Actuaries Institute

Aged Care Funding:

Assessing the Options and Implications

GREEN PAPER

DECEMBER 2021



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This paper was authored by Gillian Harrex, Andrew Matthews, Haydn Bernau and Kylie Hogan of Finity.

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1 Executive summary

1.1 Why has the Actuaries Institute released this Green Paper?

The recent Royal Commission into Aged Care Quality and Safety (Royal Commission) highlighted challenges for Aged Care, including how best to fund it. While there are calls for a seemingly never-ending expansion of services, the Government receives many requests for funding, and funding is limited.

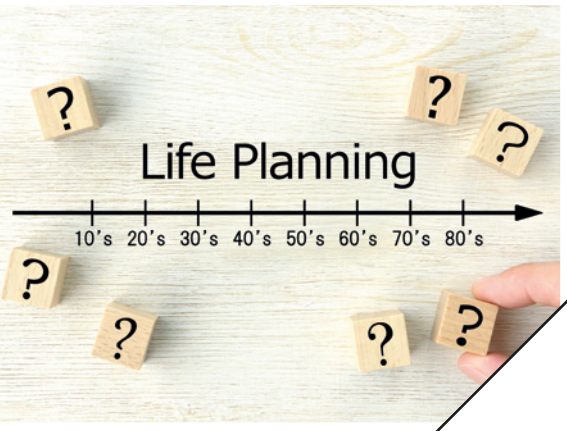
Significant investment currently goes into Aged Care Services, in the order of $32b p.a. (1.6% of GDP), with the vast bulk of this investment borne by the Commonwealth Government. This is forecast to grow strongly in coming decades. This investment (or any shortages of it) impacts staffing, physical resources and the quality of Aged Care services. In this context, it is important to understand the projected long-term costs of Aged Care, to ensure the system is sustainable and fair for current and future generations.

Actuaries have extensive experience in designing, and monitoring for, sustainable funding in a number of sectors, particularly insurance and superannuation, and extending to government funded insurance like schemes.

This Green Paper specifically explore three areas:

1. **Costs:** What are the projected costs of Aged Care over the next 40 years?
2. **Funding:** How can we assess the feasibility and implications of different funding options?
3. **Regulation:** What financial regulations would help enhance Aged Care outcomes?

We began this research with the hypothesis that Australia has a problem with the cost and funding of Residential Aged Care at an individual level, because high uncertainty exists for any individual regarding the amount and duration of paid care they will need and whether that will involve large lump sum payments such as refundable accommodation deposits. However, strong social safety nets such as means testing and provision of an increased number of government supported places help alleviate those pressures. Nonetheless, we acknowledge the complexity of the current arrangements can be a significant burden on individuals and their carers as they navigate the Aged Care system.



Our research indicates that the cost and funding pressures at government and society levels will be significantly greater than currently projected, and that these will be most acute over the coming 20 years due to the safety nets and projected demographic, social and health trends. This is when the Baby Boomer generation is expected to reach extreme old age.

The question of what is a sustainable and equitable sharing of funding between individuals and government requires further investigation. This is particularly so given the anticipated individual asset accumulation in the coming 20 years through superannuation and other investments, many or all of which will have been supported by tax concessions.

1.2 Projecting the costs

The Intergenerational Report (IGR) is one of only a few sources for the projected long-term costs of Aged Care. In this paper we have provided an alternative view and modelling approach to estimate these costs.
When projecting costs we have explicitly not covered services privately funded by consumers, and informal care provided without financial compensation from family, friends and community organisations. While recognising the very material levels of support provided by family members, there is not reliable data readily available to quantify this critical form of support.

In the short term (i.e. over the next two years) we are in a period of rapid growth in Commonwealth Aged Care spending to meet the excess demand for Home Care and Home Support and to improve the quality of Residential Aged Care. Over the long term the key drivers of Aged Care costs will be wage inflation and the ageing of the population.

Our projections find that over the next 20 years, total Aged Care costs are expected to increase from 1.6% to 2.9% of GDP, driven mainly by the current generation of Baby Boomers entering the Aged Care system and requiring services. We project that the Commonwealth's share of these costs will experience 7% annual inflation during the next 20 years, slowing to 5% thereafter. This would likely make Aged Care the fastest growing major line item in the Commonwealth Budget, compared to the IGR's estimate of 5.7% for health and less than 4% for most other areas.[1]

While we have not modelled Age Pension costs for the purposes of this Green Paper, we acknowledge these are projected in the IGR to materially decline, particularly in the medium to longer term. This is important context given Age Pension costs are another key component of expenditure on the Aged.

Costs are projected to grow and will need to be integrated with other policy settings. For example, the potential offset from decreased Age Pension expenditure does not occur until later, and reform in this industry takes time due to large capital investments into long-term construction assets. These conditions make the issue all the more pressing.

Changes are urgently needed given that projections show this is a present problem that will continue to intensify over the next 20 years.

In the short term we are in a period of rapid growth in Commonwealth Aged Care spending to meet excess demand.

1 Noting there is currently significant uncertainty around Defence funding projections.

1.3 Funding

There are three key areas of Aged Care requiring funding - care, support and accommodation (Table 1).

Table 1: Key areas of Aged Care funding

Area of Care	Description	Relevant Programs	Key Funder
Care	Personal care and healthcare costs when incapacitated through illness or injury Personal care – includes assistance with dressing, bathing, hygiene, continence, movement, taking medicines, requiring medical treatment, rehabilitation and eating Complex care – includes nursing, allied health, incontinence aids, custom bedding, mobility aids and palliative care	Home Care Carer Support Residential Aged Care	Government
Support	Building maintenance, cleaning, gardening, laundry and cooking Mobility equipment or home modifications	Home Support Residential Aged Care	Government Individuals
Accommodation	Housing, utilities, bedding and toiletries	Residential Aged Care	Government

There are at least two areas of funding worth further analysis.

The system is complex for all stakeholders. However, our examination of the current funding model concludes that it is sensible, as it demonstrates continuity of the funding principles from earlier in life pre-Aged Care. We note that the current funding structure (although not necessarily the level, detail or mechanics) has been endorsed by the Royal Commissioners and most other commentators.

Two areas remain worthy of further analysis:

1. Should consumers contribute more of their Home Support costs, given that people pay these costs during all other life stages – when they are well, and when they are in Residential Aged Care?[2]

2. Should consumers fund more of their Care costs? The Commonwealth currently funds 96% of Care costs within Aged Care, compared to 75% of broader health care costs.

We have not considered *how* consumers could meet any increased contribution. Options could include greater means testing, requiring consumers to draw on their wealth accumulated through superannuation or housing, or increased taxes. This is a complex and delicate issue, and includes important intergenerational equity issues, worthy of further detailed consideration and a paper of its own.[3]

This Green Paper is a contribution to a considered conversation about funding and future options. The current policy settings are likely to result in significant pressures on the Commonwealth budget over time.

2 Funded either through explicit payment to service providers or implicitly through their own labour.

3 Actuaries Institute (2015) covers all assets and brings a holistic perspective.

1.4 Regulation

Consideration of funding naturally also raises the question of what is the appropriate regulation.

Financial regulation in Aged Care aims to help avoid three problematic outcomes.

1. **Care continuity and quality.** If financial viability of the Aged Care provider is compromised, the care provided by the system typically is interrupted or the quality diminishes, potentially having a devastating effect on the aged population.

2. **Insolvency or insufficient capital.** With insufficient regulation, Aged Care providers may lack the funds to return residents' deposits when they leave care. Currently, in such cases, the Commonwealth Government (i.e. taxpayers) acts as a guarantor and funds the returned deposits.

3. **Burdensome regulation.** Despite the need for regulation, the governance system also needs to be efficient in order to achieve pragmatic solutions while avoiding onerous costs for providers.

Overall financial regulation of the Aged Care system is under-developed. In our view, enhancements to the system can assist in managing for continuity of care and fiscal risk to taxpayers.

We recommend minimum Aged Care system financial regulations should include:

1. **Adequacy and Capital/Liquidity Standards** – A capital standard should be introduced and supplement the existing liquidity standard to enhance providers' financial adequacy;

2. **Forward-looking viability** – The liquidity standard (and future capital adequacy standard) should be strengthened by including a forward-looking component on viability (this would be akin to continuous disclosure for listed companies); and

3. **Visibility and Disclosure** – Disclosure standards would increase visibility and usability to stakeholders (this would be akin to a financial strength rating system adjusted to be fit for purpose). This would likely consist of a strength rating scale developed or audited by an independent party and would include items such as earnings, liquidity, capital adequacy and quality of disclosures.

Regulation is important so that action can be taken before there is a problem. We suggest that a minimum specification approach be taken, where the smallest possible number of rules are defined in the regulatory system. The next steps include building industry capacity and readiness for change.

Regulation is important so that action can be taken before there is a problem, but it needs to be efficiently designed.

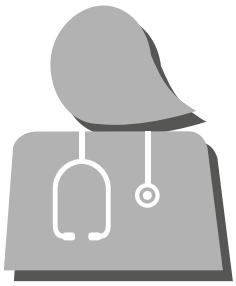


Australia's Aged Care System
at a glance

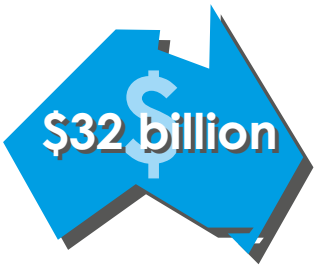
Aged Care is a significant system



1.3 m 'clients' (care recipients)[4]
~5.1% of the population
in 2018-19[5]



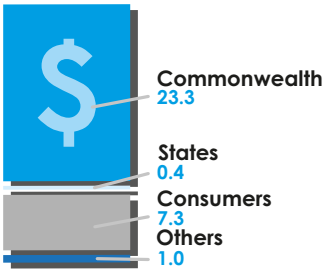
>430,000 workers[6]
~3.4% of the workforce
in 2018-19



Annual funding = 1.6% of GDP[7]

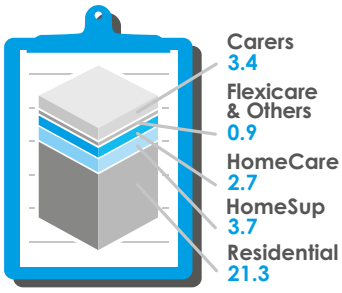
Funding is complex

by source – 2018/19 ($b)



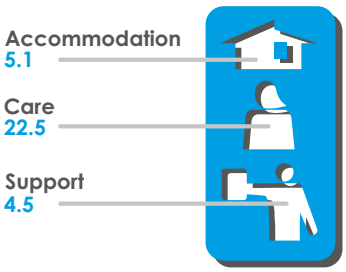
Main funder is the Commonwealth Government

by program – 2018/19 ($b)



Main program is Residential Aged Care

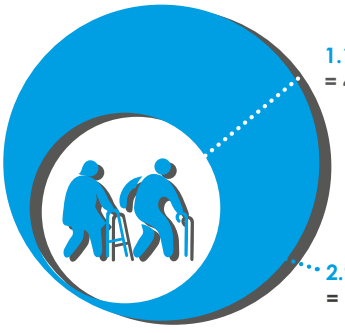
by service type – 2018/19 ($b)



Main costs are incurred by Care

Funding pressures will increase

...due to an ageing population



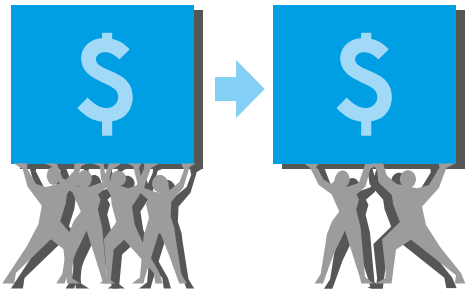
1.1m >80yrs in 2021
= 4.1% of population

2.9m >80yrs in 2065
= 6.8% of population

...and declining public funding base

16.2 workers
per 80y.o. in 2021

9.3 workers
per 80y.o. in 2065



4 Aged Care Financing Authority (2020).
5 Australian Bureau of Statistics (2018).
6 Mavromaras et al (2017).
7 Commonwealth of Australia (2021a), Aged Care Financing Authority (2020) and Commonwealth of Australia (2021e).'

