



Long-Term Care and Fiscal Sustainability

New Zealand Treasury

BACKGROUND PAPER FOR THE
2013 STATEMENT ON THE LONG-TERM FISCAL POSITION

JULY 2013



New Zealand Government

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FOR THE 2013
STATEMENT ON THE
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Long-Term Care and Fiscal Sustainability

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NZ TREASURY

New Zealand Treasury
PO Box 3724
Wellington 6008
NEW ZEALAND

Email information@treasury.govt.nz

Telephone 64-4-472 2733

Website www.treasury.govt.nz

Abstract

Long-term care represents a small but significant part of total health expenditure in New Zealand and currently stands at approximately 1.5% of GDP. Projections under the Treasury's long-term fiscal model and by the OECD suggest that expenditure on long-term care could more than double over the next 50 years. This paper provides a brief summary of long-term care provision in New Zealand and discusses likely drivers of future spending growth. It proposes a framework for thinking about options and trade-offs around managing expenditure, and outlines in general terms some possible policy and design choices.

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Long-Term Care and Fiscal Sustainability

Executive Summary

Long-term care accounts for almost a fifth of all public healthcare expenditure in New Zealand. The sector is expected to face significant spending pressure over the coming decades. This will come from a number of sources, including demographic ageing and low productivity growth relative to the wider economy. Projections under the Treasury's long-term fiscal model and by the OECD suggest that expenditure on long-term care could more than double over the next 50 years.

The majority of long-term care in New Zealand is publicly funded. For the over 65s, District Health Boards (DHBs) contract for beds for those assessed as needing rest-home level care or higher. Fees are fixed. Contributions are determined through income and asset testing and subject to a cap, with the balance funded by DHBs. Home-based services support older people to live at home where sustainable; personal care services are provided free regardless of income or assets; household management support is means tested. Disability support services for the under 65s are centrally funded by the Ministry of Health and not means tested. People with long-term care needs resulting from accidents receive support from the Accident Compensation Corporation. Disabled people and their carers may also qualify for welfare support.

Public expenditure on long-term care is projected to grow more rapidly than health spending generally, and somewhat faster than spending on New Zealand Superannuation, although spending across all these sectors is projected to rise significantly. Long-term care is projected to increase from about 18% to 21% of Core Crown Health spending between 2010 and 2060 (11% to 15% for aged care), and from about 11% to 12% of combined expenditure on health and New Zealand Superannuation (7% to 9% for aged care). There are wide margins of uncertainty around these numbers (which are projections, not forecasts).

There is a sound rationale for some government involvement in the long-term care sector. Some form of risk pooling is a sensible response to uncertain individual need and high potential cost. Experience suggests that private insurance left to its own devices will not deliver this on a society-wide basis. Government also has important regulatory and quality assurance roles. Long-term care touches on a number of different areas of public policy. This paper seeks to identify the main issues and discuss them in terms of the Treasury's Living Standards Framework. The challenge will be to ensure that people

continue to be able to access good-quality long-term care when they need it, while maintaining a sustainable growth path for expenditure.

It will be important to continue to look for ways to drive efficiency improvements in the sector. Services are labour intensive, so achieving significant productivity gains will be difficult. Possible options include an emphasis on lower acuity care where appropriate; greater use of assistive technologies and service coordination; and better targeting of resources through robust needs assessment. Individualised funding arrangements have been adopted by some overseas jurisdictions with a view to improving quality and reducing costs, with mixed results. These ideas are not new and many of them already inform New Zealand's approach. Performance-related incentives for providers are being tried overseas and may warrant further investigation. Finding the best ways of maximising allocative and cost efficiencies will be an on-going challenge.

Efficiency and productivity improvements are unlikely to avoid the need for substantive policy choices. Nothing in this paper is intended to suggest that spending on long-term care should be fixed at its current level as a percentage of GDP, or indeed at any particular level. However, decisions about the way government services as a whole are targeted and funded will clearly be required. It is therefore appropriate to consider what options might be available for long-term care.

One approach would be to change parameters within existing programmes. This could involve, for example, stricter income and asset testing for subsidised care services, or withdrawing services or subsidies from people assessed as having lower levels of need. It could also involve increasing price caps to stimulate competition and increase quality, which may mean higher contributions from some people. A key question here is the extent to which costs of care should be subsidised regardless of ability to pay.

A second key question is how far New Zealand should seek to pre-fund the costs associated with an ageing population. Long-term care in New Zealand is currently funded on a pay-as-you-go basis by government, alongside (or instead of) out-of-pocket payments by individuals. Alternative arrangements might involve greater reliance on private savings or private insurance, compulsory social insurance or other forms of hypothecated taxation, or government saving. Internationally, a number of different approaches have been tried. The issues are similar to those that arise in relation to retirement incomes policy, and include management and diversification of risk and intergenerational transfers.

Private saving and, probably, private insurance do not seem particularly promising as mechanisms for systematically pre-funding the costs of long-term care. We also have some doubt as to whether the introduction of compulsory levies or hypothecated taxes would be justified. Resuming contributions to the New Zealand Superannuation Fund seems more straightforward. In terms of managing future fiscal spending and macroeconomic risk, the level of overall provision for future liabilities seems more important than whether long-term care specifically is pre-funded.

1 Introduction

Long-term care represents a small but significant part of total health expenditure in New Zealand and currently stands at approximately 1.5% of GDP. Spending in this area is expected to rise significantly over the next fifty years, as the proportion of old and very old people in the population increases. The same demographic trends will also see the relative number of working age people reduce, putting pressure on New Zealand's largely pay-as-you-go and demand-driven model of care. This paper discusses the issues and some possible policy responses.

Projections for health and long-term care expenditure are often discussed separately in the international literature. This is the approach taken by both the European Commission and the OECD. There is clearly significant overlap between the long-term care and healthcare sectors, but the range of services and objectives is somewhat different. The drivers of future expenditure, or their relative importance, may also be different. Demographic ageing, for example, is likely to exert particular pressure on long-term care provision, while changes to social models and labour force participation rates may reduce the supply of informal care. Other cost drivers, such as technological change, may be less important than for the health sector generally.

This paper provides a brief summary of long-term care provision in New Zealand and discusses likely drivers of spending growth over the next fifty years. It proposes a framework for thinking about options and trade-offs around managing expenditure, and outlines in general terms some possible policy and design choices. The issues are complex and there are interactions with other areas of government policy. We have not attempted in this paper to work up and evaluate detailed options, or to make recommendations. Rather, the intention is to draw out what we see as the main considerations and promote discussion.

Since the users of long-term care are predominately older people, the focus of this paper is mainly (but not exclusively) on aged care. We acknowledge that it may not always be appropriate to extrapolate from the experience of older people's long-term care. For example, younger people with lifelong disabilities living in residential services will often not have had the opportunity to accrue significant assets.

The OECD data cited in this paper, and Ministry of Health data published in Health Expenditure Trends (Ministry of Health 2012), follow the OECD's system of health accounts (SHA) classifications for defining and aggregating health and health-related expenditure. These include the healthcare (nursing) element of long-term care but should exclude the social services element (OECD 2000). Relevant payments by the Accident Compensation Corporation (ACC) are included in these figures, but welfare payments are not. Residential (including hospice and palliative) nursing care, day nursing care and medical services provided at home should all be included.

Projections under the Treasury's long-term fiscal model do not follow the SHA classifications. They are based on a breakdown of Core Crown Health Expenditure provided by the Ministry of Health. These include health-related payments to ACC. We have identified three categories of expenditure most likely to be directly related to long-term care, namely Health of Older People, Psycho-Geriatric Care and Disability Support Services. These categories include a combination of health and social services provided to long-term care recipients by the Ministry of Health and/or District Health Boards.

2 Long-term care provision in New Zealand

Long-term care includes services provided to people with an enduring physical or mental disability who are dependent on assistance with the basic activities of daily living, such as washing, dressing or using the bathroom. It may be provided together with medical assistance, such as medication, health monitoring or palliative care. It may also include lower-level assistance with activities such as housework, meals or shopping. Long-term care therefore involves aspects of both medical and social services. It may be provided in an institutional setting or at home and may be formal, informal, or a combination of these. Much long-term care is provided informally by family members. The Government's role may involve direct delivery of care services, the provision of respite services and carer support, or financial assistance.

2.1 Aged residential care

Publicly provided long-term care for older people in New Zealand is the responsibility of District Health Boards (DHBs) and may involve residential care or home-based support services. DHBs are required to ensure that there is an adequate number of contracted care beds for all those assessed as needing residential care. The assessment is carried out by the relevant DHB, or on its behalf by the Needs Assessment Service Co-ordination agency (NASC). The DHB itself determines the level of need at which residential care will be provided.

Aged residential care facilities are mostly owned by private firms and non-profit organisations. Providers operate within a fixed-price environment, with different fees for different levels of care, rest-home care being the lowest level. A resident's contribution towards the cost of their care is capped at a maximum amount (unless they choose to purchase additional services). The maximum amount is based on the fixed price of rest home level care, regardless of the amount of care actually required.¹ This covers a range of services, including accommodation and assistance with activities of daily living, food, laundry, nursing care, GP visits, and prescribed medication and healthcare. It does not cover spectacles, hearing aids, dental care, unfunded medical treatments, or personal items such as toiletries.

Residents with assets over a threshold pay the cost of their care, up to the maximum amount. Their DHB pays for the additional cost of dementia, hospital or psycho-geriatric care. Residents with assets below the threshold qualify for the residential care subsidy. They pay all their income, including their New Zealand Superannuation, towards the cost of their care, apart from a personal allowance of \$42.58 a week (plus a \$266 annual clothing allowance and \$945 a year of income from investments). DHBs make up the difference between the amount the resident pays and the cost of their care.² There are around 30,000 people in residential care at any time. Around 5,000 of these pay the full cost of their care. A further 4,000 have assets over the threshold and pay the maximum contribution but receive higher-level care which is subsidised. The remainder qualify for the residential care subsidy.

