Providing and Financing Aged Care in an Aging Society: Policy Choices and Dilemmas

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Structure of this presentation

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Section 1

What does population aging mean for the level, structure and duration of demand for aged care in the future?
Population aging and the demand for aged care

• The number of Australians aged 85 and over is expected to increase five-fold between 2006 (330,000) and 2051 (over 1.6 million).

• The challenge of providing long term care of and to the elderly will become increasingly important.

• Two facts are central to this challenge:
  – Older cohorts are living longer than before. As a result, the number of persons expected to live beyond age 70, and hence be at material risk of requiring care, is expected to rise; and
  – Younger cohorts are having fewer children. Among other things this means they will have fewer carers when they reach old age.
The structure of demand for aged care (1)

• Currently there are 3 forms of long term care:
  – domiciliary or community care (for low levels of acuity);
  – residential low care (for medium levels of acuity); and
  – residential high care (for high levels of acuity).

• These forms of care define a notional continuum in which care recipients move as their ability to cope with daily living diminishes.

• Whether movement along this continuum will remain the modal pattern is questionable.
The structure of demand for aged care (2)

- There are several forces at work that reduce demand for residential care.
  - Smaller differences in life expectancy between men and women (leading to fewer years of widowhood).
  - Improved health among ‘young elderly’.
  - Strong aversion of baby boomers to institutional living.

- On the other hand, growth in numbers of ‘very elderly’ means growth in the number of suffers from dementia, extreme fragility and other serious impairments requiring intensive residential care.

- Overall it seems likely there will be growth in demand at each end of the spectrum (community care and residential high care).

- Demand for residential low care is likely to remain material but may decline as a proportion of total long term care.
Temporal structure of care also likely to change

• **Very long durations of care likely to become more common in domiciliary/community and residential high care settings.**
  - Over the last four years, the proportion of discharges from permanent residential care that were in care for at least two years after admission has risen by 1.9 percentage points (from 38.6 per cent to 40.5 per cent).

• **Very short durations of care (3 months or less) in residential high care likely to remain common, and may become more common.**
  - In the last three months of 2006, 10.9 per cent of discharges from high-level residential care occurred less than one month after admission and 12.2 per cent of discharges occurred between one to three months after admission.

• **In residential low care, very short durations of care likely to become more common but very long durations of care likely to become less common.**
  - Reflects expected growth in demand for intermittent residential care services.

**Bimodal distribution of durations of residential care likely to become more pronounced – i.e. bunching at the relatively short and relatively long ends of duration spectrum.**
Section 2

Supply side adjustment to changes in demand and cost of service provision
Growth and structural adaptation in service provision (1)

• **Large absolute increases in the level of service provision required in each part of the aged care spectrum.**
  – To meet current planning ratios of places per 1,000 aged persons in 2025, there needs to be an absolute increase of 83,100 low care places and 87,400 high care places.
  – This would be a doubling in the number of places compared to today and is still likely to fall short of demand.

• **Structure of supply will need to shift to accommodate change in structure of demand.**
  – Increased provision of domiciliary care and residential high care; and
  – Increased flexibility to cater for more very long and very short durations of care.
Growth and structural adaptation in service provision (2)

• Providers also need to manage cost pressures due to expected reduced supply of informal carers.
  – Community care particularly affected, as this form of care often relies on the presence of a co-resident informal carer.
  – Reduced supply of informal carers could impose substantial costs on the community care sector. It has been estimated that the cost to replace all home-based informal carers with services purchased from formal care providers would be equivalent to 3.5% of the value of GDP.

• These pressures will be accentuated by competition with the health care sector for specialised staff, notably nurses, which (along with accommodation) are the primary factor in care costs.

Significant innovation and flexibility in service delivery will be needed if structural pressures are to be dealt with efficiently.
Section 3

The role of government
The ideal role of government in aged care

• In an ideal world, the role of public policy would be limited to establishing a framework where market forces could provide individuals with care choices that matched their needs, while also providing an effective safety net for those with little ability to pay.