Context and this Green Paper

2

This chapter presents an overview of what is Aged Care, particularly how the various government funded programs interrelate, key dimensions about the sector and the outlook for demand.

Aged Care is a significant portion of Government spending (1.6% of GDP) and is projected to increase over the coming decades. As Australia's population ages and as our Baby Boomers are just now beginning to enter the Aged Care system, urgency is growing regarding the question of how we may best serve the needs of those requiring Aged Care to support them in continuing a life with dignity. The recent Royal Commission highlighted many challenges surrounding Aged Care. In particular, while there seems to be an unending push to expand Aged Care services, funding remains in short supply, especially given the many existing demands on Government funding.



This Green Paper examines the impacts of the growing demand, funding and financing of Aged Care services and the prudential governance required for this important sector. Three focus questions were determined.

1. **Costs:** What are the projected costs of Aged Care over the next 40 years?
2. **Funding:** How can we assess the feasibility and implications of different funding options?
3. **Regulation:** What financial regulations would help enhance Aged Care outcomes?

2.1 Defining Aged Care

Aged Care is a large system of diverse programs and policies designed to support older individuals (generally those eligible for the Age Pension).

Aged Care can essentially be thought of as a continuum, where services vary by intensity of support. Although these services should not be considered additive, the continuum of care and associated levels of support are (see Figure 2.1).

Figure 2.1 – Continuum of Aged Care Services



- Low-level support: Minimal support for select activities (e.g. meal delivery).
- Home support: Assistance with everyday living activities, such as cleaning, laundry, shopping, meals and social participation. Home Support packages are funded by the Commonwealth Government.



In 2018/19, approximately 1.3 million individuals received services from over 3,200 Aged Care providers.

- Home care: Personal care (e.g. help getting dressed, eating, showering and toileting) and health care, including nursing and allied health care. Sometimes this care is provided informally by family and friends (sometimes with Government financial support via its Carer Support program). Other times it is provided by care organisations and funded by the Commonwealth Government's Home Care packages (with a small means-tested contribution from consumers).

- Residential Aged Care: Housing and accommodation (e.g. nursing home, assisted living). Care funded mostly by the Commonwealth Government, while accommodation and living costs are funded by consumers, where they can afford to do so. This includes personal and health care.

2.2 Aged Care dimensions

In 2018/19, approximately 1.3 million individuals received services from over 3,200 Aged Care providers. The National Aged Care Workforce Census and Survey[8] is conducted approximately every four years. The 2016 census (the most recent available at the time of writing) reported the number of paid workers in the Aged Care industry exceeded 366,000, with an additional 68,000 volunteers (note: it is not clear whether this includes support from family members). As of 2019, the costs of the system exceeded $32b (1.6% GDP).

While this already seems like a large population served and supported by a large pool of funding, the Aged Care Royal Commission called for substantial increases in funding to provide additional services based on unmet demand and needs.

The Commonwealth Government provides three main programs.

- **Commonwealth Home Support Programme (CHSP)**: Provides services for those who require basic services to assist with remaining in their own homes. On 1 July 2015, the CHSP was implemented, combining the previous Commonwealth HACC program[9], the National Respite for Carers Program, Day Therapy Centres and Assistance with Care and Housing for the Aged. On 1 July 2016, the HACC Program in Victoria transitioned to the CHSP and on 1 July 2018 HACC services in Western Australia were also incorporated into the CHSP. All States and Territories now operate under the CHSP. In 2018-19 the CHSP provided services to 840,984 Australians.

- **Home Care Packages Program:** Provides services for those who have greater care needs and wish to remain living at home. Care and support are provided through a package of home care services. In 2018/19 services were provided to 133,439 Australians.

- **Residential Care:** Provides accommodation and 24-hour care for those who have greater care needs and choose, or need to be cared for, in an Aged Care facility. Care can be provided on either a temporary (respite) or permanent basis.

Analysis of Australian Institute of Health and Welfare (AIHW) Aged Care data indicates that the percentage of Australians using Residential Aged Care is decreasing for most (but not all) age cohorts. It is anticipated that the trend of a smaller proportion of the population entering Residential Aged Care will continue. Despite the smaller proportion of individuals entering Residential Aged Care, given the growing aged population the sheer number of individuals

The Aged Care Royal Commission called for substantial increases in funding to provide additional services based on unmet demand and needs.

8 Mavromaras et al. (2017).

9 The Commonwealth Home and Community Care program was created on 1 July 2012 following agreement to the transfer of all formerly joint Commonwealth-state/territory HACC programs, except Victoria and Western Australia. All States and Territories have now joined the CHSP.



entering Residential Aged Care will increase. As a corollary, usage of Home Support and Home Care are expected to increase materially in future, both in proportion and number of recipients.

In terms of costs, although 52.9% of elderly consumers utilise At-Home Aged Care services (consisting of both Home Care and Support), the bulk of the service expenses (73.6%) are incurred for Residential Aged Care (see Table 2.1). In contrast, At-Home services accounts for 26.4% of the annual spend (Home Care with 14.2% , Home Support with 12.2%). At-Home services typically are delivered through packages featuring escalating levels of care. It is important to note, however, that although Residential Aged Care services incur a sizeable expense for a relatively small population, it is not possible to reduce costs by simply transferring residential care participants to their homes for home-based care. Such individuals have been determined to require intensive (often costly) care that typically is impractical to deliver in a home setting.

Table 2.1 – Cost and Service Utilisation of At-Home Versus Residential Aged Care Services[10]

	Proportion of Aged Population	Proportion of Total Aged Care Costs
Non-consumers (i.e. healthy aged population 80+)	28.8%	0.0%
Consumers of At-Home Services	52.9%	26.4%
Consumers of Residential Aged Care Services	18.3%	73.6%

An additional part of the landscape is Refundable Accommodation Deposits (RAD) paid by residents to Residential Aged Care providers for their accommodation. These act as a source of funding support.

As an alternative to RADs, residents can choose to pay a Daily Accommodation Payment (DAP), or a combination of a part RAD and part DAP. While this paper is not about capital financing we do acknowledge these as providing implicit funding support.

2.3 Outlook for demand for Aged Care services

The Australian population is in the midst of a long-term ageing trend. ABS data[11] predicts the proportion of the population aged 80 and older (i.e. the bulk of Aged Care consumers) to increase from 4% in 2021 to 7% in 2065. Within the next two decades as the 'Baby Boomer' generation reaches older age, 540,000 Australians will move into the over 85 population, meaning approximately 3% of the nation's total population will be aged.

Peak demand for Aged Care services is anticipated to occur around 2040. Already in recent years, growing demand for in-home care and support packages has led to large waiting lists for care. Announcements from the 2021/22 Commonwealth Budget indicate the Government expects this unmet demand will largely be alleviated over the next two years. This assumes a sufficient workforce is available which is an important consideration in the work of the Aged Care Workforce Strategy Taskforce and documented in Department of Health (2018).

10 Aged Care Financing Authority (2021).

11 Australian Bureau of Statistics (2018).

Projecting costs

3

This chapter presents a picture of the short-term and long-term trends for Australia's Aged Care costs. We also have compared our forecasts to those shown in the Government's 2021 Intergenerational Report (IGR, Commonwealth of Australia 2021d).

Although relatively predictable patterns in the demographics of ageing make it possible to forecast population level demand for Aged Care, financial projections are more problematic and rely upon demand for the different forms of Aged Care assistance.

In the short term we anticipate rapid increases in Commonwealth Aged Care spending to improve the quality of Residential Aged Care and meet outstanding needs for Home Care and Home Support.

Over the long term the key drivers of Aged Care costs will be wage inflation and the ageing of the population.



3.1 Scope of modelling – included and excluded costs

As a starting point, we have assumed the current funding model remains in place, including the increased spending announced in the May 2021 Commonwealth Budget.

Throughout chapters 3 and 4, we have included the following spending in our forecasts, tables and charts:

- Direct financial spending from consumers, the Commonwealth Government and State governments on Aged Care goods and services; and
- An allowance for the annual funding provided by consumers via their RADs. We have estimated the annual funding value provided by these one-off deposits as being equal to their annual DAP equivalent. For example, in 2018/19 Residential Aged Care providers held $30.2b of RADs[12], which implicitly provided $1.8b of annual funding to Aged Care providers when we apply the current legislated Maximum Permissible Interest Rate (MPIR) of 5.95%.[13]

We have excluded the following spending:

- The value of services privately funded by consumers as well as informal care provided without financial compensation by family, friends and community organisations. While recognising the very material levels of

Over the long term the key drivers of Aged Care costs will be wage inflation and the ageing of the population.

12 Aged Care Financing Authority (2020).

13 Commonwealth of Australia (2021e).



support provided by family members, they do not form part of the actual spend. Moreover, reliable data is lacking to quantify this critical form of support; and

- Indirect government funding to maintain and improve the Aged Care system (e.g. regulation, quality assurance, consumer support, legislation and policy-making). These costs will be included as part of recurring government expenditures.

The 2018/19 figures below therefore correspond to figures provided by the Royal Commission, with the following exceptions:

- Our figures include recognition of RAD funding totalling $1.8b; and
- Our figures exclude indirect funding of $0.5b on assessment and information services, residential care capital and Aged Care quality.

3.2 Historical costs – last five years

Table 3.1 shows the historical Aged Care costs by program for the most recent five financial years available (2014/15 - 2019/20) at the time of writing.

Table 3.1 – Historical Aged Care Cost by Program ($b)[14]

Program	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Average inflation last five years
Residential Aged Care (explicit funding)	16.2	17.4	17.7	18.1	19.5	20.6	5%
Residential Aged Care (implicit additional funding via RADs)	1.2	1.4	1.4	1.6	1.8	1.6	6%
Home Care and Flexicare	2.0	2.2	2.4	2.8	3.3	4.3	16%
Carer Support	2.9	3.1	3.2	3.3	3.4	3.7	5%
Home Support	1.6	1.8	2.7	2.9	3.7	3.6	19%
Total	**23.9**	**25.9**	**27.4**	**28.8**	**31.7**	**33.8**	**7%**

Total spending has increased materially over the last four years at an annual rate of 7%, driven particularly by a 19% per annum increase in Home Support costs and a 16% per annum increase in Home Care and Flexicare costs. These programs have been progressively servicing a larger number of the aged population as they expand supply to meet the excess demand. While the further expansion planned in the next two years is an effort to completely satisfy demand, there may continue to be a backlog and it relies on the workforce being expanded in a relatively short period of time.