¹ The cap varies between local authorities. It currently ranges from \$812 to \$893 per week.

² People aged 50-64 who have a partner and/or a dependent child receive a full subsidy of their costs until they reach 65. Single people aged 50-64 who do not have children are not asset tested but are otherwise subject to the same rules as those aged 65+.

Asset testing for the residential care subsidy has been substantially relaxed since 2005 (table 1). Thresholds were increased significantly from 1 July 2005, and then increased by \$10,000 annually under a policy of progressively removing asset testing altogether. From 1 July 2012, this was replaced by the policy of increasing thresholds in line with CPI movements; this is estimated to save \$28 million a year by 2015-16.

Table 1: Residential care subsidy: asset thresholds (\$)

	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13
Single	15,000	150,000	160,000	170,000	180,000	190,000	200,000	210,000	213,297
Couple both in care	30,000	150,000	160,000	170,000	180,000	190,000	200,000	210,000	213,297
Couple one in care*	45,000	55,000	65,000	75,000	85,000	95,000	105,000	115,000	116,806

* For couples with only one partner in care, the asset test excludes house (primary residence) and car. The couple can opt for the standard asset test to apply instead.

People who fail the asset test because they own their own home may qualify for an interest-free Residential Care Loan if they have other assets worth less than \$15,000 (single person) or \$30,000 (couple). The loan is repayable when the home is sold or 12 months after the person's death, whichever is earlier. This scheme was introduced in 2005. It was intended to recognise that for many older people their home is their principal asset, which they may wish to retain when they enter residential care. Residential care loans are a small part of the system, with only 425 residents paying for their care through loans in June 2012.

2.2 Home-based support services for older people

The Ministry of Health's Operational Policy Framework provides that DHBs are expected to ensure provision of community-based care and support services that are flexible and support older people's preference to live at home where sustainable. The framework does not prescribe how DHBs should determine access thresholds for allocating services, how they are to prioritise the services, or at what level these services should be provided. DHBs decide these matters according to their financial resources, the needs of their population, their strategic priorities, and service availability.

Home-based support services for older people fall into two main categories: household management support, which provides help with activities such as housework and shopping; and personal care, which covers care needs, including assistance with showering and dressing. A person wishing to receive home-based support services funded by a DHB must first have their needs assessed by NASC. Personal care services are provided free regardless of a person's financial position, while household management support is means tested and generally limited to people on low-incomes holding a Community Services Card.³

2.3 Disability support services for younger people

Disability Support Services for most people aged under 65 and their families are centrally funded by the Ministry of Health. Services include: home-based support, residential care, supports for carers in the home, and respite services. Provision of services is subject to a needs assessment carried out by NASC. Income and asset testing does not apply.

³ Eligibility for a Community Services Card is limited to people with income (including any NZ Superannuation) of less than \$508 a week (single) or \$758 (couple). New Zealand Superannuation rates are \$349 a week (single) and \$537 (couple), net of tax.

The Ministry of Health's blanket policy of not paying family carers (parents, spouses and resident family members) for providing home and community support to their disabled family members has been held to be discriminatory under the New Zealand Bill of Rights Act 1990.⁴ The Government has not appealed this decision and is now considering how to amend its policy to address the discrimination in an affordable way. The court's decision may have broader implications for other Ministry of Health-funded disability supports and for family carers of other people receiving government-funded support services (such as older people receiving DHB-funded supports).

2.4 Long-term care following injury

Long-term care needs resulting from accidents are dealt with by ACC through its National Serious Injury Service (NSIS). As at November 2009, NSIS had a portfolio of 4,750 cases, with around 300 new clients added each year (ACC 2010).

2.5 Welfare payments for disabled people and carers

Certain welfare payments may be available to disabled people or their carers, if they are on low incomes.

2.5.1 Disability allowance (and special disability allowance)

The Disability Allowance provides financial assistance to people who have a disability that is likely to last at least 6 months and need help with everyday tasks or ongoing medical care. It is paid in respect of costs actually incurred because of the disability, up to a maximum of \$60.17 a week. It is income-tested for people not receiving a main benefit, with thresholds set at \$586 a week (single) or \$867 (couple). A Special Disability Allowance (\$37.53 a week) is available to people receiving New Zealand Superannuation or a main benefit whose partner qualifies for the Residential Care Subsidy. In 2009/10, the Disability Allowance was claimed by around 254,000 people, at an annual cost of \$309 million (MSD 2011). Policy changes in Budgets 2011 and 2012 have reduced expenditure slightly, to \$299 million in 2012/13 with a forecast reduction to \$295 million by 2014/15 (Budget 2013).

2.5.2 Benefits for people with disabilities or caring responsibilities

A person who is either blind or permanently unable to work more than 15 hours a week because of sickness, injury or disability may qualify for Invalids Benefit. A person caring for a disabled partner or spouse may qualify jointly with them for Invalids Benefit. A person providing full-time care in their own home for someone other than their spouse or partner may qualify for Domestic Purposes Benefit: Caring for Sick or Infirm (DPB:CSI). From July 2013, DPB:CSI and Invalids Benefit will be replaced by a new Supported Living Payment; eligibility rules and benefit rates will remain broadly the same.

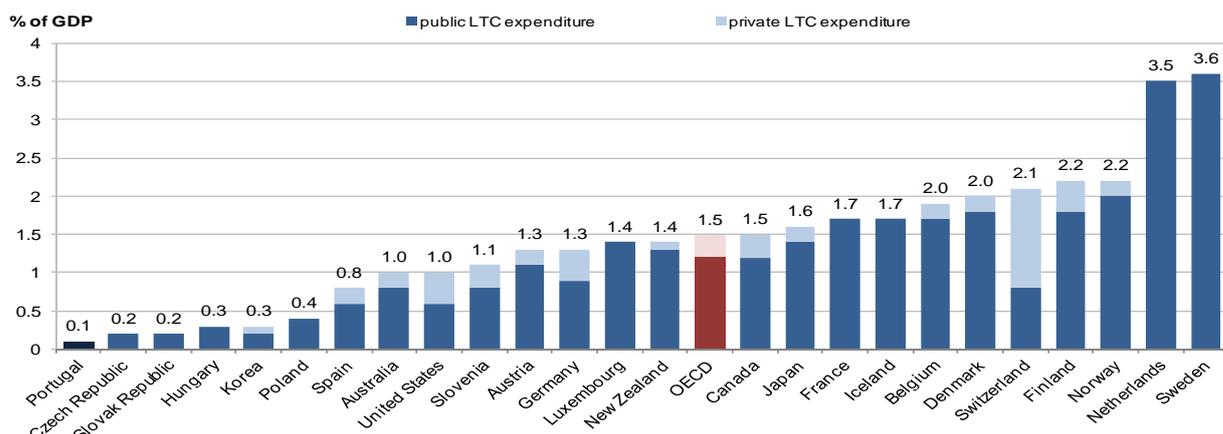
These are income-tested social security benefits, so they are only available to people on low-incomes. They are worth \$256 a week for a single person and \$427 for couples. The vast majority (>95%) of people receiving them are of working age. (Most older people qualify for New Zealand Superannuation, which is more generous.) Of approximately 85,000 working-age recipients of Invalid's Benefit, 23% are aged 40-49 and 47-51% are aged 50-64 (MSD 2012).

⁴ *Ministry of Health v Atkinson and Others* [2012] NZCA 184 (14 May 2012).

3 Long-term care expenditure in New Zealand

Spending on long-term care in New Zealand is close to the OECD average as a percentage of GDP (see Figure 1). Expenditure over the period 2005/06 to 2009/10 is summarised in Table 2 and Figures 2 and 3. These follow the OECD's system of health accounts (SHA). Total expenditure in 2009/10 was \$2.89 billion (around 1.5% of GDP). Of this, 92% (\$2.67 billion or 1.4% of GDP) was public funding, mainly administered by the Ministry of Health.

Figure 1: Long-term care expenditure in OECD countries (percentage of GDP, 2008)



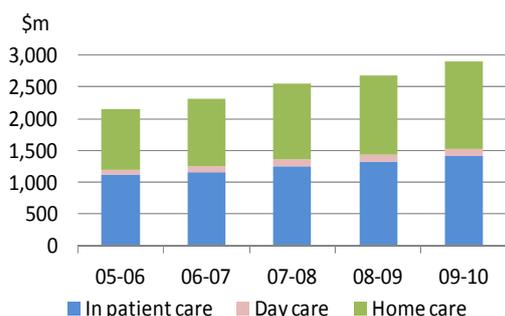
Source: OECD 2011

Table 2: Total spending on long-term nursing care in New Zealand 2009-10 (\$m)

		2005-06	2006-07	2007-08	2008-09	2009-10
MoH funding (Direct and DHB)	In-patient care	1,019.2	1,050.1	1,137.8	1,193.7	1,276.5
	Day care	89.4	100.3	104.4	108.2	113.3
	Home care	866.1	956.5	1,101.7	1,145.9	1,259.4
		1,974.7	2,106.9	2,344.0	2,447.8	2,649.2
Other public funding	In-patient care	0.4	0.5	1.0	1.1	1.3
	Day care	0.4	0.5	0.5	0.5	0.6
	Home care	14.3	15.1	17.2	17.7	19.1
		15.1	16.1	18.7	19.4	21.0
Private funding	In-patient care	94.4	106.7	109.3	130.5	137.9
	Day care	-	-	-	-	-
	Home care	66.4	76.0	79.1	79.6	84.3
		160.8	182.8	188.5	210.2	222.3
Total funding	In-patient care	1,114.0	1,157.3	1,248.1	1,325.3	1,415.8
	Day care	89.8	100.8	105.1	108.8	113.9
	Home care	946.8	1,047.7	1,198.0	1,243.3	1,362.9
		2,150.6	2,305.8	2,551.1	2,677.4	2,892.5

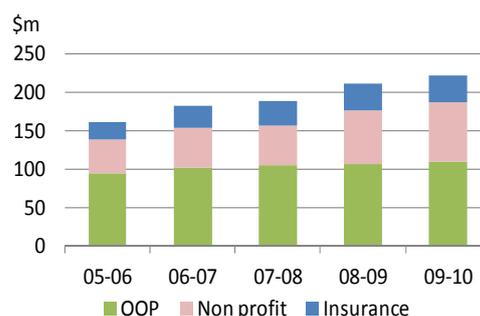
Source: Ministry of Health 2012

Figure 2: Total LTC funding, by care type (\$m)



Source: Ministry of Health 2012

Figure 3: Breakdown of private LTC funding (\$m)



Source: Ministry of Health 2012

Long-term care accounted for about 18% of the Ministry of Health's total current expenditure on healthcare services, being split about equally between in-patient care and home care, plus a small proportion spent on day care. There is some suggestion that these published figures may not capture the full extent of private spending on long-term care, although at the time of writing alternative numbers are not available.

