otherwise little variation in expectations of each older age group over all time horizons, suggesting that many of those aged 60-74 over-estimated likely need. Only those over 75 had close to realistic estimates, perhaps because of experience and facing shorter time horizons.
3. In contrast, older people overestimate their lifetime spending and worries about 'running out of money' lead to reduced consumption and over-saving.

5.2.2 'My planning' for aged care costs

Older people have shown an interest in increasing self-sufficiency in funding their aged care and in making better provision for this future cost as part of retirement planning, but even among those who have planned for their retirement, many remain worried about the costs of care, with complex interactions between respondent characteristics and time spans. Surveys of planning for later life show that the concept of planning covers a wide range of actions that might be considered, and that aged care is not often identified as a specific concern.

The Council on the Ageing (2018) asked respondents about six areas of planning. Wills were most commonly reported, at 77% overall and increasing with advancing age. Superannuation was next, reported by over 70% at ages 50-64 and falling below 50% only after age 75. The high proportions taking these two measures meant that few had taken no steps for planning, including smaller proportions who had a funeral plan or made one of three provisions for substitute decision making. Rather than demonstrating in-depth and comprehensive planning for later life, the spread of results points to limited and narrowly focused actions.

NSSS2018 asked about planning for a longer life (McCallum, Maccora & Rees, 2018). While just over half, 55%, had planned for an increasing lifespan in the area of health and medical costs, further investigation of worries about outliving savings found simultaneous experiences of confidence and uncertainty. Concerns about outliving their savings were expressed by 60% of those aged 50-69, falling to 40% for those aged 80 and over; increased worry was strongly associated with lower health status, but decreased with older age and higher savings. While these findings may be explained in terms of the time horizon over which savings have to last, they also appear to reflect growing acceptance on the part of respondents in late middle age that they will be called on to pay for more of the costs of future care. This expectation led some to view aged care as 'a financial problem for the future', with uncertainties arising from perceived changes in regulations and payment arrangements, in turn leading to caution in discussing the issue with financial advisors, to the point of driving the matter 'out of mind'. Selling the home was identified as the fall-back option for most, but not by those who wanted to leave a bequest; NSSS2017 found that just on 50% rated leaving the family home and/or other assets to their children as a very important or important part of their retirement planning. Although resistance to requiring the sale of the family home to pay for accommodation in RACH appears to have diminished over the last two decades, these findings caution against measures that could be seen to threaten inheritances.

The ACFA Consumer Report notes that while the consumer survey found higher levels of planning than other research, subsequent in-depth consultations indicated that planning might not have been as widespread as survey finding suggested (ACFA, 2018b). The survey was representative of the age structure of the population aged 60 and over, but it appears that those already using aged care services were over-represented, at 40%. The findings seem to reflect this bias: some 60% reported they had a plan for meeting the cost of ageing, and of the 57% indicated that it included funds to meet future aged care costs, most said the plan included funds to meet their current aged care costs,

implying that they were already using services. Planning did not necessarily allay concerns, and half were worried about the costs of care and among those already using services, costs influenced decisions about using a program, trading off such costs against reduced spending on other areas, including use of other health services.

The findings from the 24 in-depth interviews were closer to other research: most had under-estimated the extent to which income and assets would cover retirement needs and reported no formal planning for funding their aged care needs. Many added that with hindsight, planning would have been undertaken earlier, reasoning that they would have more money to fund their aged care needs, to access services that they wanted (either the number of services and/or quality), and to provide more certainty, independence and flexibility to cover unexpected costs associated with health care. These mixed findings suggests that those consumers who felt that they had prepared for the costs of aged care were in fact not well informed or well prepared, and consistent with the NSSS reports, revealed a lack of preparedness and poor understanding of the requirements for individuals to contribute to the costs of care.

5.2.3 Is more information the answer?

The ACFA consumer survey investigation of sources of information for planning and funding streams that would be drawn on for aged care found:

- Retirement planning sources did not always cover aged care financing, difficulties were reported in obtaining appointments with the Commonwealth Financial Information Services and the Department of Human Services which provide individualised information on means testing and costs to be met by the consumer.
- There was confusion about the roles of aged care providers and placement agencies in providing formal financial advice. (While providers are able to provide information on costs and funding sources, they are not in fact permitted to give financial advice.)
- Where planning had been undertaken, there were concerns about being given incorrect financial advice.
- Proliferation of on-line and other sources contributed to rather than resolved information issues.
- A clear unwillingness to access financial products that involved taking on debt was evident, with only 5% accessing equity release products to fund care needs when they did arise.

Notwithstanding the shortcomings with planning that had been undertaken, the lack of planning altogether, and considerable difficulties accessing useful and timely information, the 25 recommendations made in the ACFA report emphasise improving consumer understanding. The measures proposed range from incorporating aged care into retirement planning from an early age to improving on-line tools that are most likely to be used only when entry to care is imminent, and persist in seeking to promote manifestly unpopular equity release products. The numerous agencies involved over a long time frame, as charted in Table 5.1, suggest that in the light of the empirical findings of the ACFA survey and the NSSS, prospects for successful outcomes from these measures are limited.

Many of the information barriers that affect planning and decision making about aged care replicate the findings of the Super System Review (Cooper 2010) and since reiterated by the Productivity Commission (2018). Problems of poor financial literacy, lack of reliable information and disengagement in super planning are likely to be magnified in planning for and eventually making decisions about paying for aged care, especially for those facing declines in financial resources and

cognitive capacities. The marked negative effects of cognitive decline on household financial decisions documented in a large scale US study cautions against expecting very old adults to be able and willing to manage these decisions (Angrisani & Lee). Most significantly, the aged care system lacks common default provisions equivalent to the SG and MySuper. The Cooper Review emphasised that MySuper was to be a whole of life product that would facilitate sound choices in both pre- and post-retirement phases: trustees would have a duty to address longevity, inflation and investment risks to assist members develop their post retirement strategies. It emphatically called for better, not more, information.

The Cooper review and the setting up of MySuper appear to have increased engagement with superannuation; one indicator of this success is that assets in MySuper funds increased by 10.8% in the year to end March 2018, well ahead of total asset growth of 6.7% (ASFA, 2019a).

Table 5.1: Information sources for planning retirement income and aged care over the life span

Government Sources	Life Stage	Private Sector Sources
Money Smart (ASIC) **Dept. Human Services** Better Ageing 45+ on-line check-up	Working Life Accumulation phase of superannuation and planning superannuation begins ~age 20, for 45+ years	**Super Funds** Financial institutions Financial planners MySuper default options
Dept. Human Services Better Ageing 65+ on-line check-up	Around time of retirement Decumulation stage of super begins Around age 65, extends for up to 20+ years Eligibility for and getting the Age Pension	**Estate Planning** Legal and financial services
Pensioner Loans Scheme	**Centrelink**	**Reverse Mortgages** Financial institutions
Dept. Human Services Better Ageing 75+ on-line check-up	**Financial Information Service**	**Downsizing** Real estate agents Retirement Villages
	At time of needing aged care around age 80 **My Aged Care** **Navigators**	
	Centrelink • Means testing for fees and Fee Advice • Hardship status for community care • Supported resident status for RACH	**Aged care providers** • Disclosure of charges • Can provide information but not financial advice
	Regional Assessment Services **Aged Care Assessment Teams**	**Placement agencies**
	Aged Care Safety and Quality Commission	

Compiled from information sources mentioned in Aged Care Financing Authority (2018).

5.3 Attitudes towards paying for aged care

5.3.1 Surveys of older people's views

Retirees' interest in and willingness to set aside funds to pay for future aged care have been surveyed by ASFA (2015b). Taking the view that superannuation should be about more than substituting for the Age Pension both for individuals and for the social security system, ASFA canvassed other options for integration of super with aged care and health care provision. The options raised included voluntary or compulsory insurance and longevity insurance, citing a call made by Paul Keating at an ASFA conference in 2015 for adding 3% to the SG to fund a government-backed longevity insurance fund to cover longevity risk from age 80. Further options involved various combinations of social insurance and private provision, and ASFA identified a role for itself and for superannuation funds in developing possible policy options.