Although explicit spending on Residential Aged Care reduced from 68% to 62% of the total spending over the last four years, this type of care remains by far the largest component of Aged Care spending. Moreover, as shown in Table 3.1, spending on Residential Aged Care increased at a rate of 5% per annum, made up of 4% cost inflation (wage inflation of about 2% plus additional investments in care and accommodation) and a 1% annual increase in the number of residents.

Implicit spending on Residential Aged Care via RADs has increased at 6% per annum. This is attributable to the increases in RAD size. Not only did residential properties increase in value by 3% per annum over the period [15]

14 Productivity Commission (2016 – 2021), Department of Social Services (2015 – 2020), Aged Care Financing Authority (2016 – 2021), Commonwealth of Australia (2021e).

15 Australian Bureau of Statistics (2021).

but quality improvements and increased number of residents account for the remaining 3%.

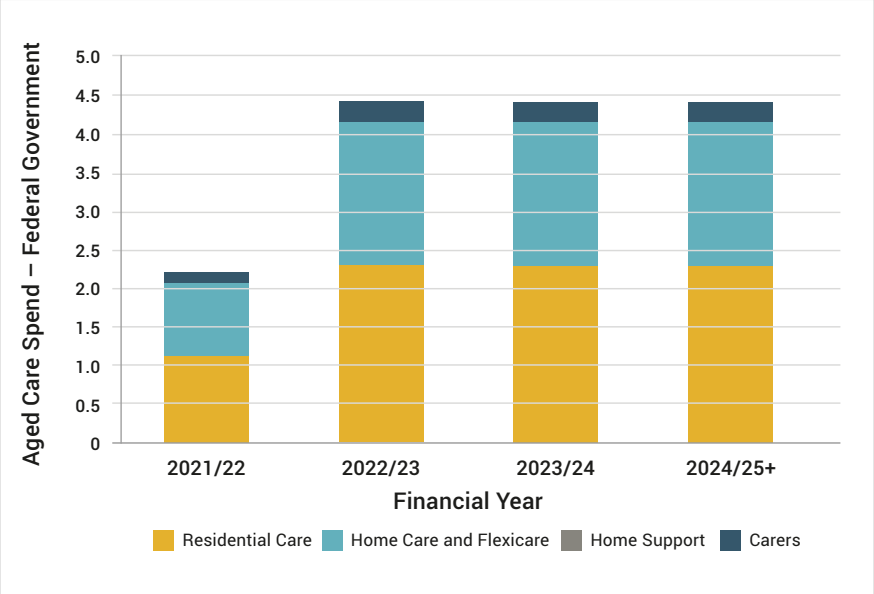
Carer Support spending increased 5% per annum on average. Unlike Home Care and Home Support, we understand there have not been material waiting lists for Carer Support over the period therefore none of the inflation relates to meeting excess demand. The annual increase is probably attributable equally to wage inflation and increased usage.

3.3 Additional spending measures in May 2021 Commonwealth Budget

The Commonwealth Budget measures announced in May 2021 include approximately $17.7b in additional funding over the next four years. Of this, $15.4b for direct spending on Aged Care programs is included in our modelling while the remaining $2.3b is excluded because it relates to quality and monitoring.

The majority of the $15.4b phases in over two years, and relates to Residential Aged Care and Home Care. The planned ongoing new spending from FY25 onwards is $4.4b per annum. (See Figure 3.1.)

Figure 3.1 – Expected additional Commonwealth Government Aged Care spend by program ($b)[16]



Increased spending in Residential Aged Care largely will be allocated to two purposes:

- Increased access to personal and nursing care, given a new legislated minimum average of 200 minutes of care per day; and
- Improved day to day services, including an additional $10 per day supplement for the Basic Daily Fee. This constitutes an increase of 18% for services such as meals, cleaning, facilities management and laundry.

The increased spending in Home Care is mostly attributable to the program's increased scale given that 80,000 new home care packages have been funded.

There is a significant step up in Aged Care funding in the short term.

16 Source: Commonwealth of Australia (2021b and 2021c). Budget 2021-22 Papers No.1-2. https://budget.gov.au/2021-22/content/documents.htm



3.4 Projecting future costs – methodology and assumptions

To project future costs for Aged Care we:

1. Use the 2018/19 and 2019/20 spending figures as our base or starting point;
2. Add the additional spending measures included in the May 2021 Commonwealth Budget;
3. Apply inflation to average costs per Aged Care consumer;
4. For demographics model the population numbers and morbidity by age in future years using a cohort modelling approach; and
5. Allow for shifts in preferences for Home Care over Residential Aged Care and for future increases in wealth levels of Aged Care consumers (more will be above means-test thresholds).

Inflation of average costs per consumer

The following table summarises our central estimate inflation assumptions, and plausible higher cost and lower cost assumptions. The appendices provide further details on each item.

Table 3.2 – Inflation Assumptions

	Central Estimate	Plausible lower	Plausible higher
Core inflation assuming steady-state population			
Services inflation - wage inflation for carers and staff (92.5% of total aged care costs)	4.0%	3.5%	4.5%
Goods inflation, including accommodation and equipment (7.5% of total aged care costs)	2.5%	2.0%	3.0%
Weighted average inflation for a steady-state population	3.9%	3.4%	4.4%
Additional impact of changes in population, morbidity and preferences			
Ageing of the population and migration	2.5%	2.1%	2.8%
Morbidity trends	-0.1%	-0.7%	0.4%
Consumer preferences shifting from residential to home care	-0.1%	-0.3%	0.0%
Total	**6.1%**	**4.4%**	**7.6%**

If our population was in a steady-state – i.e. if there was no change in the number of people at each age, no change in morbidity and no change in consumer preferences for Home Care versus Residential Aged Care – then annual inflation in Aged Care costs would be close to wage inflation (assumed to be 4%, in line with IGR wage assumptions), as most of the costs (92.5%) are care services.

However, we are not in steady state. The following three factors impact future inflation.

1. Our population is ageing. Based on ABS projections, we estimate ageing to contribute a further 2.5% per annum to inflation – 3.4% per annum over the next 20 years as the large Baby Boomers population ages and requires care, and 1.4% per annum thereafter.

2. We assume a 'shift to the right' morbidity scenario, where the number of years of care requirements for an average person remains unchanged, but the period of care starts and ends two years later, by the end of the 40 year projection period. This reduces annual inflation by about 0.1%.
3. Consumer preferences are changing. The current trend away from residential care and towards home care is reducing system inflation. In our central estimate we have assumed this reduces inflation by 0.1% per annum[17] over the 40-year projection.

We have also included plausible lower and higher scenarios for each inflation factor. Individually these scenarios are seen to be 'quite plausible' however when added together the total amount could be described as 'just plausible', as it is unlikely that all these factors would move in one direction at the same time. Overall, these scenarios show a 'just plausible' range of inflation outcomes for Aged Care spending of between 4.4% and 7.6% per annum over the next 40 years (compared to assumed GDP growth of 5% per annum, consistent with the 2021 IGR). Further details are provided in the Appendix.

Projections suggest that the dollar amounts of Aged Care spending are likely to increase significantly over time.

3.5 Estimated future costs – central estimate

Our projection generates the following estimates of future Aged Care spending, noting that there is much uncertainty around the assumptions and that actual outcomes will likely vary materially from projected outcomes.

Table 3.3 – Future Aged Care Cost by Program ($b)

Program	2018/19	2023/24	2029/30	2039/40	2049/50	2059/60	Average inflation 2023/24+
Residential Aged Care (explicit funding)	19.5	22.5	32.9	63.2	106.0	164.4	6%
Residential Aged Care (implicit additional funding via RADs)	1.8	2.0	3.3	7.6	15.2	28.0	8%
Home Care and Flexicare	3.3	11.8	18.4	36.7	65.3	113.4	6%
Carer Support	3.4	5.7	8.7	16.6	28.1	45.9	6%
Home Support	3.7	5.7	8.8	16.4	27.1	43.3	6%
TOTAL	**31.7**	**47.6**	**72.0**	**140.5**	**241.7**	**395.0**	**6%**
GDP	**1,952.2**	**2,356.3**	**3,157.7**	**5,143.6**	**8,378.3**	**13,647.4**	

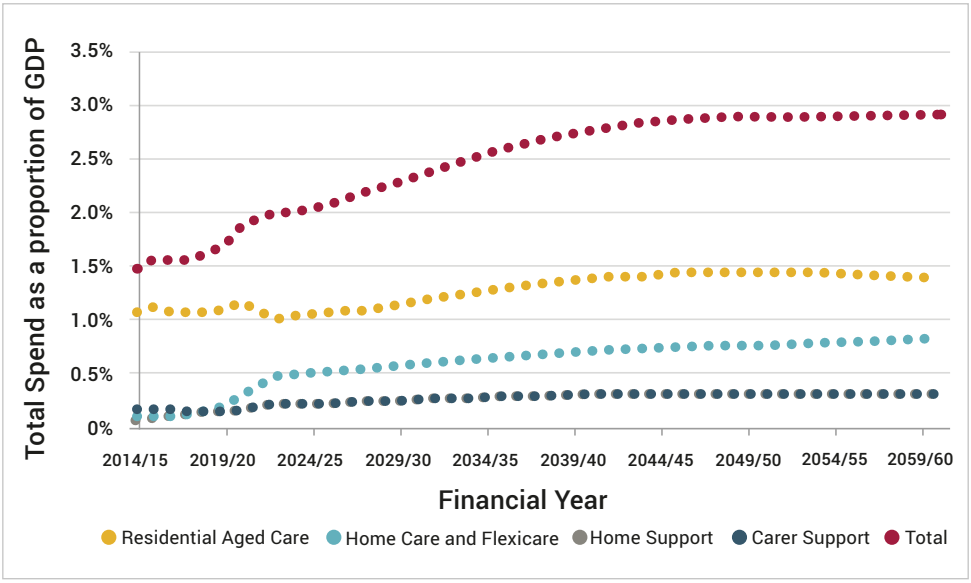
Overall Aged Care inflation is projected at about 6% per annum. By 2060/61, spending on Home Care could be approaching similar levels to Residential Aged Care, despite being only one-sixth of the size in 2018/19, and being projected to be half the size in 2023/24 after allowing for the recently announced Budget spending.

Our projection suggests that the dollar amounts of Aged Care spending are likely to increase significantly over time, due mainly to cost inflation and the ageing of the population. However, Australia's GDP (and therefore our capacity as a nation to afford these costs) is also expected to increase over time – we have assumed nominal GDP growth of 5% per annum, consistent with the 2021 IGR. In the remainder of this chapter we express projected Aged Care costs as a proportion of GDP in order to understand changes in our ability to 'afford' or fund those costs.

