5 February 2015

Mr Claudio Damiani
Fiscal Group
Budget Policy Division
Department of the Treasury
Langton Crescent
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Email prebudgetsubs@treasury.gov.au

Dear Mr Damiani

Pre-Budget submission (2015-2016)

The Actuaries Institute has prepared this pre-Budget submission in recognition of the Treasurer's stated intent to "ensure the Commonwealth lives within its means, pays down its debt and maintains a credible path to surplus". The Institute has also framed this paper in the light of Treasury's Intergenerational Reports which highlight the rising health, Age Pension and aged care costs of an ageing population.

Since it made a pre-budget submission, in 2014, the Institute has contributed a number of recommendations to the Financial System Inquiry (FSI) and to Treasury's review of retirement income stream regulation aimed at promoting the value of retirement income stream products to manage retirees' longevity risk. A corollary of improving the efficiency of retirement incomes is to reduce the impact on the cost of the Age Pension.

Accordingly, the Institute encourages Treasury to:

1. Support budgetary initiatives proposed by the FSI that will encourage retirees to favour retirement income streams over lump sums in the pension phase of superannuation.

2. Consider measures that will reduce the inequity of future health funding between various cohorts

3. Include estimates of the future costs of natural disasters in the budget's Statement of Risks

FSI recommendations

The Institute is pleased that the final Murray Committee report contains a number of recommendations that reflect the Institute's submissions on retirement income policy, specifically we **support** the following proposals;

- Recommendation 9 – seek broad political agreement for, and enshrine in legislation, the objectives of the superannuation system and report publicly on how policy proposals are consistent with achieving those objectives over the long term.

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- Recommendation 11 – require superannuation trustees to pre-select a comprehensive income product for members' retirement (CIPR). The Institute's work is directly referenced (p127). The FSI also recommends impediments to product development be removed.
- Recommendation 19 – review the costs and benefits of increasing access to and improving the use of (public sector) data to improve the quality of business and consumer decision making and public policy development.
- Recommendation 43 – introduce a mechanism to facilitate the rationalisation of legacy products in the life insurance and managed investments sectors.

The Institute's submission[1] to Treasury's review of retirement income stream regulation contains a number of suggestions regarding the removal of legislative barriers that are preventing innovation in developing retirement income stream products. Data suggests that more than 80% of retirement dollars now go into account based pensions. That trend confirms that Australian retirees are not just accumulating wealth through super and spending it all at retirement. Indeed many of them are living too frugally because they are worried about running out of money.

We are confident that implementing the FSI recommendations that aim to make retirement incomes more prevalent and efficient will eventually ease the demand for Age Pensions. In particular, adopting recommendation 11 that requires superannuation trustees to pre-select a comprehensive income product for members' retirement (CIPR)that delivers a regular and stable income stream and a component to manage longevity risk should assist the Government achieve its objective of achieving a credible path to surplus.

Retirement incomes and social security

The Institute will shortly be releasing a research report that highlights the relative financial positions of the various cohorts (income/generational) at retirement and also identifies risks and potential solutions to achieve adequate levels of retirement benefits whilst ensuring system sustainability. The report will also examine;

- How wealth is accumulated across different asset classes by the cohorts
- The impact of factors such as age pension, indexation and pension ages
- How people can turn assets into income
- How each cohort is affected by longevity risk
- How the social security system can be modified to reduce costs and improve self-funding

Although this report is due to be released after the deadline for pre-budget submissions, once it is finalised, Institute representatives will be available to meet with Treasury, in Canberra, to discuss the findings in more detail to help inform your budget deliberations around retirement income and Age Pension policies.

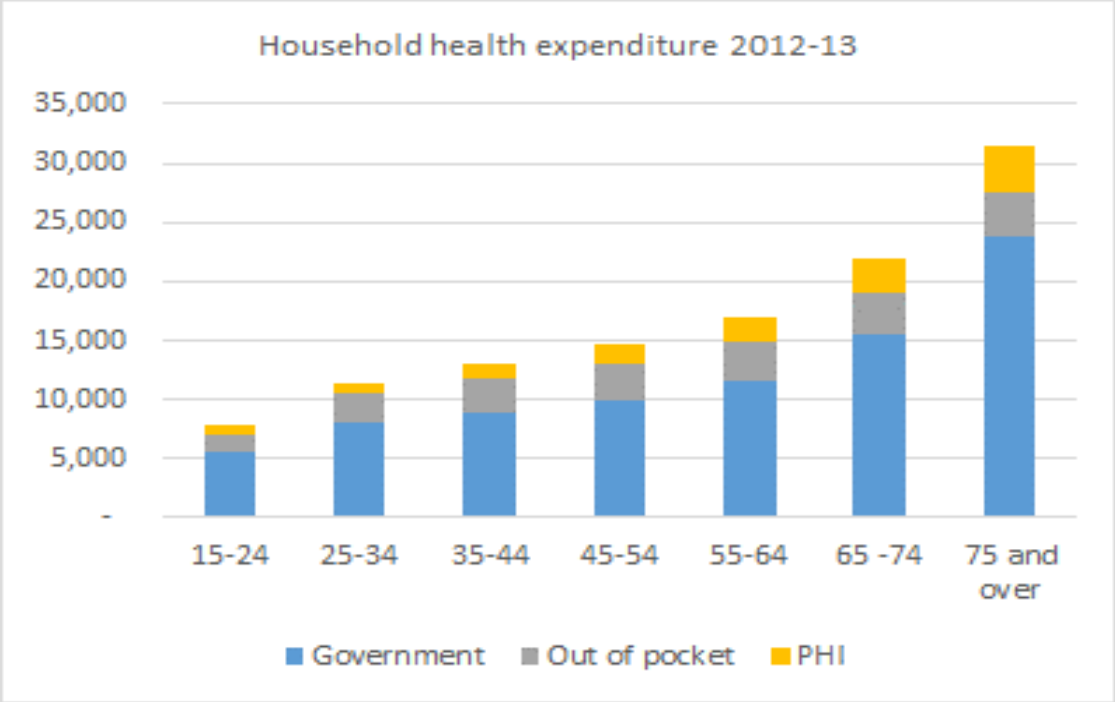
[1] Full submission attached as Annexure A

Health Costs

In December 2014 the Institute released a Green Paper – *Who Will Fund Our Health?*[2] – raising a number of financing options to manage the inexorable rise in health services costs. The Productivity commission (2013) forecasts are for spending on health care costs across all levels of government to increase from 6.5% to 10.8% of GDP over the next 50 years.

Our ageing population is a key driver of that increase. Health costs rise dramatically with age - health expenditure for an 85 year old Australian is more than four times that for a 50 year old. Significantly, the number of Australians over 85 will more than triple, by 2050, intensifying pressure on future taxpayers.

Chart 1



(Actuaries Institute Green Paper December 2014 – *Who Will Fund Our Health?)*

Demographic changes will also affect Age Pension and Aged Care costs and increase the taxation burden on the working population unless current policy settings are changed. User charges help manage health service demand up to a point but excessive imposts can have serious consequences for the health outcomes for people with low incomes or chronic disease – two characteristics strongly associated with the older population. Given projections that almost half of all household wealth will reside within concentrated segments of the over 65s cohort by 2030 Treasury should investigate ways for accessing that wealth to fund future health and aged care costs.

[2] Green Paper attached as Annexure B

Natural Disaster Funding

The Actuaries Institute supports the call in the Productivity Commission's draft report on National Disaster funding for effective planning and a greater focus by governments on natural disaster mitigation measures. Funds allocated now to appropriate mitigation projects will ultimately reduce the government expenditure for rebuilding key public infrastructure and private assets.

While the Productivity Commission acknowledges that there is now more quality information available about hazards and risk exposure, the Institute believes there remains a pressing need to ensure that this information is effectively communicated to stakeholders who face the greatest potential impact to increase their incentive to manage the risk effectively.

The Institute agrees that the Australian Government should include estimates of the future costs of natural disasters to its budget in the Statement of Risks, as identified in draft recommendation 3.3. The "Statement of Risks" should include both expected costs and also costs at different annual return intervals. This provides transparency and encourages planning for the expected cost of natural disasters, and removes some of the disincentives to mitigation identified in draft Finding 2.1of the Productivity Commission report.

Should you wish to discuss any aspects of this submission or make arrangements for a meeting with Institute representatives please contact the CEO, Mr David Bell on (02) 9239 6100 or by e-mail david.bell@actuaries.asn.au.

Yours sincerely

Estelle Pearson
President

22 September 2014

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Review of retirement income stream regulation

The Actuaries Institute identified "the pressing need to develop a more vibrant annuities market" as one of its major policy objectives some years ago. Removing the legislative barriers preventing innovation in developing-retirement income stream products such as annuities is a crucial element of making it possible to achieve this objective. [1] We therefore enthusiastically welcome the Government's Review of retirement income stream regulation.

Actuaries have a particular interest in this area as the profession has played a central role in the design and financial management of annuity products for two centuries. The mathematical models underlying annuity design form an important part of actuarial education, and the profession is active in research into relevant mortality rates and their projection.

This submission responds to the questions asked in the discussion paper. Attached as an appendix is an Institute discussion on the principles underlying our response. It was prepared by the Institute's Retirement Income Working Group that has been working on these issues over the past two years.[2]

We make various suggestions as to ways of adapting the regulations to permit greater flexibility. In particular, we suggest a unifying principle of using a prescribed real investment return and mortality basis to set a target retirement income. This is already inherent in the minimum drawdown regulations and provides a basis to answer the questions posed. Coherence of policy can therefore be maintained while permitting greater flexibility.

The Institute would be pleased to discuss any of these recommendations in more detail. Please do not hesitate to contact our Chief Executive Officer, David Bell, on (02) 9239 6106 or email david.bell@actuaries.asn.au if you wish to discuss the matters raised in this submission.

Yours sincerely

Daniel Smith
President

[1] http://www.actuaries.asn.au/Library/MediaAndPublicPolicy/2013/RetirementIncomesPolicyPosition.pdf

[2] Its background paper on the issues can be found at:
http://www.actuaries.asn.au/Library/Events/SUM/2013/Sum2013Retirement%20Incomes%20Working%20Group.pdf

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Question 1

What types of income stream products would enable retirees to better manage risk in the retirement phase (in particular longevity risk and investment risk)?

We agree with the analysis in the discussion paper on the effect of limitations in the current rules. The rules currently permit products where the retirees bear all investment and longevity risks, or contracts where the product provider takes all these risks. We see a real need for products where the risks can be shared. Such products go beyond hybrid contracts (including variable annuities), which were initially questioned as to whether they were permissible, but there are now a few versions available in the market.

For ease of reference, the word "annuity" is used in this submission to cover a broad range of products designed to provide income in return for monetary consideration, including those with a life company guarantee, products defined as hybrids for the purposes of the discussion paper and products providing longevity protection either by way of guarantee or participation in a pooling mechanism. It does not include account based pensions with no guarantees attached. Words such as "traditional guaranteed annuity" or similar are used when describing products issued almost entirely by life companies, where the amount and timing of income payments is precisely defined at the outset in either nominal dollar or inflation linked terms and are guaranteed by the product provider.

To better allow for products that permit both longevity and investment risks to be shared more efficiently between providers and retirees, we suggest that the following flexible long term products are needed. All are available internationally, some more widely than others. It is important to note that, when designing the legislative framework, retirees will often require more than one type of product to meet their retirement needs, having regard to their overall income needs and risks. Consistency of principle in regulation between products is important to ensure that choices are not distorted as well as government objectives also being met.

- Pooled annuities and Group Self-annuitisation (GSA) products. For the purpose of this paper, pooled/GSA annuities are taken in the broadest sense as any lifetime income product which involves sharing of longevity experience within a pool. These include with profit annuities (WPA's) and Group Self-annuitisation products such as tontine annuities, some forms of which are widely used internationally, but not in Australia. Pool members share longevity risk and so, if the pool is large enough, idiosyncratic (individual) risk can be almost eliminated although the members are still exposed to systematic changes in longevity. Some of the common forms are separately discussed below, but a wide variety of designs is possible:
    - With longevity risk, providers can absorb some risks (particularly shorter term risks when the pool is small), and there are different ways of sharing idiosyncratic and systematic risks between cohorts.
    - Investment risk varies with the underlying investments, with some providers providing a variety of smoothing arrangements and guarantees.
    - Under some structures, initial payments are based on assumptions as to expected mortality rates and investment returns. Subsequent payments are adjusted to reflect actual investment returns and mortality. Providers use a variety of methods to vary payments as a consequence of changes to future expectations.
    - Other mortality sharing pool arrangements may simply distribute mortality profits to survivors each year, reducing or eliminating the need for any reserving or assumptions about future mortality experience.