• Such a framework would likely involve a relatively high degree of service quality regulation, given:

  (a) the frail condition of many beneficiaries; and

  (b) the difficulties involved in relying on market forces alone to regulate service quality in an activity where consumers are poorly placed to voice their concerns or switch service provider.
In practice, the role of government goes well beyond this ideal role

• **Australian governments bear primary responsibility for funding residential aged care and also aged-related community care.**
  – Commonwealth Government has primary funding responsibility for funding residential care and shares funding responsibility for community care with the States.

• **Commonwealth Government extensively regulates care provision beyond what is required to ensure service quality.**
  – E.g. planning ratios control the number, composition and location of care places made available.
  – There are also extensive price controls, as well as means test that are used to determine the extent of the subsidies provided.

• **While there have been significant and welcome reforms in recent years, complex and at times opaque regulatory arrangements continue to impede efficiency and adjustment.**
Government as a source of inefficiency in aged care (1)

• Rationing of places via planning ratios allows Government to manage fiscal risk, but it creates an artificial scarcity that has 4 undesirable effects:
  – It limits the scope for competition;
  – It blunts incentives for innovation;
  – It causes persistent technical inefficiency; and
  – It deprives consumers of choice and creates risks of allocative and dynamic inefficiency.
– Rationing of places allows management of fiscal risk, but also creates an **artificial scarcity** that deprives consumers of choice, limits scope for competition and blunts pressures for efficiency and innovation.

- Since 2000, occupancy levels in residential care facilities have been in excess of 90 per cent for low care and of 95 per cent for high care.

- This means that there are usually very few places open in any particular locality. In 2005-2006, for example, there were (on average) fewer than 3 vacant places each day for every 1000 people aged 70 or over in a third of the 71 aged care planning regions.

– Because choice is restricted, some form of price control is needed to prevent abuse of localised market power:

- In any form of price control, there is a risk that prices will not be allowed to reach levels that cover efficient costs, compromising incentives to invest (at least in high cost locations)

- This can lead to **distortions to the pattern of investment**, with places not being available when and where needed.

– Controls on prices for ‘low care’ residential care are not especially effective – bonds are effectively uncapped and allow a significant income stream into low care

– In contrast, there are important long term issues about the incentives to invest in high care
Bonds in perspective

• In the last three years, the total value of the accommodation bonds held by the residential care industry has almost doubled from $2.7 billion to $5.3 billion

• In 2005-06, more than a third of residents who paid accommodation bonds to secure entry to residential aged care paid a bond worth more than $150,000

• Only 20 per cent of bonds were worth less than $100,000 and almost 20 per cent were worth more than $250,000

• By comparison, the average replacement cost of a residential care place is in the order of $100,000 to $120,000
It is primarily bonds that have supported revenue growth

- **Blue bar chart:** Annual cost of servicing capital debt on a new building (per bed)
- **Yellow line:** Annual income from average bond
- **Green line:** Annual income from maximum accommodation charge
However, growing dependence on bonds creates sustainability issues for High Care

– With some 30 per cent of current non-concessional “high care” residents having paid “low care” bonds, there has been a cross-subsidy, or at least a financial transfer, from “low care” to “high care”, mitigating the impacts of the price controls
  - In 2005-06, only one third of aged care homes that catered predominantly for residents needing high level care (ie, fewer than 20 per cent of residents receiving low level care) did not hold any accommodation bonds.

– Put slightly differently, the financing of high care places depends on the flow of admissions into low care. However, demographic trends suggest demand for low care places will decline in future, at least in relative terms:
  - Growing use of community care will contribute to this trend

– This means we can expect a decline in a key source of funding for high care places just as the need for such places increases.
A better model would have three elements…

1. It would reduce and ultimately remove controls over the number of places.
   This would provide more scope for competition and consumer choice.

2. It would alter the structure of the financial assistance provided by Government so as to make it neutral between the venues in which care is provided (i.e. home, community and congregated living arrangements).
   This would provide further scope for competition and choice.