Figure 3.2 summarises the results of our projections expressed as a proportion of GDP.

17 The -0.1% takes into account the drop in average costs from Residential to Home Care, offset by 'frailty inflation' in both settings as the average care needs in each setting will increase. Lower care people will leave Residential Aged Care, and they will on average have higher care needs than the average Home Care consumer.

Figure 3.2 – Aged Care spend by program as a proportion of GDP



Total spending is projected to increase from 1.6% of GDP in 2018/19 to 2.9% of GDP in 2040/41. From 2045/46 to 2060/61 we are projecting costs to be stable as a percentage of GDP at about 2.9%, implying total inflation in line with projected GDP growth of about 5% per annum. The rapid growth in projected spending from 2024/25 from 2045/46 is due to demographics – this is the period when Baby Boomers will be requiring Aged Care.

There are some significant 'shocks' between 2018/19 and 2022/23.

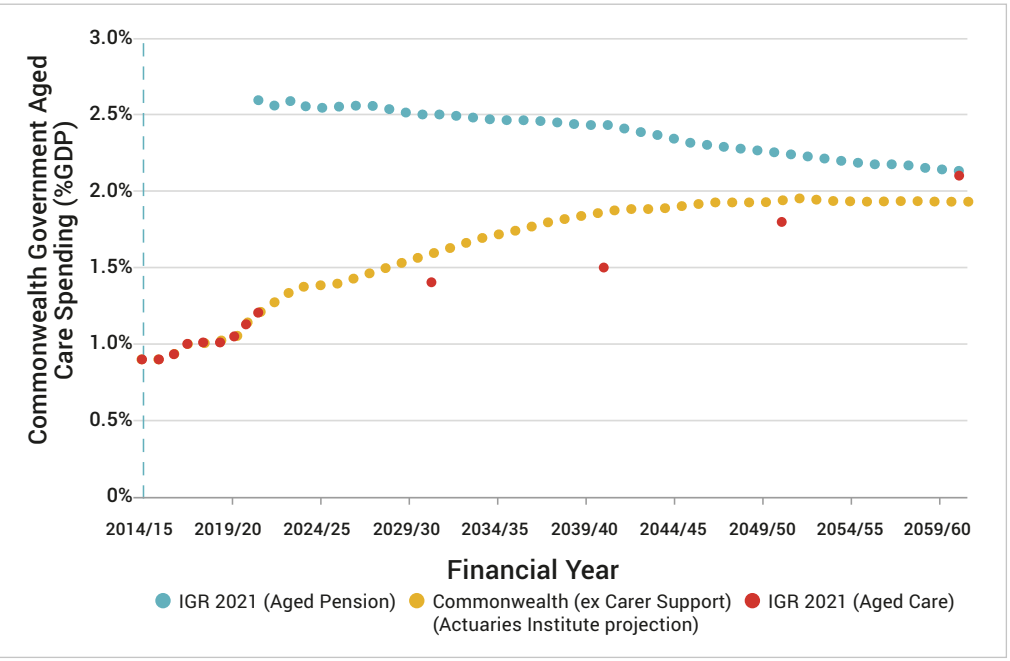
- From 2018/19 to 2020/21 spending increased from 1.6% of GDP to 1.9% of GDP, with the Commonwealth funding additional Home Care packages, and with increased uptake of Residential Aged Care.
- From 2020/21 to 2022/23 spending is projected to further increase to 2.0% of GDP, with the implementation of Budget announcements, mainly due to an additional 80,000 Home Care packages being funded. We assume some offsetting savings due to a substitution away from Residential Aged Care to Home Care for half of those 80,000 places given the preference for the latter.
- In the longer term, from 2022/23 to 2040/41, we project steady increases in total Aged Care spending of about 0.1% of GDP every two years, driven by the ageing of the population and the Baby Boomers entering Aged Care.
- We project Residential Aged Care costs to peak as a percentage of GDP in the 2040s, after which time our assumed consumer preference for Home Care has a stronger downward influence on costs, compared to the ageing of the population[18].
- Home Care, on the other hand, could be expected to continue to grow faster than GDP growth of 5%, due to the combination of demographics and the preference for Home Care. Indeed, it is conceivable that Home Care could become a bigger and more costly program than Residential Aged Care either within the next 40 years or soon thereafter.

18 Over the past five years the number of people entering Residential Aged Care as a proportion of those aged 80+ has been reducing. We have assumed that trend will continue at half the current rate over the next forty years (after the adjustments for the May 2021 Budget). However, even with this allowance, the number of people entering Residential Aged Care is still expected to increase year on year due to the greater number of people expected to be in this age cohort.

- Home Support and Carer Support have very similar projected costs to each other – their lines in Figure 3.2 are almost the same (and therefore largely indistinguishable in the Figure). The programs show some growth as a percentage of GDP, with costs for each program projected to finish at 0.3% of GDP in 2060/61.

We have compared our projections to those of the 2021 IGR (Aged Care and Age Pension) in Figure 3.3, stripping out the implicit RAD funding and Carer Support spending to match the scope of the IGR projection.

Figure 3.3 – Commonwealth Government Aged Care spend (ex Carer Support and implicit RAD funding) as a proportion of GDP compared to 2021 IGR Aged Care and 2021 IGR Age Pension



Our projection has a different shape to the IGR Aged Care projection, with a steeper rate of growth in the first 20 years, and flatter in the subsequent 20 years. While our modelling is similar to the IGR's in terms of demographics, and both include a substitution from Residential Aged Care to Home Care, the differences are likely attributable to the following three factors.

- In the first 10 years, the IGR Aged Care projection includes the four-year Budget forward estimates, plus some modelling at a component level from year 4 to year 10. Our modelling begins from year 1, projecting higher costs than the Budget estimates.

- From year 20 to year 40, our model has slightly lower inflation assumptions. We have assumed 3.8% inflation, after including shifting consumer preferences. The IGR assumes 4.5%, which is the sum of CPI inflation, demographic factors and non-demographic factors (which are calibrated to historical trends in Aged Care expenditure in excess of CPI and demographics). However, the two figures do not compare 'apples with apples'. To make easy comparison possible between our projections and that of IGR, we would need to add an additional 0.3% inflation to account for increased costs ('frailty inflation') in moving an individual from Residential Care to Home Care. The result would be an inflation figure of 4.1% compared to the IGR's 4.5%.

Funding is likely to be significantly higher in the coming 20 years than currently assumed.

- We also allow for a 0.1% reduction in inflation due to morbidity occurring later in life. The IGR Aged Care projections do not account for changes in morbidity.

We make the following additional observations.

- Due to the differences in modelling approaches in the short to medium term, the gap between the two Aged Care curves may represent the potential short fall in Commonwealth Government funding. At 2040/41 this gap is almost 0.4% of GDP, which represents about $9 billion in 2020/21 dollars.

- Government spending on the Age Pension is expected to reduce over the next 40 years, although most of the decline is projected to occur in the latter part of this period. In the long-term, by the end of the 40 year projection period, this reduced expenditure on the Age Pension will help offset the greater upward pressure on Aged Care expenditure; in the first 20 years of the projected period the offset is limited.

- This also indicates that we expect older Australians to have higher levels of wealth in the future, some of which could be used to fund the projected higher Aged Care costs (see Chapter 4 for further discussion).



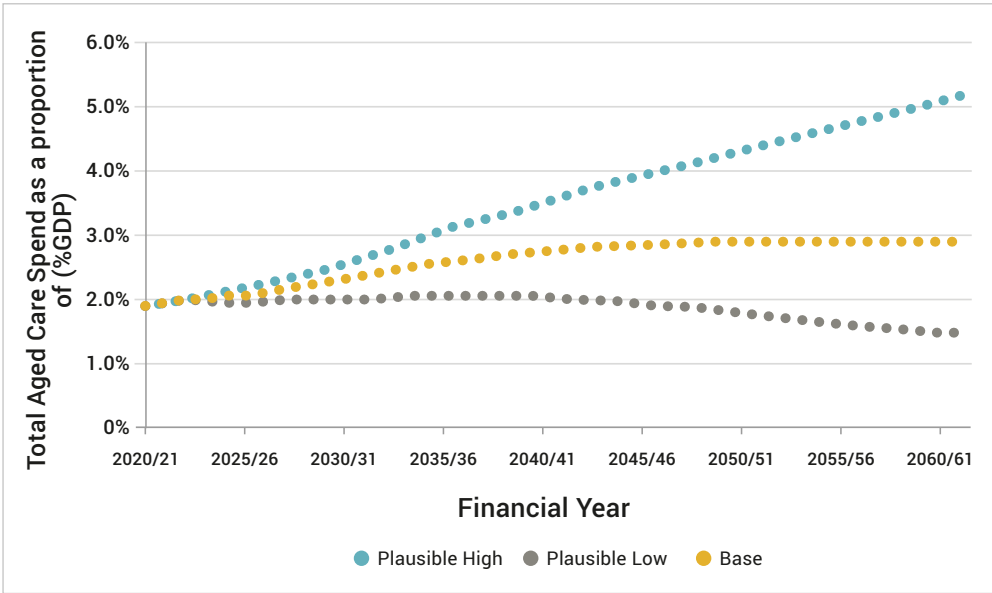
3.6 Sensitivities

Figure 3.4 shows a fairly wide 'just plausible' range of outcomes in 2060/61 – assuming the current funding arrangements remain in place. The 'plausible lower' outcome is 1.4% of GDP in 2060/61, and the 'plausible higher' outcome is 5.2% of GDP. However, 40 years is a long time to extend a sensitivity calculation, because positive or negative influencing factors are unlikely to persist consistently for such a length of time. Thus, it is probably more relevant to take the figures from 20 years from now which give a 'just plausible' range of 2.0% to 3.6% of GDP.

Older Australians are likely to have higher levels of wealth in the future, some of which could be used to fund the projected higher Aged Care costs.

The 'plausible lower' outcome is based on 4.2% inflation, lower than nominal GDP growth of 5%, which creates a downward sloping cost curve. Such a favourable outcome could be driven by low wage inflation relative to GDP growth, different net migration patterns, higher mortality, shortening periods of elderly morbidity, and/or a strong shift in preference for Residential Aged Care into lower-cost Home Care. The 'plausible higher' outcome is based on 7.6% inflation driven by higher wage inflation, lower mortality and longer periods of elderly morbidity.

Figure 3.4 – Aged Care spend by type as a proportion of GDP



3.7 Summary

The projections discussed in this chapter highlight the challenge facing Australia. Over the next 20 years, total Aged Care costs are expected to increase from 1.6% to 2.9% of GDP, driven mainly by the current generation of Baby Boomers entering the Aged Care 'system'. We project that half of the increase in funding will come from demands for Home Care, as consumer preferences shift away from Residential care toward desires for in-home support. The offset from reduced Age Pension expenditure is modest in that period. The next chapter examines how the imminent increased costs might be funded.

Almost half of the increase in future funding will come from demands for Home Care.