- Investment Linked Annuities (ILAs). These products are a form of annuity, and provide an income throughout life where the income is defined as the value of a particular number of investment units each month, quarter or year. The number of units does not have to be constant but is specified in advance. Just as with traditional lifetime annuities, the product provider prices the product based on estimates of future mortality and effectively fully insures longevity risk. However, investment risk remains with the individual not with the provider, unlike with traditional guaranteed annuities.
- Guaranteed Minimum Lifetime Withdrawal Benefits (GMLWBs). These are investment-linked products which offer protection against a combination of longevity and adverse investment experience. In retirement, the product is similar to an account-based pension with an optional guarantee that pays an annuity for life if the account balance has been exhausted. The GMLWB is typically expressed as a fixed percentage of the highest account balance achieved at a prior policy anniversary. In Australia several life insurers have recently launched GMLWBs but take up has been limited.
- Participating (with-profit) Annuity (WPAs). These products share both investment and longevity risk between the retiree and product provider. They feature a guaranteed annuity at a rate that is less generous than the equivalent rate for a non-participating annuity supplemented by additional bonuses if investment and longevity experience is favourable. Some versions set the initial payments at a level that will reduce annually if bonuses are not earned. They are also a particular form of pooled annuity.
- Deferred Lifetime Annuities (DLAs). These can take any of the forms set out above, but initial payments start after a set deferment period and are then payable for life. The benefit payments are typically large relative to the initial purchase price. This feature of a DLA would provide a way to protect retirees against the risk of outliving their retirement savings at an advanced age. GSA/mortality pool products can be structured to provide similar longevity protection but without a guaranteed level of income.
- Enhanced or Impaired Life Annuities. Annuity rates that take no account of the annuitant's individual life expectancy do not provide good value to the unhealthy and lower socio-economic groups. Providers may offer enhanced annuities, under any of the above arrangements, which pay higher incomes to people with lower life expectancies. It is not expected that special rules are required for these, as payments would generally be higher and terms on average shorter, than for non-impaired lives. However, if these were products to be widely taken up it is possible that the mortality of those taking up non-impaired products could be lower (more select) than otherwise.
- Contingent Annuities – These are deferred annuities where payments are made, or the annuity commences, on the occurrence of a contingent event. Such an event could be the death of another person, a defined decline in health or entry into care or after a particular investment loss has occurred.

We have not distinguished between SIS regulation 1.05 and 1.06, believing that they should both permit the same products for life companies and superannuation funds. We anticipate retirees investing in a range of products from different providers.

Question 2

Do the annuity and pension rules constitute an impediment to the development of new products and if so, what features of the rules are of most concern from a product innovation perspective?

Several features of the current annuity and pension rules are an obstacle to product development:

- The restrictions on indexation arrangements (e.g. to the same percentage each year or to CPI or AWE) are problematic for pooled/GSA annuities, ILAs and WPAs (where the annuity payments may vary based on experience not known in advance).
- The requirement of no further contribution creates a barrier to product innovation where the ATO has interpreted this requirement to prevent account balances being increased by insurers paying out GMLWBs and raises doubt about the distribution of "longevity bonuses" from pooled annuity arrangements.
- Rules that benefit payments are made at least annually create obstacles to DLAs. Superannuation tax on investment income therefore has to be paid in the deferral period making them unattractive to retirees.
- Minimum payment rules are not defined in situations where no well defined "account balance" exists, except for certain immediate annuity types which were in existence in 2007 when the current rules were formulated.

Question 3

What changes could be made to the annuity and pension rules to accommodate a wider range of income stream products while having regard to the need to protect against abuse of the earnings tax exemption and to promote appropriate and prudent retirement income objectives?

The rules should be broadened and to the extent possible be principles based, rather than product specific, so that product providers are able to develop with confidence a wider range of product offerings. This will facilitate more choices to retirees for balancing income needs and risks during retirement.

The broad requirement is that a product provides a regular income payable at least annually (once commenced) based on a reasonable set of product rules, which:

- Are specified in advance to the extent required to ensure retirees understand the product they are purchasing in accordance with current disclosure requirements;
- Permit variation based on actual investment, mortality and expense experience during the period, and do not require the product provider to guarantee any payments (the product provider may choose, but should not be required, to do so);
- Do not permit unreasonable deferral of income.

It is expected that the rules will need to contain parameters in order to achieve these objectives. For example:

- Minimum payment parameters will continue to be required for account based pensions.
- Existing rules for traditional guaranteed annuities linked to the minimum payment parameters are likely to still be required.

- For products other than account based pensions it is expected that, apart from the variations permitted due to experience as mentioned above, other variations must be limited in some way to ensure adherence to the principles of regular and no unreasonable deferral of income. Limitations would likely apply along the lines of requiring such variations to be specified in advance based on some risk sharing mechanism.

- Pooled annuities, ILA's and WPAs represent a particular challenge because the possible range of detailed product rules and operation is quite broad.

An example of an approach which could be followed for pooled annuities, ILAs and WPAs is by use of a scenario test, as follows:

- The scenario will comprise:
    - A prescribed real future investment earning rate on assets;
    - A prescribed mortality table.
- To meet the test the product must return, for all possible buyers and based on its disclosed product rules, a level or decreasing real income throughout the term of the product.
- The product provider will conduct this scenario test prior to product launch and provide a certification in the PDS that the minimum standards are met. Because it is in the PDS it must be continuously valid while the product is on sale, hence must be reviewed whenever the prescribed scenario or the product rules change. In force products do not have to be retested unless there is a change in product rules affecting the existing product holders.
- The initial minimum payment equals a percentage of the purchase price equal to 1/a, where 'a' is the value of a lifetime annuity of $1pa real, payable monthly, using the assumptions in the prescribed scenario. No subsequent minimum payment standards apply after year 1 for pooled, ILA or WP annuities, though the broader principles set out above limit variations.
- Annual payments from the pension or annuity will differ from the above scenario because the actual expected investment returns and longevity experience will differ from the prescribed scenario. These differences are not subject to the minimum payment rules provided they are in line with the product rules as disclosed to purchasers and incorporated in the scenario test described above. It is important to realise that the scenario testing concept does not limit product rules or require any guarantees. It is merely a scenario test conducted to ensure that the government's requirements are met in relation to protecting against abuse of the earnings tax exemption and prudent retirement income objectives.
- The following considerations apply in relation to the prescribed scenario:
    - The rate of investment return should be a real (inflation linked) risk free return, perhaps with a modest deduction to allow for fees and expenses. The risk free return would be based on the real yield on Commonwealth Government Indexed Bonds. No retiree should have a lower investment return aspiration, due to the low risk nature and inflation hedge.
    - The mortality table should again be on the light side with some allowance for expected improvements. Otherwise the test is unduly constraining, having regard to the need to allow for the self selection inherent in products in which

balances are placed in a mortality pool rather than the annuitant's estate, in event of death. Overseas annuitant or pensioner experience could be used to determine the table, though there is a practical advantage to using a widely available local mortality table that is regularly updated and suitably adjusted.

- The prescribed scenario should be reviewed regularly, perhaps every two years or when a threshold change triggers a review, whichever is first.

Allowance for DLAs could be made with following considerations (but also see our answer to question 7):

- Purchase could be permitted at any time, but investment returns should only be free of tax once the purchaser has reached a well-defined proxy for retirement age (such as preservation age, tax free age or pension age). Accumulation style superannuation tax would apply before this proxy age.
- In order to be eligible, a DLA must provide a level or decreasing income throughout life, from the payment commencing age (or deferral age), based on the prescribed scenario. The minimum payment standard is the same as for pooled annuities described above, all based on a value of a deferred lifetime annuity of $1pa real using the prescribed scenario. Provider certification applies in the same manner as pooled annuities.
- The benefits paid after vesting should be subject to the same rules applying to other annuities. Minimum payments are determined as above.

APRA's surrender standards can be an obstacle to the sale of DLAs by life companies. LPS360 permits APRA to waive the requirements of the standard, and – for immediate annuities – there is no minimum commutation benefit if there is no death benefit. We assume that APRA would apply the same rules to DLAs, but it would be desirable for this provision to be specifically included in LPS360.

Question 4

Would such changes lead to new products being brought onto the market?

There can be no certainty, but we note:

- While guaranteed annuities had all but disappeared from the Australian market, active marketing and some product innovation has seen their re-emergence, suggesting that there is more of a demand than was thought.
- Alternative products are widely available overseas and are often more popular than guaranteed annuities.
- There has been wide-spread interest in removing the regulatory barriers by individuals representing a wide range of participants in the Australian financial sector
- Financial advisers and retirees are becoming more aware of longevity risk and are looking for products which can help manage this.

Question 5

Should people only be able to purchase a DLA with superannuation money?

No. However, only DLAs purchased with superannuation money should be subject to the concessional superannuation tax rates on investment income of the product provider.

Question 6

Should people only be able to purchase a DLA for an up-front premium or should other purchase options also be allowed? If an annual premium approach is allowed, what should be the consequences if the premium payments cease?

Purchases could be made by annual premiums, although we note that the considerations suggested in question 3 become complicated. Each payment could be considered as purchasing a defined amount of DLA. If premium payments cease, a DLA equal to that purchased by premiums already paid would continue to be contractually payable.

Question 7

Should there be an upper limit on the amount that can be invested in a deferred lifetime annuity?

There are a variety of options that can be taken to prevent DLAs being used to defer tax. Sufficient limitations on possible commutation and death benefits would mean that they would not be attractive for deferring income. We suggest some limitations in our answer to question 10.

An alternative would be to limit the proportion of superannuation used to purchase a DLA benefit.

- The proportion should be no greater than a prescribed maximum percentage. It is expected this will be taken from a simple table by age group and period of deferment only. A possible refinement would be to allow for joint lives in the table, but this would make it more complex and hence is not recommended.
- Underlying the prescribed maxima are calculations of the type B/A where A and B are determined at the purchase date using the prescribed scenario assumptions described above. A is the value of a lifetime annuity of $1pa real, commencing from age of purchase of the DLA. B is the value of a deferred lifetime annuity of $1pa real commencing from the payment commencement age of the DLA (note - $1 is at date of purchase not commencing age). Results from these calculations are grouped and rounded (with judgment) to form the prescribed table. Rules will be required on how to apply the table in more complex situations such as reversionary beneficiaries, multiple DLA purchases etc.

Limiting the proportion would both stop the DLA being used to circumvent the current minimum withdrawal rules by wealthy retirees (hence obtaining significant tax deferral potentially beneficial for estate planning), and ensure that less informed individuals do not over-insure.

We note that it would be conceivable that a retiree with a significant DLA may not be able to access a benefit before the vesting age, but might not qualify for an age pension as a consequence of means tests. It would be necessary that DLA providers either make provision for retirees in such circumstances to be given access to their DLA benefits at an appropriate level or provide a prominent warning in the PDS of this risk. The prominent warning requirement might also apply to Statements of Advice issued under the legislation governing the provision of personal advice.

Question 8

Should there be a minimum deferral period for a DLA? If so, what would determine the period?

Our answers in question 7 and 10 eliminate the need for a minimum period.

We note that the simple table of maximum amounts and minimum payments for DLAs described in section 7 may operate somewhat bluntly in some cases. For example high income couples have a joint life expectancy of over 30 years at retirement.

Question 9

Should there be a maximum deferral age or period? If so, what should it be?

The nature of the suggested maximum limit for DLAs means the maximum reduces as the deferral period increases. This and the limited ability to provide an attractive death benefit at high ages means there is no need to specify a maximum deferral age or period.

Question 10

Do the payment features described in paragraphs 51 and 52 strike the right balance in allowing people to insure against longevity risk while avoiding unnecessary restrictions on product development?

- **Commutability (paragraph 51)**

The limits on commutability after retirement are a regulatory residue of the maximum payments that used to be applied to qualifying pensions and annuities. They are therefore unnecessary except in legacy situations where social security means test concessions still apply, but these concessions have not been available for many years now for new annuities and pensions.

Commutability options should therefore be permitted, but not required for immediate pensions and annuities. If commutation is permitted in whole or part for any type of product with a guarantee that payments will continue throughout life, the amount of that income will be much lower than if no commutation is permitted.

An exception could be made if rigorous evidence of good health was required for commutation, but this may well defeat some of the reasons why commutation is attractive to retirees in the first place.

Some degree of commutability can help overcome consumer obstacles to purchase and will be essential, at least in the early years, if the product is to be considered as part of a default 'MyPension' arrangement.

As discussed in our answers to question 7, there are quite likely to be circumstances where commutation may be necessary to avoid hardship. If DLAs are restricted to a sensible portion of superannuation proceeds, we believe that all commutation options should be acceptable.

Alternatively, if commutations were limited to a return of the initial investment in the first (say) five years, and to cases where there are grounds of financial hardship similar to those required for early release of pension benefits, DLAs would not be attractive vehicles for tax deferral.

- **DLA lifetime payments guaranteed or indexed (paragraph 52**

We think this leads to unnecessary restrictions on product development, and that the benefits could be payable in any way permitted for other types of annuities.

Question 11

Should providers of DLAs be able to offer a death benefit? If so, should there be restrictions on the size of the death benefit that could be offered? If so, what restrictions?

To prevent the use of DLAs for estate planning purposes, the death benefit should be restricted to the size of the initial purchase price or the commutation value (if permitted).

Question 12

Are the current minimum payment amounts for account based products appropriate to achieve the objectives outlined above, given financial conditions can change?

These reflect annuity factors that at one point would have been very conservative, but are now too high for retirees investing in government inflation linked bonds due to the low real return on such bonds. These bonds are arguably the most "risk free" investment for retirees and hence form an important benchmark return. They currently yield about 1% to 1.5% above inflation. The illustrations in chart 1 of the discussion paper, however, assume returns of 3.5% above inflation.

In the case of guaranteed pensions and annuities, providers are struggling to offer profitable products meeting the standards. Products available for those with higher life expectancies may therefore be withdrawn from the market. Application to all retirees, regardless of their life expectancy, is also somewhat inconsistent. That being said, there is merit in not distinguishing between males and females, or socio economic group, in setting the limits.

In the case of allocated pensions and annuities, balances can - at younger ages - increase if investment returns are reasonable, but at ages over 80, the minimum payment standards force members to reduce their balances at increasingly faster rates, causing them to be potentially exhausted prior to death. They do, however, ensure that the retirees using these products enjoy approximately the same tax advantages as those with other types of life annuities.

