

## RPRC Working Paper 2012-2

# Financing of Long-term Care and Long-term Care Insurance for the Aged: A Literature-based Comparison of Seven OECD Countries

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M.Claire Dale, Susan St John and Judith Hanna<sup>1</sup>

### Retirement Policy and Research Centre

Economics Department  
Business School  
The University of Auckland  
Private Bag 92019  
Auckland, New Zealand  
[www.rprc.auckland.ac.nz](http://www.rprc.auckland.ac.nz)

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<sup>1</sup> Dr M.Claire Dale, Research Fellow and Associate Professor Susan St John, co-director of the Retirement Policy and Research Centre, Judith Hanna, a Research Assistant. Thanks to Bridget Browne, Senior Lecturer, The Australian National University College of Business and Economics, and Michael Littlewood, co-director of RPRC, for their contributions to earlier drafts.

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## The Retirement Policy and Research Centre

The Retirement Policy and Research Centre is pleased to publish this Working Paper providing an inter-country comparison of pension environments and financing of long-term aged care and long-term care insurance for the aged.

Demographic change is exerting pressure on labour market, health, pension and retirement policies across the developed world. In particular, the current systems of funding the provision of in-home and institutional long-term care will be a considerable pressure point as the proportion of the population aged 65+ grows rapidly over the next 20 years. For example, in New Zealand, the elderly population is projected to almost double before 2030, from the current 600,000 to 1,100,000 for those aged 65+, and from the current 26,800 to 49,900 for those aged 90+.

International comparisons appear more frequently in today's academic literature, reflecting the growing trend to look beyond one's country and learn from the lessons of others. This working paper follows that trend. To facilitate the comparison of provision of long-term care and long-term care insurance for the aged, the paper begins with a short introduction to the concepts of actuarial insurance, long-term care insurance for the aged, and social insurance, before providing an overview of pension systems as a whole. This comprehensive approach to ageing economies may suggest possible solutions to address some of the looming fiscal and social problems, and indicate some possible lessons for New Zealand.

The individual country analyses build on the OECD's 2011 report, *Help Wanted: Providing and Paying for Long-Term Care*, as a basis for a classification system of methods for financing and provision of long-term care (LTC) and long-term care insurance (LTCI). The seven countries investigated are: New Zealand, Australia, France, Germany, Japan, England, and the US.

This primarily descriptive paper contextualises public and private funding of long-term care and long-term care insurance for the aged within each country's age pension environment in 2012. It remains a 'work in progress' as many countries surveyed here are changing policies regarding pensions, LTC and LTCI rapidly and significantly. At the time of publication, some data in this paper will already be out of date. However, the potential for lessons for New Zealand remains.

Comments to Dr M.Claire Dale: [m.dale@auckland.ac.nz](mailto:m.dale@auckland.ac.nz)



Dr Susan St John  
Co-director RPRC



Michael Littlewood  
Co-director RPRC

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## 1 Introduction

Globally, population ageing is unprecedented, pervasive, profound, and enduring (Department of Economic and Social Affairs 2001). The share of the population aged over 80 years in the Organisation for Economic Co-operation and Development (OECD) member countries increased from less than 1% in 1950 to around 4% in 2010, and is expected to reach nearly 10% by 2050 (OECD 2011b, p. 34). In addition to the enlarged burden of pension costs, a further consequence of increasing longevity (and medical and technological advances) is that total healthcare expenditure in OECD countries has climbed faster than GDP, at an average annual rate of 2% over the past 50 years, and some estimates suggest that by 2040 total expenditure could grow by another 50-100% (World Economic Forum 2013).<sup>2</sup>

The speed of this change is expected to accelerate dramatically over the next 20 years as the babyboomer generation<sup>3</sup> moves into and through retirement. Recent female and male populations aged 65+ of the selected countries by number, and as a proportion of the total population, are shown in Table 1. Significant increases in these proportions are projected, for example, New Zealand's 65+ population is expected to increase from 605,000 (2012) to 1,100,000 before 2030 (Statistics New Zealand 2012). Compounding the problem, during the Global Financial Crisis (GFC) and the following recession, many private pension funds were severely diminished (Barrett and Greene 2010; International Monetary Fund 2012), compromising potential private contributions to aged care. At the same time, female labour-market participation is increasing and there are fewer traditional family arrangements that may in the past have provided care for the aged.

**Table 1. Consolidated summary of 7 country populations: age 65+ and gender (rounded)**

Country	Female	Male	Total 65+	%	Total population
New Zealand	327,900	277,900	605,800	13.9%	4,362,000 (2012)
Australia	1,476,615	1,210,499	3,010,000	13%	21,000,000 (2006)
France	6,155,767	4,403,248	10,559,015	16.4%	65,822,000 (2011)
Germany	9,701,551	7,004,805	16,706,356	20.3%	81,859,000 (2011)
Japan	15,800,000	11,600,000	27,400,000	23.1%	128,057,000 (2010)
UK	5,458,235	4,027,721	9,485,956	15.7%	63,100,000 (2011)
US	22,571,696	16,901,232	39,472,928	12.8%	308,746,000 (2010)

One consequence of the combination of demographic and financial pressure is that pension policies and health systems are under increasing scrutiny for their sustainability in most OECD countries (OECD 2012). Rapid growth in the demand for in-home and residential long-term care (LTC) for frail and disabled seniors is accelerating changes in policy and provision in many countries. This growth and change is in turn stimulating interest in a range of markets, including annuities and long-term care insurance (LTCI).

Following the growing trend to look beyond one's country and learn from the lessons of others, international comparisons appear more frequently in today's academic literature. In order to identify the critical issues and develop workable policies for LTC, and a framework for the development of LTCI, it is necessary to understand a country's total 'aged environment', including the prevailing public age-pension and retirement income policies, current private pension policies, LTC policy, and the market for decumulation products, including LTCI and annuities, and their interplay. A country's pension system

<sup>2</sup> For example, the number of people living with Alzheimer's disease and other dementia is expected to almost double to 65 million by 2030, with 72% of cases in the developing world (World Economic Forum 2013).

<sup>3</sup> The 'babyboomer generation' was born between 1946 and 1964, so began reaching pension-age in New Zealand in 2011.

constructs the environment for, and impacts on the costs and quality of, formal and informal LTC for the frail elderly, and on how those costs are allocated between the individual and taxpayers. Whatever their financial situation, and while the experience of ageing may differ:

*... health care and support services tend to be a feature of extreme old age. The role of the family, the market, and the state in the provision of these services is likely to remain a contentious issue. For, while a school or a maternity hospital is an investment in the future for which the family, community, and taxman can all anticipate a return, a dementia care unit or a hospice is often the final cost of past returns. (Statistics New Zealand 2009, p. 8)*

In this paper, LTC refers to both in-home and institutional aged care, while residential aged care (RAC) refers only to institutional, long-term aged care. The distinction between the 'in-home' and 'residential' options is important as in general RAC costs far more than LTC, reflecting the more intensive level of care provided. For example, in 2009 in the US, individual in-home LTC services cost around \$27,740 annually while the average cost of RAC services was \$75,190 for semi-private rooms (Goda 2010, p. 746).

This working paper offers summaries of selected countries' total aged environments, and makes a preliminary comparison of those varying systems.<sup>4</sup> The purpose is primarily descriptive. The various countries' pension environments, and their suitability for future demands, are not assessed. The paper begins with an introduction to conceptual issues and definitions, including an overview of three descriptive frameworks for pension systems. This is followed by a summary of the methods for financing LTC and LTCI provision in seven countries: New Zealand, Australia, France, Germany, Japan, England, and the United States of America (US).<sup>5</sup> The next section discusses some complexities of cost, classification, measurement, local social and economic contexts, and perverse incentives associated with LTC and LTCI provision. The final discussion summarises the salient features of the various countries' pension systems and LTC and LTCI environments, toward possible lessons for New Zealand.

## **2 Conceptual issues and definitions**

A cross-country comparison of LTC and LTCI is made more complex by the international variability in both provision and terms used. Conceptual issues and definitions discussed in this section provide the foundation for describing each country's unique system.