4 Funding

This chapter analyses the current Aged Care funding model and identifies and evaluates other funding options. To facilitate this, we have categorised Aged Care spending into three key areas: care, support and accommodation. Individuals require these type of services to differing extents, throughout their lifetime. Table 4.1 compares how these care needs are funded for three populations: the general (healthy) aged population, at home Aged Care recipients and Residential Aged Care recipients.

Table 4.1 – Funding for Aged Care

Key areas	Description	Programs	Funder by Setting		
			General population	At-home care population	Residential Aged Care population
Care	Personal care and healthcare costs when incapacitated through illness/injury and where insufficient unpaid informal care is available from friends/family • Personal care – dressing, bathing, hygiene, continence, movement, taking medicines, medical treatment, rehabilitation, assistance with eating • Complex care – nursing, allied health, incontinence aids, custom bedding, mobility aids, palliative care	Home Care Carer Support Residential Aged Care	Government is primary funder, via Medicare and other support payments User* is secondary funder (e.g. out-of-pocket expenses above Medicare fees, private health insurance claims)	Government is primary funder, via Home Care and Carer Support User* is secondary funder (private arrangements and informal care)	Government is primary funder of Residential Aged Care User* is secondary funder (pay a small proportion of care fees, subject to means test)
Support	Building maintenance, cleaning, gardening, laundry and cooking Mobility equipment or home modifications	Home Support Residential Aged Care	User*	Government is primary funder User* is secondary funder (private arrangements and informal support)	User*
Accommodation	Housing, utilities, bedding and toiletries	Residential Aged Care	User*	User*	User*

** User pays (or carries out the services themselves) where they have the financial means to do so. Otherwise, the Government steps in via means-tested social security or Aged Care payments*

We make a number of observations.

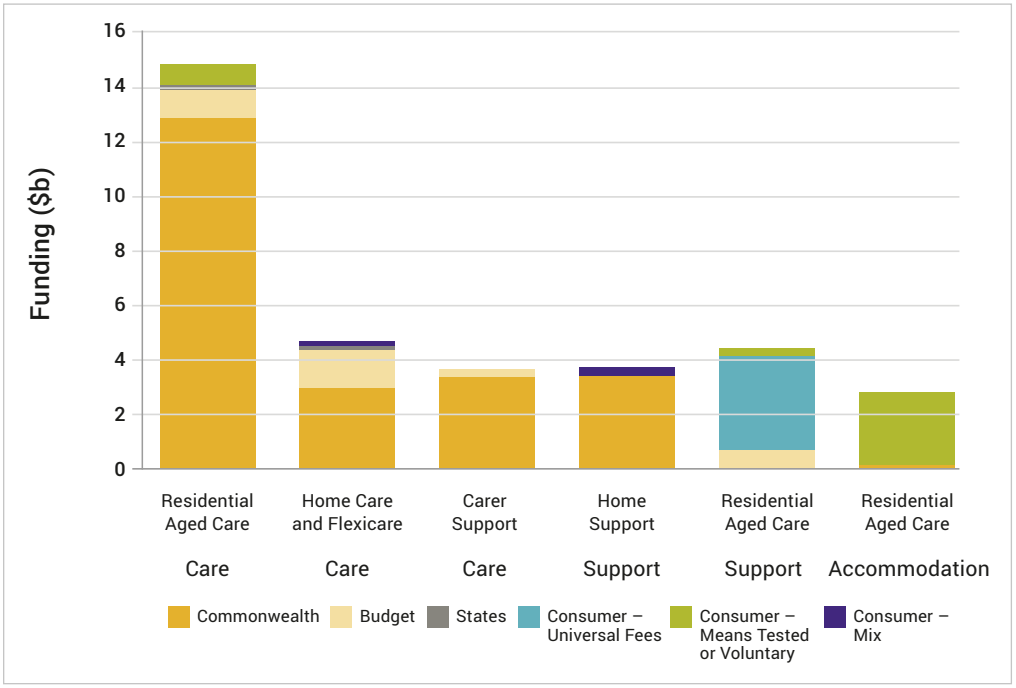
- The progression of who funds 'Care' costs for those who are unable to care for themselves appears to be logical. The Government consistently offers publicly funded care throughout each person's lifetime (although the percentage covered by Government is high relative to health care for example, discussed later in the chapter).
- The funding progression for 'Support' costs appears worthy of further analysis, as the Home Support phase is the only time in an individual's lifetime where they do not fund their own Support costs (discussed later in this chapter).
- The funding progression for 'Accommodation' costs appears logical – no matter one's life stage or circumstances, each individual is expected to cover these costs (supported by Government social security payments as needed).



4.1 Current funding by program

Figure 4.1 shows the break-down of the $33.9b directly spent on Aged Care in 2019/20, by program and by funder. This includes the base costs mentioned earlier plus an allowance for the expected future spend announced in the 2021 Budget.

Figure 4.1 – Annual Aged Care Funding (by program) – FY19 costs plus Commonwealth Budget commitments (converted to FY19 dollars)



There are a few points of note.

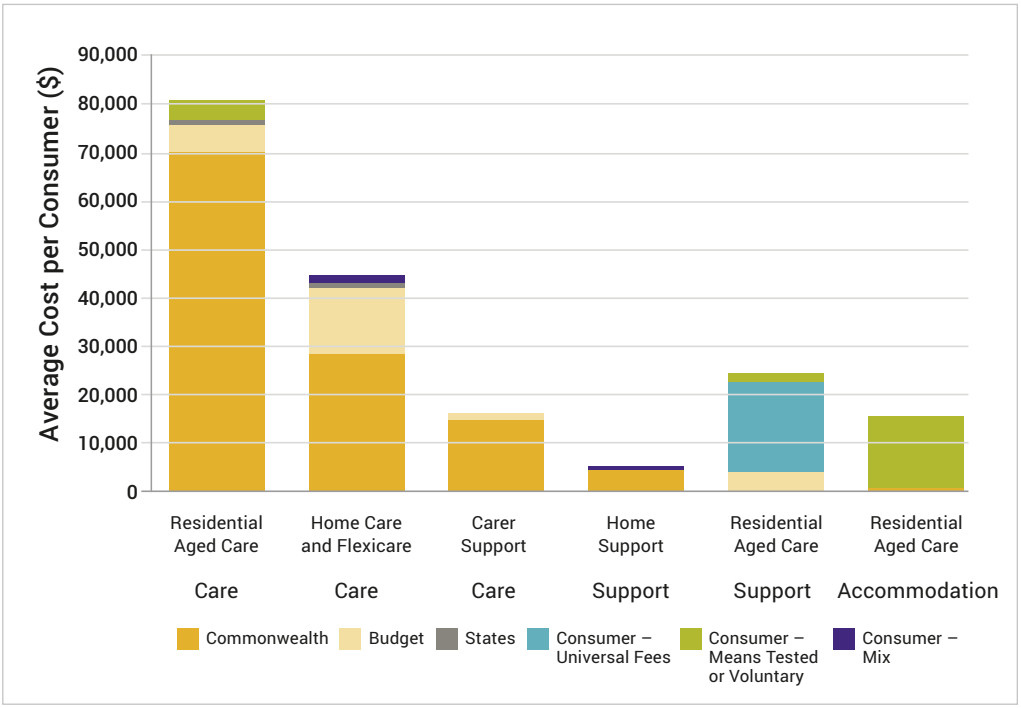
- The Commonwealth is the primary funder of Care costs (first three columns), and of home-based 'Support' costs (fourth column).
- Until the recent Budget consumers were the sole funders of Residential Aged Care Support costs with a Basic Daily Fee of 85% of the Age Pension.

The Commonwealth will in future 'top up' this amount in order to ensure a higher quality of support services.

- About 85% of consumers fund their Residential Aged Care Accommodation costs through a means-tested RAD or a DAP (included in the above). For those who are not able to pay, they enter Residential Aged Care as 'supported residents', in the first instance funded by providers. However, if providers have more than a certain proportion of supported residents, the Commonwealth pays an amount in compensation.

Figure 4.2 shows the average annual costs for a consumer using each program.

Figure 4.2 – Annual Aged Care Funding (per consumer using each program)



The Care aspect of Residential Aged Care is costly, at around $80,000 per annum per person, and is mostly funded by the Commonwealth. The cost of Care is around $45,000 per annum per person for those receiving Home Care packages. While it is likely it is cheaper to provide care for people in their homes, the difference in costs is not as large as it first appears. On average people in Residential Aged Care are less able to care for themselves than those in Home Care, which likely explains a large portion of the difference in costs.

While it is likely to be cheaper to provide care for people in their homes, the difference in costs is not as large as it first appears.

Consumer costs are modest in the current funding system and are unlikely to place users of Aged Care programs under financial strain or burden and it is only in Residential Aged Care where significant amounts may be required from consumers. Support costs are compulsory, but affordable, for everyone at 85% of the Age Pension (given that other costs are minimal once a person is in Aged Care). Accommodation costs are means-tested, and completely covered by the Commonwealth for the 20% of consumers with lowest means. For those who do pay accommodation costs, they are generally the same or lower cost than normal accommodation costs of owning or renting a small house or apartment in the same area as the residential facility. Residential care costs for consumers are for the most part means-tested, as are any consumer contributions to Home Care and Home Support.