3.1 Projections and drivers of future expenditure

There is likely to be significant upward pressure on long-term care expenditure in New Zealand over the next few decades. Projections for health expenditure generally are discussed in the accompanying paper, *Long-Term Health Projections and Policy Options*. Those projections include Core Crown Health expenditure on long-term care. Key issues relating to the projections for the long-term care sector are discussed below.

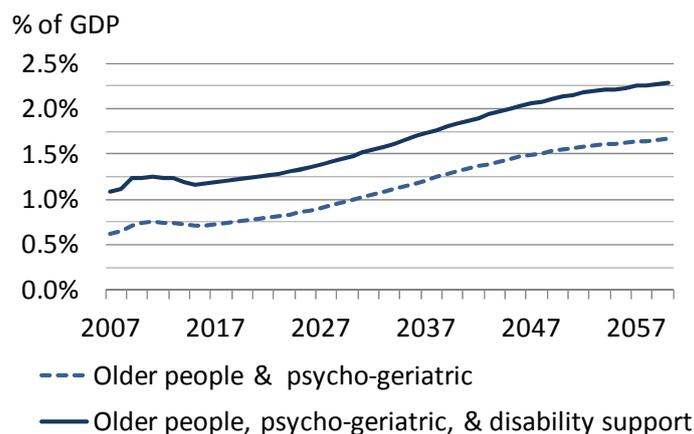
3.1.1 The long-term fiscal model

Of the categories of Core Crown health expenditure used in the Treasury's long-term fiscal model, Health of Older People and Psycho-Geriatric Care together provide a proxy for the costs of aged care. These services cost \$1.42 billion in 2009/10 (0.74% of GDP), which is some way below the \$2.65 billion figure for Ministry of Health spending on long-term care (1.4% of GDP) in Table 2. Adding the cost of Disability Support Services (mainly for under 65s) gives a figure for 2009/10 of \$2.38 billion (1.24% of GDP).⁵

Figure 4 shows projected spending for these categories as a percentage of GDP under the long-term fiscal model. This increases to about 2.3% in 2060. Various factors underpin the spending projections for long-term care, although their relative importance and how they will develop and interact over time is uncertain. These factors are discussed later.

⁵ The difference between the Core Crown Health numbers used in the long-term fiscal model and the SHA figures quoted in table 2 may be partly explained by different treatment of Goods and Services Tax, included in the SHA figures but excluded from the long-term fiscal model's projections.

Figure 4: Certain categories of Core Crown Health expenditure as % of GDP



Source: Long-term fiscal model (cost pressure scenario)

The relevant categories are also projected to increase as a proportion of health expenditure between now and 2060 (Table 3). Health of Older People and Psycho-Geriatric Care together are projected to increase from 10.8% to 15.4% of Core Crown Health expenditure by 2060. This rebalancing is caused by demographic change, along with assumptions about healthy ageing in the long-term fiscal model (we discuss this later). These categories together with Disability Support Services are projected to increase from 18.1% to 21.2% of Core Crown Health expenditure between 2010 and 2060; and from about 11.1% to 12.3% of combined expenditure on health and New Zealand Superannuation.

Table 3: Projected long-term care expenditure in context

	2010	2060	Increase
As % of GDP			
Older people and psycho geriatric	0.74%	1.67%	125.1%
Older people, psycho-geriatric and DSS	1.2%	2.3%	84.6%
Core Crown Health	6.8%	10.8%	57.9%
NZ Super	4.3%	7.9%	81.9%
As % of Core Crown Health			
Older people and psycho geriatric	10.8%	15.4%	42.5%
Older people, psycho-geriatric and DSS	18.1%	21.2%	16.9%
As % of Core Crown Health and NZ Super			
Older people and psycho geriatric	6.6%	8.9%	34.6%
Older people, psycho-geriatric and DSS	11.1%	12.3%	10.4%

3.1.2 Productivity growth rate

Long-term care is labour intensive, so the wage rates of nurses and care workers are likely to be a significant driver of future costs. At the same time, the high labour content of the sector may limit productivity growth, perhaps more so than in the healthcare sector generally, where there may be greater scope to use technology to achieve productivity gains. This may make long-term care particularly vulnerable to the Baumol effect, with wages rising in line with the general economy despite the sector not achieving corresponding productivity gains. This increases costs for a given level of output. This

relative price effect is assumed in the model to be the same across the public sector and is set at 0.9% per annum (Rodway 2012).⁶

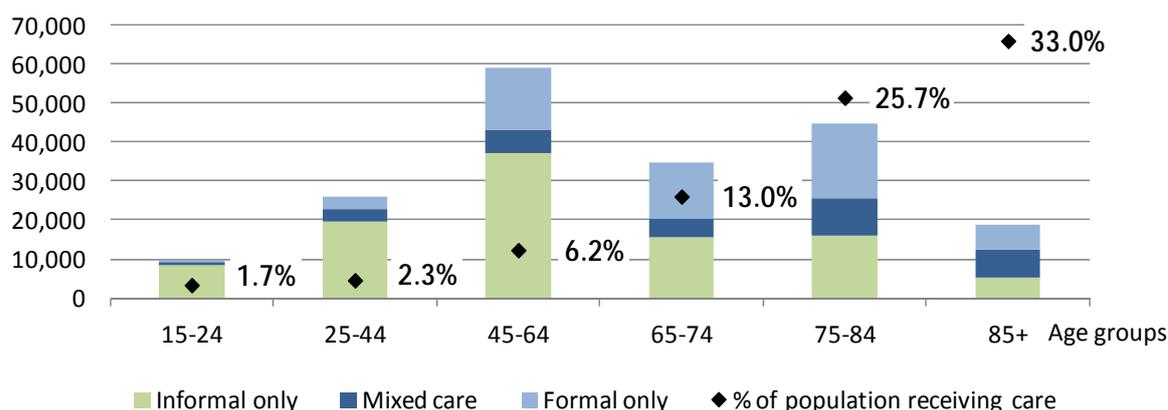
3.1.3 Non-demographic demand growth

Non-demographic volume growth for health is assumed in the model to be 1.5% per annum. This assumption has been increased from 0.8% to better reflect historical trends for public health spending and for consistency with international practice (Rodway 2012). It implies that demand for healthcare will rise in line with economy-wide real incomes. Whether this assumption holds specifically for the long-term care sector is unclear. It is certainly plausible that income growth could push up long-term care expenditure, with people demanding higher quality and greater depth of care as they become wealthier. There is no empirical evidence on the income elasticity of long-term care expenditure.

3.1.4 Balance between formal and informal care

Demand may also increase if there is a shift in the balance between formal and informal care. This factor is not separately recognised in the model. The majority of care appears to be provided currently by informal carers. It has been estimated that, on average across the OECD, around 70%-90% of those who provide care are family carers (OECD 2011). In New Zealand, the 2006 Household Disability Survey indicated that 59% of disabled adults aged 65+ receiving help with everyday activities got at least some help from an informal carer (family, flatmate, friend or neighbour), while 38% received *only* informal help. Figure 5 provides a breakdown by age. Family carers are mostly women, mainly the spouse/partner or daughter/in-law of the disabled person (Statistics NZ 2009). The outcome of the current policy development process on family carers, following the legal challenge to the Ministry of Health's blanket policy of not paying them, may also have a bearing on future costs.

Figure 5: Disabled adults receiving help with everyday activities, by age and care type (2006)



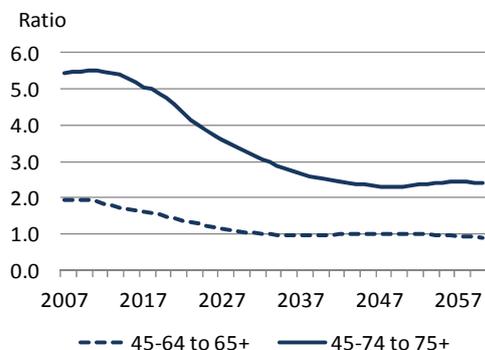
Source: Statistics NZ 2009

Social changes such as declining family size and increased female labour force participation may lead to a reduction in the number of available informal carers. In addition, the ratio of people aged 45-64 to those aged 65+ (a proxy for the availability of family carers for older people) is projected roughly to halve over the next 25 years or so

⁶ Public sector wages are assumed to rise in line with labour productivity growth in the economy as a whole (assumed to be 1.5% per annum), with a scalar of 0.8 applied, reflecting that not all price inputs are driven by labour costs. The 1.2% per annum real input price growth thus calculated is offset by 0.3% assumed public sector productivity growth.