There is a range of possible approaches to financing LTC: pre-funding; general taxation; private savings; private insurance; and social insurance including social insurance *ex post*, as in a single premium paid out of a person's estate. Defining insurance as "a device for sharing risk", Barr (2010, p. 360) describes gains from insurance as "large and obvious", and suggests that a risk-averse person, rather than self-insuring by setting aside the possible full cost of their LTC, would instead, if it were offered, purchase insurance at a cost determined by averages and statistics. The average annual cost of LTC, and the probability of needing care, provides the basis for calculating the 'fair' price for the insurance premium.

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<sup>4</sup> This paper does not explore home equity release.

<sup>5</sup> Financial and statistical comparisons are preliminary as data may be drawn from different reporting years.

## 2.1 Actuarial insurance and asymmetric information

Insurance is defined as *actuarial* if “the premium is based on the risk of an event occurring and the size of the resulting loss” (Barr 2010, p. 360): mathematical and statistical methods are applied to assess insurance risk. Actuarial insurance can cope with individual, measurable risk. It cannot set a premium when the risk is either certain, such as a pre-existing medical condition; or uncertain, where the statistical probability of the event occurring for the group as a whole is unknown.<sup>6</sup>

The principle is that the insured group all face the individual uncertainty that the event will befall them, but the cost of the event, if suffered by an individual, is pooled among the whole group, producing certainty of outcome. A rational, risk-averse person facing a risk with known probability, if offered actuarially fair insurance, will buy it.

Insurers may face a number of technical problems. Determining risk may be difficult or may contravene human rights legislation, for example, charging a premium that is gender- or race-related. Often there are asymmetric (or imperfect) information problems and the insurer cannot distinguish between those who are ‘good’ and ‘bad’ risks. With LTCI, if the group containing ‘bad’ risks cannot be identified, they will pay a premium that is too low, while the ‘good’ risks pay too high a premium. If this latter group opts not to buy LTCI, the insurance company is left with the ‘bad’ risks and forced to increase future premiums, a process known as ‘adverse selection’.<sup>7</sup>

When insurance cover alters behaviour, as in over-consumption of care encouraged by insurance, ‘moral hazard’ exists (Courbage and Roudaut 2011, p. 23). In another example, Barr (2010, p. 366) suggests it could be rational for an individual not to purchase LTCI in order to “guard against being put into residential care against one’s will”. However, other research has found that higher income individuals and individuals exhibiting risk-reducing behaviours are both more likely to purchase insurance and less likely to experience the insured risk (Shane and Trivedi 2012, p. 4).

Aware of adverse selection and moral hazard, insurers will design policies which reduce their risk exposure. For example, they may set a cap on the total annual payout; mitigate the risk by requiring full disclosure of an applicant’s medical history; or they may invalidate a policy on the grounds of failure to disclose a relevant fact (Barr 2010, p. 366). Insurers may guard against moral hazard by designing contracts that impose some of the cost on the insured through a co-payment; and/or by charging premiums that include a margin for uncertainty.

## 2.2 Long-term Care Insurance

The problems of uncertainty, adverse selection, and moral hazard impact on LTCI provision. The two central probabilities are that a person will need LTC at some stage in their life; given that need, there is a probability distribution of different durations and levels of care. However, average life expectancy at age 60 or 65 is a poor guide to the

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<sup>6</sup> An insurance actuary can estimate risks with reasonable precision if significant amounts of historical data are available, and then ascertain appropriate insurance premiums for bearing risk. However, “in the appropriate limit law of probability there will necessarily be left an epsilon of uncertainty even in so-called risk situations” (Samuelson 1963).

<sup>7</sup> As an example, dementia sufferers are often long-lived while requiring intense levels of care, and the number of people living with dementia worldwide, currently estimated at 35.6 million, is expected to double by 2030 and more than triple by 2050, with concurrent economic and social impacts (World Health Organisation and Alzheimer’s Disease International 2012).

years an individual may actually live: some will live more than twice as long as the average (Wadsworth, Findlater and Boardman 2001).

Because insurers cannot predict what needs, costs, or technological advances may apply in 20 years' time, and the direction of change is unknown,<sup>8</sup> policies for LTCI, if available, are complex. The consumer wants to know the cost, the type of care covered, and whether both in-home and RAC are supported. Will they have a weekly cash allowance and the choice of their care-provider, or is care provided under contract by a private company? What happens to premiums if physical or mental condition deteriorates? In addition, insurance policies must meet the underwriting standards; usually limit the number of years the benefit will be paid; and retain the right to increase premiums. Also, prices increase dramatically for those purchasing insurance at a later age (Georgetown University, May 2003). Such complications,<sup>9</sup> and the array of possible 'basic' packages, compromise the ability of individuals to make informed choices.

Actuarially-based insurance cannot address uncertainties associated with LTCI, including the information problems facing both providers and potential purchasers. Although there are potential welfare gains if people can purchase LTCI, Barr (2010, p. 359) concludes that such supply-side and demand-side problems mean "social insurance is a better fit".

The demand for LTC services is predicted to increase substantially over the next decades with increased life expectancy and the ageing of the baby boomers, and policymakers are showing more interest in LTCI as an alternative to public funding. In the US:

*A number of approaches to make LTCI more attractive to consumers have been undertaken, including the Partnership Program for Long-Term Care, the enactment of further tax subsidies for LTCI premiums, and the sponsoring of LTCI plans by many large employers, including the federal government. (Li and Jensen 2011, p. 34)*

### 2.3 Social insurance

Unlike actuarial insurance, because participation in social insurance is compulsory, the link between premium and individual risk can be broken. Social insurance, or social security, is a compulsory public 'insurance' programme, generally designed to serve a defined population. Unlike private insurance, protection is not wholly determined by or related to the mandatory contributions. Also, whereas the right to benefits is based on an insurance contract with private insurance, social insurance programmes are generally based on legislation, and the state can alter contributions, and change conditions for receiving social insurance and the provisions of the programme, even retrospectively.

An example of social insurance is New Zealand's Accident Compensation, funded by mandatory individual and employer levies, with the accumulated fund managed by the Accident Compensation Corporation (ACC). Whether or not an injured person is employed, and wherever in New Zealand the injury occurs, "Everyone in New Zealand has 24-hour, seven-day-a-week, no-fault comprehensive injury cover through ACC".<sup>10</sup>

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<sup>8</sup> For example, medical advances prolonging life may lead to more sufferers from dementia requiring institutional care (Barr 2010, p. 363).

<sup>9</sup> In New Zealand, it is compulsory for an insurance provider to have an internal dispute resolution system; to belong to an external dispute resolution (EDR) scheme; and to inform the insured of the process and the name of their EDR provider. See *Financial Service Providers (Registration and Dispute Resolution) Act 2008* at [www.legislation.govt.nz/act/results.aspx?search=ts\\_act\\_financial+service\\_noresel&p=1](http://www.legislation.govt.nz/act/results.aspx?search=ts_act_financial+service_noresel&p=1).

<sup>10</sup> See <http://www.acc.co.nz/making-a-claim/am-i-covered/index.htm>.

### 3 An overview of pension and long-term care systems

When LTC is required, a person's public age pension can offset some of the private cost of the care, thus understanding the pension environment provides a basis for understanding the funding of LTC. Unfortunately, there is no internationally agreed system for categorising pensions. Cash incomes for retired people in developed countries can be grouped by 'source' into three major categories: public pensions (such as 'New Zealand Superannuation'); private and occupational pensions; and other private investment and savings. As set out below, retirement provision and pensions can also be described in terms of 'pillars', and 'tiers', or the more nuanced 'levels'.

#### 3.1 Three descriptions of pension systems

A state's level of involvement is complex, and philosophically and politically determined. The World Bank's 2008 model extends its prior three pillars to five, shown in Box 1.

##### **Box 1. The World Bank's five pension pillars** (Source: World Bank 2008)

**Pillar 0:** social pension, minimal level, non-earnings-related, non-contributory social scheme.

**Pillar 1:** mandatory, with contributions linked to varying degrees of earnings with the objective of replacing some portion of lifetime pre-retirement income.

**Pillar 2:** mandatory, typically an individual savings account with a wide set of design options including options for the withdrawal phase. Defined Contribution schemes (DC: determined by contributions to the scheme) clearly link contributions, investment performance and benefits.

**Pillar 3:** voluntary, flexible, discretionary scheme, e.g. individual savings for retirement, death or disability; employer-sponsored Defined Benefit (DB: standardised pension payment) or DC; taxpayer-subsidised DC schemes.