Figure 4.3 – Spending as % of GDP

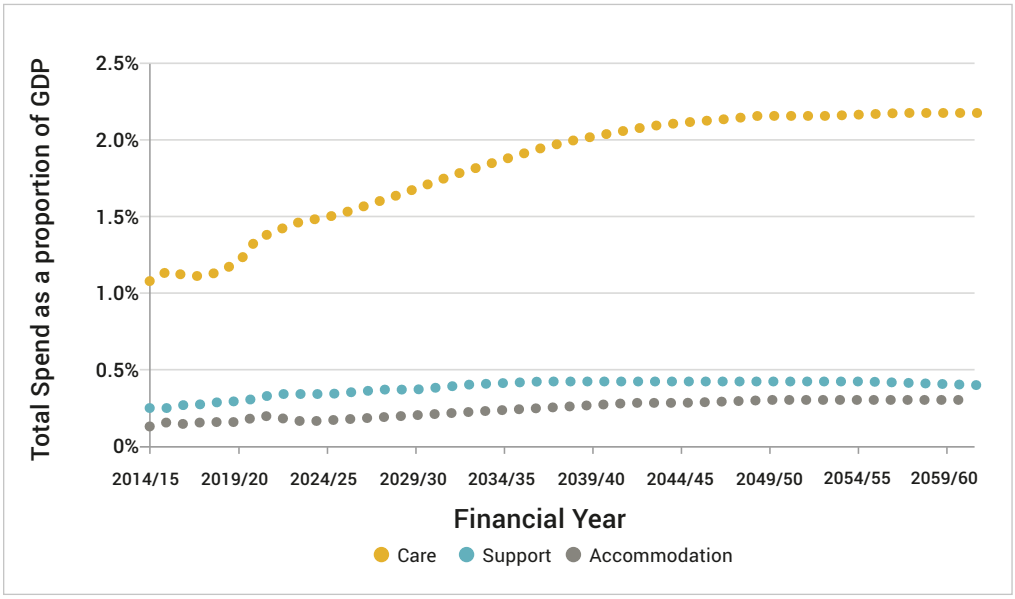
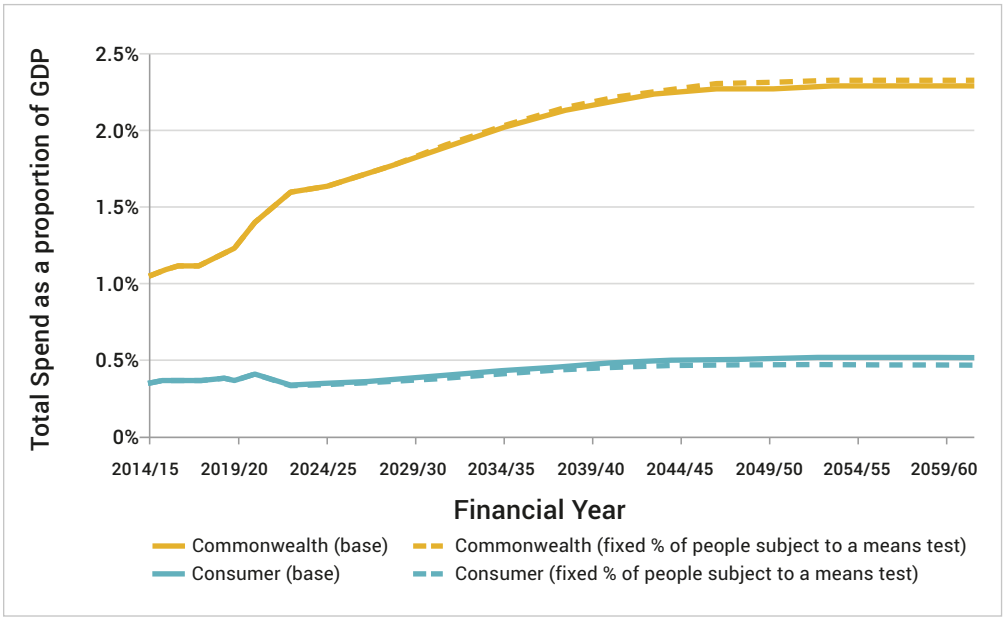


Figure 4.3 shows relatively modest growth in Support and Accommodation costs over the next 40 years, but it is the almost-doubling in Care costs (largely funded by the Commonwealth) that explains about 80% of the overall system increase. Care costs are projected to increase from 1.1% of GDP in 2018/19 to 2.1% of GDP in 2040/41.

4.2 Commonwealth and consumer cost sharing

Our projections show consumer contributions remaining fairly steady over time as a percentage of GDP – increasing from 0.4% in 2018/19 to 0.5% of GDP in 2060/61 (Figure 4.4). One reason for this is the projected continued shift from Residential Aged Care (where consumers make significant funding contributions) to Home Care (where consumers make minimal contributions).

Figure 4.4 – Total Aged Care spend as % of GDP



Changes to means tests could be considered.

It is the Commonwealth Government (and thus Australian taxpayers) who are projected to bear the majority of the extra costs, mainly because they are the primary funder of the rapidly increasing care costs. Total Commonwealth Aged Care spending is projected to increase from 1.2% of GDP in 2018/19 to 2.1% of GDP in 2040/41, implying annual inflation of 7% per annum in that period. This would likely make Aged Care the fastest growing 'line item' in the Commonwealth Budget, compared to the IGR's estimate of 5.7% for health and less than 4% for most other areas.

A relatively small proportion of overall Aged Care costs paid by consumers are subject to means tests. Therefore, changing the strength of the existing means tests would only make a marginal change to the overall costs for consumers and the Commonwealth.

In this chapter we have assumed that the means test thresholds remain the same in real terms as they are today. The implication is that as the coming generations enter Aged Care with more accumulated wealth via compulsory superannuation savings, a higher proportion of them will be subject to the means tests and pay their own contributions, reducing the cost to the Commonwealth[19,20].

An alternative scenario would be to assume that the means test thresholds will increase faster than wage inflation, in order to keep pace with the rising wealth of future generations and so that the same proportion of Australians pay their own way in Aged Care into the future.

Figure 4.4 shows, however, that tightening these existing means tests will make little difference. If the Commonwealth wished to materially increase the consumer share of spending, it would need to create new means tests covering larger areas of spending.

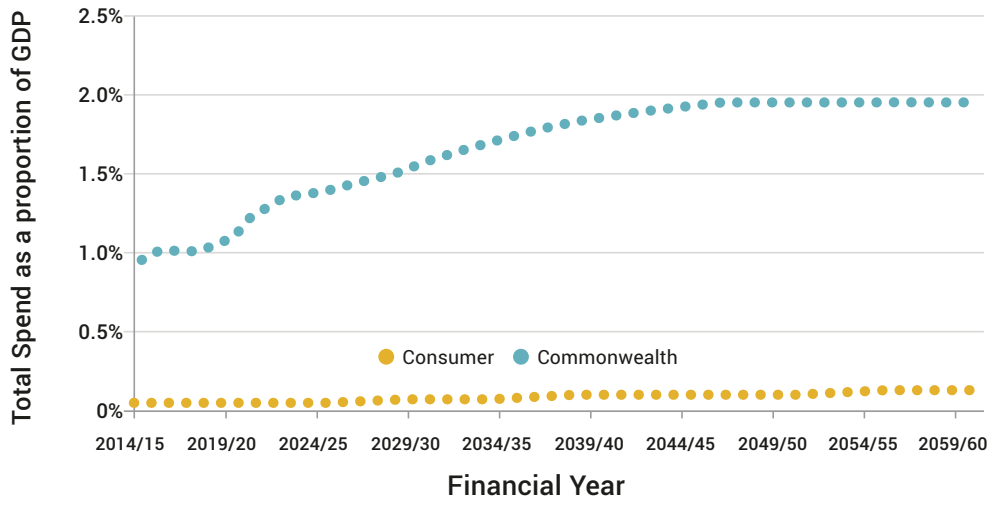
19 The Treasury (2020).

20 Actuaries Institute (2015).



4.2.1 Care funding scenarios

Figure 4.4 – Funding projection, Care



The Commonwealth funds about 96% of Aged Care 'Care' related costs and is projected to face large funding increases over the next 20 years.

Alternative options

The Commonwealth's 96% share is very high when compared to the proportion for the general population. The Commonwealth and State governments cover about 75% of all healthcare costs, via Hospitals, Medicare, the Pharmaceutical Benefits Scheme and other programs. The remaining 25% of health costs is funded by consumers through out-of-pocket expenses (16%) and private health insurance refunds (9%).

The Commonwealth could explore options to increase the consumer share from its current level of 4% through means-tested co-payments or privately funded (or privately insured or privately topped-up) Aged Care provision. This may become a more realistic option as the pool of Australians with significant savings for retirement grows. This is indicated in the Institute White Paper, *For Richer, For Poorer*[21], which shows the retirement income system is accumulating assets to fund adequate retirement income and is reducing dependence on the Age Pension. Further papers by the Institute[22] focus on retirement income needing to have high income efficiency in that tax-concession funded superannuation savings should be able to support a reasonable level of income and consumption in retirement, avoiding and discouraging the extremes of frugality or leaving of non-trivial bequests. Without pre-determining an answer this is an option for further exploring.

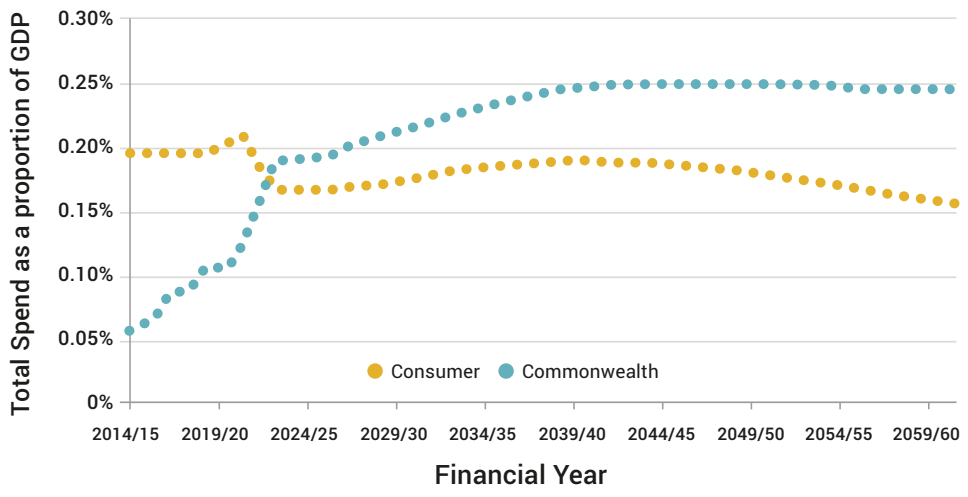
The Commonwealth could also explore the economics of investing further in Home Care and Carer Support, to reduce the number of people who move into the more expensive Residential Aged Care.

21 Actuaries Institute (2015).

22 Actuaries Institute (2021a, 2021b and 2021c).

4.2.2 Support funding scenarios

Figure 4.5 – Funding projection, Support



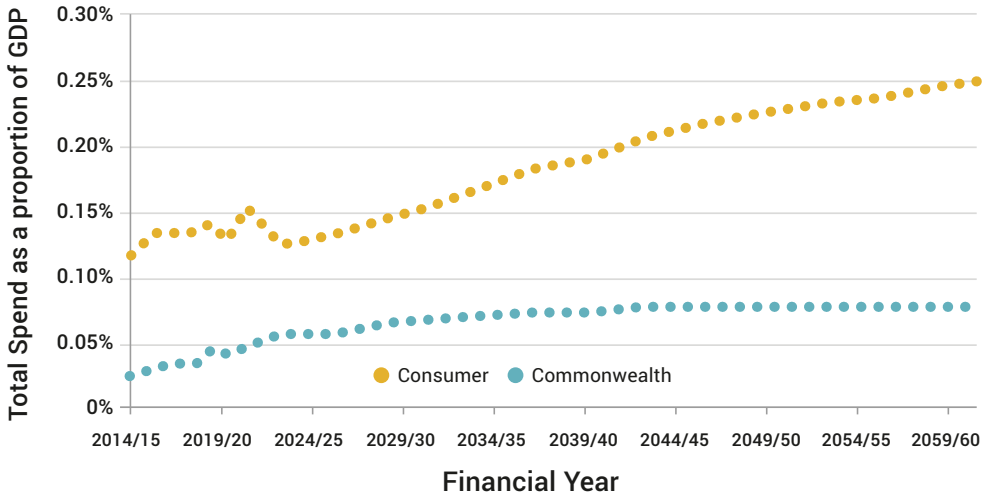
The Commonwealth covers support costs in the Home Support program, and for the first time is also funding a 'top-up' of support costs in Residential Aged Care, which explains the step up in 2021/22 and 2022/23.