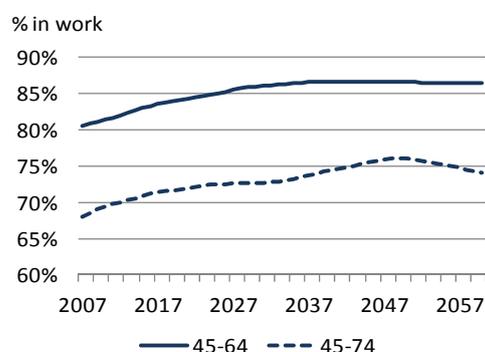
and then remain fairly static (figure 6), while labour force participation rates for this pool of possible carers is projected to increase (figure 7). These trends may increase demand for formal care services. On the other hand, if increased longevity is accompanied by an increase in the number of years spent free of a disability, this could increase the pool of older caregivers (in particular, spouses and children of the very old).

Figure 6: Age group ratios



Source: Statistics NZ

Figure 7: Labour force participation rates

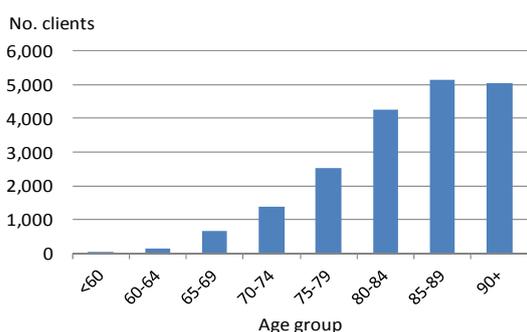


Source: Statistics NZ

3.1.5 Demographic demand growth

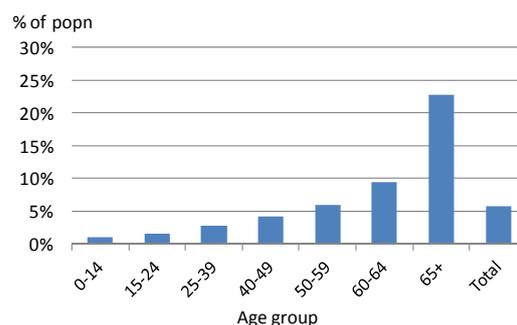
Disability and the costs of care rise sharply at older ages, especially amongst the very old (aged 80+). This pattern applies across the OECD (OECD 2006). It is also reflected in patterns of spending in New Zealand on healthcare, residential care and the disability allowance (figures 8 and 9; see also figure 16 in Rodway 2012). The likelihood of being assisted by Disability Allowance increases sharply with age. Nine percent of 60–64 year olds, and between 22% and 23% of those aged 65 years or over were assisted by Disability Allowance, compared to 5.7% of the total population. Three quarters of those receiving Residential Care Subsidy are aged 80 or older (MSD 2012).

Figure 8: MSD clients receiving residential care subsidy, by age (June 2011)



Source: MSD 2012

Figure 9: Proportion of population receiving Disability Allowance (June 2010)



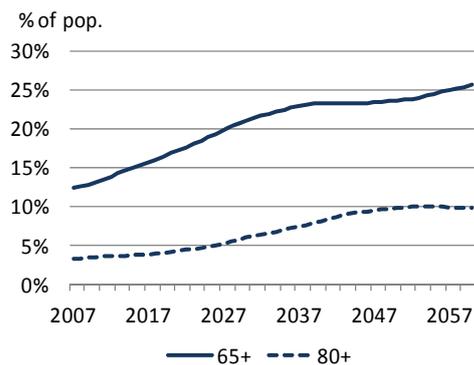
Source: MSD 2012 (table PP.15) and SNZ August 2011 (table 3)

The proportion of New Zealand's population that is old (65+) or very old (80+) is expected to increase (figure 10). The extent to which population ageing influences long-term care expenditure depends partly on assumptions about “healthy ageing” – whether, and to what extent, increased longevity is accompanied by an increase in the average number of years spent in good health. Healthy ageing assumptions have now been included in the long-term fiscal model for the first time, which tends to reduce projected expenditure

growth.⁷ These assumptions, their evidence base, and their impact on the projections are discussed in the accompanying paper, *Long-Term Health Projections and Policy Options*.

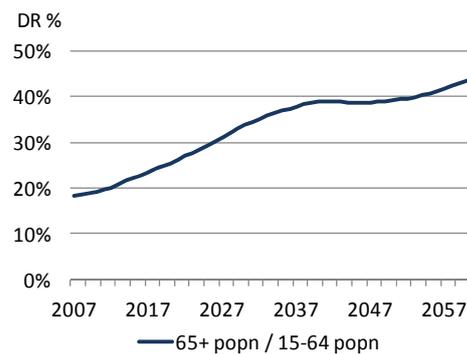
As well as increasing demand for long-term care services, demographic ageing will reduce the proportion of working-age people within the population, upon whom the burden of financing a tax-based pay-as-you-go (PAYGO) system predominately falls. The projected increase in the aged dependency ratio (the population aged 65+ as a percentage of the population aged 15-64) is shown in figure 11). Although income and consumption taxes do apply to older taxpayers, a high proportion of their income is composed of Government transfers (figure 12). This may change over time if labour force participation rates among older people increase and savings rates improve.

Figure 10: Population aged 65+ and 80+



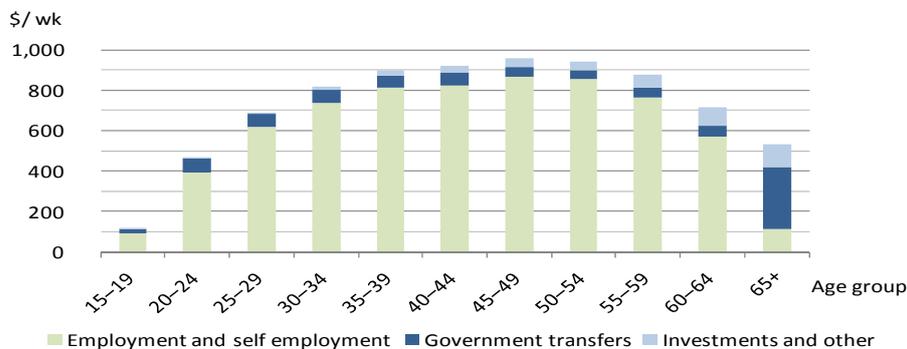
Source: Statistics NZ

Figure 11: Aged dependency ratio (DR%)



Source: Statistics NZ

Figure 12: Average weekly income: June 2011 quarter



Source: SNZ October 2011

3.1.6 Comparison with OECD projections

OECD projections suggest that average expenditure on long-term care in member countries could double by 2060. The OECD has estimated that public long-term care expenditure in New Zealand could increase from 1.3% of GDP (2006-2010 average) to between 2.0% and 2.6% of GDP by 2060, depending on assumptions, compared to the OECD average increasing from 0.8% of GDP to between 1.6% and 2.1% (OECD 2013).⁸

⁷ This has been modelled by adjusting cost weights for most categories of health spending as life expectancy increases. Generally, the rate of shifting applied is 0.75 for every year of additional year of life expectancy. For categories more closely related to aged care (psycho-geriatric and health of older people), the rate of shifting is 0.5. No shifting is applied to the public health category, which is more focused on younger people.

⁸ The OECD has estimated future demand for long-term care by splitting the population into dependants and non-dependants based on projections of life expectancy and future healthcare spending. Changes in the mix of formal and informal care are estimated based on projected changes in the labour-force participation rate of women aged 50-64. Income elasticity of demand is assumed

4 Policy framework and general themes

Long-term care touches on a number of different areas of public policy. The core policy objective is to ensure that people are able to access good quality care and support when they need it. While long-term care is often organised and approached primarily from a health system perspective, it intersects with aspects of social and welfare policy. It also shares characteristics with retirement incomes policy, since it can directly affect the financial position of older people and may (and in New Zealand does) involve intergenerational transfers.

The need for long-term care (timing, duration and intensity) is unpredictable at an individual level, and the costs can be very high.⁹ For these reasons, some form of public or private risk pooling is generally considered desirable. Take up of private insurance is low, in New Zealand and internationally, for reasons including adverse selection, myopia, and lack of affordability (we return to these issues later). Governments are therefore frequently involved in the provision and financing of long-term care, as they are in the health and welfare sectors generally.

Publicly funded long-term care arrangements can involve both intra- and intergenerational transfers. Intra-generational transfers arise through risk pooling between members of the same cohort, some of whom will not utilise funded care, and through subsidisation by higher-income households of those on lower-incomes. Intergenerational transfers arise when a PAYGO scheme is introduced or expanded, including as a result of demographic change (cohort size and/or longevity). In an economy that is dynamically efficient, with returns to capital greater than the economic growth rate, the expansion of a PAYGO scheme redistributes resources between generations at the expense of future cohorts, who face higher taxes and an investment opportunity cost (Coleman 2012).

New Zealand's long-term care system is predominately a PAYGO regime, although not exclusively so. Income and asset testing for the residential care subsidy means that older people are required to draw down much of their accumulated wealth (if any) and contribute towards the costs of their care, adding a SAYGO element to the way the current arrangements apply to some people.

Specific policy proposals would need to be assessed in terms of their impact on care outcomes and the welfare of care recipients and their families. They would also need to be evaluated against broader government objectives. The Treasury's Living Standards Framework sets out the following criteria for assessing policy options:

- Sustainability for the future. Specifically, fiscal sustainability
- Increasing Equity. Both intergenerational and intra-generational distribution
- Managing risk. Increasing national savings and reducing debt
- Economic growth. Reducing inefficiencies in taxes and spending
- Social infrastructure. Social cohesion and broad political support.

to be equal to 1. The upper end of the range cited is calculated using a full Baumol effect, with the lower end assuming a half Baumol effect.

⁹ It currently costs \$43,000 a year for rest home-level care and \$74,000 a year for hospital-level care.

4.1 Fiscal sustainability

Whether New Zealand's long-term care model in its current form is fiscally sustainable is not an easy question to answer. As noted earlier, spending projections are sensitive to assumptions, and the way various cost-drivers will interact is uncertain. Nevertheless, it seems clear that, given demographic and other demand and price pressures, keeping public funding for long-term care at around its current %/GDP ratio (for example) would imply much tighter targeting and/or more efficient use of resources relative to the status quo.