**Pillar 4:** non-financial, including access to informal support (e.g. family support), other formal social programmes (e.g. health-care and/or housing), and other individual financial and non-financial assets (e.g. home ownership and reverse mortgages).

Another way to describe the framework of a country's retirement income arrangements focuses on 'tiers', as shown in Box 2:

##### **Box 2. Tiers of pensions** (Source: Littlewood and Dale 2010, pp. 16 - 17)

**Tier 1:** the state age pension may be universal (New Zealand) or means-tested (Australia and the US). It is almost always a DB PAYG pension. It may have a residency requirement and may count socially contributive periods out of the workforce (such as caring for children).

**Tier 2:** a mandatory, work-related, contributory pension. It may be PAYG and DB as in the US and most of Europe; or pre-funded and DC. It can be managed privately and delivered as a lump sum as in Australia, or can be a public pension as in France and Germany. It can also be both private and public as in the UK's S2P and its contracted-out alternative.

**Tier 3:** covers all other private, voluntary, retirement savings, whether through the workplace, formal saving schemes, or by direct investment. Most governments participate indirectly through generous tax concessions that encourage particular types of retirement saving, and prescribe the ways in which those savings can be accessed at retirement.

As discussed above and shown in Box 3, in any particular country, state levels of involvement range from private unsubsidised saving, to a subsistence poverty-alleviation approach provided by a means-tested welfare benefit, unrelated to either former contributions or residence requirements. No developed country relies on these extremes

exclusively (St John, Dale and Littlewood 2009), and each country has a unique combination of the levels.

**Box 3. Spectrum of levels of state involvement in retirement income provision** (Source: St John and Ashton 1993, revised)

<b>PRIVATE</b>	1. Pure voluntary saving
	2. Tax-subsidised private saving
	3. Mandatory private saving
	4. Mandatory public saving
	5. Social insurance
	6. Earmarked taxes
	7. Tax-funded flat-rate universal pensions
	8. Tax-funded means-tested pensions
<b>PUBLIC</b>	9. Social assistance

This spectrum reflects the diminishing influence of a market economy's contributory principle, colloquially: 'you get out what you put in', as the role of government increases from levels 2 to 9. Thus level 1 is purely private, providing prefunded benefits through a pool of separately identified assets, has no government involvement and no redistribution from rich to poor. At levels 2 and 3, the role of government starts increasing, although the private savings principle can still apply with compulsory public saving at level 4. At level 5, retirement income is not wholly determined by the mandatory contributions although the contributory link remains. Social insurance can be redistributive, and does not require pre-funding. At levels 6 and 7, private contributions are loosely linked to the pension received, but do not determine the amount of the pension. Level 8 breaks all links between contributions and pension, however the means-test may be a gentle one. Level 9 is purely redistributive and provides a heavily targeted payment that is provided only once the case of poverty is established.

For example, New Zealand has 1: pure voluntary saving, 7: tax-funded flat-rate universal pensions, and KiwiSaver represents a modest move in the direction of 2: tax-subsidised private saving.<sup>11</sup> Subsidies like the Accommodation Supplement are available to all who meet the income test, including pensioners, so 9: social assistance is not included as an aspect of retirement income provision.<sup>12</sup> In comparison, the US has 1: pure voluntary saving, 2: tax-subsidised private saving, 5: social insurance, and 9: social assistance.

The 'spectrum of levels' analysis provides a more comprehensive description of the various types of retirement income arrangements and is used in the following inter-country comparison of pension systems, and public and private funding of LTC and LTCI.

### **3.2 A classification system for long-term care provision**

Three commonly identified costs associated with LTC are health care, personal care, and board and lodgings. Residential aged care (RAC) services may be universally covered for all those assessed as needing that level of care, while private board and lodgings may be a cost to the recipient. For those unable to pay the extra costs, public assistance is usually available. Some types of care such as RAC may be subsidised through the health

<sup>11</sup> The New Zealand Superannuation Fund could be described as mandatory public saving (level 4) as it was established to provide a level of pre-funding for NZS, but as the Government's contributions to the Fund were suspended in 2009 until the their Budget returns to surplus, it does not form part of this discussion.

<sup>12</sup> The Accommodation Supplement and similar assistance is included as an aspect of the LTC environment.



system, while others, such as in-home care, may entail cost-sharing between the health and social welfare systems.

The OECD's 2011 report, *Help Wanted: Providing and Paying for Long-Term Care*, examines the mechanics of each country's public financing of formal LTC.<sup>13</sup> Based on two criteria: scope of entitlement, and the nature of benefit delivery as a single system, multiple benefits, services or programmes, the countries are divided into means-tested safety-net schemes; universal coverage within a single programme; and mixed systems (OECD 2011a, p. 215). The OECD's classification system is summarised below.

### **3.2.1 Means-tested safety-net schemes**

These schemes provide publicly-funded LTC assistance to those with income and/or assets below a set threshold. Independent professional assessment usually determines the level of care needed, and thus the degree of public assistance that will be provided. Means-tested safety-net schemes vary, with some countries exempting the family home as long as it is occupied by family, while other countries assess all income and assets, and require spending-down of assets before public assistance is made available.

### **3.2.2 Universal coverage with a single programme**

Universal programmes offer publicly-assisted LTC through a single system where all people assessed as care-dependent and requiring assistance automatically receive a benefit consistent with the assessed level of care. A universal system may require personal contributions through co-payments, user charges, or lump-sum deposits.<sup>14</sup> Full cost-exemption (but not choice of the level of care) can be given to those assessed as unable to pay. The universal systems may offer a comprehensive range of services and still achieve wide cost-sharing. The financing of universal benefits can be: tax-based; mandatory purchase of public LTCI; or the provision of personal care through the public health system. Public assistance may be limited by age,<sup>15</sup> but some countries base assistance purely on assessed needs.

### **3.2.3 Mixed systems**

Mixed systems vary from country to country. They can have multiple programmes and benefits operating simultaneously; and they can operate as 'parallel universal schemes', where some benefits are universal and others are means-tested, with the resulting LTC costs either partially or fully state-funded.

Mixed systems can also operate as 'income-related schemes', where all benefits or subsidies are universal, but the state contribution is scaled back according to the individual's ability to pay. Some countries have established a floor beyond which the benefit must not be reduced, described by Fernández, Forder et al. (2009, p. 5) as 'progressive universalism', which may achieve the dual purposes of greater buy-in from those who would not qualify under ordinary circumstances, while preventing public expenditure from escalating out of control.

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<sup>13</sup> Public policies shape both formal provision and financing of LTC services, and informal provision (family and friends). Often, policy attention focuses excessively on paid-care systems, ignoring their interaction with informal and private structures (OECD, 18 May 2011c).

<sup>14</sup> If the level of care chosen by an individual is higher than the government-assessed level of need, the extra cost becomes the responsibility of the individual or their family.

<sup>15</sup> The 'qualifying' or 'eligibility' age for an age pension may not be the same as the age of 'retirement' from employment. In New Zealand, the eligibility age for NZS was reduced from 65 to 60 in 1978, then increased from 60 to 65 during 1992–2001. Also, the Human Rights Act 1999 made it unlawful to discriminate in employment on the grounds of age, thus abolishing the concept of a compulsory retirement age.

### 3.2.4 An extended typology

The 2011 OECD report's useful classifications of current national systems of LTC provision are perhaps more usefully understood as a continuum (similar to Box 3's spectrum), with means-tested safety-net schemes and universal coverage systems at either extreme, and mixed systems overlapping both. This paper extends that typology to tease out more detail, including use of pensions and private funding of LTCI. Further inter-country variations include whether benefits are cash or services. Cash allowances, which may be universal benefits, enable greater recipient-choice of the type and level of care received (OECD 2011a). In-kind services may be means-tested, or universal with an income-determined, limited co-payment required (OECD 2011a, p. 226).