We submit that the minima should be adjusted periodically as per our suggestion in question 3 above: they should be determined as the amount required to purchase a level real income payment throughout life using the prescribed scenario. The scenario described in question 3 may need to be converted to a simple table of minimums for account based pensions. It is arguable the mortality assumption should be higher, taking out the allowance for self selection applicable to pooled and deferred annuities. The use of the scenario in question 3 ensures some consistency of principle between account based pensions and other products.

Question 13

Should there be an automatic mechanism for adjusting the minimum drawdown amounts in response to significant adverse investment market performance? If so, what should that mechanism be? How would this also satisfy the rationale for setting minimum payment amounts?

We understand that one reason for the relief given to the minimum drawdown amounts was that retirees were being required to base their drawdown amounts on their balances of the previous 1 July. We think that there would be arguments for permitting the use of more recent balances should they be less than, say, 85% of the value at the beginning of the financial year.

Our suggestion in response to question 12 could be applied here. Some automatic mechanism for adaptation should be incorporated into the minimum drawdown requirements. It is suggested that the table of minimums be reviewed whenever there is a change to the prescribed scenario tests.

It should be based on long term real interest rates as they are the appropriate benchmark for retirement incomes. Those invested in share markets should be aware of the risks attached. Very large falls in the share market will often (but not always) be accompanied by falls in real yields. It should be noted that market falls are accompanied by a rise in income yields (interest, dividend or rents). Thus the most important quantity for retirees, being income, is more stable than asset values.

Overall, as the rules as apply to allocated pensions and annuities are intended to ensure that such retirees do not obtain excessive tax benefits, it is difficult to support any changes to the limits.

Question 14

Should the minimum drawdown amounts also increase in response to very strong market performance? Would the mechanism be similar to that for decreases? Would this satisfy the rationale for setting minimum payment amounts?

As above, the minima should be based on long term interest rates and take no account for share market movements.

Question 15

For how long should the change remain in place? Should it be left in place only for the year in which the shock occurs, or until balances have 'recovered' by a particular extent?

As mentioned in the answer to question 3, the prescribed scenario would be reviewed every two years or when a threshold change triggers a review. The latter is most likely for real yields, when a 1% change review trigger might apply.

Question 16:

What other issues need to be considered if the minimum drawdown amounts should fluctuate?

The mechanism of changing the level of minimum drawdown may consider the mean-reversion of long-term investment return. Other than market factors, the future longevity improvement and future needs of age care should also be considered.

APPENDIX

Draft Principles for the Development of Eligible Retirement Income Products

Retirement Income Working Group (RIWG)

1 Introduction

This paper has been prepared by the RIWG of the Actuaries Institute, and recommends changes to regulatory settings to permit a fuller range of retirement products in Australia.

Changes that would make retirement products more attractive than currently eligible arrangements - from the perspective of tax or means tests – are out of scope.

There are well-recognised regulatory barriers to the development of retirement income products in Australia. As a result, Australian retirees are currently limited to choosing between lump sums, account based pensions and guaranteed immediate annuities to provide their income in retirement. Lump sums and account-based pensions provide no longevity protection, whereas guaranteed immediate annuities reduce the flexibility and tax concessions available to retirees. Internationally a much broader set of retirement income products are available (see Appendix A), however there are barriers to the development of these products in Australia.

The issues and some suggested principles for a way forward were published in an ASFA research paper "Changes to Regulatory Settings for Financial Products Dealing With Longevity" by Ross Clare in October 2013. That paper indicated the following matters requiring attention:

1. Amend SIS regulations, mainly to be less product specific;
2. Amend APRA's minimum surrender value standard (LPS360) and other standards unnecessarily inhibiting retirement product innovation;
3. Amend the means test treatment for longevity products;
4. Reform approval processes for such products;
5. Facilitate advice provision for retirement products;
6. Ensure the tax treatment has parity, for both provider and beneficiary, with well established products;
7. Allow superannuation funds (including SMSFs) to purchase any eligible retirement product which an individual is entitled to purchase.
8. Allow MySuper products to pay benefits as pensions

This paper focuses on the product aspects - primarily the matters covered in 1, 2, 3 and 6 above – and some of the issues arising from regulatory requirements designed to:

a. ensure products receiving favourable tax treatment do fulfil the intended purpose of providing retirement incomes on a systematic basis; and
b. provide no opportunities for tax minimization and deferral inconsistent with that purpose.

Currently, if the regulatory requirements are met then investment income earned on assets backing the retirement income is tax free. For beneficiaries over age 60 the benefits (income or withdrawals) are also tax free. This contrasts with:

- superannuation fund investments, other than those referable to pensions and annuities meeting SIS requirements, where the investment income is taxed at 15% (10% for certain capital gains), and
- assets held outside superannuation where investment income earned each year forms part of taxable income so is taxed at standard rates (which range from 0% to 45% plus the Medicare levy), subject to deductible amount rules.

One proposal that could be considered is to begin retirement income product rules from scratch. The current legislation is so complex that it substantially increases the cost of product development.

2 SIS requirements

The SIS regulations describing the requirements an annuity (r1.05) or pension (r1.06) must satisfy to be classed as eligible are complex, in part to "grandfather" a number of legacy arrangements not available to new pensions and annuities. Some of the definitions that apply in the Income Tax Acts and the Superannuation Regulations are shown in Appendix B. The main requirements for ***new*** pensions and annuities are:

2.1 No contributions or rollovers may be added;

Comment: This restriction is presumably to ensure that contributions are paid into active accounts and not accounts in the drawdown phase.
It is potentially a barrier to product innovation in that we understand that the ATO has interpreted it to prevent account balances being increased by insurers paying out variable annuity guarantees or the redistribution of "longevity bonuses" from pooled annuity arrangements. This can potentially be addressed by the ATO amending its interpretation or by defining contributions in the regulations as payments made by members.

2.2 Transfer cannot occur other than on death of the last beneficiary, and cannot be used as security for borrowing;

This does not appear an obstacle to product development.

2.3 Pension or annuity payments must be made at least annually;

This does create obstacles for deferred annuities, but does not appear an obstacle to product development for other types of annuity.

2.4 Minimum payment requirements in relation to pensions must be met and for guaranteed annuities there are some additional restrictions on design. Brief key requirements are:

2.4.1 For an account based pension payments in each financial year must not be less than a percentage of the account balance at the beginning of the year, as follows:

Age of Beneficiary	Percentage
Less than 65	4%
65 - 74	5%
75 - 79	6%
80 - 84	7%
85 – 89	9%
90 – 95	11%
95 and above	14%

Comment: These reflect annuity factors that at one point would have been very conservative, but would now not be adequate for higher socio-economic groups investing in government inflation linked bonds. At younger ages, balances can increase with reasonable investment returns, but at ages over 80, they increasingly force members to reduce their balances at a rate that means their super draw-downs reduce at increasingly faster rates. They are therefore only really suitable for annuitized pools, which are currently not permitted.

The minimum payments standards are not benchmarked to real rates of return available in the market. The lower the real investment return environment the quicker is the reduction in residual product value of an account based annuity. In the case of guaranteed immediate annuities (see 2.4.4) providers may struggle to offer profitable products meeting the standards, if real and nominal interest rates are low enough. It is unlikely this is deliberate policy.

2.4.2 The minimum payment requirements are defined in very product specific terms, making product innovation uncertain or impossible from this perspective.

Comment: They do not permit deferred annuities and are seen as an obstacle to product innovation.

2.4.3 For a guaranteed immediate annuity, the residual capital value at the end of the annuity must not exceed 100% of the purchase price. Where a residual capital value is paid, a minimum pension payment must occur in each year defined by the above table, with initial purchase price replacing account balance in the calculation;

The products described are fixed interest investments rather than income stream products, and the restrictions do not appear to be an obstacle to product development.

2.4.4 For a guaranteed immediate annuity where

i) no residual capital value applies, and

ii) the annuity is either constant throughout the term, or increases annually at a constant fixed rate specified at outset, varies annually by CPI or AWE indexation specified in advance (perhaps subject to an upper limit); and

iii) the term is either throughout life or is fixed and does not exceed [100 years less age of primary beneficiary at purchase], the minimum payment requirements only apply in year 1 of the pension or annuity.

Comment: The restriction to guaranteed CPI or AWE indexation effectively prohibits with-profit annuities, and annuities linked to other indices. Permitting them does require an amendment to the regulations, which is suggested in 4.4 below.

3 Principles

There is no clear statement of policy or principles in terms of what the government is seeking in return for the favourable tax treatment referred to above. Therefore this must be determined by inference from the above requirements. The following conclusions may be drawn:

3.1 Benefits remain with the primary or reversionary beneficiary while they are alive. Requirement 2.2 is designed for this and hence should remain after any review;

3.2 The income stream requirements result in releasing income and reducing account balances and residual real product value systematically over beneficiaries' lifetimes.

3.3 All products are subject to minimum payment requirements though there is variation by product.

These principles do form a benchmark against which alternatives may be evaluated.

4 SIS Requirements – Possible Changes

The following changes are considered desirable, in the interest of freeing product development from unnecessary constraints, while either retaining principles 3.1 to 3.3 outlined above, or substituting alternatives, such that the integrity of government revenue is not compromised.

4.1 *Clarification for account based products:* As suggested in the comment on 2.1 above, the following either needs a change in the ATO interpretation or a change in the regulations to permit contributions from a guarantee or the redistribution of a pool.

Where an account based annuity has an additional benefit which may result in income payments even after the account balance has reduced to zero (as with GMLWBs), this additional benefit should be regarded as part of the original account based annuity for minimum payment standard purposes..

4.2 *Allowances for deferred annuities:* If deferred annuities are to be permitted within the principles outlined above, the following restrictions should apply:

- Purchase should be permitted only at retirement or age 60, after which they would offer no tax advantages if they were part of life annuity with a term certain guarantee – so they can be tax free.
- The benefits should only be payable as an annuity that conforms to the requirements set out for the new category below. The maximum amount that may be used to purchase a deferred annuity would be that which, when combined with other superannuation proceeds, would provide for the pattern set out in 4.4.3 below.

- The vesting date may be advanced where the fund/insurer permits, subject to evidence of health.

Discussion: It can be questioned whether the arguments for the desirability of deferred annuities have adequately considered the possibility that the assets set aside for the deferred period prove inadequate. If they are exhausted, there will be a demand to bring forward the deferred annuity payment. There is therefore an argument for combining the two phases/products – into a life annuity with a guaranteed period.

4.3 *New Category of Flexible Longevity Products:* This is a new category of product, with suggested criteria as follows:

4.3.1 An admissible longevity product is one which pays a defined income stream from a specified commencement date (after retirement or preservation age) throughout the life of the beneficiaries.

4.3.2 After the specified commencement date, income stream payments must be made at least annually.

4.3.3 Income stream payments are not required to be guaranteed in dollar terms but are subject to minimum payment requirements (refer item 4.4 below).

4.3.4 The benefit structure of a longevity product may be defined entirely in terms of units or other well defined interest in an investment pool, or units whose value varies directly in line with a regularly published economic or investment index, or in nominal dollar terms. This change provides more product flexibility and is necessary to enable longevity products to be developed free (where desired) from the constraints of providing long term guarantees of investment returns or life expectancy.

4.4 Minimum Payment Requirements for Longevity Products: These are suggested as follows:

4.4.1 The requirements are assessed at the point of purchase of a longevity product, not on an ongoing annual basis after purchase;

4.4.2 The same numeric table applies as other products but is used differently.

- The income stream payment in the first year after the specified commencement date must not be less than the percentage of the purchase price specified in the table, based on age at the specified commencement date. Where the benefit structure of the product is entirely defined in units, this requirement may be assessed in units rather than dollars.

  This does reduce the minimum payments required, and an argument can be made to escalate the purchase price where the annuity is not account based.

4.4.3 If the income stream payments are not guaranteed in advance in dollar terms, then the product provider must certify that the income stream payments are intended to form a pattern that would provide a level income in real terms throughout the life of each beneficiary (possibly taking account changes to Age Pension entitlements), based on:

i) the method of determining the payments within the product structure, which would allow for deviations from the pattern because of unanticipated changes to longevity and investment experience or changes to the Age Pension in and

ii) a hypothetical scenario of a constant 3% investment return from the specified commencement date and longevity equal to the most recent Australian Life Table. The life table would be adjusted for impaired lives, where a greater income was paid after the underwriting of the annuitant. {PARAMETERS ARE PLACEHOLDERS ONLY}

4.4.4 The life expectancy of any possible entrant or entrants to the product (entry ages, sex, other relevant characteristics).

4.4.5 The benefits are non-commutable.

4.4.6 A pre-determined reduction in the income stream at the point where the income stream switches from primary to reversionary beneficiary is permitted.

5 Provider Tax Issues

All reserves held in respect of annuity payments should be subject to post-retirement tax treatment (no tax and refund of tax credits.) Shareholder capital should be subject to corporate taxation.

6 Retiree Tax Issues (Accruals Tax Treatment)

We believe that the products that might be created possible changes suggested in section 4 would not be more attractive than existing products – from a taxation perspective.

Second order effects on government revenue might arise if retirement income products became more popular. It is not however clear what the net impact would be. The impacts are beyond the scope of this paper, as is any consideration of whether any products should be given favourable treatment.

7 APRA surrender value standards

The recent flexibility introduced into the standard should be made explicit.

8 Other APRA standards? – e.g. investment linked/other separate statutory fund requirements

No change recommended.