In its survey of attitudes of super fund members aged 45 and over, ASFA (2015) found that:

- Half of the respondents had first-hand experience of the aged care system, having dealt with aged care on behalf of family member in the past or doing so at the time of the survey and only 10% did not see aged care as something they would have to deal with.
- Asked about sources of support for organising aged care, providers were most likely to be approached, followed by government then family; super providers were nominated by only 8% as a source of support.
- But many wanted more support; excepting those whose main super fund was a self-managed fund, around 60% would use advice and educational materials if offered by their super fund, almost as many thought that fund providers should give advice on organising and paying for aged care, and more than 40% would like to receive support in dealing with aged care.
- Close to 50% supported a rise in the SG above 12% specifically to address the cost of aged care, nominating an additional 4% on average.
- Other roles for superfunds in aged care included quarantined components of account balances and compulsory social insurance.

Further strong support for linking specific provision for aged care funding to super stems from ASFA's most recent survey of community support for compulsory superannuation (ASFA, 2019b). Fully 70% expressed very strong support and another 20% strong support, with little variation between men and women or over 4 generations defined with specific reference to the Baby Boomers (under 38, 39-53, 54-73, and 74 and over). Similarly high levels of support were found across household income and super fund types (retail, industry, corporate, public sector and SMSFs).

These levels of support for compulsory super identify it as a much more favoured vehicle for making provision for aged care funding than unpopular mechanisms such as reverse mortgages. The findings also point to provision for aged care as a priority initiative that would strengthen lifetime coverage as the super system matures and address growing concerns over the cost of aged care as an expected part of late retirement. The system is well established and compulsory contribution is widely accepted and shortcoming are being addressed through MySuper and other measures. The introduction of an ACL at age 50 would be a suitable time for prompting 'reset and forget' reviews on the part of individuals and by funds with ASFA to inform policy.

Findings from recent NSSS are consistent with ASFA. Ensuring that 'my money lasts for my lifetime' was rated a very important attribute of savings and finances by close to 80% of respondents, second only to having a 'regular, constant income that covers my essential needs' (84%), and

followed by ‘being able to pay for aged care and medical costs’ (71%). While just over half, 55%, reported they had planned for an increasing lifespan in the area of health and medical costs, NSSS2018 found ambivalent responses to options for income protection past age 85 when aged care is most likely to be needed:

- Over half (55%) supported super funds offering an insurance option that would keep paying an income if the individual lived to over age 85, and another 9% were undecided, but 35% did not support the option.
- Support for paying 10% of savings at retirement to receive an income for life was less clear cut: just over 25% wanted the option for themselves, as many again said the option should be available but they would not use it, another third said it was unlikely they would consider the option.
- The remaining 11% said they did not support the option because they did not expect to live as long.

5.3.2 Preferred options

More specific indications that older Australians are prepared to pay in advance for greater certainty in meeting the costs of aged care come from the experimental survey of just over 1000 Australians aged 55-64 reported by Wu and others (2017). This study investigated respondents’ interest in taking out three insurance products and how much of their retirement savings they would allocate to paying a single premium to purchase the products which provided income rather than only reimbursing care expenses. All three products provided income and based on willingness to allocate 30% their retirement income:

- Over 70% selected the income indemnity product that would provide a predefined income in the event of need for care, and regardless of the cost of care; as income was provided whether care came from informal or formal sources, this option was especially appealing to those who expected to rely on high levels of family care.
- Around 60% selected the life annuity product that provided an immediate, inflation-indexed lifetime income and only 35% selected the liquid investment account where withdrawals could be made at any time.
- The findings also suggested that precautionary savings would be released to purchase insurance products if they were available.

Other work at CEPAR modelled choices between insuring or borrowing against home equity to cover long term costs, drawing on US data for private insurance (Shao et al., 2017). The two options were found to cater for groups with different mixes of fixed and liquid assets, and availability of both stimulated demand overall rather than one crowding out the other. Reverse mortgages dominated but the two options were complementary, and the greatest welfare benefits came from combined products.

5.3.3 Generational views

A view of whether older people are getting more than their fair share of government support, and if so, by implication can and should pay more of their own way, comes from an investigation of views of different generations. The Attitudes to Ageing in Australia Study (Kendig et al., 2017) reported on perceptions of opportunities and equity for current retirees (over age 65) compared to Baby Boomers (aged 50-64 in 2015-16) and two younger age groups (aged 18-34 and 35-49). The findings show that:

- Younger age groups had more sympathetic attitudes towards current retirees than retirees themselves; compared to 50% of retirees, some 60% of each of the three younger generations agreed that Baby Boomers had better lifelong opportunities than retirees, and that retirees received less than their fair share of government benefits.
- There was no difference between the generations in perceived levels of conflict between older and younger people, with around 70% of each generation considering there was no or not very strong conflict.

These authors conclude that the evidence of a strong intergenerational contract is likely to see resistance to policy measures aimed at taking benefits away from older people. While these subjective views contrast with the objective findings of the Grattan Institute that point to the scope for doing so in the interest of intergenerational equity, they are at least equally important in making and selling policy options.

5.4 Behaviour and resources

Actual spending behaviour and asset holdings provide a firmer basis for understanding the capacity of older people to meet costs of aged care than expectations or intentions.

5.4.1 Spending within means

A report from Challenger (2018) based on analysis of data from the Household, Income and Labour Dynamics in Australia (HILDA) survey showed differences across age groups, between single and couple households, and between spending on needs compared to wants. While total spending fell by about 30% overall from age 60-64 to 80 and over, amounts spent on needs remained fairly constant across all age groups and at equivalent levels for single and couple households, but discretionary spending fell markedly with increasing age, and more so for singles. These trends suggest that at advanced ages over 80, when need for aged care becomes increasingly likely, many have little spare resources to meet additional costs of care.

It is possible that products providing longevity or aged care insurance could help to increase the welfare of retirees by reducing the need for precautionary saving as part of the decumulation stage of retirement. Wu et al. (2014) found considerable heterogeneity among pensioner households' decumulation experiences, reflecting the wide range of incomes of those coming within the Age Pension means test interacting with different spending and saving behaviours. As a consequence of holding savings as buffers, Age Pensioners on average held as much wealth when they died as at the beginning of the 8 year study period, but experiences varied between a significant minority of retirees spending (or losing) a big part of their assets, and others gaining significantly. The complexity of these changes again indicates that averages mask considerable diversity within the aged population as a whole; for many individuals, their assets are very different in early and late retirement, except for those who have the least at the start have the least near the end.

Focusing specifically on spending on aged care services which mostly occurs in the later part of retirement, the picture of how those using aged care services fund their care is complex in terms of the multiplicity of combinations of sources, but simple in terms of dominant financing streams. ACFA (2018b, Appendix B) tabulates a total of 14 streams of income, assets, loans and other sources for seven types of services. These were private funding for in-home support and for retirement villages, and fees for services under subsidised programs: the Commonwealth home support program (CHSP), care packages, post-acute care, and respite and permanent RAC. Even though the data do not detail the volume of funds from different streams or the frequency of use of different services,

the dominance of the Age Pension is clearly evident compared to all other sources and across all service types.

The proportion drawing on the Age Pension was highest at 72% for CHSP and no other source came close to this figure for any service: 40-50% drew on personal savings, and some 35-45% drew on superannuation or other income streams for one or other program, falling to 27% for retirement villages. Turning to use of assets, proceeds from selling the family home or selling other assets were only used to any extent when capital funding was required, by 36% for residential aged care and for retirement village accommodation. Asset realisation is an infrequent source of funding for any care in the home, and equity release against the family home was reported by only 8-10% for any kind of care.

5.4.2 Holding on to assets

Capacity to realise the desire to make a bequest is evident in an analysis of assets held at death by Temple, McDonald and Rice (2017). Property accounted for three quarters of all assets held by those who died at age 65 and over in 2009-10, averaging $350,000 and totalling $40.3bn; the value of these assets far exceeded government expenditure of $7.3bn on aged care services and $29.3 billion on the Age Pension in that year. The authors note the stability of these property assets over the age range and observe that the preservation of assets and limited decumulation prior to death points to their importance in inheritance as the major form of intergenerational transfers. Tax arrangements preclude very large pre-death asset transfers, with early intergenerational transfers also being limited by the illiquid nature of property assets. The slight decline in net per capita property assets from age 65 to 70 is likely due to adjustments between asset classes at retirement, such as downsizing and some level of early bequeathing to younger family members, but assets held then increase and only decline again after age 80, most steeply close to age 85.