3. Once the changes brought about by the first two elements have come into effect, and competition becomes a real factor in shaping market outcomes, controls over prices could be eased and eventually eliminated, ensuring efficient providers of aged care could fully recover their costs.
   This would provide scope for efficiency improvements and innovation in service delivery.
Residential high care is a sensible place to start

• Expanding capacity by relaxing controls over the number of residential high care places is a sensible place to start because:
  – We have good reason to expect demand for residential high care will increase due to demographic changes outlined earlier.
  – Liberalising the supply of high-level care places is therefore consistent with what we would observe in an effectively competitive market.
  – Fiscal risk and more generally moral hazard are less of a concern in high care than other forms of long term care.
Community care is a little more complicated…

• Relaxing controls over the number of community care places is more complicated as the risks of moral hazard are greater for community care than for other forms of care.
  – This risk need not prevent an expansion in the number of community care places at the upper end of the care spectrum – i.e. at the levels of disability corresponding the current Extended Aged Care and Home (EACH) packages, which provide high-level care nursing services in the home.
  – Further policy development aimed at managing fiscal risk is needed before substantial liberalisation of community care occurs across the board.

• Over the longer term, however, the “care” available in community and congregated living settings should be allowed to compete.
  – Requires unbundling of the “care” and “accommodation” components of any subsidy, with each component becoming portable.
Section 4

Options for funding aged care costs
Who should finance rising aged care costs? (1)

• The bulk of aged care funding is currently provided by the Commonwealth via consolidated revenue.
  – This means that current taxpayers, who are mainly in the labour force, are paying for the costs of caring for older Australians.

• There is clearly a case on social equity grounds for the community to continue to fund the cost of long term care for older Australians who could not do so themselves.
  – The extent of inter-generational wealth transfer this entails should not be exaggerated as it is also correlated with the preservation of bequests to the heirs of care recipients.
Who should finance rising aged care costs? (2)

- However, the burden on taxpayers and the Commonwealth budget associated with the existing arrangements seems likely to increase sharply over time.
  - Aged care funding currently consumes about 3% of Commonwealth revenues.
  - By 2046-47 it is projected to grow (under current policy setting) to about 9%, assuming Commonwealth revenues remain at their long term average of about 22% of GDP.

- Pressures to reduce this growth and to see more of the cost burden borne by beneficiaries are likely to progressively intensify.
Older Australians are already making a material contribution to aged care costs on a “pay as you go” basis

- 25% of female and male part-pensioners with total income of $30,000 per annum and assessable assets of $160,000 who enter permanent residential low care will face an additional lifetime cost of more than $78,000 and $48,000, respectively.

- 25% of female and male self-funded retirees with total income of $60,000 per annum and assessable assets of $280,000 who enter permanent residential low care will face an additional lifetime cost of more than $153,000 and $94,000, respectively.

- 25% of female and male self-funded retirees with total income of $60,000 per annum and assessable assets of $280,000 who choose to receive permanent residential care on an Extra Service basis will face an additional lifetime cost of more than $257,000 and $157,000, respectively.

These are clearly substantial amounts, even relative to average (much less median) wealth levels.
Increasing the co-payment rate: is it feasible? (1)

• The level of income available to older Australians is an immediate constraint on placing greater share of the cost of aged care on care recipients.
  – Among the population of Australians aged 80 or over, 72% of men and 83% of women have Government pensions and allowances as their main source of cash income.
  – Although older Australians have significant assets, those assets are unevenly distributed and consist mainly of the family home.
  – Securing greater labour income is generally not an option, particularly for the very elderly.

• Market may respond to an increased co-payment requirement for aged care through the future development of financial products that allow consumers to convert relatively illiquid assets into current income.

• Given the portfolios typically held by older Australians, the most relevant product is the reverse mortgage...
Increasing the co-payment rate: is it feasible? (2)

• However, while reverse mortgages are becoming more widespread, there are some significant constraints on their potential.
  – The owner of a portfolio of reverse mortgages may be exposed to correlated risk which limits the loan volumes they will make available and increases the cost of those loans.
  – Reverse mortgages also tend to expose the mortgagee to adverse selection by mortgators who have a high expectation of prolonged tenancy in homes or who are in homes that are particularly vulnerable to price depreciation (or both). In practice, this risk may not be all that great.

A materially higher co-payment rate is therefore unlikely to be feasible in the short term even if it was desirable.
Pre-payment of aged costs via a pure savings scheme (1)

• The risk of incurring long term care costs is significantly, though not entirely, a function of longevity.
  – The longer one lives, the greater the likelihood of needing aged care and, if one lives much longer than one’s cohort, one is likely to need aged care for longer.