Alternative options

Support costs may be an area for further analysis and reform, with the aim of moving towards more of a user-pays system. It may be an area of spending that the community accepts should be borne by consumers, as these costs are funded[23] by consumers at all other life stages, including in Residential Aged Care (refer Table 4.1).

4.2.3 Accommodation funding scenarios

Figure 4.6 - Funding projection, Accommodation



The Commonwealth covers support costs in the Home Support program, and for the first time is also funding a 'top-up' of support costs in Residential Aged Care, which explains the step up in 2021/22 and 2022/23.

Alternative options

There does not seem any need for alternative means of funding. For Residential Aged Care, consumers have the option of paying a lump sum RAD or an ongoing DAP, and do not need to pay if it is beyond their means.

23 Either explicitly by payment to service providers or implicitly through their own labour.

4.3 Exploring how consumers' share of funding may be increased

In line with our observations above, several stakeholders have suggested increasing consumer contributions for Aged Care costs. For example, COTA Australia's submission to the Royal Commission[24] suggested a policy framework that allows flexibility in consumer funding, and a recent paper by National Seniors Australia[25] highlighted the need for better understanding of the benefits of Aged Care, Home Support and Home Care as a possibility for increasing motivation to include care costs in financial plans for later life.[26]

We have deliberately not considered in this paper how consumers could meet any increased contribution. Options could include greater means testing, requiring consumers to draw on their wealth accumulated through superannuation or housing, or increased taxes. This is a complex and delicate issue, and includes important intergenerational equity issues, worthy of further detailed consideration and a paper of its own.

4.4 Summary

While acknowledging the complexity of arrangements at an individual level, in broad terms the current funding model is logical and in keeping with the way such costs are funded across the broader Australian population. However, the current policy settings are likely to result in significant pressures on the Commonwealth budget over time. Consequently, we see an ongoing need for exploring the feasibility of a range of options addressing the balance between individual and Commonwealth funding of Care and Home Support costs.

In addition, it is noted that many infrastructure assets in the sector are quite durable, being long-term capital investments involving considerable construction planning and costs. This adds to the imperative for a conversation about the feasibility and implications of different funding options.

Consideration of funding naturally also raises the question of what is the appropriate regulation. It is imperative to assure consumers and their loved ones that providers are maintaining care continuity and quality and avoiding issues of insolvency or insufficient capital as the overall costs of Aged Care increase. The next chapter considers this important issue of regulation.

We should explore a range of options for how costs are shared.

24 See p.3 point c of COTA Australia (2020).

25 National Seniors Australia (2021).

26 National Seniors Australia (2021) also notes that while the vast majority of survey respondents (85%) support increasing funding for Aged Care through government contributions in some form, 5% of respondents support increasing consumer contributions.



5 Regulation

In this chapter we focus on the financial regulation that might be appropriate for the Aged Care system in Australia; we do not consider regulation of care provision. Although we primarily focus on Residential Aged Care, because it has the greatest capital and financial outlays compared to other forms of care, increased financial regulation of Home Care providers also is needed.

While some may argue that regulation is bureaucracy, good regulation provides benefits, such as providing guardrails to help organisations navigate change while ensuring maintenance of community-expected standards of care. Regulation is important so that action can be taken before there is a problem. For example, testimonies provided to the Royal Commission (and subsequently by the Commissioners in their report) highlighted that financial pressures can lead to declines in quality of care, care delivery, insolvency and facility closures. Regulations are designed to avoid such devastating outcomes.

A key goal of regulation is to ensure residents and their families are provided reasonable assurances around the quality and continuity of care. Well-designed regulation in Aged Care can help mitigate three problematic outcomes:

A key goal of regulation is to ensure residents and their families are provided reasonable assurances around the quality and continuity of care.

- **Insolvency or insufficient capital.** With insufficient regulation, Residential Aged Care providers lack the funds to return deposits to people when residents leave care, creating an adequacy risk. In such cases, the government (i.e. taxpayers) currently steps in to return the monies. This is a significant contingent liability (approximately $30b currently).
- **Care continuity and quality.** If financial viability is compromised, the care provided by the system typically is interrupted or the quality diminishes, potentially having a devastating effect on the aged population. This would be particularly true for Residential and Home Care providers in regional and rural settings, where they may not be other providers available to step in at short notice.
- **Burdensome regulation.** Prudential regulations also need to be efficient in order to achieve pragmatic solutions while avoiding onerous costs for providers. More than half of the almost 1,000 Residential Aged Care providers run only one facility, usually with less than 100 beds.

5.1 Current regulations

The existing regulatory framework for Aged Care is the Aged Care Act of 1997. There are currently four key financial standards relating to Aged Care.

- **Liquidity standard:** Protects RADs and entry contribution balances of people receiving care.
- **Governance standard:** Indicates arrangements for RADs and systems to govern balances held on behalf of care recipients.
- **Disclosure standard:** Outlines guidelines regarding the provision of information about the financial management of approved providers and transparent reporting requirements to ensure accountability in the Aged Care industry.
- **Records standard:** Outlines rules related to sound financial management of providers.

There are currently four key financial standards relating to Aged Care.

The Royal Commission summary report indicates a need for prudential reform[27]. In particular, there is a need for:

- more comprehensive financial reporting;
- more regular and timely reporting;
- liquidity and capital adequacy standards; and
- improved capacity within the regulator to use the information effectively.

5.2 Changes underway

The Department of Health (DoH) is working through a program of regulatory uplift over the next several years. This includes increasing its financial information collection for both Residential Aged Care and Home Care with the introduction of quarterly reporting in addition to the detailed annual reports submitted by providers. There are, or soon will be, increased regulatory powers, improved public reporting of financial metrics, strengthening of the Liquidity Standard and implementation of a Capital Adequacy Standard.

27 Royal Commission into Aged Care Quality and Safety (2021), page 161.



5.3 Mapping current standards to objectives

Mapping current standards to typical regulatory objectives reveals where gaps may lie in financial related regulation.

Table 5.1: Gap Analysis of Current Financial Regulation Standards

Regulatory Objective	Current Standards	Possible Gaps
Financial Safety (Soundness of individual entities that receive RADs)	**Liquidity** – Minimum financial requirements in liquidity for RADs	Minimum capital adequacy requirements
System Stability (In event of problems these seek to minimise the impact on stakeholders)	No standard other than with respect to liquidity	No forward looking viability No requirement on approved providers to report when continuity of care may be compromised due to financial pressure (or, in the worst case, alternative care needs to be found at short notice)
Disclosure Standards (Information available to stakeholders)	**Disclosure** – The focus of this Standard includes: • supplying the DoH with a completed Annual Prudential Compliance Statement (APSC) • making available information to RAD paying residents or prospective RAD paying residents about the provider's level of compliance	No easily accessible rating system of providers These standards only apply to those collecting RADs
Governance and Supervision (Rules for approval and structured approach to assessing risk in approved organisations)	**Records Standard** – Providers are required to record and maintain accurate, up to date information about the RADs they collect **Governance Standard** – Ensures that providers only use the balance of RADs for a permitted use and that balances are returned to residents or their estate as and when required	Will centre around role and capability of the regulator
Efficiency (Least cost regulatory option relative to prudential objective)	Not a specific standard	Ensuring that any requirements include simpler options for smaller players

Enhancements for prudential regulation to support organisations becoming consistently financially sound over the long term could include:

- Strengthening the liquidity standard;
- Creating a capital adequacy requirement which currently is lacking and is a serious gap in terms of financial safety objectives – capital adequacy standards are a core feature of other deposit holders regulated by the Australian Prudential Regulation Authority;

- Early warning (forward-looking) financial indicators that indicate not only risks of insolvency, but also risks that care levels may be compromised;
- Disclosure wherein organisations must disclose on a forward-looking basis those matters that affect their financial viability. This could be extended beyond organisations receiving RADs so that continuity of care is better protected; and
- New reporting to allow some rating of providers without full financial strength ratings.



5.4 Determining the appropriate prudential standards

To accomplish the task of updating the framework without substantially increasing the burden on the system, we suggest that a minimum specification ('min spec') approach be taken, where the smallest possible number of rules are defined in the regulatory system. This is necessary because with too many rules, the system (providers and regulators alike) becomes overwhelmed with the outcome being the risk that rules are not followed or enforced.

Instead, in a min spec environment, only three to five critical specifications are defined, and each must be met. Min spec deepens players' clarity regarding what must be done and what must not be done. This strikes the balance between securing the needed consumer and community assurance on one hand and avoiding additional regulatory burden for care providers on the other. In such circumstances the focus is on remembering what is important.

Creating the min spec regulation begins with identifying a clear purpose and then outlining all the desired specifications ('max spec'). Next, each specification is interrogated by asking, 'If we do not achieve this specification, is it still possible to achieve the purpose?' Non-essential specifications are then removed, ultimately yielding the min spec list.

Based on our analysis, we propose the following min spec within Aged Care.

1. **Adequacy:** Assurance that organisations can pay back money they owe where RADs have been or are collected. This concerns both liquidity and capital adequacy requirements and should be at typical reporting times (e.g. quarterly). This rule is necessary because this money otherwise could be lost and needs to be returned when the individual no longer uses the accommodation.

2. **Viability**: Assurance that organisations can continue to provide quality care. This specification applies to all care providers and facilities and may require heightened or interim reporting where adequacy also may be at risk. The requirements may be likened to a lighter version of the continuous disclosure requirements for listed companies. Ideally, there would be indicators of potential problems being identified early and intervened with before they mature into large problems. This necessitates some effort to identify indicators along with appropriate interventions. Culmination of this effort could yield a rating system for providers based on evaluation of the provider.

Ideally the number of rules in the regulatory system should be minimised as far as possible.

3. **Visibility:** Assurance that organisations have a way to share information that consumers can understand, such as awarding a star rating to providers – ideally based on the four to five features most indicative of provider financial quality. The system can be set or agreed with external input or reviewed and then applied by the DoH. Receiving a star rating is anticipated to create competitive pressure for providers to achieve efficiency and effectiveness without compromising quality of care. This approach is anticipated to be effective for all types of care providers.

For organisations that cannot achieve these aims, there would be a ladder of intervention, starting with education and proceeding through increasing intensity of investigation and ultimately sanctions and removal. Those that do achieve adequacy, viability and visibility are permitted to continue.

5.5 Conclusion



Our analysis suggests that prudential governance of the Aged Care system is under-developed. Specifically, the Aged Care system needs to be regulated to ensure continuity of care and lessen the fiscal risk to taxpayers. At the same time, it cannot be overemphasised that the regulations created and implemented must be kept to a minimum. Thus, with too few rules or too many rules the outcome is the same: all parties are exposed to excessive risk. With only the few, crucial requirements defined, observed and enforced, the resilience of the system is optimised. Moreover, early warning signs that critical regulations are being violated need to be identified and monitored and, in concert with that effort, appropriate interventions need to be created and implemented in the event of any early warning signs being detected.