9 Social Security and Aged Care Means Test

As with the comments in section 6 above, there may be second order effects of the recommended changes, but they are beyond the scope of this paper. We also do not consider changes that might favour one or other product.

Actuaries Institute

Who Will Fund Our Health?

GREEN PAPER
December 2014

Contents

This Green Paper was commissioned by the Actuaries Institute and prepared by Kirsten Armstrong and Sophie Dyson, Directors, Three Rivers Consulting.

Executive Summary

The Actuaries Institute has a vital interest in public policy issues linked to demographic change. Actuaries understand the financial risks associated with Australia's ageing population and have long advocated greater policy focus on managing longevity risk – the risk of the elderly outliving their financial resources. This green paper highlights the growing risk for society and government of failure to recognise and respond to the impact of demographics on our health system.

This paper is not a blueprint for fixing the health system. It is intended to be a catalyst for the generation and discussion of ideas in order to help policymakers and stakeholders manage the challenges facing Australia's health care system. Although potential remedies are raised in the paper these are not endorsed solutions, but financing options for further consideration and debate to drive sensible policy reform.

Although this paper does not investigate the important area of seeking cost efficiencies in the delivery of health, we acknowledge it is another area that is being, and must continue to be, addressed.

Demographic change is increasing health care expenditure

Governments around the world are facing the challenge of increased health care expenditure driven by, ageing populations, the cost of new medical technologies and higher public expectations.

Health care costs rise dramatically with age – health expenditure for an 85 year old Australian is more than four times that for a 50 year old. By 2049-50 the number of Australians over 85 will more than triple.

Lifestyle factors also play a key part in rising health care costs and Australia scores poorly on many of these factors e.g. some 28% of Australians aged 18 or over are now obese.

Ageing is the most predictable factor which will influence future health expenditure. It is a key factor that affects our ability to fund health care. Ageing and demographic change is therefore the focus of this paper.

Our population is predicted to live significantly longer and forecasts indicate that spending on health care across all levels of government is expected to grow from 6.5% to 10.8% of GDP over the next 50 years.

In other sectors, governments have acted decisively to try to 'future-proof' some of the future costs to government of ageing. Examples include compulsory superannuation introduced in the 1990s and the more recent overhaul of aged care funding.

Who pays for health care?

It is working age households who contribute the most to health care costs, through taxation.

Health care remains almost entirely funded on a pay-as-you-go basis and largely through general taxation. Pre-funding of future health care needs is virtually non-existent.

Total expenditure on health goods and services in Australia was an estimated $147.4 billion in 2012–13 (9.7% of GDP). Currently 68% of health expenditure is funded by Australia's various levels of government.

It is not just governments that need to worry about the cost of health care. At all ages, a considerable share of health care costs are borne directly by the Australian population through out-of-pocket payments and private health insurance.

Implications for future generations

Some intergenerational cross subsidy is an inevitable part of our health care system (as it is with other services) but the cost on the working population through taxation needs to be addressed in order to protect the quality of Australia's health care services and system.

Working age people will be supporting the health care costs of an increasing number of older people. By 2049-50, there will be twenty people aged 75 and over for every 100 working age people, compared to ten now. For the over 85s, where health care costs rise dramatically, there will be seven people aged 85 and over for every 100 working age people, compared to just three now.

Without policy action, the working population may be paying almost double their own health expenditure to subsidise older Australians compared to a current rate of 1.4.

How can we tackle the challenge?

Australia is not alone in facing the need to address the future funding of health care costs. Across the OECD, many countries are seeing rapid ageing, and Australia is roughly in the middle of these changes.

The following policy options to tackle this long-term challenge are explored, drawing on lessons from other countries and from other sectors in Australia. These are not endorsed solutions but examples of the approaches that should be discussed.

Working longer

Enabling people to work longer improves health status and boosts personal savings, and will be a critical part of meeting future health care costs. Both government and businesses need to support workers who are able to work longer to stay in the workforce.

Savings and pre-funding

There are several international approaches involving pre-funding of future health care costs including Medical Savings Accounts, Sovereign Wealth Funds and pre-funding future health insurance premium increases. Pre-funding is often a good long-term strategy for future-proofing, but with the first of the baby boomer generation already starting to retire, we may be too late to pre-fund some of the more significant generational health care costs looming on the horizon.

The potential role of wealth

By 2030, almost half of household wealth will be in the hands of the over 65s. This fact leads to the question does it make sense, and is it equitable, to ask this cohort to pay more to help fund future health care costs? The major reforms to the funding of aged care – *Living Longer Living Better* – which came into law on 1 July 2014 focus on just this issue. These reforms include a greater emphasis on 'user-pays' with increased means testing arrangements along with fee caps and lifetime limits.

The challenges in health care provision are unique, and a 'user-pays' approach could lead to higher mortality and poor health outcomes. Solutions to address this question will need to be equitable, practical and acceptable to the community whilst ensuring that all Australians have access to free or low-cost health care, consistent with Medicare's aims.

The way forward

Without a rigorous and comprehensive policy effort, the Actuaries Institute argues that Australia will face a series of major public policy problems in the funding of health care. The Institute argues that the next steps to address this major social policy challenge are consistent with the approach the Institute advocated in its submission to the Financial System Inquiry including:

- **adopt a comprehensive framework for policy formulation on all issues relating to the sustainable financing of our ageing population;**
- **manage the system using 'insurance principles' by focusing on risk management, financial sustainability and data analytics; and**
- **create an open data regime to allow increased access to and analysis of important government-held data and modelling information to better manage macro-level health financing risks.**

The way forward

The current health care funding system needs to be future-proofed effectively, to relieve the future cost on younger generations, and ensure later life health care quality is not downgraded.

1 Why is health care expenditure increasing?

Total expenditure on health goods and services in Australia was an estimated $147.4 billion in 2012–13 (9.7% of GDP) (AIHW 2014c). Although 2012-13 saw a 'dip' in per capita health care expenditure, when measured as a percentage of GDP, health expenditure continues to rise.

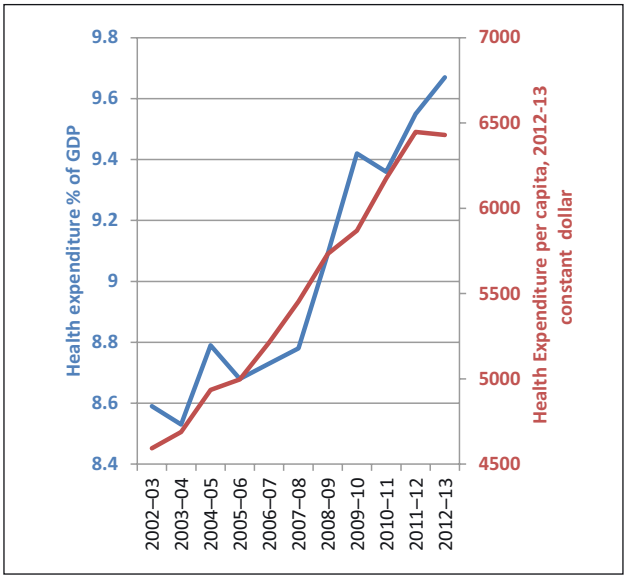


Figure 1: Health Expenditure (all sources), % GDP and per capita, Australia 2002-03 to 2012-13

Source: AIHW Health Expenditure 2012-13 >

Changes in the price of health services, and the volume of services used contribute to health care expenditure growth[1]. Considerable efforts have been made in recent years to rein in health care costs by seeking efficiencies in health care delivery, managing the prices of some health care services (particularly hospital services) and seeking to manage health care demand through the use of co-payments and other means.

The Australian Institute of Health and Welfare (AIHW) (2014c) reports that health inflation has been lower than general inflation in at least half of the decade to 2012-13. Excess health inflation across the period was around zero[2].

With health inflation well managed over the last decade, the type and volume of services used have been the biggest contributors to expenditure growth in Australia in recent years.

Technological change is the pre-eminent driver of volume growth, and in many ways this needs to be encouraged, provided patient outcomes are improved. CAT and MRI scanners, for example, have allowed clear, non-invasive imaging of body systems and have revolutionised diagnosis. The downside is that technology use can spread beyond where it is most valuable and replace existing, often less costly, methods.

Community expectations also drive demand for health services. Consumption of health care increases with income. As per capita income and the capacity to pay more for health care rises, so does demand.

Supply side issues are equally important, as they determine what services are available. Labour is a major component of health expense. A growing

1 Healthcare expenditure is expenditure on health goods and services, such as medications, health aids and appliances, hospital, dental and medical services; public health activities and other activities that support health systems, such as research and administration. It includes relevant capital expenditure, encompasses both preventative healthcare and curative care, but excludes non-health personal care / attendant care associated with aged and disability care.

2 Health inflation is the change in the total health price index. Excess health inflation is the amount by which health inflation exceeds general inflation (the average rate of change in prices throughout the economy, not just consumer prices). Box 2.1 of Health Expenditure Australia 2012-13 (AIHW 2014c) contains a full explanation of health and other inflation measures.

workforce is needed to meet health demand, but health professionals also create demand for the services they provide.

Ageing is an inexorable cost driver. Population ageing has been a relatively small contributor to the increase in health spending in the past – only 0.5% p.a. in OECD countries excluding the US (compared with 3.2% a year from other factors) according to research by the Economist Intelligence Unit (2012). However, the impact of ageing will become more significant in the future, a topic explored in detail by the Productivity Commission (2006).

Although ageing has not been the most significant factor influencing the growth in health spending, it is the most predictable factor which will influence future spending. More importantly, as we consider in the next sections, it is a key factor that affects our ability to fund health care. Ageing and demographic change are therefore the focus of this paper.

2 Population ageing: a funding challenge for future generations?

Despite radical reforms in other sectors, little has changed in health care funding

Our population is predicted to live significantly longer and forecasts indicate that spending on health care across all levels of government will grow over four percentage points of GDP over the next 50 years.

In other sectors, governments have acted decisively to try to 'future-proof' some of the future costs to government of ageing. Examples include compulsory superannuation in the 1990s and the more recent overhaul of aged care funding.

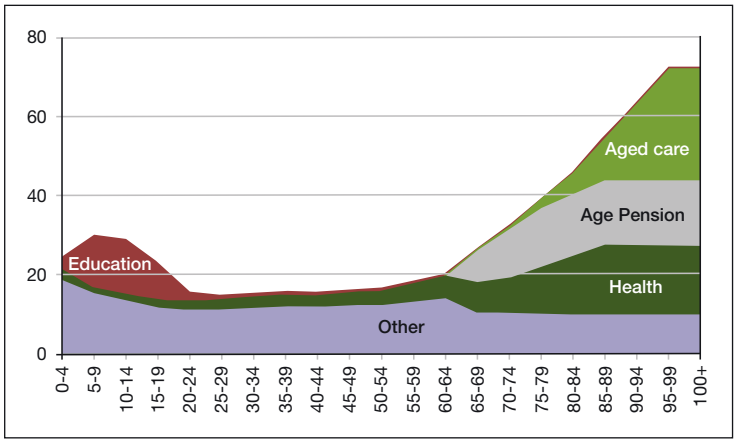
These changes have sought to clarify where government's role finishes and personal responsibility starts, while clearly addressing future funding needs. It means putting aside money for the future in the case of superannuation. In the case of residential aged care, it means ensuring wealth can be tapped into, to cover the costs of aged care accommodation.

Health care remains almost entirely funded on a pay-as-you-go basis, and largely though general taxation. Pre-funding of future health care is virtually non-existent.

This lack of 'future-proofing' is evident in recent forecasts by the Productivity Commission (2013), which indicate that spending on health care across all levels of government will grow over four percentage points of GDP over the next 50 years, from 6.5% to 10.8% of GDP. This is by far the most significant change in government expenditure in the coming decades. Health care, already the single biggest item in governments' budgets, will take a much larger share in future.

Figure 2: Age-related government spending, all governments, 2011-12 ($'000 per capita)

Source: Productivity Commission (2013) >



It is not just governments that need to worry about the cost of health care. At all ages, a considerable share of health care costs are borne directly by individuals, through out-of-pocket costs and private health insurance.

Figure 3:
Projection of Government spending by category, % of GDP, 2011-12 and 2059-60

Source: Productivity Commission (2013)>

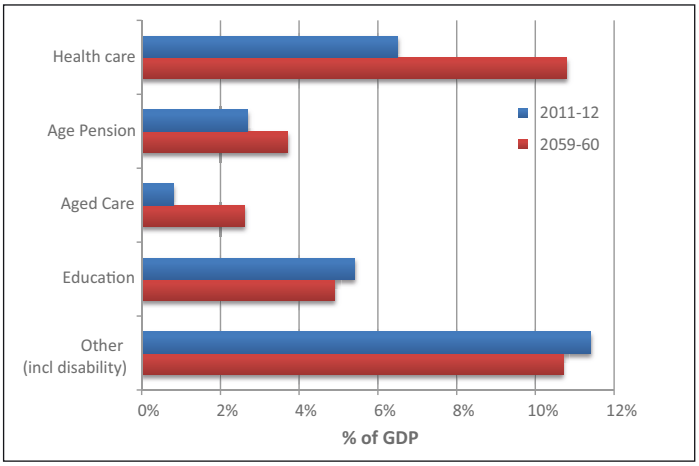


Figure 4 shows this Green Paper's analysis of per capita health expenditure by age and source of funding. While government is the predominant funder of health care in older ages, those over 65 are averaging more than $2,250 in out-of-pocket payments each year, in addition to paying for private health insurance.