To the extent that this drop reflects the impact of RADs paid for residential aged care, the impact on inheritance should be largely redressed when the RAD is refunded. Variations in housing and assets at death were not reported by Temple, McDonald and Rice (2017), but must be substantial given that 25% of older Australians do not own their own home and similar proportions had no super on retirement. Increasing variation over the age range is also evidenced in four out of 10 of those admitted to residential care having insufficient means to pay a RAD in full or in part and so qualify for the Accommodation Supplement.

Given the centrality of housing assets to the wealth of older Australians, varying the means test applied to those taking up aged care services has provided a way of drawing on some of that wealth. The Productivity Commission (2010, pp. 78-82) modelled the effects on the eligibility of those of pension age to receive aged care services under different criteria of continued use of the Age Pension means test which excludes the value of the person's home, the current full and part Age Pension criteria applied to those whose assets limit them to receiving a part Age Pension, and a new means test that treated all assets, including the family home in the same way. As of 2010, under the existing Age Pension means test, fully 83% were eligible to receive the full rate of subsidy for community or residential care, and even with increased superannuation incomes, this would fall only modestly, to 77% by 2030. In contrast, inclusion of the family home in the assets test would see the proportion receiving full subsidies drop to 23% by 2030, 22% would receive mid-level subsidies and 55% would receive only low level subsidies. The introduction of the combined means test in residential care in 2014 should see changes in line with this modelling, except that as the Commission itself

notes, those at the oldest end of the age spectrum are likely to have lower assets. The analyses of home-ownership earlier in this paper confirms this observation.

5.5 Alternatives on offer

5.5.1 Options for prolonging income in retirement

Options for reforming superannuation aimed at preserving income through late retirement have been linked to enhancing capacity to meet aged care costs, albeit indirectly rather than by making specific provision for this eventuality. Increasing the Superannuation Guarantee and Comprehensive Income Products in Retirement (CIPRs) have both been the subject of extensive analysis, and discussion here focuses on how they compare to an ACL as a means of funding future aged care costs.

Increasing the Superannuation Guarantee

The increase in the SG to 12% of wages is legislated to occur in series of steps to 2025. One of the leading proponents of increasing the SG has been Paul Keating whose initial formulation of the compulsory superannuation scheme proposed an eventual 12%. He has more recently advocated longevity insurance as an adjunct to increasing the SG to ensure lifetime income in line with increasing life expectancy (Keating, 2018). Although adding to retirement income, the measure would have a very distant and indirect impact on capacity to pay for aged care, especially for women.

Criticisms of increasing the SG focus on the impact on take home pay, especially for young and low income earners, in the current period of low wages growth. A number of participants in the 2018 CEPAR Policy Dialogue also noted that while increasing the SG to 12% would raise retirement incomes overall, it would compound differences between higher and lower paid workers and between men and women. Further, the effects would not be seen for decades and would be moderated by shifts between voluntary contributions and increased compulsory contribution, and would not necessarily ensure that higher incomes in retirement lasted longer. It would exacerbate inequitable STEs unless other measures are taken to correct these distortions, and implementation of an ACL alongside the increase in the SG would provide a trade-off for such changes.

Notwithstanding these criticisms, the government has asserted its support for the already legislated increases. An ACL would run whatever the level of the SG, with an increase leading to a flow-on increase in revenue over the long term.

CIPRs - Comprehensive income products in retirement

The development of new MyRetirement products by Treasury (2016) has focused on longevity insurance by way of CIPRs. While ensuring income over longer lives, CIPRs only address aged care costs indirectly. Over and above questions of product design, poor financial literacy with regard to superannuation is even more likely to inhibit decisions about purchasing CIPRs on retirement or at a later age. The tendency to underestimate longevity and the corresponding need for aged care point to poor capacity for making such decisions, although the level of precautionary savings held by a proportion of retirees indicate CIPRs would be affordable and possibly reduce other risks.

The complexity of CIPRs and other annuity products mean that many of those most likely to need them will be least likely to purchase, and capacity to manage the income generated by these products is likely to diminish exactly at the time they mature and when close management is most needed. A number of other factors affecting decisions to purchase CIPRs are likely to be problematic:

- The decision cannot be reversed, making CIPRs a less attractive option than more flexible, although possibly more risky, use of Account-Based Pensions for allocation of superannuation balances available on retirement.
- The outcomes of decisions will depend on the economic climate at the time of purchase; poor or uncertain conditions could see terms of CIPRs both suppress purchase and long term outcomes.
- Declining trust in financial institutions in the wake of the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry is a likely to inhibit interest in CIPRs and related products, even with more regulation.

The prospect of aggressive marketing of CIPRS to cherry-pick purchasers raises the risk of moral hazard on the part of those who do purchase could buy up more of the services available in a system where supply is constrained by many factors beyond government planning and regulation; the expectation that a market response would be forthcoming is a risky proposition. At the same time, exclusion of bad risk customers would push them back to publicly financed care, counteracting and possibly exceeding the impact of privately funded products on public expenditure. Any move to offer concessions as an incentive to purchase CIPRS would very likely result in further perverse redistribution of tax concessions to wealthier individuals who had the resources and know-how to benefit. The long lead time and likely low take up mean that outcomes may not be evident for decades, but product availability may preclude consideration of other options, especially when combined with wishful thinking on the part of policy makers and insurers.

A less optimistic view of the role of CIPRs has come from the Productivity Commission (2018) in its report on the efficiency and competitiveness of superannuation which concluded that the variety of retirement income products was sufficient and the risk was rather that excessive choice came at some cost to income flow. The more critical question was whether people acted with discernment in the decumulation phase of retirement when decisions were more complex than over the accumulation stage as more multiple interactions between super balances, drawdown options, access to the Age Pension, other assets including housing and personal circumstances, had to be taken into account with little chance of going back once decisions were made. Given the flexibility of account-based pensions for drawing on super, and that remedies to whatever problems they had would not be addressed by CIPRs, the Commission gave only limited support to CIPRs compared to other means of ensuring income lasted over retirement.

5.5.2 Options linked to use of housing assets

Reverse mortgages

As well as having most of the limitations of purchasing CIPRs or deferred annuities, reverse mortgages (RMs) present other particular risks as a means of paying for aged care:

1. Aversion to debt and encumbering the family home pose emotional barriers to taking out RMs that can overwhelm any objective advantages they may offer. These reservations may grow in what are seen as uncertain times, especially with regard to the housing market, with individuals motivated more than ever to hold on to their housing assets free of debt.
2. An underlying reason for holding on to debt-free housing assets is precisely the possibility that the house may have to be sold to pay for aged care accommodation at some future time. Lump sum payment of a RAD can be seen as a form of delayed or quasi RM, with the aged care provider acting in much the same way as a financial institution holding a RM. As RAD balances

are refunded on exit from residential care, there is no risk of negative equity, notwithstanding RM protections against negative equity.

3. RMs are presently only available to owner occupiers while they are living in the house and so would only be available to fund home and community care services. Taking out a RM could have the perverse effect of locking ageing home owners into accommodation that is not only unsuitable to their changing needs but which also incurs other cost increases over time, such as rates, utilities and maintenance, and may limit subsequent choices for downsizing to more appropriate housing. RMs will also reduce the amount available from selling the house should admission to residential care become necessary.

Expectations that RM or variants such as the Pensioner Loans Scheme provide would open up an untapped source of funding seem unlikely to be realised. RMs have been available through general financial markets for many years, but there is widespread evidence that older Australians are either unable or unwilling to access them, regardless of the value of housing assets, and that banks are not keen on promoting them. The first government backed PLS introduced by the Hawke Government in 1986 in conjunction with changes to Age Pension asset testing was revised in 1996, and the scheme was supported by the Productivity Commission (2011) which recommended a government backed reverse mortgage scheme.

The continuing policy support for RMs and related schemes is not reflected in the evidence on take-up. A report on *Housing Decisions of Older Australians* by the Productivity Commission (2015) stated that as of 2014, there were only 800 loans outstanding under the PLS, with a value of only $31m and held by only 0.04 percent of Age Pension households. ACFA (2018b) reports a continuing decline to only 650 loans in 2018. Beyond the PLS, take-up of reverse mortgages has remained low; the 2015 Productivity Commission report noted that a rise from 2006 to a peak of around 40,000 RMs in 2010 was followed by subsequent decline.