On the other hand, long-term care accounts for less than a fifth of current healthcare spending by the Ministry of Health and a much smaller fraction of total government expenditure, so sustainability depends partly on policy choices in other areas. Funding could be rebalanced away from other sectors, or taxes could rise, to fund higher spending on long-term care.

4.2 Equity considerations

Different perceptions of fairness exist, and may conflict.

4.2.1 Fairness between older people and younger people receiving long-term care

The relaxation of asset testing for the residential care subsidy between 2005 and 2011 was partly motivated by the idea that it was unfair to require older people to run down their assets in order to pay for long-term care, whereas younger people qualified for free care regardless of their financial circumstances (Dyson 2004). An alternative approach would be to extend asset testing to all users of long-term care regardless of age, although this may raise questions of within-cohort fairness across groups with different healthcare needs.

4.2.2 Intergenerational equity

To what extent is it fair (even if it is sustainable) to expect current and future working-age populations to fund the costs of long-term care through general taxation, as longevity and expenditure rise and the dependency ratio increases? To some extent, this depends on one's point of view. Intergenerational transfers may be regarded either as theft from future cohorts or as justifiable on the basis that future generations are likely to be wealthier than we are (Coleman 2012).

The size of these transfers will depend partly on policy choices in other areas. For example, if the current PAYGO approach to NZ Superannuation is retained, then by 2060 the demands on the working age population to fund both retirement incomes and care for the elderly are likely to be considerable. Since the cost of NZ Superannuation is projected to increase to around 8% of GDP by 2060, reform in that area could go a long way to addressing intergenerational equity issues, regardless of changes to long-term care. The scale of reform in each area, and collectively, will be important.

Timeframes for reform are also important. A fundamental shift to pre-funding or SAYGO models for both retirement incomes and long-term care implemented over the next 20 years or so might reduce macroeconomic risk and increase national savings, but all the costs of transition would be borne by the cohort of people working during that period, who would have to fund both their own care and that of previous generations.

4.2.3 Vertical equity and horizontal equity

Vertical equity refers to the idea that people with a greater ability to pay should pay more. In the context of long-term care, this concept could be applied to argue that people with accumulated wealth should contribute more to the cost of their care. The rationale for asset as well as income testing is that this gives a better indication of economic welfare, leading to a fairer allocation of resources, particularly for older people given they will typically draw down capital during retirement.

Horizontal equity is the idea that people with a similar ability to pay should be similarly taxed. Notwithstanding the relaxation of the asset test over the last few years, people who need long-term care may be required to run down their assets substantially, with a corresponding impact on the value of their estate. On that basis, it has been suggested that asset testing for long-term care operates rather like a random inheritance tax, applying to one family but not another, even if both have a similar ability to pay (OECD 2011; St John & Dale 2011).

4.2.4 Personal responsibility and just deserts

Another concept of fairness is that people should enjoy the benefits of their hard work or prudent behaviour and take responsibility for their mistakes. In the context of a system that subsidises care for people who cannot afford to pay for it themselves, this could be interpreted as meaning that people who have accumulated savings should not be required to use them to fund their own care costs. A relaxation of means testing could be regarded as consistent with this idea.

4.3 Reducing risk

At an individual or family level, access to quality long-term care provision will mitigate some of the personal costs associated with dependency and ageing by helping care recipients and their families to maintain dignity and independence and maximise quality of life. Regulatory controls (quality assurance, consumer protection, building regulation) and information and support services address risks around poor quality, unsafe or inappropriate care. Decisions about care are often made at times of medical or emotional crisis, or at other times when people are vulnerable and need protection.

At a macroeconomic level, the Treasury is concerned about New Zealand's net external debt position. Policy choices about long-term care may affect national savings, with implications for economic resilience and growth. Tax and other financial incentives are often used internationally to encourage private saving, although the literature suggests that there are ambiguous and probably limited effects on levels (but not composition) of household and national savings (Inland Revenue 2010; Treasury 2010). Likewise, a transition towards SAYGO funding of long-term care, on either a public or a private basis, would have uncertain implications for savings rates, capital stock, productivity and growth. Treasury's judgement in relation to retirement incomes policy is that rebalancing towards a SAYGO system would be directionally positive for savings and growth.

Means testing publicly-funded assistance could discourage private saving prior to retirement and/or encourage retirees to consume their assets before the need for long-term care arose. It may also encourage financial planning – for example, through gifting or the use of trusts (St John & Dale 2011). Existing rules favour some assets (residential housing) over others (stocks and bonds, for example), which all else equal may bias investment decisions. The extent to which these factors influence behaviour in practice is unclear. Because the need

for care is unpredictable, it is possible that means testing may have less negative impact on saving than if applied to superannuation; this needs further analysis.

Long-term care arrangements affect the way risks are shared, between generations and between individuals and the Crown. The importance of risk pooling in the face of unpredictable needs has been already been discussed. PAYGO schemes allow for the sharing of risks between generations which may be difficult to diversify within a single cohort. In particular, they can hedge productivity risk, investment risk, cohort size risk and longevity risk using the government's ability to tax future generations (Coleman 2012). SAYGO schemes may increase capital stock, but would also increase New Zealand's exposure to investment risk; the way this was shared between individuals and the Crown would depend on the balance between public and private savings and the extent to which the government protected individuals from investment underperformance.

4.4 Economic growth and efficiency in public spending

Long-term care policies may impact on economic growth primarily through their impact on savings rates and capital stock (discussed above) and taxation. Taxation imposes deadweight economic costs, for example through reduced labour market incentives and the distortion of savings decisions. These negative effects would arise under both PAYGO and SAYGO funding arrangements, although the impacts may be less under a private SAYGO approach if contributions are regarded as increasing personal wealth instead of as a tax (see the separate paper on retirement incomes policy).

So efficiency in public spending is important. The existing structure of New Zealand's long-term care system has some strengths in this respect.

- Disability funding for the over 65s is devolved to DHBs, along with funding for general healthcare. This gives DHBs both means and incentive to manage the supply of residential care so that older people with moderate care needs do not occupy higher-cost hospital beds.
- There is a purchaser-provider split, with the role of DHBs being to assess individual need (through NASC), contract for services, and certify and audit providers. Audit results are made public and individuals are free to move between approved facilities. Providers operate within a capped-price environment and therefore compete primarily on quality.

Nevertheless, it will be important to look for opportunities to achieve efficiency gains in future. This may involve improvements within the existing model, for example to strengthen competition or improve information and monitoring. Consideration could also be given to alternative models of care and/or funding structures. A 2006 study by DHBs of the community support workforce found problems in recruitment and retention, with high staff turnover (cited in OAG 2011). This appears to be a common theme internationally (OECD 2011). Workforce issues have implications for service quality and productivity. Research shows that nursing homes with greater staff turnover have higher costs associated with vacancy and recruitment, lost productivity, and lower service quality (Booth et al 2007).

4.5 Social infrastructure

A comprehensive and accessible system of long-term care contributes to social infrastructure by providing a publicly-funded insurance mechanism. It contributes towards social cohesion by avoiding a large disparity in care outcomes. Tighter targeting (for example, by reference to income or assets) would not necessarily undermine these outcomes, although it may erode political support for the system. On the other hand, the sustainability of the current PAYGO system depends on its acceptance by current and future working generations. Without this intergenerational consensus, it is possible that future cohorts will decide to restrict the generosity of the scheme, with potentially significant impacts for care recipients (see discussion in Coleman 2012).

5 Possible policy responses

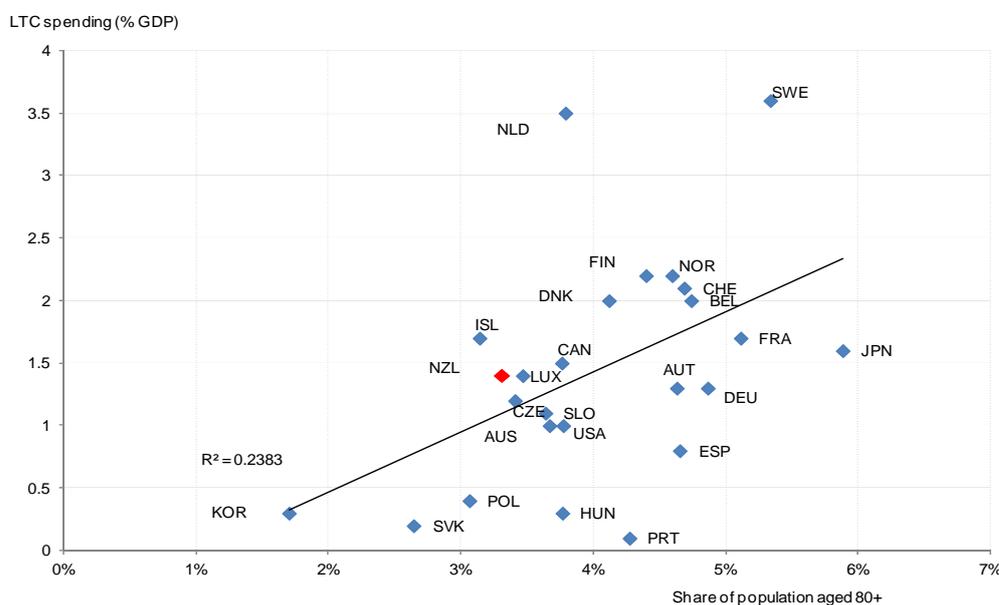
This section of the paper discusses some of the policy choices that might be available to achieve a more sustainable expenditure path for long-term care. The issues raised by some of the options are reasonably complex, and in some cases have implications for other policy areas, including tax and superannuation. A combination of different approaches may be desirable.