Figure 4:
Estimated expenditure per capita by age group & source, 2013

Source: The Treasury IGR 2010, AIHW Health Expenditure Australia 2012-13, This Green Paper's analysis >

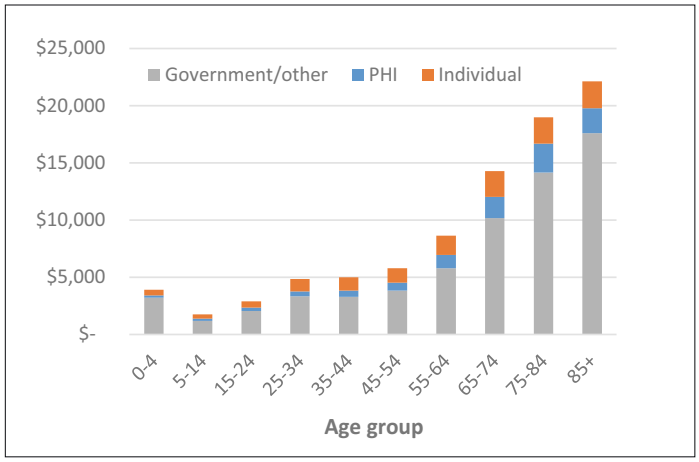
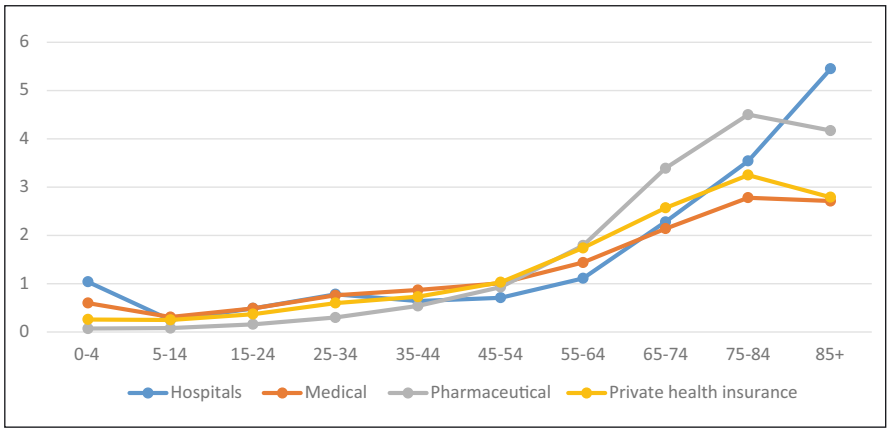


Figure 5 shows the indices of relative health expenditure by age used in the Commonwealth Treasury's 2010 Intergenerational Report, illustrating the rise with age in all areas of health expenditure.

Figure 5:
Index of relative expenditure on health care, 2008

Source: The Treasury IGR 2010 >



Health care costs may be growing more quickly in older age groups

Across all types of health sector services – private hospitals, medical services, pharmaceutical services and, most significantly, public hospital services, health care expenditure is higher at older ages. Furthermore, it appears that per capita health expenditure is growing faster in the older age groups, which will exacerbate the health expenditure effects of population ageing.

Detailed estimates of health expenditure by age are not reported in the annual AIHW Health Expenditure reports. Hospital separations and Medicare benefits were examined instead. These suggest that more and more investment in health care is being directed toward older age groups.

Hospital services, which comprise around 38% of total health care costs, and Medicare benefits, which represent around 12% of total health expenditure, have grown more rapidly in older age groups (Figures 6 to Figure 9). Increasing life expectancy has the potential to magnify the effect even further.

Figure 6: Hospital separations per capita in each age group, 2007-08 and 2012-13

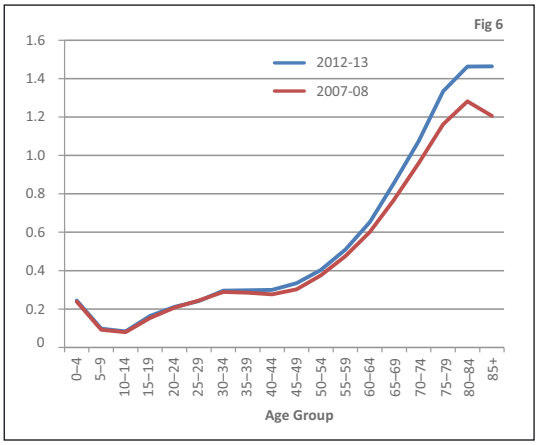
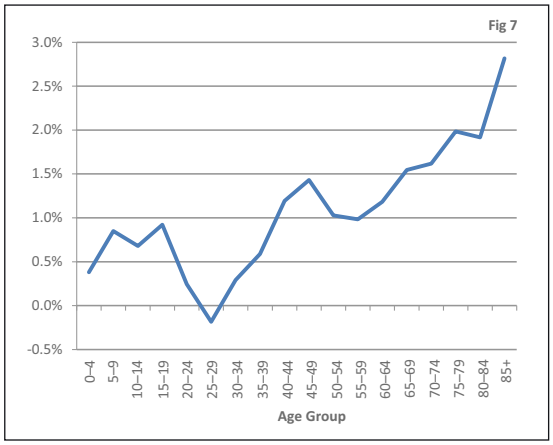


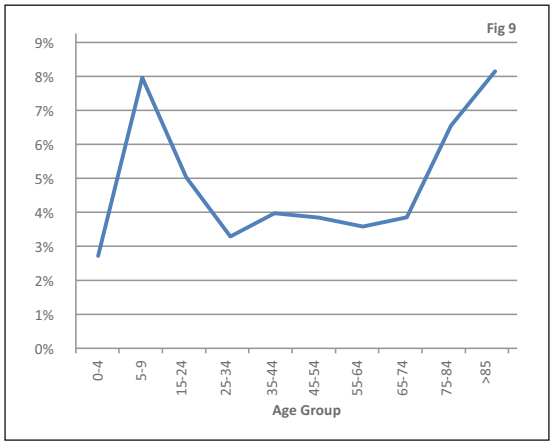
Figure 7: Annual change in Hospital separations per capita, 2007-08 to 2012-13



Figs. 6-7 Source: AIHW Hospital Statistics 2012-13 and 2007-08

Figure 8: Medicare benefits per capita in each age group, 2007-08 and 2013-14

Figure 9: Annual change in Medicare benefits per capita, 2007-08 to 2013-14



Figs. 8-9 Source: Medicare Statistics 2013-14 and 2007-08

***Obesity** is a medical condition in which excess body fat has accumulated to the extent that it may have a negative effect on health, leading to reduced life expectancy and/or increased health problems. In Western countries, people are considered obese when their body mass index, a measurement obtained by dividing a person's weight by the square of the person's height, exceeds 30 kg/m, with the range 25-30 kg/m defined as overweight.*

Behavioural risks – like poor diet and obesity – are getting worse

The growth in chronic diseases like cardiovascular diseases, cancers, chronic obstructive pulmonary disease (COPD) and diabetes, and the emergence of a growing number of older people experiencing multiple chronic diseases may explain why health expenditure is increasing more rapidly at older ages.

Currently, 9 in 10 deaths have chronic disease as an underlying cause (AIHW 2014a), and chronic diseases also cause the greatest burden of disease[3]. The Institute for Health Metrics and Evaluation's Global Burden of Disease study (IHME 2013) found that in Australia and New Zealand, chronic diseases together caused 85% of the total burden of disease.

Initial results from the Global Burden of Disease study highlighted that dietary risks, a high body mass index (BMI) and smoking were the three most important risk factors contributing to the burden of disease in Australia (IHME 2013).

Smoking rates, which account for 8% of the total burden, have declined dramatically in Australia over several decades. However, there is evidence that two important risk factors, dietary risks (11% of the total burden) and high BMI (9%), are continuing to rise.

Successive health surveys in Australia have shown that Australians' intake of fruit and vegetables is well below that recommended by the National Health and Medical Research Council (NHMRC) Nutrition Guidelines, and in 2011–12, just 49% of adults were eating enough fruit for optimum nutrition, while 92% of adults were not eating enough vegetables. According to the ABS Australian Health Survey 2011–13, nearly two-thirds of Australians aged 18 or over are now overweight or obese, compared with about 56% in 1995. The deterioration is continuing, and apparent across all ages. Figure 10 shows the rise in obesity since 1995. The direct cost of obesity has been estimated at $14.5 billion per year (Colagiuri et al 2010).

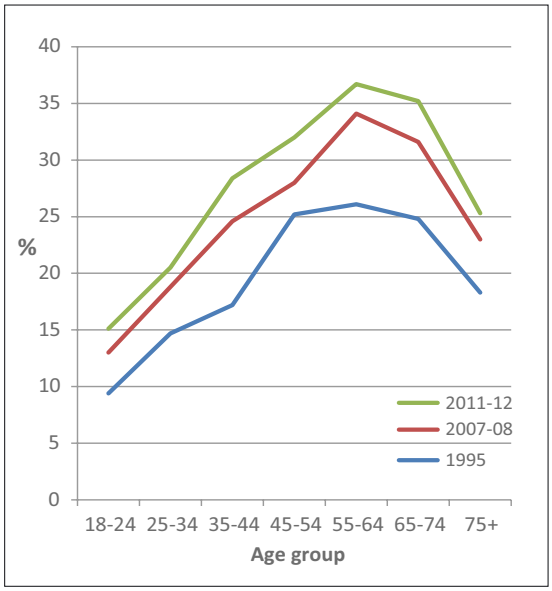


Figure 10:
% of persons who were obese, 1995 to 2011-12

Source: ABS Australian Health Survey, 2011-13, ABS National Health Survey 2007-08, & 1995 >

The deterioration in lifestyle risk indicators and the rise in chronic disease are likely to lift per capita health care costs at younger ages, so it is not just ageing that is the concern. Whatever the source of rising expenditure, the ability to fund it in the future needs to be addressed.

[3] Burden of disease is measured in disability-adjusted life years (DALYs), which are the number of years lost due to ill health, disability or early death.

3 Who pays for health care?

Almost all health is funded with a pay-as-you-go approach

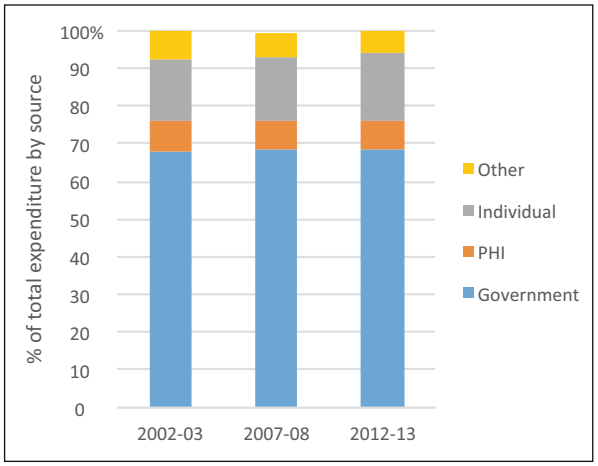
In 2012-13 (the latest figures available from the AIHW), 68% of health expenditure was funded by governments. Some 18% was funded by individuals through out-of-pocket payments, a further 8%[4] by private health insurers and 6% by other sources, mainly injury compensation insurers like workers' compensation and motor injury insurers.

This split between the different funders has remained largely unchanged over the past decade, albeit with a small shift from the Australian Government to state and territory governments.

[4] Excludes the value of government PHI rebates, which are included in government funding.

Figure 11: Source of Funds, % of Total Health Expenditure, Australia 2002-03 to 2012-13

Source: AIHW Health Expenditure 2012-13 >



Working age people bear most of the cost of health care, despite using a relatively small share of health services

To understand who pays for healthcare, who uses it, and how this balance might change as a result of future demographic change, health care expenditure and funding patterns by age group were analysed and compared. To take account of the economic inactivity of children, the comparative analysis included age groups using households, rather than individuals as the unit of analysis.

Our modelling approach

The 2010 Intergenerational Report indices of relative health care expenditure by age (shown in Figure 5), were combined with the AIHW's estimates of health expenditure by area and source of funds for 2012-13. Where the age-based relativities could be updated, we did so – this was the case for Medicare and private health insurance spending. New components were added for non-government expenditure, using private health insurance data for private hospitals, dental care and other extras treatments, and out-of-pocket health expenditure from the 2009-10 ABS Household Expenditure Survey were estimated. Health expenditure was then allocated to households, using information about the composition of households from the ABS Household Income and Income Distribution survey 2011-12.

To estimate the relative funding that households of different ages contribute to government health care, taxation data was analysed. Household income tax and GST by age of reference was used as a proxy (GST was estimated from household consumption). While there are many other sources of government revenue, income tax and GST make up half of total revenue and are the least ambiguous to allocate by age. Individual out-of-pocket funding is, by definition, the same as out-of-pocket expenditure. PHI funding is based on the PHI premiums paid by households of different ages. Although PHI is community-rated (i.e. in each state, policyholders pay the same price for the same product) product choice accounts for the differing levels of PHI 'funding' in households of different ages.

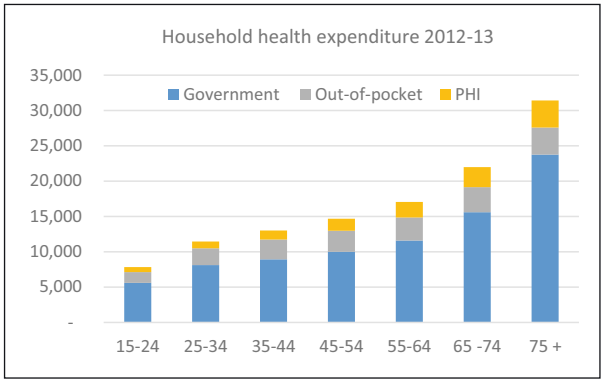
The results are shown in Figure 12. The first chart shows the breakdown of health expenditure by source: government, individual out-of-pocket and PHI claims. The second chart shows the contribution that households make towards overall health funding, by source, as described above.