These figures not only show that older people are reluctant to take up RMs of any kind, but suggest that financial institutions have been reluctant to offer them, leading to the conclusion that they have very limited benefits for borrowers or lenders. In the face of these outcomes, there seems no real basis for the continuing support for RMs as a source of additional retirement income, let alone for funding aged care. Research by CEPAR has demonstrated the technical feasibility of RMs (Shao, Hoa & Sherris, 2017) and others have seen them as a useful avenue for assisting older people's well-being, but a wide range of considerable barriers have been identified in extensive investigations by the Australian Housing and Urban Research Institute (Bridge et al., 2010; Ong et al., 2013). The limits to accessing RMs or the PLS for those seeking to increase their incomes early in retirement are likely to be much greater for even older and frailer individuals requiring aged care.

More recently, the pros and cons of drawing on housing assets specifically to finance aged care have been presented by Ong (2016) in the context of addressing inequitable intergenerational transfers associated with housing wealth. While recognising the macro-level policy rationale for requiring individuals with housing assets to draw on them, she argues that such measures could threaten elements of intergenerational reciprocity such as family caregiving across generations, and also conflict with policy aimed at supporting family care of older people. Against Ong's identification of the further policy development needed to make housing equity release a realistic option, the simple extension of access to the PLS in the 2018-19 Budget can be seen as a 'free-kick' that appeared to increase support for seniors but comes at no likely cost to government, and is unlikely to attract take-up on a scale sufficient to affect outlays on the Age Pension or aged care.

Downsizing and retirement villages

Older individuals with housing assets are able to, and many appear willing to, make choices outside the formal aged care system by way of converting their housing assets into various forms of retirement accommodation and paying for varying levels of support services, and possibly reducing the likelihood or at least duration of use of RAC. The view that older Australians want to remain in their *own home* means they want to stay in the *same house* is misleading and has obscured the extent to which they have, or are planning to change one house to make a *new home* in *another house*. The NSSS2017 found that one third of the homeowners surveyed had already downsized around the time of retirement, close to another 25% intended to downsize and less than half were stayers (Rees & McCallum, 2017).

Among the options for downsizing, retirement villages now accommodate around 200,000 older Australians, about as many as are living in RACH. Choices to move to a retirement village are far less constrained than moves into a RACH necessitated by declining functioning and moderated by mandatory assessment. It is apparent that many make this choice and as retirement villages come in diverse forms across a wide price range, matched to housing prices in different localities, they do not cater only for the wealthiest (Jones et al., 2009). While the diversity of contracts for buying into retirement villages cater for a range of incomes and assets, and offer different forms of tenure, these options may not all be well understood by purchasers, and the purchase of varying bundles of amenity and services as well as housing make comparison with usual real estate transactions difficult. State legislation covering retirement villages focuses on consumer protection and while there have been a number of reviews, no action has been taken on the recommendation of the Productivity Commission 2011 Inquiry that State and Territory government should pursue nationally consistent retirement village legislation under the aegis of the Council of Australian Governments.

The steady growth of retirement villages, combined with the ‘younging’ of the older population may explain some of the decline in demand for RAC seen in falling occupancy rates as retirees choose retirement villages in which they remain to older ages. While promoted as ‘over 55s housing’, two recent surveys (StewartBrown, 2018; PwC/Property Council, 2018) report that the average age of entry to retirement villages has been increasing over time and is now around 75, with the average age of residents being 80; these age increases have been accompanied by changes in the service offerings in villages, especially add-on assisted living options. Residents live in villages for an average of 8-9 years, putting those leaving villages into their mid-80s, at least matching the average age of entry to RAC, suggesting that living in a village may have a protective effect and marginally delay admission. Comparison with the wider population is however confounded by the selective composition of the retirement village resident population.

To the extent that moves to retirement villages or other downsizing results in a reduction in admission to RACH for those with assets who can choose these options, more admissions will be drawn from those without assets. The protective effects of downsizing are likely to see those without this option due to lower incomes and lower assets, particularly lower levels of home-ownership, more likely to be admitted to a RACH. These outcomes are consistent with the pattern of payment for accommodation by those admitted to RACH and the stability of the share receiving Accommodation Supplements. So while older people in general may be better off, it is precisely the wealth that would enable the better off to pay for more of their aged care that also gives them the ability to make other choices that forestall entry to RACH, at least for a time.

5.6 Who is contributing different views on policy options?

The voices of older people and their narratives present the views of those who are most directly concerned about paying for aged care, the options in which they are interested and those which have little appeal, and their behaviour when faced with having to make these decisions. The main findings from the perspectives of older people are:

1. In the face of apparent acceptance that they will have to pay for more of the cost of future aged care, ability to assess 'my risk' of needing care and the extent of 'my planning' for the eventuality are limited. Among the limiting factors are difficulties in obtaining accurate and useful information, and the long timeframes ahead for those early in retirement. In line with improved engagement with superannuation, better rather than more information, and fewer rather than more choices are likely to improve decision making. Against these information gaps, narratives were often informed by experience of managing aged care for family members.
2. Widespread concern about whether and how they will meet such costs is associated with expressions of interest in making better advance provision for ageing. Possibly because of familiarity with superannuation, it was widely supported as a means to this end, with many prepared to contribute to a super-related or similar insurance scheme to provide more certainty about their money lasting to meet costs of aged care late in their lifetime.
3. Attitudes of both younger and older generations show that maintaining the generational contract remains a central tenet in policy making.
4. Actual behaviour confirms that the Age Pension plays a major role in meeting aged care costs when they do arise; in contrast, use of reverse mortgages and similar equity release products remain distinctly low. Notwithstanding wide variations in levels of assets, most held on to whatever they had, and realised housing or other assets at the time of admission to residential care only when prompted to do so by the combined means test that is applied to assessing user charges for accommodation and care fees.

These preferences, attitudes and behaviours of older people are at odds with current policy proposals which only address aged care funding indirectly. In comparison to an ACL:

1. Increasing the SG has a long term horizon and an ACL could be implemented in parallel to achieve more direct results in a much shorter time frame and without any impact on wages.
2. Longevity insurance products are complex and as well as facing considerable information barriers, may not offer any advantages over the flexibility of account-based pensions that are currently widely used for drawing on super in the decumulation phase.
3. Policy support for reverse mortgages persists against the considerable evidence of low take up and unpopularity, with far more choosing to downsize, notably to retirement villages, possibly with a protective effect against admission to RACH.

Resolving these differences points to the need to recognise that, as noted by Eling and Ghavibazoo (2019), emotional narratives and subjective experience play a part alongside statistics and the other kinds of information that usually shape policy. Doing so will require a reframing of the roles of different actors in considering options for funding aged care and including an ACL in response to support for options linked to superannuation.

CONCLUSIONS

The conclusions that follow first draw together the answers to the questions posed at the end of the five parts of the paper. Looking beyond these separate conclusions, a wider view leads to three broader conclusions about the potential for a major change in funding arrangements to support further development of the aged care system.

The when, where, why, how and who of an Aged Care Levy

Part 1: When will the next chapter be written?

Discussion of social insurance for aged care has been associated with major policy reviews over the last three decades, and the range of emerging interests points to renewed attention to the topic through two current opportunities.

1. ***The review of retirement incomes*** announced in mid-2019 in advance of the already legislated increase of the SG from 9.5% to 10% is the first opportunity. National Seniors were among the groups calling for inclusion of aged care funding, and while the Terms of Reference of the review do not mention aged care, the Consultation Paper released in November 2019 notes the need to take account of interactions between the retirement incomes and aged care funding systems (Treasury, 2019a). This review provides an opportunity for bridging the separate policy thinking about aged care funding and superannuation that has prevailed to date, and thereby widen the view of policy directions in both sectors.
2. ***The Royal Commission into Aged Care Quality and Safety*** provides the second opportunity as its terms of reference include *(f) how best to deliver aged care services in a sustainable way*. The breadth of the Commission's terms of reference overall invites thinking that goes well beyond the austerity view of government funding and immediate priorities that have left little space for canvassing alternative approaches to securing the long term sustainability of aged care funding. The only option that need not be on the table is private long term care insurance.

Part 2: Where would another pillar for aged care funding fit?