5.1 Models and settings for long-term care

Notwithstanding the importance of demographic drivers, the way a country's system of long-term care is configured – eligibility, breadth and depth of coverage – will influence fiscal cost. The share of GDP that OECD countries devote to long-term care is not strongly correlated to the proportion of the population aged 80 or older, although New Zealand's current allocation of resources does appear to be broadly consistent with its demographic profile (Figure 13). There are a number of countries with a greater proportion of very old people who spend less on long-term care as a proportion of GDP, including Spain, Germany and Japan. The reverse is true for the Netherlands and some of the Nordic countries. Note, however, that the SHA definitions are hard to apply consistently across countries and this may account for some of the differences. Substitution between hospital and long-term care may also be a factor in explaining some of the outliers.

The Ministry of Health has a policy of supporting older people to remain at home where sustainable. Making greater use of home-based, rather than residential, care may help to reduce per capita costs, although this is not clear cut. Home-based care may involve lower capital and labour costs. However, it is also likely that people in residential care will, on average, have higher levels of disability and medical needs. For some, residential care may be the more cost-effective option. Eligibility and utilisation rates for home-based care may also be higher than for residential care, offsetting per capita savings. In terms of overall cost to the government, the long-term sustainability of home-based care models may partly depend on the extent to which future cohorts are mortgage-free by the time they require care; where this was not the case, subsidies for private accommodation costs would also need to be taken into account.

Figure 13: % of population aged 80+ and % of GDP spent on LTC (2008 or nearest available year)



Source: OECD 2011

There may be scope for improving efficiency within the home-based care sector. The Auditor General identified a number of practical issues, including deficiencies in performance information and an inconsistent approach to managing quality (OAG 2011). Addressing those issues may help to give a clearer picture of quality and efficiency in the sector, and the circumstances and extent to which home-based care is indeed more cost effective than institutional care. In turn, this could better inform decision-making and resource allocation. Maintaining an integrated funding stream for older people's care within DHBs ought to support the provision of home-based care to the extent that this is viable and cost effective.

Maximising the use of home (and day) care may depend partly on health system performance around acute and post-acute care for the elderly, to maintain and restore the functional independence of elderly patients during hospital stays and reduce discharges into residential care rather than back home. Greater use of telephone support and assistive technologies for people with mobility or sensory-impairments may also help to maintain people at home for longer.

Providing care in a broader range of settings could provide scope to manage down costs as demand increases. Some European countries provide supported accommodation (retirement villages or other assisted living arrangements) as an alternative to home-based or full residential care. In New Zealand, this type of accommodation is predominately within the private sector and not available to those with limited financial resources, although there is some non-profit activity in the sector. It is possible that developing this type of lower acuity accommodation within the public sector might help to absorb additional demand for residential care at lower per-capita cost than the current arrangements (Grant Thornton 2010). However, the evidence seems mixed. A 2006 review of UK studies into housing schemes combining independent living with relatively high levels of care found that, for some people in some circumstances, they could provide an alternative to residential care; but numbers of people nevertheless moved on from such housing into residential care, suggesting that one was not always a substitute for the other. The evidence on cost effectiveness was particularly limited and sometimes contradictory: what there was indicated that housing with care may be more expensive than residential care, although cheaper than care delivered in ordinary housing (Croucher et al 2006).

Many OECD countries provide care co-ordination services for people in long-term care, to improve integration with medical care, help people to access appropriate services, and reduce unnecessary costs (OECD 2011). There is some evidence that coordination of services could be improved in New Zealand, with acute hospital days, emergency department visits and number of prescriptions for people in aged care apparently higher than international benchmarks (Grant Thornton 2010). Case management for older people can reduce the use of health services, although it is less clear that such services are cost-effective; specifically, whether the costs of providing case management are offset by savings from reduced service utilisation (Hutt et al 2004). Scope for savings can be limited in practice because of the difficulty of downsizing acute hospitals. Focusing on patients most likely to have high health service utilisation – for example, because of poor self-management or lack of family/informal support – is likely to be important.

5.2 Workforce productivity

Addressing workforce issues within a fiscally constrained environment will be challenging. Various possible responses are mooted in the literature, including recruitment from under-represented sectors (men and retirees, for example) and strategies to improve recruitment

and retention, including more structured training opportunities and career paths (Fujisawa & Colombo 2011). As the OECD has pointed out, these proposals may have “relevance for job satisfaction, turnover and intention to stay. But such measures, as well as measures to address workforce shortages, are likely to increase the costs of [long-term care]” (OECD 2011). In its 2010 report on the aged residential care sector in New Zealand, Grant Thornton suggested that a projected increase in demand for long-term care services was likely to push up wages in the sector (Grant Thornton 2010).

It will be important to consider whether there is scope to increase the productivity of the existing workforce – for example, by making better use of information technology, adopting new models of care, or adjusting the mix of skills within the sector. A likely pressure point will be competing demand from the acute care sector for registered health professionals. The way in which registered professionals are used in long-term care services and supported by ancillary staff will influence future productivity and labour costs (Grant Thornton 2010; Fujisawa & Colombo 2011).

5.3 Individualised funding

Consumer directed funding arrangements are fairly common overseas. The Netherlands and the United States both allow care recipients to directly employ their personal care assistants, while a number of Nordic countries operate voucher systems to promote personal choice in the use of long-term care. In Austria, all support for home-based care is provided in cash, with the recipient being able to decide whether or not to purchase formal care. In Germany and Luxembourg, people entitled to long-term care have a choice between benefits in kind or a cash payment set at a lower level. (OECD 2005)

These funding models are intended to increase consumer direction and choice for recipients of long-term care. This can have a number of different objectives, including empowerment of care users and optimisation of care packages. A key objective is to stimulate competition amongst providers, based on consumer choice, with a view to improving quality and/or reducing costs. These arrangements may also raise the visibility of the cost of services and increase public understanding of the need for prioritisation.

The use of individualised funding in New Zealand is not particularly common. The option is available to people receiving long-term care through ACC following a serious injury. The Ministry of Health has recently started to increase its use of individualised funding for younger disabled people, although the numbers are still quite small: 421 users in 2010; 934 users in 2011 (Synergia 2011). It may be worth considering whether wider use of individualised funding has the potential to achieve efficiency gains, including in the aged-care sector.

There is some evidence that such arrangements increase satisfaction and contribute to better quality of life at similar cost to traditional models, provided they are properly targeted according to need (OECD(2) 2005). However, reform in many countries has been accompanied by an increase in expenditure, and robust evidence of efficiency gains seems lacking (OECD 2005; OECD 2011). The Dutch experience suggests that costs can be difficult to control, with claims there increasing tenfold and spending more than fivefold between 2002 and 2010 (Ginneken et al 2012). Where funding can be used to compensate informal carers, there may also be a negative impact on labour force participation (Lundsgaard 2005). A move towards new funding arrangements in New Zealand would need to be carefully designed and accompanied by rigorous expenditure controls.

5.4 Pay for performance

The idea of linking payments to providers to quality of care is relatively new in the long-term care sector, although there is more experience of pay-for-performance models in the health sector. Evidence of the effectiveness of such arrangements is limited (OECD 2011). Nevertheless, health authorities in a number of countries – including the United Kingdom and the United States – have started to include quality-related incentives in care contracts. This is not an area that we have looked at in depth. It may warrant further investigation as international experience develops.

5.5 Audit, regulation and assessment tools

The Office of the Auditor General has carried out two reviews into the effectiveness of arrangements to check the standard of services provided by rest homes, in 2009 and 2012. The latest review found that there had been good progress in strengthening how rest homes are certified and monitored (OAG 2012). Changes over the last three years include the introduction of unannounced audits, more frequent audits in higher-risk cases, and the reintroduction of third-party accreditation of auditors. The review found there was still scope for certification and auditing to provide better assurance about quality of care. It recommended that the focus of audits should continue to shift from examining written policies and procedures towards assessing the quality of care delivered to residents.

DHBs have recently (2008-2012) adopted standardised InterRAI assessment tools to inform decisions about what home-based services should be provided to older people.¹⁰ The InterRAI Long Term Care Facility module, which assesses need for aged residential care, is currently being rolled out and will be made mandatory for aged residential care providers from 2015. These tools are intended to establish an older person's need for services such as personal care, household management or residential care. The introduction nationally of standardised tools should enable systematic, consistent and comparable assessments across DHBs. In the short term, it is expected that these tools will increase the capacity of DHBs to assess more people, through shorter reassessment times and electronic transfer of information between services.

The tools create scope for more significant changes in future. It should be possible to make assessment information available to health professionals involved in the care of an older person, allowing for more informed decisions and tailored services. Data from individual assessments can be anonymised and aggregated, allowing it to be used for policy, planning and funding purposes. Such changes are outside the scope of the initial implementation plan but offer significant opportunities to improve planning and drive service improvements. There may also be scope to increase transparency about levels of assessed need that are funded, and to target resources according to need on a robust basis.

The 2012 review by the Office of the Auditor General noted that the Ministry of Health monitors the quality of rest home care by measuring the number of complaints, setting the time that rest homes are certified for, and assessing the number and type of audit findings. This was not considered sufficient. The review recommended that the Ministry should take the opportunity presented by the introduction of InterRAI – as well as a new Provider Regulation and Monitoring IT system – to consider how to bring together and use data to encourage improvements in the quality of rest home care.

¹⁰ InterRAI refers generically to a suite of assessment tools, of which two – the Home Care and Contact Assessments – have been implemented across DHBs.