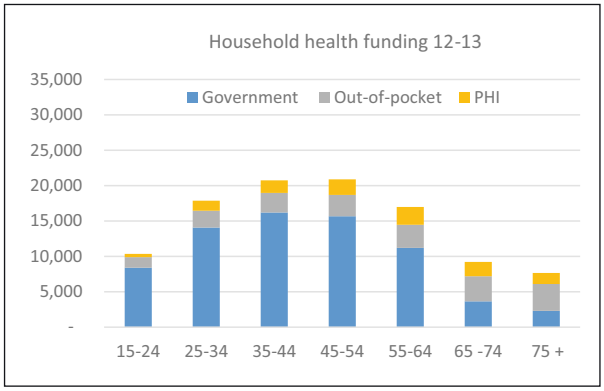
The results show that:

Out-of-pocket expenditure on health care can be considerable, particularly at older ages. Data from the Household Expenditure Survey indicates that in older households (65+), out-of-pocket spending per person on medical and health care expenditure is over $2,250 per year, compared with under $1,000 a year for those under 55.

Figures 12a+b: Estimated health expenditure and contribution to health financing per household 2012-13 by reference age of householder

Source: This Green Paper's analysis >





[5] The Association of Superannuation Funds of Australia

This spending comes from income. Whether future superannuation savings can fund growing health care costs has not been tested, but evidence from the superannuation sector suggests this will be a stretch for many.

The ASFA[5] Retirement Standard estimates the annual budget needed by Australians to fund either a 'modest' or 'comfortable' standard of living in retirement. The 'modest' standard of living includes an allowance of $2,100 for health care expenditure each year, below the $2,250 the over 65s are paying in out of pocket expenditure, and well below the $2,900 once average private health insurance premiums are added in.

Research by ASFA (2011) demonstrated that the average superannuation payout of retirees in 2009-10 was $192,000 for men and $113,000 for women, not adequate to provide a 'modest' lifestyle for retirees without the benefit of an age pension. While superannuation balances are projected to increase, few will move beyond 'modest' to a 'comfortable' lifestyle.

The mismatch between government funding and expenditure is significant.

Working age households are contributing, through taxation, on average more than 1.5 times the government-funded health care they receive (over 1.8 times in some age groups) and effectively cross-subsidising government health care costs of those aged 65 and over ('Government' line in Figure 13).

Households with a reference age over 75 meet 10% of their government-funded health care costs through tax contributions, and just 25% of all their health care costs when other sources of expenditure and funding are considered.

This intergenerational cross-subsidy would be sustainable in a stable population distribution, but the demographic shape of the population will change dramatically over the next 30 years.

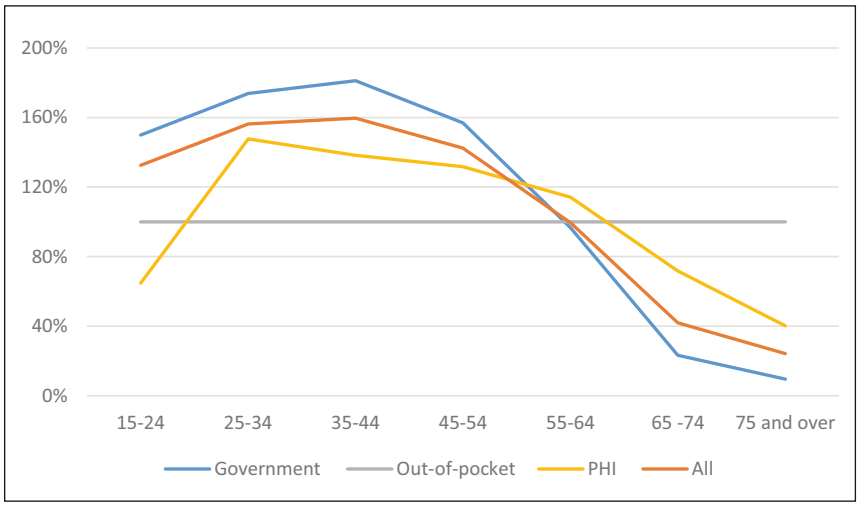


Figure 13: Ratio of household funding to expenditure on health, by source 2012-13

Source: This Green Paper's analysis >

4 What does this mean for future generations?

Working age people will be supporting the health care costs of more and more older people

There has always been a subsidy from working age households to retired households, and this is expected in our society. When the proportion of non-working to working people is stable, and the cross-subsidy is sustainable, this is not an issue. What is notable about the demographic shift that Australia is expected to experience over the next 40 years is the extent of the intergenerational cross-subsidy that will result from population ageing and demographic change.

Consider 100 working age people now and in 2049-50. Right now, for every 100 working age people there are **ten people aged 75+, of whom three are aged 85+**. By 2049-50, for every 100 working age people there will be **20 people aged 75+, of whom seven will be aged 85+** (Figure 14).

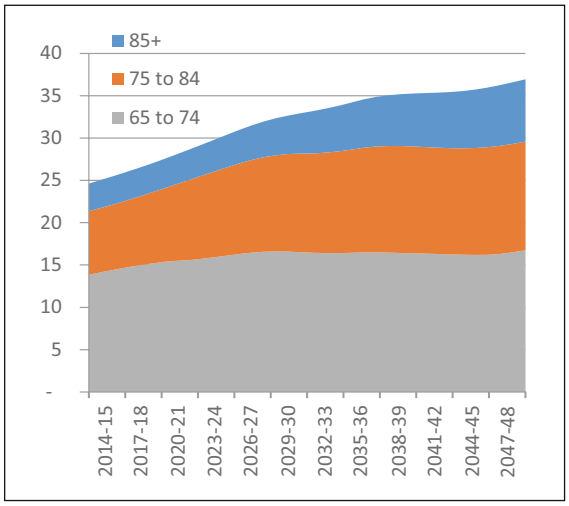


Figure 14: Number of older persons per 100 working age persons, 2014-15 to 2049-50

Source: ABS Cat No. 3222.0 Population Projections, Series B >

The substantial change in the 'dependency ratio' raises serious questions about who will pay for future health care costs.

Using the analysis described in the previous section, and assuming that the patterns of health expenditure and funding by household remain the same as in 2012-13, this Green Paper has projected how the ratio of funding to expenditure of different age cohorts might change as the population ages. By definition, this analysis ignores the effect of health inflation and the impact of chronic disease and other factors. One projection assumes no change in the use of health services by age, and another allows for moderate increases in health service use by age – 0.2% a year at age 0-4, rising to 1% a year at age 85+ (well below the levels seen in recent years). The results are shown in Figure 15.

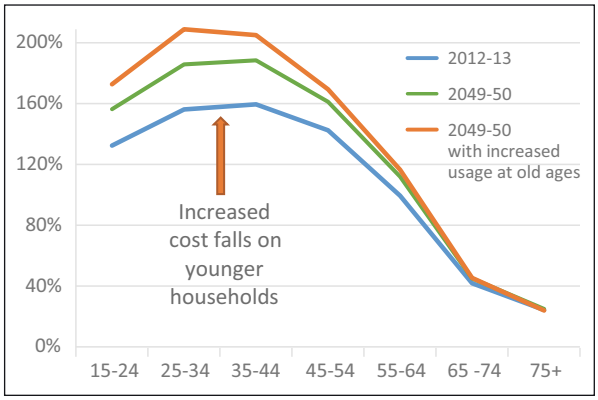


Figure 15: Ratio of household funding to expenditure on health, by source 2012-13 and 2049-50

Source: This Green Paper's analysis >

Projecting forward, the working age population might be paying 1.6 times the cost of their own health care expenditure (compared to 1.4 times now) in order to fund the health care costs of the increasing proportion of older age groups.

If per capita expenditure at older ages continues to grow more quickly, this will exacerbate the results. Medicare expenditure and hospital separations per capita have been growing 8% and 3% respectively faster per annum in the over 85s, compared with younger ages. If this extra growth were to continue at just 1% a year for the over 85s, the funding cost shifts even further, with younger ages funding 1.8 times their own health consumption (and up to 2.1 times in some age groups). Translating this change into income terms, this represents an additional 12% of income needed to fund health care for some age groups (through higher PHI contributions, out-of-pocket expenditure and funding government spending). We note that this is not just about the health costs of the older age groups – rises in the volume of services have an effect at all ages. A 2% rather than 1% increase for the over 85s would result in an even greater funding cost with younger ages funding 1.9 times their own health care costs.

The perceived value of private health insurance will likely change

For private health insurance (PHI), younger households might pay more than 1.5 times the cost of their own PHI, in order to fund older age groups (up from 1.3 times currently). Will this change people's choices to insure? There are various financial incentives that exist to encourage younger and/or healthier age groups to take out and maintain health insurance, including Lifetime Health Cover and tax penalties for not having hospital cover. The existence of these incentives means that younger people may still make the choice to insure, but the 'sticks' used to encourage PHI uptake may be less palatable to the community if PHI becomes more expensive and less attractive.

The demographic shift has implications for the average level of premiums too. As the average age of those with private health insurance increases, so too will hospital cover premiums. Because older ages have fewer tax penalties from a failure to hold PHI, it may be the older aged people that choose to drop PHI cover for cost reasons. Although numerous studies show that older people value PHI highly, the coverage level in the over 85s is already lower than average (38% have hospital cover compared with 47% of the population overall). Faced with the difficult choice of whether to continue to purchase insurance coverage, or to rely solely on the public health care system, some will choose the latter.

Older people will need to find ways to fund their out-of-pocket costs

Older age groups incur the highest *level* of out-of-pocket expenditure on health care, although this represents a lower *proportion* of their health care costs than in younger age groups.

A comparison of out-of-pocket expenditure to income, shows that the cost of individual health spending is greater for older people. In the 2009-10 ABS Household Expenditure survey, out-of-pocket expenditure on health care represented 4% of household gross income for the oldest age groups against 1% for the youngest households. (Private health insurance premiums represented a further 2.3% of income in the oldest households versus 0.4% for the youngest households). As health care costs grow, so will the need to meet those costs from personal resources, and as discussed above, the ability of older Australians to fund additional expenditure from their superannuation is limited.

This means the changing cost of health expenditure is not just about the inter-generational shift, there are intra-generational factors concerning the ability of older Australians on low incomes to fund their health care needs.

5 How does Australia compare?

Australia is not alone in the need to address the future funding of health care costs. Across the OECD, many countries are seeing rapid ageing, and Australia is roughly in the middle of these changes.

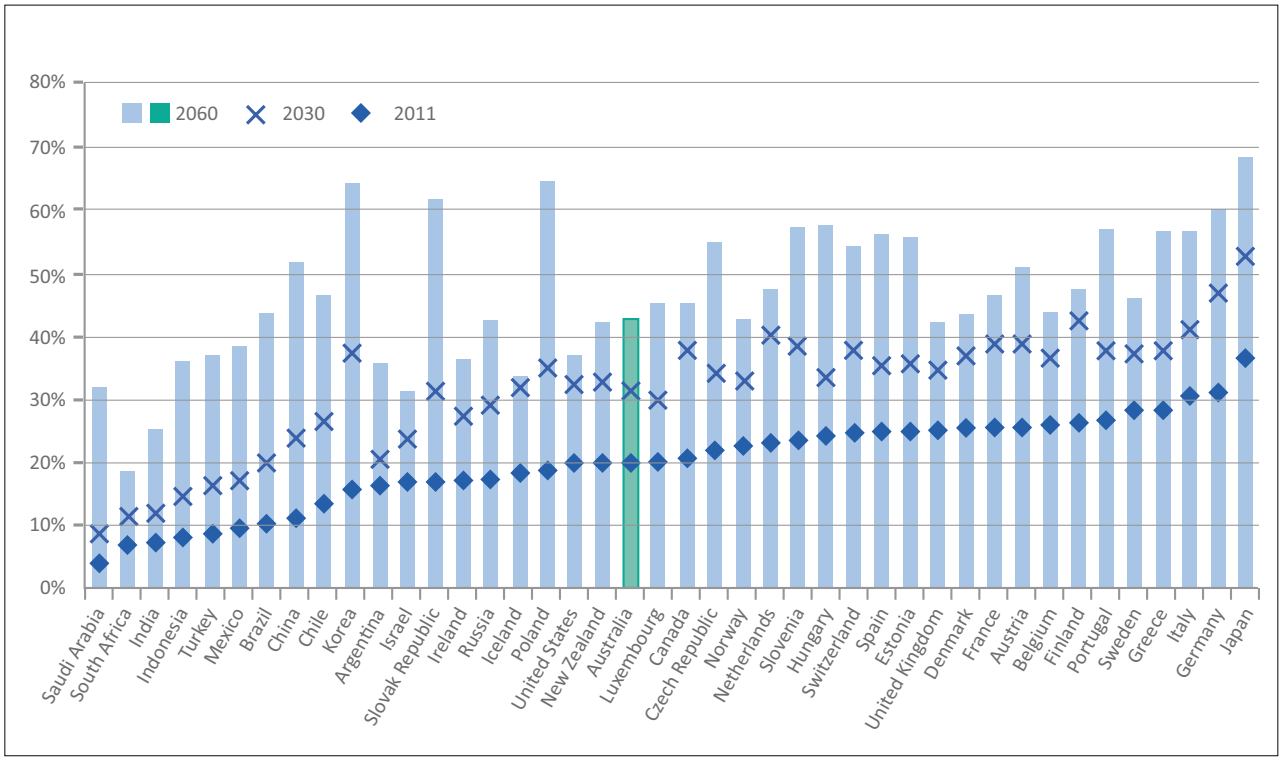


Figure 16:
Old age dependency ratio: Population aged 65+ as per cent of population aged 15-64

Source: OECD (2012). Looking to 2060: Long-term global growth prospects, OECD Economic Policy Paper No. 03

Despite being one of the 'younger' countries, per capita health expenditure in Australia is higher than average.