In summary, minimum Aged Care system financial regulations should include:

1. **Adequacy and Capital/Liquidity Standards** – A capital standard should supplement the liquidity standard in enhancing adequacy;

2. **Forward-looking viability** – The liquidity standard (and future capital adequacy standard) should be strengthened by including a forward-looking component on viability; and

3. **Visibility and Disclosure** – Disclosure standards would increase visibility and usability to stakeholders (akin to a financial strength rating system adjusted to be fit for purpose). This would liking consist of a strength rating scale developed or audited by an independent party and would include items such as: earnings, liquidity, capital adequacy as well as quality of disclosures.

The next steps include conducting a thorough investigation of industry capacity and readiness for such change, including the most appropriate prudential regulator. Transitioning or phasing of changes will be important.

Strengthened financial regulations for Aged Care are required.

Appendix 1 – Adequacy, viability and visibility requirements

Adequacy

Adequacy includes both liquidity and capital adequacy. Liquidity refers to having enough money and other liquid assets to pay monies to meet short-term expected and unexpected liabilities. Capital adequacy, a key aspect of protecting consumers and reducing systematic risk, means that institutions must hold sufficient financial resources (e.g. capital, cash, liquid securities, credit lines) to cover their liabilities.

Recommendation 132 from the Royal Commission was as follows:

From 1 July 2023, the Prudential Regulator should be empowered under statute to impose liquidity and capital adequacy requirements on approved providers, for the purpose of identifying and managing risks relating to whether:

a. providers have the financial viability to deliver ongoing high-quality care

b. providers of residential care services that hold Refundable Accommodation Deposits are able to repay those deposits promptly as and when required.

We agree with this recommendation. The liquidity and capital adequacy requirements could take a number of forms, such as:

- Simple Buffer: Assets must be equal to a specified proportion of liabilities (e.g. 120%), with both assets and liabilities being valued according to a prescribed basis; or
- Probability: Sufficient assets must be held to assure that the probability of insolvency over a particular time period is lower than a specified level (e.g. 1 in 200 probability over the next year), considering the company's risks.

Our recommendation is that both standards use a probability-based approach that fits with the regulator's risk appetite. Given this will be relatively new to the industry, we would suggest a simple rules-based approach where the calculations are clear and easy to carry out for the full range of providers.



Viability

In practice, good liquidity and capital adequacy standards will not only test whether assets are sufficient to meet liabilities right now, but also test whether the provider will be able to continue to meet its future obligations as they fall due. This is important given the disruption to care when a provider fails.

A further step to enhance forward-looking viability would be for the regulator to request that providers submit a board-endorsed liquidity management plan and capital management plan, outlining target and trigger levels of liquidity and capital adequacy above the minimum regulatory requirement, and actions that management will take if those targets and triggers are breached. This has been a very effective tool used by APRA in its regulation of insurance companies and banks. At the same time, these plans would not be publicly available and only shared within small, highly-trusted circles.

The Royal Commission outlined the creation of a legislative authority to:

- Allow independent review by the Commonwealth of providers' current financial information (audited and unaudited);
- Allow the DoH to require the provision of current financial information; and
- Allow the DoH to require the provision of relevant supporting information for the provider and related entities when concerns exist regarding the provider's financial viability.

Additionally, the Commission advised that providers be required to inform the regulator (the Secretary of DoH) of any financial viability concerns. In principle, we agree with this recommendation with the challenge being to formalise some guidelines for the requirements to disclose viability concerns.

Visibility

Regarding visibility and disclosure, we support an increase in the level of disclosure, while keeping it simple and minimising the regulatory burden.

One option is to require providers to publicly disclose certain things. We do not believe that publishing accounts adds much useable information to the average consumer, although publishing some simple liquidity and capital management metrics could. There is even an option to work with an independent ratings agency to provide a simple financial or credit rating (if this could be done in a way that is not cost-prohibitive). Any of these initiatives could be optional, certainly at first, as this would still provide a strong incentive for providers to disclose their financial information so that consumers do not doubt their viability.

Another option worth pursuing is for the DoH to begin publishing one or two simple liquidity and capital adequacy metrics across all providers, once regular quarterly reporting is established. If this is implemented, it is critical that there is not a conflicting rating system.

In other industries, such improvements in disclosure have been associated with reduced cost of capital, improved reputation and confidence, and increased clarity among stakeholders.

Appendix 2 – Model of future costs – further details and limitations

Projecting the number of consumers

We have adopted a cohort-based modelling approach. We estimated the number of consumers using Aged Care services over the next 40 years by:

- Calculating the proportion of consumers by age group using Aged Care services (i.e. , Residential Aged Care, Home Support, Home Care and Flexicare) in 2018/19.[25]
- Calculating the number of people using each service by age group at each future year (to 2060/61) by multiplying the 2018/19 service usage proportions by the estimated population using ABS population projections (series B).[26]
- We have adjusted these projections to allow for:
  - Variations in consumer preferences to stay in the home vs entering residential Aged Care;
  - Improvement in the general population health over the next 40 years, resulting in the need for Aged Care services later in life; and
  - Increased wealth levels of Aged Care consumers (i.e. more will be above means-test thresholds as they currently apply).



Projecting annual costs per consumer

We then calculated the average annual cost per consumer for the following Aged Care services:

- Residential Aged Care (including an implicit allowance for RAD funding)
- Home Support
- Home Care
- FlexiCare
- Carer Support.

We then multiplied the average annual cost per consumer by the projected number of consumers to estimate the annual cost in 2018/19 dollars for each future year. We increased the average cost over the next four years to allow for

25 Australian Institute of Health and Welfare (2021).

26 Australian Bureau of Statistics (2018), (Series B).

the expected increase in Commonwealth Government spending as announced in the May 2021 Budget (further information below). We then applied inflation to the projected costs to estimate nominal cost by program (see Table A.1).

Table A.1 – Inflation assumptions by Aged Care program

Aged Care Service	Inflation Rate
Residential Aged Care – Accommodation	3.25%
Residential Aged Care – Care	4.00%
Home Care	4.00%
Home Support	3.78%
Support for Carers	4.00%
Flexicare	4.00%
Superimposed Inflation	
Residential Aged Care - Care	0.46%
Home Care	0.22%

RADs to DAPs

In our modelling we have made an allowance for the annual funding provided by consumers via Residential Accommodation Deposits (RADs). The below table summarises the total RADs held by Residential Aged Care Facilities and the corresponding equivalent annual Daily Accommodation Payment (DAP).

Table A.2 – Assumed DAP ($b)[27]

Financial Year	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
RAD Balance	**18.2**	**21.9**	**24.8**	**27.5**	**30.2**	**32.2**
MPIR	6.61%	6.20%	5.83%	5.73%	5.95%	5.08%
DAP	**1.2**	**1.4**	**1.4**	**1.6**	**1.8**	**1.6**
DAP=(RAD x MPIR)/365						

We have adopted a growth assumption for future years of 6% per annum, in line with growth in RADs over the past three years. For the purpose of summarising these costs in other parts of our modelling, RADs are shown with consumer funding in Residential Aged Care Accommodation costs.

Nominal Gross Domestic Product

We have shown most of our projections as a proportion of GDP. To estimate GDP at future years, we have adopted assumed nominal GDP growth of 5% per annum, consistent with the 2021 Intergenerational Report.

Mapping Aged Care program costs

We used the mapping summarised in Table A.3 to estimate the proportion of costs spent (a) by consumers vs government and (b) for Care vs Support vs Accommodation. The total figures correspond to those provided to the Royal Commission[28] for Aged Care spending in 2018/19.

27 Aged Care Financing Authority (2020), Aged Care Financing Authority (2021), Commonwealth of Australia (2021e).

28 Commonwealth of Australia (2021a).

Table A.3 – Mapping Aged Care program costs

Program and Funding Source ($m)		Total	Accom.	Support	Care	Quality
Assessment and information services						
Australian Government	Aged Care Assessment Program	**128**				128
Australian Government	Other access and information services	**102**				102
Support for Carers						
Australian Government	Carer Payments in respect of care recipients aged 65+	**2,286**			2,286	
Australian Government	Carer Allowances in respect of care recipients aged 65+	**921**			921	
Australian Government	Carer Supplements in respect of care recipients aged 65+	**237**			237	
Home Support Services						
Australian Government	CHSP	**2,618**	393	1,518	707	
Australian Government	DVA Community Nursing	**127**			127	
Australian Government	Veterans Home Care	**102**	21	64	16	
Australian Government	Continence Support	**90**			90	
Australian Government	Continuity of Support Program	**496**	169	278	50	
Consumer Contributions		**252**	86	141	25	
Home Care						
Australian Government		**2,469**	62	185	2,222	
Consumer Contributions		**107**	3	8	96	
Other Revenue		**75**	2	6	67	
Residential Care						
Australian Government	Department of Health	**11,949**			11,949	
Australian Government	Department of Health	**146**	146			
Australian Government	Department of Veterans Affairs	**920**			920	
State and Territory Government		**177**			177	
State and Territory Government		**2**	2			
Consumer Contributions	Basic daily fee	**3,426**		3,426		
Consumer Contributions	Means Tested Fee	**586**			586	
Consumer Contributions	Other Care Fee	**79**			79	
Consumer Contributions	Accommodation Fees	**829**	829			
Consumer Contributions	Extra Service Fees	**118**		118		
Consumer Contributions	Additional Service Fees	**122**		122		
Other Revenue		**1,137**			1,137	
Residential Care Capital						
Australian Government		**78**	78			
State and Territory Government		**80**	80			
Flexible Care Services						
Australian Government	Multi-purpose Service Program	**177**	18		160	
Australian Government	National Aboriginal and Torres Strait Islander Flexible Aged Care Program	**44**	1	3	40	
Australian Government	Restorative Care (Transition Care and Short-Term Restorative Care)	**294**			294	
Australian Government	Other flexible and residential aged care	**5**			5	
State and Territory Government		**118**	4	1	113	
Aged Care Quality						
Australian Government		**147**				147
Total expenditure on aged care		**30,444**	**1,893**	**5,871**	**22,304**	**377**

Budget costs and mapping

The Commonwealth Budget measures announced in May 2021 include approximately $17.7b in additional funding over the next four years. Of this $15.4b is included in our modelling , as it relates to direct spending on Aged Care programs, while the remaining $2.3b is excluded as it relates to quality and monitoring and, thus, is excluded.

Table A.4 summarises the estimated additional spending by the Commonwealth Government by both Aged Care program and area of spending.

Table A.4 – Expected additional Commonwealth Government Aged Care spend ($b)

Program	2021/22	2022/23	2023/24	2024/25+
Residential Care	1,157	2,314	2,314	2,314
Home Care and Flexicare	929	1,857	1,857	1,857
Home Support	0	0	0	0
Carers	114	228	228	228
Total	**2,200**	**4,400**	**4,400**	**4,400**
Type	**2021/22**	**2022/23**	**2023/24**	**2024/25+**
Care	1,641	3,282	3,282	3,282
Accommodation	25	51	51	51
Support	533	1,066	1,066	1,066
Total	**2,200**	**4,400**	**4,400**	**4,400**



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Institute of Actuaries of Australia
ABN 69 000 423 6546

Level 2, 50 Carrington Street
Sydney NSW Australia 2000
t +61 (0) 2 9239 6100
e actuaries@actuaries.asn.au
w www.actuaries.asn.au