## 4 Seven countries and seven systems of LTC and LTCI provision

<b>Table 2. Countries compared: Age Pension, Long-term Care Provision &amp; Funding:</b>							
<b>Levels of state involvement in Age Pension provision</b>							
	New Zealand	Australia	France	Germany	Japan	England	US
1. Pure voluntary saving	✓	✓	✓	✓	✓	✓	✓
2. Tax-subsidised private saving	✓	✓		✓	✓	✓	✓
3. Mandatory private saving		✓	✓	✓	✓	✓	
4. Mandatory public saving							✓
5. Social insurance			✓	✓	✓	✓	✓
6. Earmarked taxes							
7. Tax-funded flat-rate universal pensions	✓						
8. Tax-funded means-tested pensions		✓			✓	✓	
9. Social assistance			✓				✓
<b>In-home Long-Term Care (LTC) systems: provision and funding</b>							
Care & support: state cash allowance			Income-test	Income-test			✓
Care & support: state in-kind provision	✓	✓		✓	Income-test	Means-test	Means-test
Care & support: private contribution		Income-test	Income-test	Income-test	Income-test	Means-test	Means-test
Health services: state subsidy	✓	✓	✓	✓	✓	✓	✓
Health services: private contribution	✓	✓	✓	✓	✓		Means-test
Accommodation: state subsidy	✓	✓	✓	✓	✓	Means-test	Means-test
Other state assistance	✓	✓	✓	✓	✓	✓	✓
<b>Residential Aged Care (RAC) systems: provision and funding</b>							
Care & support: private contribution	NZS + Means-test	Pension + Means-test	Pension + Means-test	Pension + Means-test	Pension + Means-test	Pension + Means-test	Pension + Means-test
Health services: private contribution	✓	✓	✓	✓	✓	✓	✓
Accommodation: state subsidy	✓	✓	Means-test	Means-test	✓	Means-test	Means-test
Accommodation: private charge	✓	✓	✓	✓	Means-test	Means-test	Means-test
Accommodation Bond		Asset-test					
<b>Long-Term Care Insurance (LTCI) provision and take-up</b>							
Availability private LTCI			✓	✓			✓
Public LTCI - tax or compulsory levy			✓	✓	✓		✓
% take-up (2011)	0%	0%	15% (40+)	100%	100%	0%	10% (60+)

**Note:** means-test includes both income- and asset-test. The individual is required to contribute income and/or assets over the country's threshold toward the costs of LTC or RAC.

An international comparison requires a multi-dimensional approach. The form and value of LTC and LTCI in each country are largely dependent on the pension environment. The extent of expenses covered by public assistance varies from country to country; for example, assistance for activities of daily living (ADL) comes under the umbrella of LTC, yet there is a large observed variation in provision (OECD 2011a, p. 215). In some countries, only the LTC costs of health services are state-funded, and expenses such as board and lodging must be met by the individual out of their public pension and/or their personal savings. This system puts extra pressure on the health system which becomes the substitutable option for LTC for those ineligible for full assistance.

Sections 4.1 to 4.7 below describe the pension system, LTC provision and funding, and availability of LTCI in each of the seven countries. Table 2 sets out in summary form each of the countries' arrangements.

## 4.1 New Zealand

### 4.1.1 Retirement incomes in New Zealand

New Zealand's old-age dependency ratio (the ratio of those of working age to those aged 65+) is already comparatively high (see Table 3), and "New Zealand will have the most profound numerical ageing of any OECD country, because it had the highest and longest baby boom of the OECD countries" (Jackson 2011, p. 4). The population aged 65+ is projected to exceed 1 million in the late 2020s, up from the current 605,800; while the population aged 90+ is expected to almost double from the current 26,800 to 49,900 (Statistics New Zealand 2013). This will have an impact on superannuation and healthcare costs, and public expenditure is likely to rise significantly (Makhlouf 2011; OECD 2011m).

New Zealand is unusual in having a Universal Pension, New Zealand Superannuation (NZS). It is funded from general taxation on a Pay As You Go (PAYG) basis, and

Gender	Aged 65+	Total population
Female	327,900	7,5%
Male	277,900	6.4%
All	605,800 (13.9%)	4,362,000

does not require individual contributions to a fund or separate tax contributions, or even retirement. NZS is paid out of general taxation on a PAYG basis to all people aged 65+ who have resided in New Zealand for a minimum of 10 years, including at least 5 years after age 60. In terms of the spectrum of state involvement (see Box 3), New Zealand's pension system could be described as 1, 2, and 7: level 1, pure voluntary saving (and KiwiSaver moves New Zealand in a modest way to level 2, tax-subsidised private saving), and level 7 is NZS, the tax-funded flat-rate universal pension.

KiwiSaver, introduced in 2007, is an auto-enrolment, opt-out, work-based savings initiative that is voluntary for employees but compulsory for members' employers (each contributing a minimum 2% of gross wage or salary).<sup>17</sup> Except in cases of financial hardship, permanent emigration or first home purchase, contributions are locked in until

<sup>16</sup> See Statistics New Zealand (2012)

[http://www.stats.govt.nz/browse\\_for\\_stats/population/estimates\\_and\\_projections/NationalPopulationEstimates\\_HOTPMar12qtr.aspx](http://www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/NationalPopulationEstimates_HOTPMar12qtr.aspx).

<sup>17</sup> KiwiSaver advantages include a \$1,000 'kickstart' from the government when an account is opened, and a government subsidy of up to \$520 annually on member contributions of at least \$1,040. From 1 April 2013, while KiwiSaver membership remains voluntary, contributing members must contribute a minimum of 3% of their remuneration, and their employers must match that contribution.

the member is eligible for NZS. KiwiSaver is paid at as a lump-sum, with no requirements for the purchase of an annuity or other decumulation instrument. The design of KiwiSaver means:

*... the "problem" of long term care has been deferred, rather than resolved. An important opportunity has been lost to introduce a longer term insurance-based solution which is fiscally sustainable, and which integrates long term residential care with care provided in the home. (Ashton and St John 2005)*

While Universal Pensions are the least common form of public pension, and the most fiscally expensive way of providing a minimum income for retirees (Littlewood and Dale 2010, pp. 16 - 17), NZS is "generally acknowledged to be the simplest retirement set-up in the OECD" (Rashbrooke 2009, p. 98). The adequacy of NZS is evidenced by the low levels of poverty among those aged 65+ at around 5% (at the 50% of before-housing costs median (Perry 2011, p. 104, Table G.3), compared with the 13.5% average in other OECD countries (Department of Economic and Social Affairs 2008). However, NZS is not primarily a poverty-alleviation device and is currently treated more favourably with regard to indexation and entitlement than 'welfare' benefits such as Unemployment, Sickness and Domestic Purposes Benefits. Age pensioners also receive a SuperGold Card, offering discounts and concessions from local and national government and businesses, including free off-peak public transport.<sup>18</sup>

#### **4.1.2 The Long-term Care environment in New Zealand**

Although, in New Zealand, 74% of people aged 65–74 live at home without assistance, the proportion needing assistance increases with age:

*Around half of people aged 85 and over live at home with assistance and 27% live in residential care. While the percentage of people aged 65 and over in residential care at any point in time is relatively low (around 5%), it has been estimated from overseas data that 25 to 30% of people who reach the age of 65 can expect to spend some time in long-term care before they die. (Ministry of Health 2002)*

In addition to NZS, age-pensioners with regular, ongoing costs such as doctor visits, medicines, travel, or extra clothing because of a disability, can access from Work and Income a weekly Disability Allowance of up to \$60.17.<sup>19</sup> Access to Home and Community Support Services after a needs-assessment<sup>20</sup> is universal (not income- or asset-tested) and funded primarily through District Health Boards (DHBs) (Ministry of Health 2011, p. 7).<sup>21</sup> Services include personal care (help with dressing, hygiene, medications), preparing meals, cleaning, therapy, and support for informal carers (including respite care). In 2010, DHBs spent \$224 million providing such services to the elderly, at an average cost of around \$3,000 per person (Patterson 2012). Also available to pensioners is the income- and asset-tested Accommodation Supplement,<sup>22</sup> paid when

<sup>18</sup> See <http://www.supergold.govt.nz/>.

<sup>19</sup> See <http://www.workandincome.govt.nz/individuals/a-z-benefits/disability-allowance.html>.

<sup>20</sup> See <http://www.health.govt.nz/yourhealth-topics/disability-services/home-and-community-support-services>.

<sup>21</sup> The Community Services Card can reduce the cost of: prescription fees; fees for after hours or locum doctor visits; emergency dental care provided by hospitals and approved dental contractors; travel and accommodation for treatment at a public hospital outside your area when you have been referred; and home help. See <http://www.workandincome.govt.nz/individuals/a-z-benefits/community-services-card.html>.