Australia's health care expenditure is comparable to many countries in the OECD and indeed, on a range of health delivery measures, we are roughly in the middle of our OECD comparators. But does that mean our health system is performing well?

Comparisons of health care systems are notoriously difficult, with many factors influencing health costs and outcomes. The OECD's regular series of statistics comparing health systems (OECD 2014a) provides some useful information for 2012, although some degree of caution is needed in making comparisons. High-level analysis shows that:

- In terms of health expenditure per capita, Australia was **above average**, ranking twelfth of 34 countries. However, in terms of ageing, Australia is **below average**, ranking 24th in terms of the proportion of the population aged 80+. In other words, we are spending more per capita on health care than might be expected, given our relatively young population. Indeed, of the 22 countries that are relatively older than Australia, 12 spend less per capita than Australia on health.

- There's no clear evidence that extra spending is translating into better health outcomes. Indeed, several countries have been able to achieve higher life expectancies than Australia with lower health care spending per capita (Italy, Spain, Iceland and Japan).
- The growth in per capita health spending Australia experienced in the decade to 2012 was slower than average (third quartile) but we have also been ageing considerably slower than most countries. Between 2002 and 2012, the percentage of the population aged over 80 increased by just 0.5%, from 3.3% to 3.8%, compared to Japan (2.6% increase), Greece (1.9%), France (1.4%) and Germany (1.3%).

Table 1: Health expenditure per capita and Population 80+, Australia and OECD, 2012

	In 2012		Change – 2002 to 2012	
	Australia	Ranking	Australia	Ranking
% of population aged 80+	3.8%	24 3rd quartile	0.5%	26 4th quartile
Health expenditure per capita, $US PPP	$4,196	12 2nd quartile	5% p.a.	20 3rd quartile

Source: OECD Health Statistics: Key Indicators, 2014 (OECD 2014a) >

Risk factors like obesity are a worrying sign for Australia.

Relative to other OECD countries, we rank high on several risk factors, which will lead to significant health pressures through chronic disease as people age. Australia ranked fifth (behind USA, Mexico, NZ and Hungary) in the OECD in terms of obesity rates, well above the OECD average (OECD 2014b). These behaviours, if left unchanged, will lead to high rates of chronic disease such as diabetes and cancer. Figure 17 shows obesity rates for selected countries only, with clear evidence of ongoing increases for Australia.

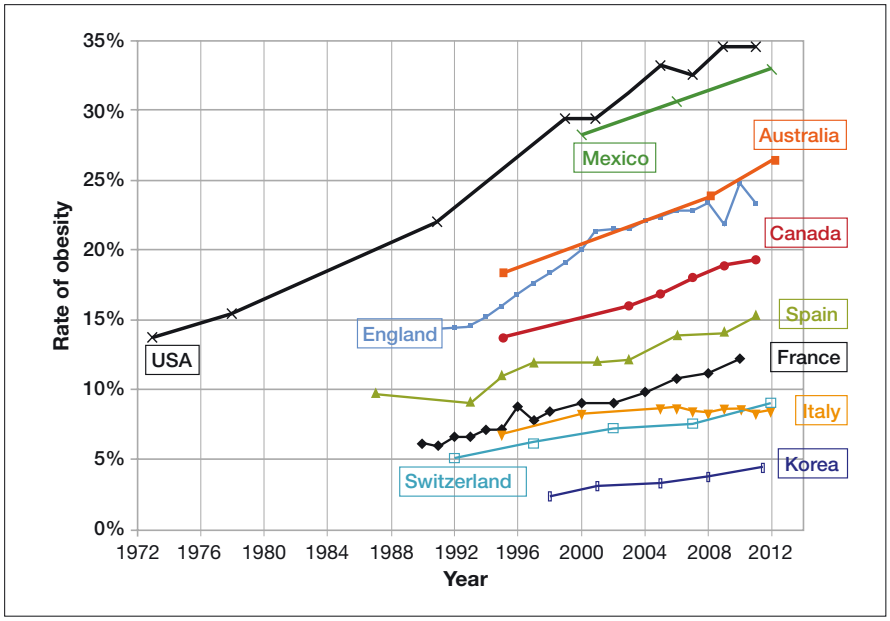


Figure 17: Age/gender adjusted obesity rates (2005 OECD standard population), Selected countries OECD, 1972-2012.

Source: OECD Obesity Update June 2014 (OECD 2014b) >

6 How can we tackle the challenge?

In *Australia's Health 2014,* the AIHW proposed three important 'expenditure' side measures to help contain future health care costs: promoting good health across the lifespan; enabling healthy ageing; and enhancing productivity in health-care delivery.

But is this enough? Even with good management of future health care expenditure, attention must turn to long-term financing solutions to meet future health care costs. Given the predominance of public funding in the mix, attention must focus on how public finance can respond to population ageing. If ignored, it is younger people who will increasingly need to pay for the growing health expenditure for older Australians, through successive tax increases. The alternative is that we may face difficult choices about what health care we fund and for whom and the consequent social, equity and welfare issues that arise.

In this section, some of the financing solutions being used in other sectors in Australia and in other countries to tackle this long-term challenge are explored.

Working Longer

Enabling people to work longer improves health status and boosts personal savings and will be a critical part of meeting future health care costs. Both government and businesses need to support workers to stay in the workforce.

Working longer can support the financing of health care costs, both through additional tax contributions and through the contribution of a longer working life to superannuation balances and other household savings. Deloitte (2012) estimates that even a relatively small increase in mature age participation from 6 to 6.5 in 10 will boost the economy by a projected $48 billion in 2050 and increase retirement savings for individuals. There is also evidence that employment has a positive influence on health status, however it is acknowledged that some types of occupation may find it difficult to work longer.

Working longer is already a trend internationally. PwC (2014) estimates that in the mature economies of North America and Europe, one in two people work into their 60s. In the United States one in five people in their 70s have some form of paid work.

What about Australia? The AIHW (2014a) estimates that in 2013, 12% of people aged 65 and over were in the labour force. Australia still has some catching up to reach North American and European participation rates, but it appears that the trend to working longer is already underway. In 2003, just 6% of the over 65s were working and among people aged 65–69, the proportion of women in the labour force was 2.3 times as high in 2013 (20%) as in 2003 (8.5%), and 1.7 times as high for men (33% and 20% respectively).

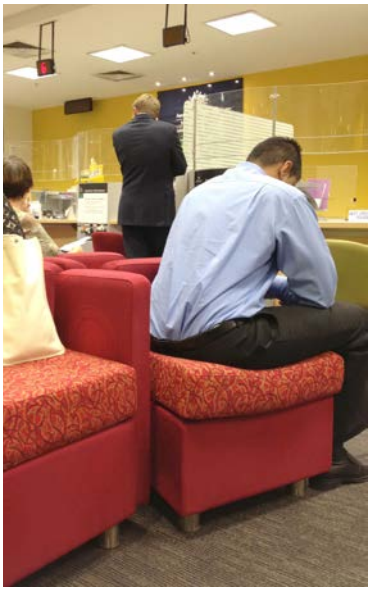
The effect of working longer on future 'dependency ratios' depends on the age to which people work. In 2049-50, there would be 19, rather than 20, people aged 75+ for every 100 working age people, if working age is extended from age 65 to 70. But, if we can extend the age at which health costs start to really climb by two years – from age 75 to age 77 – then the ratio drops from 20 to 16. Increasing retirement savings and reducing age pension payments would also take pressure off governments, allowing them to support further health care costs.

This change will need to be supported by government and businesses. The Actuaries Institute (2012) argued for several financial measures to support extended working including: removing age limits on superannuation contributions; encouraging workforce participation by changing the age pension means test; and offering an increased age pension for people who continue to work past the eligibility age. PwC (2014) argues that businesses may need to redesign jobs, tools and practices to accommodate older workers, and in service industries match the age of their workforce to their customers. The potential benefits are substantial.

Incentivising Individual Savings – Medical Savings Accounts

Medical Savings Accounts are unlikely to make a substantive difference, without being mandated, and it is already too late to use Medical Savings Accounts to fund the health care costs of the baby boomer generation. Unless well designed, they could also widen the 'wealth gap' in access to health services to an unacceptable extent.

Several countries have introduced Medical Savings Accounts to encourage personal saving for future health care costs. In some countries, funds in the medical savings accounts can be used to finance future health expenses and, in the case of Singapore, Germany, Hungary and the US, can also be used to finance future health insurance premiums.



Schemes in Singapore, China and Germany are compulsory and hence similar in many respects to superannuation in Australia, albeit with far more restrictions on the ultimate use of funds. The schemes in Hungary, New Zealand, South Africa and the US are all voluntary. Apart from New Zealand, all offer tax incentives to encourage savings.

Table 2: Features of Medical Savings Accounts in selected countries

	Compulsory	Tax incentives	Can fund private health insurance premiums	Can fund direct health care costs
China	✔	✔		✔
Singapore	✔	✔	✔	✔
Germany	✔	✔	✔	
Hungary		✔	✔	✔
South Africa		✔		✔
US		✔	✔	✔
New Zealand				✔

Could this work in Australia? Voluntary medical savings accounts might seem appealing, but experience in other countries suggests voluntary accounts have not been particularly popular. In the US, recent data (AHIP 2012) showed that uptake of medical savings accounts has been relatively low, despite significant tax incentives, and most contributions – perhaps 50% to 75% – are being withdrawn each year to pay for the current year's medical expenses. In other words – they provide minimal 'future-proofing'.

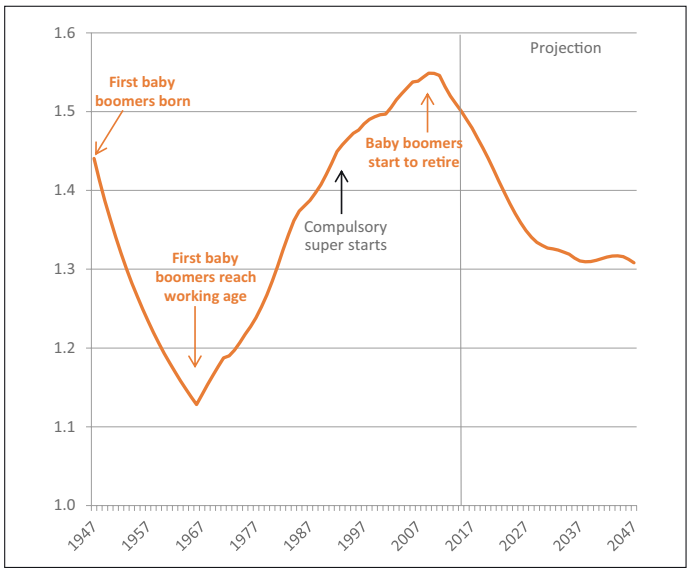


Figure 18: Ratio of working age to non-working age population 1947 to 2047

Source: ABS Census data, Australian Demographic Statistics 2014 and Population Projections, Series B >

Considering the compulsory approach, one option would be to further increase compulsory contributions to superannuation in order to part-fund future health care costs or future private health insurance premiums. While Australian employers contribute 9.5% of salaries to superannuation, Singaporean employees and employers contribute a total of 36% of salaries to a Central Provident Fund to finance retirement, health care, home ownership and post-secondary education. Of this up to 16% of salaries go to an individual *Medisave* account – a substantial contribution.

Both voluntary and compulsory savings options mean more tax incentives for saving – a difficult sell. Indeed, the current Government has proposed to defer planned increases in the superannuation contribution rate by three years.

Is it too late?

It may be too late if we want to pre-fund some of the more significant generational health care costs looming on the horizon. The first of the baby boomer generation (born 1946 to 1964) reached aged 65 in 2011 and the ratio of working age population (20-65) to non-working age has declined from its peak since then.

Compulsory superannuation, launched in 1992, has harnessed the savings of the baby boomers for the past 20 years, but with most retiring over the coming decade, it will be too late for many for a Medical Savings Account to grow to any meaningful size.

Indeed, if Australia is to consider mandating that the current working population save to meet their own future health care needs, further work would be needed to understand the implications of asking the current generation to pre-fund part of its own health care needs, while at the same time meeting the unfunded and rising health care costs of the baby boom generation over the coming decades.

Equity and incentives to save

> **A sovereign wealth fund is worth considering when Australia returns to government budget surpluses, but that could be some way off.**

Medical Savings Accounts introduce another fundamental question – equity. The Productivity Commission (2011) estimates that the top 25% of baby boomers own 60% of the boomers' household wealth, while the bottom 25% own just 4%. Average personal wealth of the top 25% of baby boomers is some 13 times that of the bottom 25%. Further incentives to save are likely to widen the gap between wealthier and less wealthy households and could create undesirable differences in access to health care.

Boosting national savings – Sovereign Wealth Funds

Can we grow savings while maintaining equitable access to healthcare?

Sovereign wealth funds are one way governments can boost savings to benefit all, creating national rather than individual savings pools.