• Traditionally, defined benefit superannuation schemes provided insurance against longevity.

• The move away from such schemes to defined contribution schemes has, somewhat paradoxically, removed this form of longevity insurance just as population aging makes longevity risk a matter of great concern.

• Even so, the spread of superannuation (even in defined contribution form) means that more and more Australians will enter old age with some savings that can be used to contribute to aged care costs.
Pre-payment of aged costs via a pure savings scheme (2)

• However, it will be superannuants that bear longevity risk, unless they purchase annuities (to shift the longevity risk to the issuer).

• In any event, annuities are not a panacea.
  – They generally have high loadings and low rates of voluntary take-up.
  – Even if some degree of annuitisation of retirement savings was mandatory it seems unlikely that the amount those annuities could realistically provide for long term care costs.
  – There is likely to be inefficiency in relying on annuitisation of retirement savings to meet long term care costs because there will still be considerable unevenness among the older population in the distribution of long term care use and care duration…
Pre-payment of aged costs via a pure savings scheme (3)

• There is a nearly 50% chance that a woman (32% for men) aged 65 will enter permanent residential care at some time in their remaining life.

• Of those women that do enter such care, the average stay is 3.5 years (2.3 years for men). However, actual durations of care vary considerably.
  – 30% of female residents (46% of male residents) stay for less than 1 year and 14% of female residents (23% of male residents) stay less than 3 months.
  – At the other end of the spectrum, 26% of female residents (14% of male residents) stay for at least 5 years and 6% of female residents (3% of male residents) stay for at least 10 years.

• This implies significant unevenness in the distribution of expected care costs within the elderly population.

A pure saving scheme would either result in savings that were inadequate to cover care costs or in excess of care costs (forcing them to make larger bequests and have lower lifetime consumption than preferred).
Pre-payment of aged costs via insurance (1)

- It would seem more efficient to allow the risk to be pooled through insurance... but does the risk of long term care possess the characteristics required for a risk to be insurable?

- There is no obvious reason why it should not be possible for private insurance markets to offer insurance against long term care costs.
  
  - The event that would be insured is definable. It is possible to determine whether or not the event “a need for long term care” has occurred through assessment instruments that measure disability.
  
  - The losses associated with long term care costs have a probabilistic character. While the likelihood of ever requiring long term care is relatively high, the duration of that care, and hence its costs, varies greatly within the population in ways that are amenable to statistical characterisation.
  
  - Given annual long term care costs of $50,000 or more, the severity of the event should be high enough to induce risk averse individuals to finance the loadings (related to underwriting and administration costs) needed to make an insurance product viable.
Pre-payment of aged costs via insurance (2)

• It is therefore not surprising that insurance products aimed at covering long term care costs exist in a number of countries. Indeed, it was part of the aged care arrangements in Australia up until 1981.

• However, both overseas and past Australian experience suggests that widespread development and take-up of these products is difficult.

• The difficulties seem to stem from three sources:
  1. The complexity involved in devising and properly pricing long term care insurance products.
  2. Demand side constraints on the development and take-up of effective long term care insurance.
  3. Complex transition issues.
Difficulties due to complexity in devising and pricing long term care insurance products (1)

• The risks associated with the need for long term care may **not** be independent (i.e. uncorrelated across the population).
  – Correlated risk limits scope for intra and inter generational risk pooling and means that insurers would need higher reserves.
  – This implies higher loadings or exclusions and therefore reduced demand.

• A narrowly drawn insurance instrument for long term care – e.g. covering only residential high care – would likely be inefficient in the sense that it would perpetuate existing delivery models and stifle incentives to innovate.

• An insurance instrument that covered a wide range of forms of care could be exposed to adverse selection and moral hazard problems.
Difficulties due to complexity in devising and pricing long term care insurance products (2)

- The need for long term care is not just a question of health status but also the availability of informal, and especially spousal, care.
  - There is little experience with the design and assessment of risks relating to family circumstances.
  - This means high loadings, at least initially, and therefore reduced demand.