<sup>22</sup> See <http://www.workandincome.govt.nz/manuals-and-procedures/income-support/extra-help/accommodation-supplement/accommodation-supplement-92.htm>.

accommodation costs exceed the 'entry threshold', which varies depending on the family situation.<sup>23</sup>

Adding the Disability Allowance to the cost of DHB-funded Home and Community Support Services shows the average annual total cost of provision of publicly-funded home-based care services in 2010 was around \$6,000 per person. This contrasts sharply with the \$43,500 per year that may be paid in tax-payer-funded subsidies for a person assessed as needing RAC. All things being equal, there is a distinct cost advantage in supporting people's desire to remain independent and in their own home for as long as possible (Patterson 2012).

Financing RAC is a mix of the general taxation-funded NZS, Government subsidies through the Health budget, and private, asset-tested payments.<sup>24</sup> Almost all who need RAC have NZS to contribute. Of the 19,055 Residential Care Subsidies paid in 2010, only 113 were not in receipt of NZS, Veteran's Pension, or Unemployment, Sickness, Invalids or Domestic Purposes Benefit (Ministry of Social Development 2011, p. 192).<sup>25</sup> Following Government promises since 1999 to review the means-test, the asset limit progressively increased from 2006 (St John and Dale 2011). After 1 July 2012,<sup>26</sup> rather than increasing by \$10,000 annually as in previous years, the asset threshold for the Residential Care Subsidy will only increase in tandem with the Consumer Price Index (CPI): in 2012, from \$210,000 to \$213,297 for single people, or for a couple in care. Couples with only one in long term care can choose either the asset threshold of \$213,297 or the alternative asset threshold of \$116,806 where the family home, car and a pre-paid funeral of up to \$10,000 are exempt assets (Ministry of Health 2012).

In 2009, approximately 3.6% of the over 65 population received RAC, and 11.6% received LTC (OECD 2011). Individuals must be assessed by a health professional as in need of LTC before being accepted into an RAC facility, and must be income- and asset-tested by Work and Income (New Zealand's welfare agency) to determine their eligibility for the Residential Care Subsidy. This Subsidy is only available to those with assets below the maximum limit discussed above. Once the asset threshold is reached, income must be used up to the capped amount.

The cap on personal contributions for RAC in 2012 was \$812.45 - \$892.73 per week (up from \$786 - \$864 in 2011) depending on the region (Director General of Health 2012),<sup>27</sup> although the cost of hospital-level care can exceed \$1,500 a week. Remaining assets can then be bequeathed in full at death, as estate duties were abolished in New Zealand in 1992. Taxpayers effectively subsidise the asset accumulation of some wealthier residents who could pay their fees entirely out of income from their assets. Inheritances are thus similarly subsidised.

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<sup>23</sup> For every dollar over the entry threshold that a client pays in accommodation costs they receive a 70% subsidy. For example, a single pensioner living alone in Auckland with rental or mortgage payments could receive a maximum weekly subsidy of \$145. See [http://www.workandincome.govt.nz/manuals-and-procedures/deskfile/extra\\_help\\_information/accommodation\\_supplement\\_tables/entry\\_thresholds\\_and\\_maximum\\_rates-47.htm](http://www.workandincome.govt.nz/manuals-and-procedures/deskfile/extra_help_information/accommodation_supplement_tables/entry_thresholds_and_maximum_rates-47.htm).

<sup>24</sup> New Zealand and Sweden are unusual in having a high proportion of the financing from general revenue sources and none from social insurance arrangements such as social security.

<sup>25</sup> It is worth noting that 19,055 residents x \$43,500 = \$82,889,250, a significant burden on current taxpayers.

<sup>26</sup> See Social Security (Long-term Residential Care-Budget Measures) Amendment Act 2012.

<sup>27</sup> See <http://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/maximum-contribution>. The maximum contribution is set by the Director-General of Health through a notice in the New Zealand Gazette under the Social Security Act 1964 and varies between Territorial Local Authority (TLA) regions. [Gazette Notice – Maximum contributions in each region from 1 July 2012](#).

There are pressures that may compromise services for the poorer elderly. Currently, contract prices paid by DHBs to providers of RAC are reviewed annually. While the cap on fees prevents providers from cost-shifting by increasing the price charged to non-subsidised (i.e. private) patients (Ministry of Health 2007), residents can still be charged for services 'outside the contract specifications', including, for example, superior rooms, special equipment, transport to outside services or functions, and specialist care. If RAC providers consider contract prices inadequate, they may not service lower-socioeconomic areas where residents are less able to afford extra charges, or rural areas with less potential to offset operating losses through property development.

Total expenditure on LTC (including home care) for people aged 65 years and over in New Zealand in 2008 was 1.3% of GDP, just below the OECD average of 1.5%, with 92% of the spending from public sources (OECD 2011a, p. 231). In 2011/12, New Zealand's DHBs spent \$910 million a year to subsidise RAC. The residents themselves spent around \$730 million for contracted care as a result of income- and asset-testing, about \$250 million of which came from the residents' NZS. This suggests that about 42% of total expenditure on RAC was paid for by the individual's own state pension or other savings and income (Ministry of Health, personal communication). Of those in rest home care, about 30% were paying privately up to a maximum limit, while 70% were (fully or partially) state-subsidised.

#### 4.1.3 Long-term Care Insurance in New Zealand

Although there is a small market for annuities, LTCI is not available. Annuities with state subsidies could be designed to specifically incorporate LTCI (St John, Dale and Ashton 2012).

The costs of LTC and RAC are met by current taxpayers funding NZS through general taxation, and LTC and the Residential Care Subsidy through the Health budget, plus co-payments by the individuals receiving the care.

<b>Table 4. Summary of Age Pension &amp; Long-Term Care Provision &amp; Funding: New Zealand</b>	
<b>Levels of state involvement in Age Pension provision</b>	
1. Pure voluntary saving	✓
2. Tax-subsidised private saving	✓
3. Mandatory private saving	
4. Mandatory public saving	
5. Social insurance	
6. Earmarked taxes	
7. Tax-funded flat-rate universal pensions	✓
8. Tax-funded means-tested pensions	
9. Social assistance	
<b>In-home Long-Term Care (LTC) systems: provision and funding</b>	
Care & support: state cash allowance	
Care & support: state in-kind provision	✓
Care & support: private contribution	
Health services: state subsidy	✓
Health services: private contribution	✓
Accommodation: state subsidy	✓
Other state assistance	✓
<b>Residential Aged Care (RAC) systems: provision and funding</b>	
Care & support: private contribution (capped)	NZS + Means-test
Health services: private contribution	✓
Accommodation: state subsidy	✓
Accommodation: private charge	✓
Accommodation Bond	
<b>Long-Term Care Insurance (LTCI) provision and take-up</b>	
Availability private LTCI	
Public LTCI - tax or compulsory levy	
% take-up (2011)	0%

## 4.2 Australia

### 4.2.1 Retirement incomes in Australia

Based on the 'spectrum of levels of state involvement' (see Box 3), the Australian age-pension environment comprises levels 1, pure voluntary saving; 2, tax-subsidised

private saving and 3, mandatory private saving (tax-subsidised): the Superannuation Guarantee Levy (SG), a compulsory levy on employers of 9% of employees' gross ordinary earnings that applies to employees to age 75;<sup>28</sup> and level 8, tax-funded means-tested age pension<sup>29</sup> which represents 27.7% of average individual income.<sup>30</sup>

In 2007, the median accumulated saving (including superannuation, excluding the home) of all 55-64 year olds, was AU\$51,500 (NZ\$65,400)<sup>32</sup>

Gender	Aged 65+	Total population
Female	1,476,615 (2006)	6.5%
Male	1,210,499 (2006)	5.3%
All	3,010,000 (13%)	21,000,000

(Australian Department Of Health 2011). This apparently inadequate accumulation drove the Government's 2010 decision to increase the compulsory SG saving rate from 9% to 12% by 2019/20.<sup>33</sup>

As Table 5 shows, Australia's population aged 65+ in 2007 was a slightly lower proportion (13%) than New Zealand's (13.9%). However, between 30 June 1992 and 30 June 2012, the proportion of the population aged 65+ increased from 11.5% to 14.2%.<sup>34</sup>