Singapore's *Medifund* provides one example. For those with inadequate *Medisave* accounts, *Medifund* ensures that no Singaporean is denied good basic care because of inability to pay. *Medifund* was established in 1993 to subsidise health care for the poor (roughly 10% of the population) on a means-tested basis. It draws on the interest of an initial capital injection of US$150 million and contributions to the fund during years of overall budget surplus.

Other sovereign wealth funds have been created by resource rich countries, as a way to stabilise economies and allow future generations to benefit from current resources. Examples include:

- the Kuwait Investment Authority, established in 1953 from oil revenues;
- the Revenue Equalization Reserve Fund of Kiribati, created in 1956 from levies on phosphate fertiliser exports;
- the Government Pension Fund of Norway, established in 1990, again from oil revenues.

What about Australia? Australia's Future Fund is similar but with a narrower remit than many other schemes. Established in 2006, its purpose is to make provision for government's unfunded superannuation liabilities. In theory, a 'Health Future Fund' could do the same to balance the pressures of future health care spending.

The challenge of course is how to finance such a fund. The Future Fund tends to be financed in times of government budget surplus and, following several years of budget deficits, the value of the Future Fund remains well below the superannuation liability it is intended to offset. That leaves little room to start financing a 'Health Future Fund'.

Pre-funding future private health insurance increases

Pre-funding future health insurance premium increases would have only a modest impact on health financing and may introduce a significant amount of additional administration for little gain.

As noted earlier, private health insurance premiums will rise faster than inflation, as the average age of those insured increases. Could this predictable increase be pre-funded?

Germany has tackled this challenge head on by establishing 'ageing reserves'. German private health insurance is purchased as a 'substitute' for cover under the Government's health insurance system. While the German Government system is effectively a social tax, and hence community-rated, private health insurance is not, and premiums rise significantly with age. A key challenge for the German Government is that once a person has opted out of the government system, they cannot opt back in as they would move from an age-based premium to a lifetime community-rated premium. Therefore it's critical that private health insurance premiums remain affordable in the private system as people age.

Since 2001, rather than community rating premiums, insurers in Germany have been required to charge policyholders 10% more to build up an

'ageing reserve' to cover the cost of future premium increases. Ageing reserves are collected from insureds while young and then set aside and used to minimise the increase in premiums as the insured ages and requires greater levels of health care.

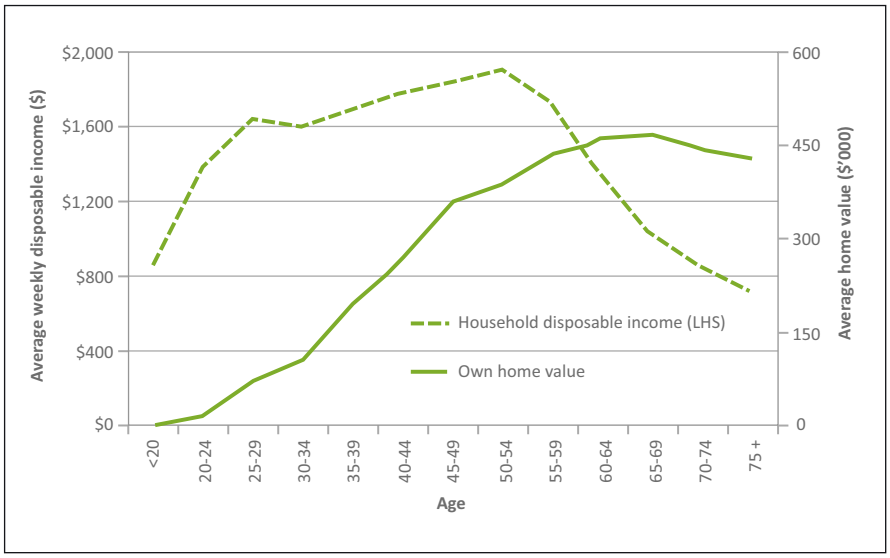
Could this work in Australia? The German ageing reserves explicitly pre-fund ageing's share of future health insurance premium increases. But which costs should be pre-funded in the Australian PHI system? An older average age for policyholders will bring about a relatively modest increase in future private health insurance premiums – around four percent for each year of increase in average age - because community rating keeps premium increases in check. Younger policyholders could pay a little more now, to offset this ageing cost. This extra cost probably wouldn't deter people from private health insurance – indeed, private health insurance membership has remained resilient despite numerous changes in government incentives. However, administering ageing reserves could be cumbersome and the extra costs to administer such a small reserve are unlikely to be worth the benefit.

Of course, a greater share of future premiums could be pre-funded – for example, pre-funding the PHI premiums which would be paid in retirement – but this starts to sound very like a Medical Savings Account, with all the challenges they bring.

Private health insurance is a relatively small part of Australia's health funding – in 2012-13, PHI represented just 8% of total health funding (12% if the Government's contribution via premium rebates is included). The largest effects of ageing are seen in the public health system, where most older people are treated, and the relative spending on older people is so much higher. So all this effort to balance the effects of population ageing on private health insurance would have only a minor effect on overall health system financing.

Figure 19: Home value and disposable income, by age, 2009-10

Source: Productivity Commission (2014) >



The potential role of wealth

With almost half of household wealth projected to be in the hands of the over 65s by 2030, we may need to find ways to tap into that wealth to fund future health care and aged care costs. The challenge will be to do so in a way which is acceptable to the community, practical and equitable.

The financing challenge goes well beyond what can be done inside the health sector. General tax reform to increase the incidence of tax on older people to pay for health care is one key proposal.

It is our conclusion that tax reform will need to consider tapping into the **wealth**, rather than the incomes of older people. The baby boomers will own the major share of household wealth – the Productivity Commission (2011) estimates that in 2030, 47% of total net household wealth will be owned by the over 65s (up from 22% in 2000), thanks in part to the strong growth in asset values, including residential property.

Further, tax reform will need to be structured in such a way that avoids excessive user charges. The RAND Health Experiment showed that up to a point, user charges help manage service demand, but beyond that can have serious consequences for the health outcomes and mortality of people with low incomes or chronic disease – two characteristics strongly associated with the older population.

Are there ways we can tap into the wealth of older people in order to help fund health care costs and reduce the extent of the funding shift to younger generations?

Major reforms to the funding of aged care, which came into law on 1 July 2014, focus on just this issue. *The Living Longer Living Better* reforms stipulate that self-funded retirees will be responsible for accommodation and personal living costs, and that government will provide for health care costs. They include:

- A greater focus on keeping people in home for longer and funding in-home care packages
- A greater emphasis on 'user pays' with increased means testing arrangements, along with fee caps and lifetime limits
- New accommodation payment arrangements for residential aged care, which will result in residents paying more in most cases.

Figure 20: Aged care fees payable at different income/ asset levels

Source: Living Longer. Living Better. Commonwealth of Australia 2012

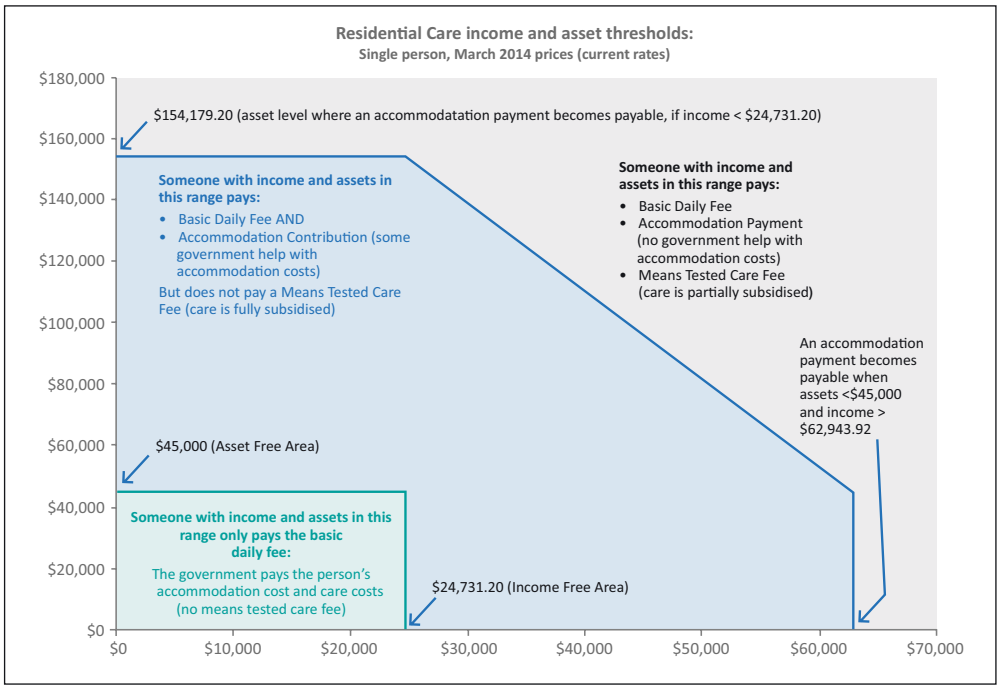


Figure 20 gives an overview of the income and asset thresholds at which various levels of fees apply for a single person moving into an aged care home from 1 July 2014.

Could this work in Health? The sensitive part would be how to do this in a way that is acceptable to the community, practical, and equitable. That may mean taxes and a social welfare approach, rather than driving more individually-funded health care and out-of-pocket costs.

In one sense we moved further away from 'future-proofing' in 2007 when the tax on superannuation benefits post age 60 was removed. Most superannuation benefits are now completely tax-free, shifting the burden of taxes away from older people. At the time, superannuation benefits taxes were relatively small and overly complex, so the change had little effect on the government's budget. But with more people contributing to superannuation for longer, superannuation balances growing, and more people reaching retirement age, the impact of this change could be far-reaching.

Offsetting increases in the Age Pension would also need to be considered – so the net budgetary impact of any superannuation taxes may be far lower. The resultant impact on standards of living would also need to be addressed. For many, superannuation balances will be only just adequate to meet a modest level of personal living costs, and taxing superannuation benefits would decrease disposable income.

Alternative forms of taxing wealth in older ages, through inheritance taxes or similar, haven't been acceptable. A second challenge arises because almost half of the wealth of older people is held in the family home (ABS 2014d, Table 24 and 25). Taxing the family home simply hasn't been an option in Australia. This issue has been raised in numerous submissions to Government reviews i.e. the *Harmer Pension Review* and the *Henry Tax Review*.

7 A comprehensive policy framework – the way forward

Australia can minimise undesirable differences in access to health care by sensible measures on the demand and supply sides, and by well thought out taxation measures aimed towards financing health expenditures. This requires an urgent community debate, to build the understanding to support sensible reform.

A comprehensive framework

In its recent submission to the Financial System Inquiry, the Actuaries Institute recommended the adoption of a **comprehensive framework for policy formulation on all issues relating to the sustainable financing of our ageing population**. Anticipated demographic changes and the resultant increases in aged care and health costs will adversely affect society's ability to finance a desirable level of health care, unless we establish consistent policies with **agreed long term targets**.

A health care policy framework would involve setting overall targets for financing future health care needs, such as

- the goals and principles of the health care system;
- the level of government expenditure on health care which is considered appropriate and sustainable; and
- how that funding could be split between funding current health care needs, offering incentives for individuals, and pre-funding future health care costs, to optimise health outcomes.

Management using 'insurance principles'

Major changes in policy and funding for disability care introduced through the National Disability Insurance Scheme (NDIS), reflect this comprehensive framework approach. They also go a step further, to **management of the system using so-called 'insurance principles'**. By focusing on defined support need, rather than defined funding, the NDIS requires risk management similar to that faced by insurance companies.

Drawing on these 'insurance principles', the policy and governance frameworks which protect the NDIS from cost escalation include:

- a heavy focus on data, systems and analysis of both sides of the system – the demand side, represented by disability support needs, and the supply side, represented by services and workforce, and natural and mainstream supports;
- detailed demographic analysis to project the supply-demand equation into the long-term future at all levels;
- strong case management, reporting, and independent systems governance, supported by the overarching requirement for 'scheme financial sustainability'; and
- a focus on evidence-based practice, research and innovation and an 'investment philosophy' which recognises the long-term economic potential of early intervention.

Many of these techniques could well be applied to a more data and analytics driven health system to enhance financial sustainability, with more use of community support, innovation and early intervention.

An open data regime

> **An open data regime is essential to allow increased access to and analysis of important government-held data and modelling information to better manage macro-level health financing risks.**

To achieve such a policy framework and progress toward system management based on 'insurance principles' requires considerable research and analysis to better understand the financing dynamics of the Australian health care system. The creation of an **open data regime** is essential to allow increased access to and analysis of important government-held data and modelling information to better manage macro-level health financing risks.

The research undertaken for this report revealed a wealth of data for services funded by private health insurance, but 'mixed' results for publicly-funded health care. It simply wasn't possible to use publicly available data to construct an age profile of government health spending, with detailed public hospital data a particular gap – State government approval is still required to access this relatively straightforward data. With public hospitals representing some 30% of health care expenditure, this is a critical gap.

At a more detailed level, researchers have been unable to access linked longitudinal data – linking the range of government funded services to individuals, to better understand the patient journey and individual funding choices. This information simply hasn't been available due to fear of privacy breaches.

Naturally, confidentiality and privacy concerns need to be managed. However, if we are to effectively test new policies, allow room for policy innovation outside of government, and foster constructive public debate, more data must be readily available to researchers, academics, analysts and businesses. An informed community debate is essential. ■

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