An ACL on earnings of super funds would not only add a third pillar to aged care funding but closer interaction with the retirement income system would see the whole add up to more than the sum of the parts of both by bringing together what to date have been separate pillars in policy thinking and in practice. The restructuring of the pillars of aged care funding would see:

1. The large pillar of government funding would be divided into two smaller pillars, one covering a share of care costs funded by the ACL, and the other covering remaining care costs and accommodation supplements funded from general revenue.
2. The Age Pension would remain central to both aged care funding and retirement incomes and its roles would be unaffected by an ACL applied over a time interval over late working life and early retirement, and well ahead of entry to care. It would not affect transfer payments from the Age Pension towards the Basic Daily Fee in aged care which is governed by means testing for the Age Pension, applied at the time of using care services.
3. An ACL would establish a direct link with the second pillar of superannuation in the retirement incomes system, and would strengthen the role of super in providing for lifetime needs in retirement. By extending to super earnings in the early years of retirement, an ACL would bridge the gap between cessation of contributions to super on retirement, for most by their mid to late 60s, and take up of aged care services in their 80s. It would be much more reliable than the

slender pillar of other income that will be even smaller for most by advanced old age; even with increases in super and other retirement incomes across the older population in general, few of the much more selected population who come to use aged care, especially very older women, will have sufficient non-pension incomes to make substantial user payments.

4. The pillar of home-ownership has been found to be not as strong as it appears. Although a solid base for most at the time of retirement, it is considerably eroded by changes in tenure and living arrangements associated with advancing age by the time of admission to residential care. These changes explain why although more than 3 out of 4 are home owners at retirement, only one in two are able to pay for their aged care accommodation some 15 to 20 years later. The ACL would not affect current arrangements of user payments for accommodation, but it could cover government funding of the Accommodation Supplement.
5. An ACL would leave Carer Payments and Carer Allowance as they are. CA especially moderates the need for cash payments in Australia, and an ACL would not automatically provide for cash payments which would instead rest on consumer directed options available through different service delivery programs.
6. An ACL is highly compatible with the SG and the Medicare and NDIS levies that fund part of those service systems. This compatibility is likely to extend to community acceptance of social insurance as a way of sharing risks in aged care, with user contributions playing a residual role.

Part 3: Why is an ACL needed?

Aged care funding is set to increase in coming decades, and regardless of whether these increases will place undue pressure on the national budget or not, the analysis of funding trends shows four reasons why an ACL is needed.

1. The scale of expenditure growth warrants a stronger funding system than is in place at present. The main objective of an ACL is to inject a new stream of revenue into the aged care budget to relieve whatever pressures do arise, not to increasing the total amount of funding available for aged care other than in line with the growth of super assets. It would smooth the impact of ‘good times’ and ‘bad times’ on government capacity to meet costs of care at any one time by spreading revenue and expenditure more widely between different cohorts.
2. The overall stability of past and projected growth demonstrates very limited margins for reducing Commonwealth outlays or for markedly increasing revenue from user payments. Efforts to control government outlays have instead resulted in short term instability; it remains to be seen whether declines in the most recent years can be sustained.
3. Attempts to decrease the share of revenue from government sources and increase revenue from user payments have so far yielded little result, in part because of links between government and user sources that set limits to the Basic Daily Fee and DAPs. Instead of nibbling away at smaller revenue flows, a major new flow of funding is needed to complement government sources. An ACL provides this revenue and would have a large and lasting effect compared to small changes that appear to be soon countered by other measures.
4. The window of opportunity identified in demographic trends over the next three decades presents a strong reason for action in the short term to prepare for the longer term. The proportion of the population aged 50-69, the contributor cohort at the base of an ACL, remains a large and stable share of the total aged 50 and over after a decline over the decade 2020-30; this decline is partly offset by an increase in the transition cohort that grows most over the coming decade, and the user cohort only exceeds its current share after 2030. The aged care system has also been in a steady state over the last two decades, resulting from interactions between increases in life

expectancy, falling dependency rates and changes in provision and use of residential care. Maintaining a steady state over coming decades would be supported by a steady funding system incorporating an ACL.

Part 4: How would an ACL make a difference?

An ACL would make a difference at both the general level of generational transfers and the specific level of aged care funding.

At the general level, intergenerational accounting analyses show how an ACL could rebalance inter- and intra-generational transfers that currently flow through STEs on superannuation and housing.

1. An ACL would begin to redress the distortion of the purpose of superannuation by directing a part of the STEs on super contributions and incomes to provide for aged care as a common part of late life.
2. It would reduce current intergenerational transfers by substituting for a part of tax funding of aged care by younger working age tax payers and reducing STEs paid by these cohorts through tax concessions to late middle aged and early retiree groups. This shift would increase generational self-sufficiency; although not a forward funded system, an ACL would see the latter cohorts contribute relatively more to the cost of aged care for the very old generation, and increase greater intra-generational equity through transfers from early to late retirement, from higher to lower income older people, and especially between men and women. In the event that revenue from contributors exceeded expenditure, a new trust fund agency could be established to manage such a surplus for future funding.
3. Further understanding of the scope for these transfers requires accounts of the wealth of the total older population, whether taken as aged 60, 65 or 70 and over, to be supplemented with more fine grained investigations to show cohort differences in income and assets, especially housing assets. Cross-sectional and longitudinal research is needed to provide a clearer account of changes that come about over the 15-20 years from entry to retirement to entry to aged care, and the processes contributing to these changes. The role for an ACL will be supported to the extent that such investigations confirm that not all people will be better off on retirement and even more so at advanced old age, and moderate optimistic expectations of how far very old individuals will be able to meet a larger share of the cost of their care from their own resources.

Focusing specifically on aged care funding, assessment on four criteria finds that an ACL would make positive contributions.

1. An ACL is affordable; a 5% levy on the earnings of 50% of aggregate assets held in superannuation by the population aged 50 and over with high balances would generate revenue sufficient to cover some 30% of recurrent government funding for the care component of residential care.
2. An ACL is adequate in terms of contributing a worthwhile share of aged care funding; allocation to a defined core care component funded at a flat rate, in line with current proposals, would bring other advantages in testing value for money and greater control over spending.
3. Sustainability comes from a quadruple multiplier effect that supports strong growth in aggregate superannuation assets; an ACL collected through smaller contributions from a larger share of the population, over a longer time, is more sustainable than user charges of varying but uncertain amounts, collected from a small share of the population over a short period in late old age when

savings and incomes of many individuals are likely to have been diminished by the vicissitudes of advancing age.
4. An ACL would cover an insurable risk based on the predictability of admission to residential care and length of stay. These two risks are known now, and these and other parameters can be further modelled with extensive, high quality data already available over many years.

Finally, while the proposal for an ACL put forward here has focused on residential care, it could be extended to community care. The simplest approach would be to allocate a share of funds from the ACL to a single community care program, integrating the current Commonwealth Home Support Program and Home Care Packages, as is being considered by the Royal Commission (Smith, 2018). Alternatively, if funding of care packages continues to be aligned in some way to residential care, with different levels of funding allocated to individual recipients, a core care component could be defined for community care.

Part 5: Who is contributing different views on policy options?

The voices of older people and their narratives present the views of those who are most directly concerned about paying for aged care, the options in which they are interested and those which have little appeal, and their behaviour when faced with having to make these decisions. The main findings from the perspectives of older people are:

1. In the face of apparent acceptance that they will have to pay for more of the cost of future aged care, ability to assess 'my risk' of needing care and the extent of 'my planning' for the eventuality are limited. Among the limiting factors are difficulties in obtaining accurate and useful information, and the long timeframes ahead for those early in retirement. In line with improved engagement with superannuation, better rather than more information, and fewer rather than more choices are likely to improve decision making. Against these information gaps, narratives were often informed by experience of managing aged care for family members.
2. Widespread concern about whether and how they will meet such costs is associated with expressions of interest in making better advance provision for ageing. Possibly because of familiarity with superannuation, it was widely supported as a means to this end, with many prepared to contribute to a super-related or similar insurance scheme to provide more certainty about their money lasting to meet costs of aged care late in their lifetime.
3. Attitudes of both younger and older generations show that maintaining the generational contract remains a central tenet in policy making.
4. Actual behaviour confirms that the Age Pension plays a major role in meeting aged care costs when they do arise; in contrast, use of reverse mortgages and similar equity release products remain distinctly low. Notwithstanding wide variations in levels of assets, most held on to whatever they had, with the combined assets test for aged care now the only mechanism for drawing on the family home at the time of admission to residential care, whether to pay for accommodation or means tested care fees.