Available supplements and concessions to age-pensioners range from Rent Assistance to the Continence Aids Payment Scheme (Department of Human Services 2012). The Commonwealth Seniors Health Card<sup>35</sup> contributes to the cost of prescription medicines under the Pharmaceutical Benefits Scheme (PBS); medical services funded by the Australian Government; concessional rail travel on Great Southern Rail services; and access to concessions provided by state, territory and local governments, and in some cases, private businesses. The Seniors Supplement or Pension Supplement is a quarterly, non-taxable payment<sup>36</sup> provided to eligible Commonwealth Seniors Health Card holders, to help with regular bills such as energy, rates, phone and motor vehicle registration. The Pensioner Concession Card gives cardholders access to Australian Government health concessions and helps with the cost of living by reducing the cost of certain goods and services such as property and water rates, energy and telephone bills, public transport fares, and vehicle registration.<sup>37</sup>

<sup>28</sup> In Australia, the tax rate on investment earnings (within superannuation) is a maximum of 15%, but is generally lower due to dividend imputation credits and the discounted tax rate on capital gains, whereas in New Zealand the tax rates are typically either 17.5% or 30% depending on the individual's income. In both countries, withdrawals are generally lump-sum, and tax-free, New Zealand's KiwiSaver after age 65 (except hardship) and Australia's schemes after age 60 (Guest 2010, p. 5).

<sup>29</sup> The Australian Government's Human Services website Chart B shows the generous asset-test limits for part pensions. A single homeowner with AU\$696,250 can still qualify for a part pension; a non-homeowner can have AU\$835,750; a home-owning couple is allowed AU\$1,032,500, while a non-homeowning couple is allowed assets of AU\$1,032,500. See: <http://www.humanservices.gov.au/customer/enablers/assets>.

<sup>30</sup> Adequate couple replacement income is regarded as 65 to 70% of preretirement income (Guest 2010, p. 6).

<sup>31</sup> See [www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442454211](http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442454211).

<sup>32</sup> Based on the New Zealand spot rate December 2011.

<sup>33</sup> The SG rate increases to 12% by 2019-20. It is estimated that 55-64 year olds will have accumulated median balances (today's dollars) of AU\$200,300 (NZ\$254,380) - females, and \$350,900 (NZ\$445,650) - males by 2040; enough, with a part pension, to provide a modest retirement lifestyle (Guest 2010, p. 2). See: [http://www.futuretax.gov.au/content/Content.aspx?doc=FactSheets/super\\_guarantee\\_rate\\_to\\_12\\_percent.htm](http://www.futuretax.gov.au/content/Content.aspx?doc=FactSheets/super_guarantee_rate_to_12_percent.htm).

<sup>34</sup>

[http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3101.0Feature%20Article1Jun%202012?opendocument&tabname=Summary&prodno=3101.0&issue=Jun%202012&num=&view=.](http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3101.0Feature%20Article1Jun%202012?opendocument&tabname=Summary&prodno=3101.0&issue=Jun%202012&num=&view=)

<sup>35</sup> See <http://www.humanservices.gov.au/customer/services/centrelink/commonwealth-seniors-health-card>.

<sup>36</sup> See <http://www.humanservices.gov.au/customer/services/centrelink/seniors-supplement>.

<sup>37</sup> See <http://www.humanservices.gov.au/customer/services/centrelink/pensioner-concession-card>.

The (2009) Harmer Review suggested that integrating the multiple supplementary payments into a single payment or absorbing them into the base rate of pension would simplify the structure of pensions, however, multiple, complex options remain in 2012.

#### 4.2.2 The Long-term Care environment in Australia

Under the OECD classification, Australia's LTC provision would be described as 'mixed'. There is currently no nation-wide system for the funding and delivery of subsidies and supplements (Department of Health and Ageing 2012c). In-home Community Care is funded almost completely by the Federal and State Governments (YZnet Communications Pty Ltd 2012), with some means-tested private contribution. The scheme protects the elderly from poverty and ensures access to necessary care. Before the Government provides a subsidy, an individual must be assessed for the level of care needed. The state-funded value of LTC benefits is determined by a 3-tier process: the government's independent assessment of the level of need; the individual's independently-determined ability to pay; and the type of care an individual chooses.

Since the introduction of the Aged Care Funding Instrument (ACFI) in 2008, government funding per resident has been trending up at a significantly higher rate than previously. Consequently, on 21 June 2012, as part of implementing the *Living Longer Living Better* package (Department of Health and Ageing 2012; Department of Health and Ageing 2012b), a range of changes to the ACFI were announced, effective from 1 July 2012. The changes aim to return funding to the long-term trend rate, and to redirect funding for other aged care reforms. Government funding for residential care will increase from AU\$8.806 billion in 2011-2012 to AU\$10.945 billion in 2015-2016.<sup>38</sup>

*The Productivity Commission... argued the aged care system is difficult to navigate; provides limited services and consumer choice; supplies services of variable quality; suffers from workforce shortages that are exacerbated by low wages and some workers having insufficient skills; and is characterised by marked inequities and inconsistencies in the availability of services, pricing arrangements and user co-contributions. In response, the Commission proposed an integrated reform package, which would fundamentally change the structure and dynamics of Australia's aged care system. (Department of Health and Ageing 2012c)*

The Department of Health and Ageing offer a range of LTC programmes and services: Home and Community Care (HACC), Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACHD) (OECD 2011c, pp. 2 - 3).<sup>39</sup> The Government will pay AUD\$345 (NZ\$440) per week to providers of at least 20 hours of in-home care (Centrelink Sept 2011). An income-tested fee is required as a co-payment for these personal care services, with the rest of the costs borne by federal and state government. Co-payments for HACC are nominal at roughly AU\$10 (NZ\$12.70) per week, and for CACP, EACH and EACHD the maximum is 17.5% of the Age Pension and up to 50% of income above the Age Pension (Browne and Bridet 2011, p. 59). Those unable to pay the fee will not be denied a service they need.

The three costs associated with RAC, each with varying financial incidences for the recipient, are:

- the basic daily fee or accommodation charge,
- personal caring costs, and

<sup>38</sup> See <http://www.health.gov.au/internet/main/publishing.nsf/Content/currentissue-P12000023>.

<sup>39</sup> See Department of Health and Ageing (2012).



- an asset-tested charge paid as an accommodation bond.<sup>40</sup>

For RAC, the maximum daily fee in 2011 was AU\$66.43 (NZ\$84) (Australian Government Sept 2011, p. 1). The income-tested co-payment is determined at 5/12<sup>th</sup> of assessable income over the allowable threshold of AU\$866.60 (NZ\$1,100) per fortnight (Centrelink Sept 2011). The government subsidy accounts for about 70% of the RAC personal care costs (OECD 2011a, p.225). This feature is an example of 'progressive universalism', typical of a mixed system: all those assessed as needing LTC receive the care subsidy, but the amount received is scaled back according to each individual's ability to pay. The floor to the abatement process means individuals will pay the lesser cost of 5/12<sup>th</sup> of assessable income, AU\$84 (NZ\$107) per day, or the total cost of care.

The *basic daily fee* is the standard resident contribution after 1 July 2012 of 85% of the annual single basic age pension (Department of Health and Ageing 2012), paid directly to service providers on behalf of the resident. This covers the accommodation costs, food, cleaning, laundry, nursing care, personal care, heating and cooling; and leaves individuals with a minimum residual pension amount for any extra personal costs. The *basic daily fee* can be reduced under hardship provisions (Australian Government 2009, p. 96). The amount of the accommodation charge is negotiated between the provider and the resident within the maximum level set by the Government, currently AUD\$41 (NZ\$52) per day (Australian Government Sept 2011, p. 1). Additional service fees may be negotiated with the recipient and charged by the provider.

*Personal caring costs* are the second aspect to which the government automatically contributes through a variable subsidy paid to the provider (Australian Government 2009, p. 93). As with in-home LTC, recipients usually make a financial contribution, based on an income-test, to personal caring costs.