5.6 Changing parameters within existing programmes

Managing a low growth track for long-term care expenditure within the existing framework is likely to require some fairly significant trade-offs as the population ages and demand and fiscal pressures grow. Apart from simply reducing the quality or availability of services (for example, using hard expenditure caps, which are already part of our system), there are various mechanisms for controlling costs that could be considered, including means testing, increased cost-sharing, and better targeting of resources. For example:

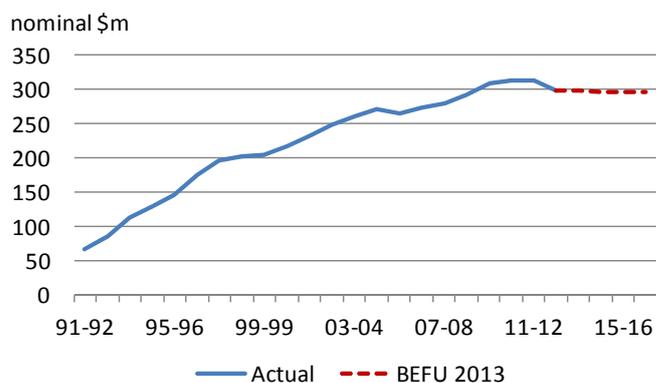
- Stricter income and asset testing. This could involve lowering (or freezing) thresholds and/or restricting allowances for the residential care subsidy. Introducing means-testing for home-based personal care services could also be considered, particularly given that there has been a shift in government funding towards this sector in recent years.
- Raising or removing the contributions cap for residential care.
- Removing or restricting the asset-test exemption for the residential home where only one partner in a couple is in care.
- Reducing allowable annual gifting limits when applying the financial means test for the residential care subsidy. The primary purpose would be to further limit the transfer of assets into family trusts where these assets could otherwise be used to help meet the costs of a person's residential care.
- Changing or removing the residential care loan scheme. It may be worth looking at whether there is a strong rationale for government continuing to operating what is effectively a reverse equity scheme with a nil rate of interest in order to subsidise continued home ownership after people have moved into residential care. The criteria for residential care loans could alternatively be tightened up without taking away the option entirely. Currently, the client is simply required to maintain the former home and pay all rates (which may be by way of a deferred rates scheme), insurance and other outgoings until the loan is repaid. There is no obligation on the client to generate an income from the home. There is also provision for the loan repayment to be deferred in some circumstances, and no interest is charged while the loan is deferred. Having said all that, the fiscal cost of this programme is currently very small (<\$5 million a year), although this may change over time.

This sort of change would represent a shift towards a more heavily means-tested, safety net system. Considerations of fairness, as outlined in the previous section, are relevant here, with the arguments running both ways. There may be a negative impact on private savings, since people who had saved more during their working life would have to contribute more towards their long-term care costs.

Another approach would be to introduce stricter limits on access to services based on need, with a view to better targeting available resources. One option would be to look at setting higher thresholds in the needs assessments administered by NASC, removing or reducing assistance for people with lower levels of need. Another might be to place higher expectations on families to themselves provide care – for example, by assuming that a certain amount of unpaid care will be provided when determining entitlement to home-based support. These options avoid some of the drawbacks associated with stricter means testing, but would reduce access to care for some people.

There may scope to align Disability Allowance spending more closely with medical need (for example, by using a NASC assessment process). The Disability Allowance is a fairly significant programme in fiscal terms, with expenditure having grown substantially over the last two decades (figure 14). Policy changes in Budget 2011 and Budget 2012 are expected to generate some savings in the short-term, but demographic trends will continue to exert upward pressure on costs. Around half of those receiving this allowance over the period 2009-11 were pensioners (MSD 2012).

Figure 14: Disability Allowance expenditure (nominal \$m)



Source: MSD, SNZ and Budget 2013. Note that vocational services for disabled people were removed from these expenditure figures from 2005-06. The estimated cost of those services in 2012-13 was \$89 million (Budget 2012).

It may be worth considering whether DHBs have incentives under the current fixed-fee purchaser-provider model to enable sufficient competition between providers on quality. Incentives and quality depend on getting the price cap right, with a possible risk that the regulated price may be driven below the cost of providing care of an appropriate quality, particularly during periods of fiscal consolidation. The interaction between price regulation and competition is complicated by the way in which returns to investment in the care home market depend partly on asset prices (and capital gains) in the property market. As noted earlier, the fixed fee for rest home care currently matches the level of an individual's maximum contribution. It would be possible to separate these instruments. Raising fees without similarly increasing the maximum contribution would imply some level of subsidy for all rest home users regardless of their financial status. Raising the maximum contribution but not the fixed fee would have no impact on people using rest-home level care, but people receiving higher levels of care would be required to pay more.

5.7 Encouraging private saving to fund care

Private savings are one source of funds that could possibly be used to help meet future long-term care costs. This could be done using either a voluntary or a compulsory model, although some sort of incentive would be needed under a voluntary scheme as people would otherwise have no reason to lock up a portion of their capital in an illiquid savings vehicle. One approach would be to ring-fence a portion of KiwiSaver funds, so that they could not be accessed on retirement but had to be retained for use against future long-term care costs.

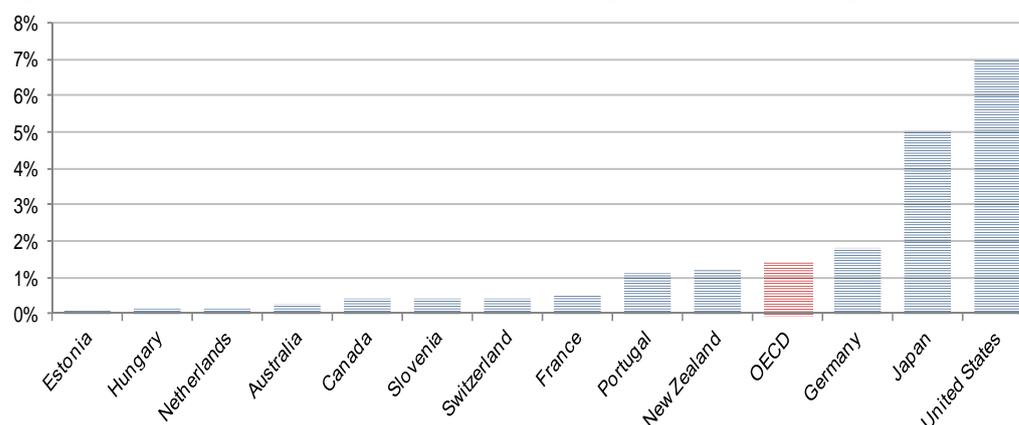
Greater reliance on private savings would tilt New Zealand more towards a SAYGO approach to funding long-term care. The main drawback of relying on private savings is that there is no mechanism (such as risk pooling) for mitigating uncertainty and cost. For those who need long-term care, private savings are likely to be inadequate. Other people would have a significant pool of accumulated wealth which they would be unable to access, with an associated loss of welfare.

The Australian Productivity Commission has suggested that private saving may be appropriate as a mechanism for contributing to “more predictable” costs, such as everyday living and accommodation expenses and basic support costs (APC 2011). For most people in New Zealand, a significant proportion of retirement income consists of NZ Superannuation, which cannot be drawn down early and is already diverted towards meeting the costs of care for people receiving the residential care subsidy.

5.8 Encouraging private insurance

Private insurance is another SAYGO mechanism. It does allow for risk pooling. Both internationally and in New Zealand, it makes only a modest contribution towards financing long-term care (figure 15). Private insurance plays the greatest role in the United States; but even there, less than 10% of the population aged 65 or over is covered, and private insurance accounts for only about 7% of total expenditure. In France, about a quarter of those aged 60 or over have private insurance, but (so far) its contribution to total spending is small. Product innovations may be possible – for example, combining lifetime annuities with long-term care insurance (St John & Dale 2011). To date, however, these do not seem to have contributed to a significant expansion of the market.

Figure 15: Private insurance as a share of total long-term care spending



Note: Year for data varies by country (2005 to 2010). Source OECD 2011

Various explanations are offered for this (discussed more fully in Cremer & Pestieau 2009; OECD 2011; APC 2011). In particular:

- Adverse selection. People who are most likely to incur future long-term care costs are also more likely to purchase insurance against those costs. Insurers therefore tend to restrict eligibility to people with no pre-existing conditions, limiting coverage.
- Myopia in planning for dependency in retirement, with people underestimating risks and costs.
- Poor incentives due to publicly funded alternatives.
- Affordability issues. In part, these seem to result from the problems of adverse selection and moral hazard, which drive up premiums. Also, people tend to consider purchasing long-term care insurance later in life, when they are closer to needing it and when there are fewer competing priorities (such as children and mortgage costs). At this point, risk is greater so premiums are higher.

Policy interventions to encourage voluntary uptake of private insurance could take a number of forms. These include:

- Financial incentives. Tax concessions exist in the United States, Spain and Mexico, amongst other countries. These might stimulate demand by reducing the effective cost of premiums, or by raising the profile of long-term care insurance as a tool for mitigating financial risk. Drawbacks include complexity and fiscal cost. Tax incentives also tend to be regressive, favouring those on higher incomes; designing this out adds complexity. Importantly, such concessions benefit people who would have taken out insurance anyway, undermining fiscal benefits for the government. Evidence on the elasticity of demand is limited, but suggests that most (>75%) of the incentive would be captured by individuals who would have taken out a policy anyway (OECD 2011).

An alternative form of financial incentive involves the concessionary treatment of insurance payouts when means-testing eligibility for publicly funded long-term care. This approach has been adopted in the United States, with apparently mixed results (OECD 2011). Such concessions might help to improve the quality of care by increasing funding in individual cases and may, over time, create scope for reductions in publicly funded care (for example, through reduced services or tighter means testing).

- Regulatory controls to improve quality, access and coverage. For example, regulatory controls might standardise premiums regardless of clients' health status, or prevent insurance companies from raising premiums for existing clients as they age and/or develop new conditions. Regulatory controls might also discourage insurers from offering policies and increase premiums. International experience of this sort of approach seems quite limited, in part because EU law inhibits the regulation of private insurance contracts except where they are related to a compulsory scheme. In Germany, compulsory long-term care premiums are capped and people with pre-existing conditions cannot be charged higher rates. (OECD 2011.)
- Automatic enrolment into approved schemes. This could follow the KiwiSaver approach of automatically signing people up to private insurance schemes, and allowing them to opt out. This is likely to increase take up of private insurance, partly through inertia. Singapore adopted this approach in 2002, with people aged between 40 and 65 being automatically enrolled into its publicly designed / privately managed EldersShield programme. Opt out rates declined from 38% to 14% over the first four years of the scheme, with coverage at the end of 2006 standing at about 50% of the population aged over 40. (OECD 2011.)