It remains to be seen whether the insurance industry is capable of generating products that provide reasonable cover for care costs at affordable premiums.
Demand side constraints on development and take-up of effective long term care insurance (1)

- Continued Commonwealth assurance of access to a high quality safety net service through Commonwealth funding of aged care constrains demand for long term care insurance.
  - This safety net has obvious benefits in terms of allowing Government to achieve equity objectives, but it inevitably reduces the incentives for individuals to make provision for themselves.

- There is scope for long term insurance relating to “extra service” care. However, in a means-tested scheme, the availability of Commonwealth subsidy will “crowd out” demand for extra service insurance.
  - This is because the cost to the insured of the extra service care is the sum of the direct cost of that care (as reflected in the insurance premiums and applicable excesses) less the foregone subsidy.
Demand side constraints on development and take-up of effective long term care insurance (2)

- There are also complex behavioural factors that may constrain demand.
  - Potential insureds may be reluctant to purchase insurance if this makes it more likely that their children will place them in long term care (or limit supply of informal care).
  - Those close to or in retirement would face premiums so high that obtaining insurance may be unattractive, if not unaffordable.
  - Long term care insurance most affordable for younger consumers, however young consumers often under estimate the potential value of income claims that are in the relatively distant future by applying hyperbolic discount rates.

For these reasons, voluntary demand for long term care insurance may not be sufficient to make this an attractive market for insurers.
Complex transition issues in moving to situation where greater share of long term care costs covered by pre-payment

- In the transitional phase, the working age population (i.e. taxpayers) could face a “double whammy”:
  - Potential users at material risk of needing long term care in very near future are likely to be effectively uninsurable. This means that their care costs will have to be funded mostly by taxpayers (with some co-payment).
  - At the same time that they are funding the longer term care of older Australians, taxpayers will need to start contributing to whatever pre-payment instrument they intend to use to fund their own eventual use of aged care.

- Greater longevity may ease this problem as it implies that there is a longer period of time separating the current working age population from entry into aged care.

There is a need to manage a period in which there is both a tax burden and a pre-saving burden on the working age population. This may slow the rate of transition to a new funding arrangement.
Section 5

The way forward
The way forward (1)

• The case for progressing reform of aged care arrangements is compelling.
  – Population aging will place the system under great stress.

• Reform needs to protect equity of access and be mindful of fiscal risk, but also provide greater scope for competition, service differentiation and innovation than the current arrangement permits.

• If it is a goal of policy to prevent future tax rates on income earners from having to rise substantially, some savings need to be set aside now to fund future aged care costs.

• Some of these savings can be achieved through Government budget surpluses, but…
The way forward (2)

• There could be efficiency gains if individuals do more to provide for themselves.
  – E.g. by accumulating assets required to self insure against long term care costs or by purchasing financial products that supply that insurance.

• This would provide scope for financial markets to play a much larger role in the future financing of aged care costs.
  – Could make for highly innovative approaches to care provision and better monitoring of care providers (as we now observe in the context of private health insurance).

• Ultimately, however, consumers will have little incentive to provide for long term care costs if they believe the Commonwealth will continue to do so for them.

• This gives rise to a commitment problem:
  If potential beneficiaries doubt the political feasibility of future governments reducing eligibility for care subsidies, they may choose not to insure against these costs, which in turn makes it difficult for future governments to reduce eligibility.
The way forward (3)

• Government could address this commitment problem by pre-announcing policy change with a considerable lead time (e.g. by legislating now to increase co-payment rate in 10 or more years time.)

• From an equity and an efficiency perspective such pre-announcement has much to commend it.
  
  – It would minimise the burden on the current elderly, who have little scope for vary their wealth accumulation and savings decisions.

  – It provides more time for the required savings to be accumulated, which reduces the consumption sacrifice involved.

  – It gives private capital and insurance markets time to develop the products which could assist savings in providing for their long term care costs.

• It is too early to say for sure, but an element of compulsion may be needed to make pre-saving for aged care costs widespread.
The way forward (4)

• The political acceptability of a pre-payment model – an approach that takes advantage of the inventiveness of financial markets – will be greater if accompanied by a genuine expansion in the range of choices available to care recipients.

• Phased liberalisation of the current restriction on the number of places is therefore a sensible element in a move to a system in which consumers have greater financial responsibility but also more choice and more control.
  – Note that phased liberalisation is not the same as complete deregulation.