These preferences, attitudes and behaviours of older people are at odds with current policy proposals which only address aged care funding indirectly. In comparison to an ACL:

1. Increasing the SG has a long term horizon and an ACL could be implemented in parallel to achieve more direct results in a shorter time frame and without any impact on wages.

2. Longevity insurance products are complex and as well as facing considerable information barriers, may not offer any advantages over the flexibility of account-based pensions that are currently widely drawn on in the decumulation phase of superannuation.
3. Policy support for reverse mortgages persists against the considerable evidence of low take up and unpopularity, with far more choosing to downsize, notably to retirement villages, possibly with a protective effect against admission to RACH.

Resolving these differences points to the need to recognise that, as noted by Eling and Ghavibazoo (2019), emotional narratives and subjective experience play a part alongside statistics and the other kinds of information that usually shape policy. Doing so will require a reframing of the roles of different actors in considering options for funding aged care, particularly an ACL as a response to support for options linked to superannuation.

Looking ahead through a wider policy lens

Looking beyond the answers to these five questions, consideration of an ACL suggests three conclusions for reframing the policy view to address some of the gaps that are now evident between policy objectives, measures adopted to pursue them, and outcomes achieved.

Widening the policy framework

Three considerations inform the need to look more widely than the separate ‘narrow band’ solutions that have been increasingly pursued over the last two decades to a ‘broad band’ solution that positions aged care alongside retirement incomes, health care and disability. As with those systems, an ACL widens the revenue base by adding a third pillar that draws on large part of the population, over a wide age range for a longer time, and provides a more certain means of funding aged care directly rather than relying on indirect measures that boost late life incomes.

In this wider view, an ACL does not step away from the proposition that those who are able to pay should contribute more to the cost of their care. Rather, it recognises the limitations of leaving contributions to the time of using services or expecting individuals to plan ahead, including the likelihood that changes to age care arrangements *per se* make planning a difficult and possibly fruitless task even for the best of planners. A contingent policy of requiring individuals to make provision for future costs is that they be provided with a means to do so that offers some certainty of outcomes. An ACL pillar would do this as a default, akin to MySuper.

Writing on pension reform in OECD countries more than a decade ago, Whiteford and Whitehouse (2006) observed that diversification improved sustainability and affordability of pension systems. The SG has diversified Australia’s retirement income system, and a similar move is now needed in aged care funding. More recently, and notwithstanding the growth of policy support for private welfare, Whiteford observed at the 2018 CEPAR Policy Dialogue on Retirement Incomes that the design of the Australian model for retirement incomes demonstrates enduring support for compulsory over free market approaches, for universal coverage over individual decision-making to manage risk, and for inclusiveness over choice to opt in or out. Just as compulsory super through the SG fits this narrative as a response to calls for better incomes in retirement for all members of the community, an ACL fits as a means of providing a universal response to risks that are not readily managed by individuals.

An ACL also supports other social policy goals that cannot be readily pursued through alternative approaches. For example, it avoids invidious distinctions between those who rely on public funding

and 'self-funded' users who may in fact have benefited from public funding through other channels, such as STEs on superannuation and property. By promoting solidarity between and within generations, an ACL supports the view of aged care as a 'whole of society undertaking' that benefits not only those who use services directly but also contributes to the social policy goals of supporting carers and enhancing workforce participation, including in aged care services.

Making big changes

The Productivity Commission (2011) argued that moving to a compulsory insurance scheme for aged care would be a big change from current arrangements. The magnitude and complexity of the issues did not cause the Commission or the government to resile from making big changes in funding disability services, and the NDIS demonstrates that big change is possible. Funding change in aged care has not yet been addressed on a scale comparable to the major reforms that saw the Medicare levy provide universal access to health care, the SG enhance retirement incomes of the majority of Australians, and the NDIS levy drive fundamental change in disability services. In all three cases, funding change was not an end in itself but a means to driving other changes.

These major initiatives provide highly relevant precedents for a major funding change aimed at securing an equally desirable social policy goal of enhancing the sustainability of aged care funding in the face of known projected growth of the older population and less certain economic conditions. They also demonstrate that universalist social insurance approaches have prevailed over market based strategies.

A policy imperative

The policy imperative is now to move beyond addressing the 'urgent and immediate' to serious examination of options most likely to realise 'important and long term' outcomes. An ACL linked to superannuation warrants such consideration as no other option can deliver the revenue outcomes that would be generated in line with population ageing and the growth of superannuation assets, individually and in aggregate, over at least the next two decades. Adding this pillar to aged care funding would be very likely to advance other changes that may be recommended by the Royal Commission.

Returning to the Introduction to this paper, an ACL offers the kind of optimal funding arrangement noted by Eling and Ghavibazoo (2019) by effectively embedding contributions in the superannuation system which serves as Australia's defined contribution pension scheme. The next chapter on social insurance for aged care in Australia may be about to be written. Or if an ACL is not given serious consideration, the questions that have to be answered are why not, and what other better options are there?

REFERENCES

1. Aged and Community Services Australia. 2016. *Submission to the Department of Health Aged Care Legislated Review*. https://acsa.asn.au/getattachment/Publications-Submissions/Submissions/ACSA-Submission-to-Legislated-Review-December-2016.pdf.aspx. Accessed 8 February, 2019.
2. Aged Care Financing Authority. 2019. *Seventh report on the Funding and Financing of the Aged Care Sector.* Australian Government Department of Health, Canberra. Also cited: 3rd Report 2015, 4th Report 2016, 5th Report 2017a, 6th Report 2018a.
3. Aged Care Financing Authority. 2018b. *Understanding how consumers plan and finance aged care.* AFCA, Canberra.
4. Aged Care Financing Authority. 2017b. *Report on access to care for supported residents*. AFCA, Canberra.
5. Aged Care Sector Committee. 2016. *Aged Care Roadmap*. Australian Government Department of Health. Canberra. https://agedcare.health.gov.au/aged-care-reform/aged-care-roadmap.
6. Angrisani M & Lee J. 2019. Cognitive decline and household financial decisions at older ages. *J Economics Ageing*. 13: 86-101.
7. Applied Aged Care Solutions Pty Ltd. 2017. *Review of the Aged Care Funding Instrument Report. Vol 2: Main Report*. Report to the Australian Government Department of Health. AACS, Melbourne.
8. Arthur D. 2015. *The Pension Loans Scheme: an old program attracts new interest*. Parliamentary Library. Posted 24/02/2015.
9. Association of Superannuation Funds Australia. 2019a. *Superannuation Statistics May 2019*. ASFA, Sydney.
10. Association of Superannuation Funds Australia. 2019b. *Community support for compulsory superannuation*. ASFA, Sydney.
11. Association of Superannuation Funds Australia. 2017. *Women's economic security in retirement*. ASFA, Sydney.
12. Association of Superannuation Funds Australia. 2015a. *Superannuation account balances by age and gender.* ASFA, Sydney.
13. Association of Superannuation Funds Australia. 2015b. *Discussion paper: the future interaction of superannuation with aged care and health care.* ASFA, Sydney.
14. Association of Superannuation Funds Australia. 2015c. *Mythbusting superannuation tax concessions.* ASFA, Sydney.
15. Association of Superannuation Funds Australia. 2014. *An update on the level and distribution of retirement savings.* ASFA, Sydney.
16. Australian Bureau of Stastics (2019) *Australian Demographic Statistics, March 2019*. ABS Catalogue 3101.0
17. Australian Bureau of Statistics. 2018a. *Life Tables, States, Territories and Australia, 2015-2017*. ABS Cat No 3302.0.55.001.

18. Australian Bureau of Statistics. 2018b. *Household income and wealth, Australia*. *Summary of results 2015-16.* ABS 65230DO12_201516.

19. Australian Bureau of Statistics. 2018c. *Population projections, Australia, 2017(base)-2066.* ABS Cat No. 3222.0

20. Australian Bureau of Statistics. 2017a. *Retirement and retirement intentions, Australia, July 2016 to June 2017*. ABS Cat No. 6328.0.

21. Australian Bureau of Statistics. 2017b. *Deaths Australia 2017*. ABS Cat No 3302.

22. Australian Bureau of Statistics. 2017c. *Life expectancy.* ABS Cat No. 6328.0

23. Australian Bureau of Statistics. 2017d. *Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016 - Ageing Population*. ABS Cat No. 2071.0.

24. Australian Bureau of Statistic. 2015. *Disability, Ageing and Carers, Australia: Summary of Findings 2015*. ABS Cat No. 4300DO030_2015.