5.9 Compulsory insurance, hypothecated taxes and pre-funding

A number of countries have introduced compulsory insurance for long-term care, including Germany, the Netherlands, and Japan. This generally involves publicly-managed social insurance arrangements rather than compulsory private insurance (although this would also be possible). The Accident Compensation Scheme provides an analogous model in New Zealand.

Compulsory social insurance has certain advantages, including compensating for poor decision making by individuals (although this can also be criticised as paternalistic); avoiding the problem of adverse selection associated with voluntary schemes; ensuring that risks are pooled across as broad a group as possible; and allowing for some degree of income redistribution, subsidising those on low-incomes to access the scheme.

Compulsory insurance is a form of hypothecated taxation and ought therefore to be evaluated according to tax policy principles. Hypothecated taxes can be criticised on the

grounds that they confuse revenue and expenditure decisions and may lead to non-optimal policy choices in both areas. A number of countries (for example, Germany) impose levies for long-term care insurance in the form of payroll taxes, whereas others (Japan) charge levies on income generally (Glendenning & Moran 2009). Drawbacks of payroll taxes may include complexity, economic distortion, and negative impacts on labour productivity (IRD 2006). Labour market participation rates may also be affected. Countries that have introduced such schemes nevertheless face on-going pressure around managing demand and constraining costs.

Payroll and other hypothecated taxes should be compared against the efficiency, equity, and integrity aspects of other tax changes (or other policies) that could raise the same level of revenue. It is important to be clear about objectives. For example, if the purpose of moving towards compulsory insurance were to address issues of inter-generational equity by increasing the contribution made by pensioners (as a group) towards the costs of long-term care, this could equally be achieved by reducing net payments of New Zealand Superannuation.

Compulsory insurance and other forms of hypothecated taxation may be used as a mechanism for pre-funding future liabilities (SAYGO). (But note that hypothecation, even if nominally part of a social insurance arrangement, does not necessarily involve pre-funding. In the United Kingdom, National Insurance Contributions are paid into the Consolidated Fund.) Pre-funding may increase national savings. It may also improve inter-generational equity, although this would depend on the detailed design of any scheme. Imposing levies exclusively on people of working age would do little to reduce the overall financial burden borne by this group in future, and could impact significantly on cohorts working during the transitional period. Compulsory social insurance schemes in other countries typically require contributions from pensioners. In Japan, premiums are only paid by those aged 40 or older, although half the cost of the scheme is funded from general taxation (Glendenning & Moran 2009). Indeed, many countries with social insurance schemes for long-term care fund them partly from general taxation and a fully-funded model may not be appropriate given impacts on the transitional cohort and uncertainty about future costs of care (OECD 2005).

Alternative options for pre-funding are available, which may or may not involve hypothecated taxes. One example that does not is the New Zealand Superannuation Fund, established as a mechanism for investing budget surpluses to offset future liabilities. It would be possible to introduce a similar arrangement for long-term care, or to extend the remit of the Superannuation Fund. Alternatively, the government could simply focus on maximising its pre-funding of superannuation payments and thereby create fiscal headroom for future spending in other areas, including long-term care.

6 Conclusion

Long-term care represents a small but significant proportion of government expenditure, and one that is projected to grow considerably over the next fifty years. It is subject to many of the same cost drivers as health and superannuation spending, including demographic ageing and relative price increases. Long-term care is a relatively modest part of the overall fiscal story, accounting for approximately 12% of projected Crown expenditure on healthcare and New Zealand Superannuation by 2060.

As for health services generally, it will be necessary for the sector to drive cost and allocative efficiencies and maximise productivity on an on-going basis in order to achieve the best possible outcomes for a given level of resources. This is easy to say and hard to do, but nonetheless important. This paper has discussed some general themes.

Efficiency measures will not avoid the need to consider how the future costs of an ageing population are funded. One important question is the extent to which people should be required to meet their own costs of care when they are able to do so. This is mainly relevant to aged care, with older people being more likely to have accumulated significant assets, including residential property. The question is contentious, and difficult to answer from a purely analytical perspective. If public provision of long-term care is a form of population-wide risk pooling, then it could be argued that higher-wealth households (who will typically make the largest contribution) should enjoy some protection. Public health provision in New Zealand is generally not means tested, partly for this reason. However, arguments about fairness and long-term care provision are complex and often contradictory. Whether and to what extent government should subsidise aged care in order to protect individuals' capital and facilitate bequests is a matter for debate.

Currently, New Zealand has a predominately PAYGO approach to funding healthcare, long-term care and retirement incomes. Previous papers to the Long-Term Fiscal External Panel have considered the case for rebalancing somewhat towards SAYGO funding of retirement incomes. Similar issues arise in relation to long-term care (and, to some extent, healthcare generally). The most important question is probably not whether any one sector in particular should be pre-funded, but rather the extent to which it is sensible for New Zealand as a whole (and government specifically) to pre-fund the costs of an ageing population. Once that question is answered, then choices about what to pre-fund and how to achieve it are to some degree matters of practicality and political economy.

Private savings, and probably also private insurance, seem unlikely to provide effective mechanisms for pre-funding long-term care, partly due to unpredictability of need at an individual level. Compulsory insurance and hypothecated taxes may have presentational advantages relative to other forms of taxation, but they also conflate decisions about tax and spending. A hypothecated levy is still effectively a tax, funding current or future expenditure, and may be a less efficient and more complicated way of raising revenue than other forms of taxation. On balance, we are doubtful whether introducing such a scheme specifically for long-term care would be justified, or better in terms of its overall effect than simply increasing taxes. Resuming contributions to the New Zealand Superannuation Fund seems a more straightforward way of pre-funding future liabilities.

References

- Accident Compensation Corporation, *Overview for the Welfare Working Group* (September 2010)
- Australian Government: Productivity Commission (APC), *Caring for Older Australians* (2011)
- Matthew Bell, *Note on Projections for August long-term fiscal health forum* (August 2012)
- Mark Booth, Edward Alan Miller & Vincent Mor, Through the looking glass: toward a brighter future for long-term care in a greying New Zealand, *New Zealand Medical Journal*, Vol. 120, No. 1249 (February 2007)
- Budget 2012, *The Estimates of Appropriations 2012/13: Vote Social Development, and Information Supporting the Estimates: Vote Social Development.*
- Budget 2013, *Information Supporting the Estimates: Vote Social Development.*
- Helmuth Cremer & Pierre Pestieau, *Securing long-term care in the EU: some key issues* (2009)
- Karen Croucher, Leslie Hicks & Karen Jackson, *Housing with care in later life: a literature review* (2006)
- Ruth Dyson, *Progressive Removal of Asset Testing: Questions and Answers* (6 December 2004).
- European Commission, *The 2012 Ageing Report* (2012)
- Rie Fujisawa & Francesca Colombo, *The long-term care workforce: overview and strategies to adapt supply to growing demand*, OECD health working paper No. 44 (2009)
- Ewout van Ginneken, Peter P Groenewegen & Martin McKee, Personal healthcare budgets: what can England learn from the Netherlands?, *British Medical Journal* (2012; 344)
- Caroline Glendenning & Nicola Moran, *Reformed long-term care: recent lessons from other countries* (2009)
- Grant Thornton, *Aged Residential Care Service Review* (2010)
- Patrick Graham, Tony Blakely, Peter Davis, Andrew Sporle & Neil Pearce, Compression, expansion, or dynamic equilibrium? The evolution of health expectancy in New Zealand. *Journal of Epidemiology and Community Health*, 58(8):659–666 (2004)
- Ruth Hutt, Rebecca Rosen & Janet McCauley, *Case-managing long-term conditions: what impact does it have in the treatment of older people?* (2004)
- Inland Revenue, *Business Tax Review: a discussion document* (2006)
- Inland Revenue, *Sensitivity of Household Savings to Taxation: a paper for the Savings Working Group* (October 2010)

Long-Term Fiscal External Panel, *Summary: Session One – Fiscal Framework and Projections* (30 August 2012)

Jens Lundsgaard, *Consumer direction and choice in long-term care for older persons, including payments for informal care: How can it help improve care outcomes, employment and fiscal sustainability* (2005)

Ministry of Health, *Health Expenditure Trends in New Zealand 2000-2010* (2012)

Ministry of Social Development, *2010 Statistical Report* (2011)

Ministry of Social Development, *2011 Statistical Report* (2012)

Office of the Auditor General (OAG), *Home-based support services for older people* (2011)

Office of the Auditor General (OAG), *Effectiveness of arrangements to check the standards of rest home services: follow-up report* (2012)

OECD, *A system of health accounts* (2000)

OECD, *Long-term care for older people* (2005)

OECD(2), *Policy Brief: Ensuring quality long-term care for older people* (2005)

OECD, *Projecting OECD health and long-term care expenditures: what are the main drivers?*, Economics Department Working Paper No. 477 (2006)

OECD, *Help Wanted. Providing and paying for long-term care* (2011)

OECD, *A projection method for public health and long-term care expenditure* (2013)

Paul Rodway, *Long-Term Fiscal Projections: Reassessing Assumptions, Testing New Perspectives: Draft Paper for the Long-Term Fiscal External Panel* (August 2012)

Susan St John & M. Claire Dale, *Funding the long-goodnight: more intra-generational risk sharing* (2011).

Statistics NZ, *Disability and Informal Care in New Zealand* (2009)

Statistics NZ, *National Population estimates, June 2011 quarter* (August 2011)

Statistics NZ, *The New Zealand Income Survey, June 2011 quarter* (October 2011)

Synergia, *Evaluation of individualised funding following the expansion to new host providers: report for the New Zealand Ministry of Health* (October 2011)

Treasury, *Savings in New Zealand: Issues and options* (September 2010)