The *accommodation bond* is an asset-tested, interest-free, unsecured loan from the new resident to the institution, ranging from AU\$50,000 to AU\$750,000+ (NZ\$64,655 to NZ\$969,835) depending on the institution and on the needs and financial status of the new resident (Australian Government 2009, p. 98). The institution can use the interest income on the bond for maintaining or extending buildings and equipment (not for provision of services), and when the resident leaves the facility the majority of the bond is returned (Aged Care Connect 2012). A resident cannot be charged a bond which would leave them with less than 2.25 times the basic age-pension amount, currently AU\$40,500 (NZ\$52,370), excluding houses accommodating a partner or dependent child (Department of Health and Ageing 2012d). Those with low asset levels pay a reduced bond, and those with assets below the threshold are Government-subsidised (Australian Government 2009, pp. 98-99).<sup>41</sup>

Australia's LTC expenditure for 2007 was sourced 88.9% from general government (both federal and state) with 0.3% funded from private insurance and 8.5% private households' out-of-pocket expenses (OECD 2011a, p. 231). In 2011, over 1 million people aged 60+ were receiving some aged-care service at a public cost of \$10 billion, including 160,000 people in RAC at a public cost of \$6.7 billion (Bridet and Browne

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<sup>40</sup> Similar to the License to Occupy that applies in New Zealand's Residential Villages.

<sup>41</sup> However, the Australian Productivity Commission (2011, p. xxxvii) has recommended that private homes, as a major store of wealth, be included in the income- and asset-testing for financial assistance.

2011). It is likely that this LTC cost-burden will need restructuring, and there is a current move to create a single national aged-care system (OECD 2011c, p.3).

### 4.2.3 Long-term Care Insurance in Australia

While equity release products such as home reversion schemes and reverse mortgages are available (Browne and Bridet 2011, p. 62), there is neither direct provision of private voluntary LTCI products in Australia, nor an annuities market to support decumulation.

The annuity industry, with estimated worth in 2011 of AU\$9.5 billion (NZ\$12.07 billion), is strictly regulated by the Australian Prudential Regulation Authority, and annuities can only be issued by life insurance companies (Hasib 2011). After only 19 life annuities were purchased in the first quarter of 2008 (Ganegoda and Bateman 2008); by 2010 there was a range of pension/annuity products available for converting lump sums into income streams such as lifetime or term annuities and allocated pensions (Guest 2010).

For example, at Challenger Annuities from 1996-7 to 2008-9 “the share of benefits [drawn from SG funds and] taken as an income stream increased from one fifth to one half” (Guest 2010, p. 9). Recognising the growing pressure of an ageing population on the taxation system, the Henry Review (2010, p. 641) recommended the Productivity Commission consider the “potential for insurance to play a role in helping to fund aged care as Australia’s population ages”. While both voluntary and compulsory insurance are pre-funded approaches to the costs of aged care, the Commission argued that “compulsory insurance would extend coverage and provide a more effective risk-pooling mechanism” (2011, p. 119).

<b>Table 6. Summary of Age Pension &amp; Long-Term Care Provision &amp; Funding: Australia</b>	
<b>Levels of state involvement in Age Pension provision</b>	
1. Pure voluntary saving	✓
2. Tax-subsidised private saving	✓
3. Mandatory private saving	✓
4. Mandatory public saving	
5. Social insurance	
6. Earmarked taxes	
7. Tax-funded flat-rate universal pensions	
8. Tax-funded means-tested pensions	✓
9. Social assistance	
<b>In-home Long-Term Care (LTC) systems: provision and funding</b>	
Care & support: state cash allowance	
Care & support: state in-kind provision	✓
Care & support: private contribution	Income-test
Health services: state subsidy	✓
Health services: private contribution	✓
Accommodation: state subsidy	✓
Other state assistance	✓
<b>Residential Aged Care (RAC) systems: provision and funding</b>	
Care & support: private contribution	Age Pension + Means-test
Health services: private contribution	✓
Accommodation: state subsidy	✓
Accommodation: private charge	✓
Accommodation Bond	Asset-test
<b>Long-Term Care Insurance (LTCI) provision and take-up</b>	
Availability private LTCI	
Public LTCI - tax or compulsory levy	
% take-up (2011)	0%

Given the long lag between the purchase and the event, and the uncertainty of price changes and technological advances, private provision of LTCI is likely to be costly for consumers (Bridet and Browne 2011). However, in theory, competition among providers could generate more choice for consumers, and the system could be made equitable by means-tested premiums.<sup>42</sup>

<sup>42</sup> Deloitte Access Economics (2010, p. 32) argues that an LTCI scheme would not resolve intergenerational inequities, and “Private provision would be more efficient than public provision as there would be less dead-weight loss.” See <http://www.deloitteaccesseconomics.com.au/>.

## 4.3 France

### 4.3.1 Retirement incomes in France

In France, those aged 65+ already make-up over 16% of the total population (see Table 7). In response, in 2010, despite public protest, entitlement to the French age-pension was raised from 60 to 62 years, with full pension benefits delayed until age 67 instead of 65. However, in June 2012, the newly elected President returned the retirement age to 60 years for those who entered the workforce aged 18 or 19 years.<sup>44</sup>

Gender	Aged 65+	Total population
Female	6,155,767	9.3%
Male	4,403,248	6.6%
All	10,559,015 (16.4%)	65,821,885 (2011)

*In the private sector, the pension system has two tiers: an earnings-related public pension and mandatory occupational schemes, based on a points system. The public scheme also has a without means test minimum contributory pension ("minimum contributif"). In addition there is a targeted minimum income for the elderly ("minimum vieillesse"). (OECD 2011f)*

Applying the spectrum of levels of state involvement, France has levels 1, 3, 5, and 8. Pure voluntary saving is level 1; a mandatory system requiring contributions from both employers and employees (a full pension requires 40 years of contributions) is level 3. Levels 5: social insurance, and 8: social assistance, are the public contributory pension and the 'solidarity' allowance, an income-tested minimum payable if other income is less than €9,326 (individual) or €14,480 (couple).

The Generalized Social Contribution (CSG) is a tax to fund health insurance, family benefits, and the Retirement Solidarity Fund (FSV). The CSG is levied at source on most earned income including salaries, bonuses, annuities, and capital gains, and on unearned income and investment, with reduced rates for pension and benefit income. The publicly run FSV, a work-related, DB age pension is based on adjusted earnings over the best 25 years. The 2 main schemes, one for wage-earners and one for salaried employees, each require a 15% contribution from covered earnings up to an annual maximum of €34,600 (NZ\$57,413).<sup>45</sup> The minimum pension is €6,958 (NZ\$11,546) annually.

### 4.3.2 The Long-term Care environment in France

Using the OECD classification, the LTC social system is 'mixed' (OECD 2011a, p.225). It is fragmented between state provision and a large private insurance market, and across LTC insurance, residential care, domiciliary care, cash for care, and tax deductions for families who employ a carer (Le Bihan and Martin 2010, p. 392). The two elements of the social health care system are health insurance (Sécurité Sociale), and cash payments (APA: Allocation Personnalisée d'Autonomie: Personalised Allowance for Autonomy), funded from the Government's general budget for health and social services.

Health insurance pays for health costs and RAC. The means-tested APA cash payments, available to those aged 60 years or older, are paid directly to the individual, with the

<sup>43</sup> See [http://en.wikipedia.org/wiki/Demographics\\_of\\_France#Age\\_structure](http://en.wikipedia.org/wiki/Demographics_of_France#Age_structure).

<sup>44</sup> The change will affect approximately one in 6 workers. See <http://www.telegraph.co.uk/finance/financialcrisis/9314666/French-president-Francois-Hollande-cuts-retirement-age.html>.

<sup>45</sup> Based on New Zealand spot rate as at 16 May 2012.

amount determined firstly by need: those assessed with higher needs have a higher ceiling on the potential cash value receivable. Secondly, the benefit is abated against weekly incomes above €682 (NZ\$1,150) (Le Bihan and Martin 2010), and cash benefits are reduced down to a minimum of 10% of the assets which by law must be left for any beneficiaries (OECD 2011a).<sup>46</sup> The remaining 90% of the abated benefit represents the maximum co-payment an individual provides towards the cost of their LTC.

The cash benefit received is controlled by the negotiated RAC or LTC care package. The cash APA payment allows greater flexibility and choice in the type of care the individual can receive through the system. Where institutional care is required, the individual can offset part of their personal-care costs resulting, on average, in a remaining 33% of LTC cost requiring personal contribution (Espagnol, Lo and Debout 2008, p. 4).