25. Australian Bureau of Statistics. 2014. *Australian Historical Population Statistics 2014.* ABS Cat No. 3105.0.65.001.

26. Australian Bureau of Statistics. 2007. *Retirement and retirement intentions, Australia, July 2016 to June 2017*. ABS Cat No. 6328.0.

27. Australian Bureau of Statistics. 2004. *Life Tables, Australia, 2003*. ABS Cat No 3302.0.55.001.

28. Australian Institute of Health and Welfare (AIHW). 2010. *Residential aged care in Australia 2008-09: A Statistical Overview.* AIHW cat no. AGE 62. Published annually to 2014-15. AIHW, Canberra.

29. Australian Institute of Health and Welfare (AIHW). www.GEN-agedcaredata/*Topics/People-using-aged-care. 2015-16*. Updating of online data may lead to small differences in figures reported here and later online data.

30. Australian Institute of Health and Welfare (AIHW). 2017. *Life expectancy and disability in Australia: expected years living with and without disability*. Cat. No. DIS 66. Figure 2 and Table A2.

31. Aged Care Workforce Strategy Taskforce. 2018. *A matter of care: Australia's aged care workforce strategy.* Report of the Aged Care Workforce Strategy Taskforce. Australian Government Department of Health, Canberra.

32. Bridge C, Adams T, Phibbs P, Mathews M & Kendig H. (2010) *Reverse mortgages and older people: growth factors and implications for retirement decisions*, AHURI Final Report No. 146, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/final-reports/146.

33. Borowski A. 2008. Back at the crossroads: The slippery fish of Australian retirement income policy. *Australian Journal of Social Issues*. 43(2): 311-334

34. Carnell K & Paterson R. 2017. *Review of National Aged Care Quality Regulation Processes*. Australian Government Department of Health, Canberra.

35. Challenger Retirement Income Research. 2018. *Spending patterns in retirement*. https://www.challenger.com.au/-/media/Challenger/Documents/Thought-leadership/CRIR-Spending_Patterns_in_Retirement.pdf. Accessed 19/04/2019.

36. Chen, Y-P. 2001. Funding long-term care in the United States: The role of private insurance. *The Geneva Papers on Risk and Insurance*. 26(4):656-666.

37. Chen, Y-P. 1994. Financing long term care: An intragenerational social insurance model. *The Geneva Papers on Risk and Insurance*. 73:490-495.

38. Chen, Y-P. 1993. The three-legged stool: A new way to fund long term care, in Institute of Medicine. *Care in the Long Term: In search of community and security*. National Academy Press, Washington DC. pp. 54-70.

39. Chomik R, Bateman H, Graham S, Piggott & Yan S. 2018a. *Retirement income in Australia Part 1 – Overview. CEPAR Research Brief*. CEPAR UNSW, Sydney.

40. Chomik R, Bateman H, Graham S, Piggott & Yan S. 2018b. *Retirement income in Australia Part 11 – Public Support. CEPAR Research Brief*. CEPAR UNSW, Sydney.

41. Chomik R, Bateman H, Graham S, Piggott & Yan S. 2018c. *Retirement income in Australia Part 111 – Private Resources. CEPAR Research Brief*. CEPAR UNSW, Sydney.

42. Chomik R & MacLennan R. 2014a. Aged Care in Australia: Part 1 – Policy, demand and funding. *CEPAR Research Brief 2014/01*. CEPAR UNSW, Sydney.

43. Chomik R & MacLennan R. 2014b. Aged Care in Australia: Part 2 – Industry and practice. *CEPAR Research Brief 2014/02*. CEPAR UNSW, Sydney.

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

45. Commonwealth Department of Community Services. 1986. *Nursing Homes and Hostels Review*. DCS, Canberra.

46. Council on the Ageing. 2018. *State of the (older) nation*. Prepared by Newgate Research for the COTA Federation, Canberra. www.cota.org.au/policy/state-of-the-older-nation/

47. Cooper J. Chair. 2010. *Super System Review Final Report*. www.SuperSystemReview.gov.au

48. Courbage C. 2011. Long-term care insurance: partnership or crowding out? *Health and Ageing Newsletter*, 25, October. The Geneva Association for Risk and Insurance Economics. Geneva.

49. Cullen D. 2019. Medium- to long-term pressures on the system: The changing demographics and dynamics of aged care. *Royal Commission into Aged Care Quality and Safety. Background Paper 2*. Office of the Royal Commission, Adelaide.

50. Cullen D. 2004. *Long term aged care: International experience*. Background Paper 4 prepared for the Review of Pricing Arrangements in Residential Aged Care. Commonwealth of Australia, Canberra.

51. Daley J, Coates B & Young W. 2016. *Age of entitlement: Age-based tax breaks*. Grattan Institute, Melbourne.

52. Daley J & Wood D. 2014. *The wealth of generations*. Grattan Institute, Melbourne.

53. Daniel A, Hua C, Cho D, Katja H & Sherris M. 2013. Developing equity release markets: Risk analysis for reverse mortgages and home reversions. *CEPAR Working Paper 2013/01*. CEPAR UNSW, Sydney.

54. Department of Health and Ageing. 2011. *Technical paper on the changing dynamics of residential aged care. Prepared to assist the Productivity Commission Inquiry Caring for Older Australians.* Department of Health and Ageing, Canberra.

55. Department of Health, Housing, Local Government and Community Services. 1993. *Aged Care Reform Strategy Mid Term Review: Stage 2 Report*. DHHLGCS, Canberra.

56. Eagar K. 2019. *An-ACC: A national classification and funding model for residential aged care: synthesis and recommendations*. Australian Health Services Research Institute, University of Wollongong, Wollongong.

57. Eling M & Ghavibazoo O. 2019. Research on long-term care insurance: status quo and directions for future research. *The Geneva Association Papers on Risk Insurance Issues and Practice.* 44 (2): 303-356.

58. Fifield M, The Hon. Senator. 2014. Cessation of the Dementia and Severe Behaviour Supplement. Media Release from the Minister for Ageing, 26 June, 2014.

59. Hawke, RJL & Howe BL. *Towards a fairer Australia: social justice strategy, 1990-91.* Australian Government Publishing Service, Canberra.

60. Hetherington D & Smith W. 2017. *Not so super for women: Superannuation and women's retirement outcomes.* PerCapita, Melbourne.

61. Hixon L. 2011. Sharing the burden: Understanding the roles of public and private insurance in financing aged care. *Economic Papers*. 30 (3):316-325.

62. Hogan W. Chair. 2004. *Review of Pricing Arrangements in Residential Aged Care: Final Report*. Commonwealth of Australia, Canberra.

63. Howe A & Healy J. 2005. Generational justice in aged care policy in Australia and the United Kingdom. *Australasian Journal on Ageing.* Special issue with the International Academy of Law and Mental Health. 24S:12-18.

64. Howe AL. 1986. Finance of health care for the aged. Ch. 11 in Mendelson R. *Finance of old age.* Centre for Research on Federal Financial Relations, ANU, Canberra.

65. Howe AL. 1999. Extending the pillars of social policy financing to aged care. *Social Policy and Administration.* Special Australasian Issue. 33:535-549.

66. Howe AL & Sarjeant H. 1999. Strengthening the financing of aged care in Australia. *Policy Implications of the Ageing of Australia's Population: Conference Proceedings.* Productivity Commission and Melbourne University Institute for Applied Economic and Social Research. The Commission, Canberra.

67. Howe AL. 1982. Beginning at the end: Patterns of death among the aged. *Community Health Studies*. 6 (3): 253-262.

68. Hudson, RB. 1993. Social contingencies, the aged, and public policy. *Milbank Quarterly*, 71 (2): 253-277.

69. Institute of Actuaries of Australia. 2019. *Options for an improved and integrated system of retirement*. Green Paper. Actuaries Institute, Sydney.

70. James A, Rowley S, Stone W, Parkinson S, Spinney A & Reynolds M. 2019. *Older Australians and the housing aspirations gap*. AHURI Final Report 317. Australian Housing and Urban Research Institute Limited, Melbourne.

71. Jones A, Howe A, Tilse C, Bartlett & Stimson B. 2009. *Service integrated housing for Australians in later life.* AHURI Final Report 141. Australian Housing and Urban Research Institute Final Report AHURI, Melbourne.

72. Kastenbaum R & Candy SE. 1973. The 4% fallacy: a methodology and empirical critique of extended care facility population statistics. *International Journal of Aging Human Development*. 4 (1): 71-74

73. Keating P. Paul Keating urges insurance scheme to back up superannuation. Reported in The New Daily, October 24, 2018.

74. Kendig H, O'Loughlin K, Hussain R & Cannon L. Attitudes towards intergenerational equity: Preliminary Australian evidence. *Australasian Journal on Ageing*. 36 (2): 107-111

75. McCallum J, Botsman P, Clarke A, Pearse W et al. 1998. Ensuring quality of later life: financing aged care services within the context of an ageing society: A discussion paper, commissioned by Southern Cross Homes NSW. Inc. *South West Health Care Papers.* No. 2. University of Western Sydney. 46pp.

76. McCallum J, Maccora J & Rees K. 2018. *Hope for the best, plan for the worst: Insights into planning for our longer life.* National Seniors, Brisbane.

77. McDonald P. 2016. Ageing in Australia: Population changes and responses. In Kendig H, McDonald P & Piggott J. Eds. *Population ageing and Australia's future.* ANU Press, Canberra. pp. 65-83.

78. McNamee J, Poulos C, Seraji H et al. 2017. *Alternative Aged Care Assessment, Classification Systems and Funding Models Final Report.* Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong, Wollongong.

79. Muir T. 2017. Measuring social protection for long-term care. *OECD Health Working Papers*. No. 93. OECD Publishing, Paris.

80. National Commission of Audit. 1996. *Report*. NCOA, Canberra.

81. National Seniors and Challenger. 2019. *Feeling financially comfortable? What retirees say*. National Seniors, Brisbane.

82. National Seniors and Challenger. 2017. *Seniors more savy about retirement income.* National Seniors, Brisbane.

83. Ong R, Wood G, Cigdem M & Salazar S. 2019. *Mortgage stress and precarious home-ownership: implications for older Australians*. Australian Housing and Urban Research Institute Final Report 319. AHURI, Melbourne.

84. Ong R. 2016. Financing aged care: The role of housing wealth and intergenerational relationships. In Kendig H, McDonald P & Piggott J. Eds. *Population ageing and Australia's future.* ANU Press, Canberra. pp. 281-303.

85. Ong R, Jefferson T, Wood G, Haffner M & Austen S. 2013. *Housing equity withdrawal: uses, risks and barriers to alternative mechanisms in later life*. Australian Housing and Urban Research Institute Final Report 217. AHURI, Melbourne.

86. Parliament of Australia. 1982. *In a home or at home: accommodation and home care for the aged.* Report from the House of Representatives Standing Committee on Expenditure. AGPS, Canberra.

87. Parliamentary Budget Office. 2019. *Australia's ageing population: Understanding the fiscal impacts over the next decade*. Report No 2/2019. PBO, Canberra.

88. Piggott, J. 2016. Population ageing in Australia – National policy challenges and future directions. In Kendig H, McDonald P & Piggott J. Eds. *Population ageing and Australia's future.* ANU Press, Canberra. pp. 47-62.

89. Productivity Commission. 2019. *Report on Government Services: Aged Care Services*. Part 14 and Attachment 14 Tables. The Commission, Canberra.

90. Productivity Commission. 2018. *Superannuation: Assessing Efficiency and Competitiveness. Inquiry Report.* The Commission, Canberra.

91. Productivity Commission. 2015. *Housing decisions of older Australians*. Commission Research Paper, Canberra.

92. PwC/Property Council. 2018. *Retirement Census.* Property Council of Australia. https://www.propertycouncil.com.au/Web/Advocacy/Retirement/Web/Advocacy/SectorBasedAdvocacy/Retirement_Living.

93. RSM. 2016. *Aged Care Sustainability Review 2016*. RSM.com.au.

94. Rees K, Maccora J & McCallum J. 2018. *You don't know what you don't know: The current state of Australian aged care services literacy.* National Seniors, Brisbane.

95. Rees K & McCallum J. 2017. *Downsizing: movers, planners, stayers*. National Seniors, Brisbane.

96. Siewert R (Chair). 2019. *Effectiveness of the Aged Care Quality Assessment and Accreditation Framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical standards are maintained and practised*. Final Report, Community Affairs References Committee, The Senate, Parliament of Australia, Canberra.

97. Shao AW, Hoa C & Sherris M. 2017. To borrow or insure? Long term care costs and the impact of housing. *CEPAR Working Paper* 2017/11. CEPAR UNSW, Sydney.

98. Smith C. 2019. Navigating the maze: An overview of Australia's current aged care system. *Royal Commission into Aged Care Quality and Safety. Background Paper 1*. Office of the Royal Commission, Adelaide.

99. Stebbing A & Spies-Butcher B. 2016. The decline of a homeowning society? Asset-based welfare, retirement and intergenerational equity in Australia. *Housing Studies*, 31(2):190-207.

100. Stebbing A & Spies Butcher B. 2010. Universal welfare by by 'other means'? Social tax expenditures and the Australian dual welfare state. *Journal of Social Policy*. 39(4): 585-606.

101. StewartBrown. 2018. *Aged Care Financial Performance Survey: Sector Report 2018 Financial Year*. Downloaded from www.stewartbrown.com.au.

102. Spies-Butcher B & Stebbing A. 2019. Mobilising alternative futures: generational accounting and the fiscal politics of ageing in Australia. *Ageing and Society,* 39 (7): 1409-1435.

103. Spies-Butcher B & Stebbing A. 2011. Population ageing and tax reform in a dual welfare state. *The Economic and Labour Relations Review,* 22 (3): 45-64.

104. Temple J, McDonald PF & Rice JM. 2017. Net assets available at age of death in Australia: An extension of the national transfer accounts methodology. *Population Review*, 56 (2):78-101.

105. Temple J, Rice JM & McDonald PF. 2017. Mature age labour force participation and the life cycle deficit in Australia: 1981-82 to 2009-10. *J Economics Ageing.*10:21-33.

106. Treasurer, JB Hockey. 2015. *Australia in 2055: 2015 Intergenerational Report.* Australian Government, Canberra.

107. Treasurer, W Swann. 2010. *Australia to 2050: Future Challenges. The 2010 Intergenerational Report.* Australian Government, Canberra.

108. Treasurer, P Costello. 2007. *Intergenerational Report 2007.* Australian Government, Canberra.

109. Treasurer. 2002. *Intergenerational Report 2002-03. Budget Paper No. 5.* Commonwealth of Australia, Canberra.

110. The Treasury. 2019a. *Retirement Income Review Consultation Paper*. Treasury, Canberra.

111. The Treasury. 2019b. *Portfolio Budget Statements 2019-20 Budget Related Paper No. 1.9 Health Portfolio.* Treasury, Canberra.

112. The Treasury. 2018. *Portfolio Budget Statements 2018-19 Budget Related Paper No. 1.9 Health Portfolio.* Treasury, Canberra.

113. The Treasury. 2012. *Distributional analysis of superannuation taxation concessions. A paper to the Superannuation Roundtable*. Treasury, Canberra.

114. Treasury. 2016. Development of the framework for Comprehensive Income Products for Retirement. *Discussion Paper*. 15 December 2016. Treasury, Canberra.

115. Treasury. 2010. *Australia's Future Tax System: Report to the Treasurer, December 2009. Commonwealth of Australia.* Henry Review. Treasury, Canberra. Part F7. Funding of Aged Care. pp. 629-643.

116. Tune D. 2017. *Legislated Review of Aged Care 2017.* Commonwealth of Australia Department of Health, Canberra.

117. Whiteford P & Whitehouse E. 2006. Pension challenges and pension reforms in OECD countries. *Oxford Review of Economic Policy*. 22 (1): 78-94.

118. Woodhouse AO & Meares CLD. (Chairmen). 1974. *Compensation and Rehabilitation in Australia: Report of the National Committee of Inquiry*. AGPS, Canberra.

119. Wu S, Asher A, Meyricke R & Thorpe S. 2015. Age Pensioner Profiles: A longitudinal study of income, assets and decumulation. *CEPAR Working Paper 2015/17*. CEPAR UNSW, Sydney.

120. Wu S, Bateman H, Stevens R & Thorp S. 2017. Income-indemnity long term care insurance: Selection, informal care and precautionary savings. *CEPAR Working Paper 2017/08*. CEPAR UNSW, Sydney.