### 4.3.3 Long-term Care Insurance in France

Often the APA and pension payouts for middle income earners are not sufficient for all the LTC costs, and a supplementary income stream is required. In response, despite the expectation of market failure for private insurance for LTC (see 2.2 Long-term Care Insurance), the French system encourages greater investment in private LTCI. Wide coverage in the press of national debates around the search for solutions to the risk of LTC need have increased the public's awareness, and supported the development of private insurance. Market growth is also encouraged by the choice of the products offered by French insurers, for example, cash benefit products provide greater choice of both care service and service provider (Courbage and Roudaut 2011, p. 23).

The LTCI market in 2007 had 3 million policy-holders and a market size of €2.1 billion (NZ\$3.55 billion) (Le Bihan and Martin 2010, p. 396).<sup>47</sup> In 2008, the average age of subscribers to private LTCI was 55-66 years old; and their annual premium of €400-500 (NZ\$676-845) guaranteed them, from the age of 60, a monthly payment of €600 (NZ\$1,014) in the event of severe dependency, or €200-400 (NZ\$338-676) for moderate dependency (OECD 2011a, p. 250).

In 2010, 15% of the population aged 40+ had private LTCI, and the market had annual growth close to 15% (OECD 2011a, p. 248). The LTCI policies may be individual or collective (contractor is an enterprise, mutual insurance company or a non-profit-making organization), and when they are collective they may be either optional or compulsory (Le Bihan and Martin 2010, p. 397). The four main insurance policies available are:

- Contingency Cover- a regular premium is paid so that a pre-defined benefit is received in the event of dependency;
- an option for those with Life Insurance where Death or Retirement cover is paid in advance if the insured individual becomes dependent on care;

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<sup>46</sup> The French Civil Code imposes limits upon how much may be left by Will to a particular person. A person's estate is divided between the *réserve légale* which must be inherited by the children, and the *quotité disponible* which is freely disposable by will. The value of the former is determined by how many "reserved heirs" the deceased has. In the absence of children, the surviving spouse is a reserved heir for 25% of the estate. For one child the reserved portion is 50%, 67% for two children and 75% for three or more children, split equally between them. The remaining unreserved portion may be left as the owner pleases. [http://www.russell-cooke.co.uk/clientUpload/document/file/French Inheritance Law Brochure 2011.pdf](http://www.russell-cooke.co.uk/clientUpload/document/file/French%20Inheritance%20Law%20Brochure%202011.pdf).

<sup>47</sup> For example, an indemnity insurance policy enables an individual to guarantee their LTC cover by paying an annual premium so that a determined future stream of income will occur once/if they become dependent (OECD 2011d, p. 3).

- an option of Life Insurance and Dependency Cover where savings on the policy accumulate and the individual, on becoming dependent, can choose to have the savings converted into a monthly benefit; and
- additional health cover can be purchased (Le Bihan and Martin 2010, p. 397).

Apparent reasons for the French success with private LTCI take-up include the availability of employers' group plans (45% of all LTCI contracts in 2009 (FFSA 2010, as cited in OECD 2011a, p. 256)); a culture of financial conservativeness; and encouragement of young people to take up insurance during their working lives (Fédération Française des Sociétés d'Assurances 2009, cited in OECD 2011a, p. 250).

LTCI policies guarantee a monthly cash benefit in the event of dependency, which simplifies pricing the security (Le Bihan and Martin 2010, p. 397), and there is a variety of LTCI products. Also, means-testing and inheritance laws provide incentives; insurance is underwritten; and premiums and benefits are reviewable (Browne and Bridet 2011, p.70).

<b>Table 8. Summary of Age Pension &amp; Long-Term Care Provision &amp; Funding: France</b>	
<b>Levels of state involvement in Age Pension provision</b>	
1. Pure voluntary saving	✓
2. Tax-subsidised private saving	
3. Mandatory private saving	✓
4. Mandatory public saving	
5. Social insurance	✓
6. Earmarked taxes	
7. Tax-funded flat-rate universal pensions	
8. Tax-funded means-tested pensions	
9. Social assistance	✓
<b>In-home Long-Term Care (LTC) systems: provision and funding</b>	
Care & support: state cash allowance	Income-test
Care & support: state in-kind provision	
Care & support: private contribution	Income-test
Health services: state subsidy	✓
Health services: private contribution	✓
Accommodation: state subsidy	✓
Other state assistance	✓
<b>Residential Aged Care (RAC) systems: provision and funding</b>	
Care & support: private contribution	Age pension + Means-test
Health services: private contribution	✓
Accommodation: state subsidy	Means-test
Accommodation: private charge	✓
Accommodation Bond	
<b>Long-Term Care Insurance (LTCI) provision and take-up</b>	
Availability private LTCI	✓
Public LTCI - tax or compulsory levy	✓
% take-up (2011)	15% (aged 40+)

## 4.4 Germany

### 4.4.1 Retirement incomes in Germany

Germany already has over 20% of the population aged 65+ (see Table 9). The social security system covers age pensions, health, sickness, and carer's insurance, as well as unemployment, maternity benefits and child allowances. It is a PAYGO system funded by contributions from the employed, employers and self-employed as well as the state, in four insurance schemes: Health (15.5% of salary/wage, 8.2% paid by the employee and 7.3% paid by the employer),<sup>49</sup>

<b>Table 9. Population of Germany 2010: age 65+, gender<sup>48</sup></b>		
<b>Gender</b>	<b>Aged 65+</b>	<b>Total population</b>
<b>Female</b>	9,701,551	11.8%
<b>Male</b>	7,004,805	8.5%
<b>All</b>	16,706,356 (20.3%)	81,859,000 (2011)

<sup>48</sup> See [http://en.wikipedia.org/wiki/Demographics\\_of\\_Germany#Population](http://en.wikipedia.org/wiki/Demographics_of_Germany#Population).

<sup>49</sup> The payroll tax collects payments for both public and private insurance providers to fund Health Insurance (*Krankenversicherung*) (Brune 2012). There is a separate funding channel for LTC from Health Insurance that is not run on a PAYG basis: funds are not matched with the costs incurred despite the payroll tax rate

Unemployment (3%), Nursing Care (1.95%, with an additional 0.25% imposed on those with no children over the age of 23 years), and Age Pension (19.6%) (Swiss Life Network 2011; Brune 2012).

The spectrum of state involvement suggests levels 1: pure voluntary saving; 3: mandatory private saving; and 5: social insurance. Also, since the GFC, the German Government has offered tax breaks to encourage workers to supplement their state pensions with private retirement schemes (level 2: tax-subsidised private saving), with the result that a raft of new private retirement schemes have hit the pension market, offered by most banks and insurance companies (Universitat Bonn 2009).

The Institute for Pension Insurance is the national body, and state institutes administer the pension funds of employees in their area. The funds deal with registration in the schemes (and the relevant occupational health agency for accident insurance), and provide employees with a social security number and a social security insurance document. Top-up pensions are available through additional private pension schemes.

State pension benefits are paid out on retirement which currently begins at age 65 for both males and females, although there is discussion about increasing that to 67 or even 69 years (Ketels 2011). In order to qualify for benefits, at least 5 years' contributions into the system are required. The benefits paid (up to a specified ceiling) are approximately 67% of the average net income earned whilst working. The exact amount paid out depends on the amount and the duration of contributions and other factors.

#### **4.4.2 The Long-term Care Environment in Germany**

Those employed people earning less than the gross annual threshold of €48,600 (NZ\$82,134)<sup>50</sup> are automatically and compulsorily insured in a public health insurance scheme. This includes the universal, mandatory, LTCI scheme covering LTC and RAC. Unlike most countries, LTCI covers all (adult) ages subject to a medical needs-assessment, and provided contribution to the scheme has been for a minimum of two years prior to the benefit payout (Rothgang 2010, p. 438; OECD 2011a, p. 2). However, more than 80% of beneficiaries are over the age of 65 years (Rothgang 2010, p.438).

Agencies, and the list of benefits 'in-kind' and services they provide, must be pre-approved by the LTCI funds. Most people who opt for in-home care take the cover as a combination of benefits-in-kind and a cash allowance (Arntz and Thomsen 2010).

Institutional care, RAC, with the highest cost to the government, requires a co-payment for the threefold costs of: care, board and lodging, and investment. The individual bears the latter two costs as well as 25% of the care cost (Gibson and Redfoot 2007; Gleckman 2010). In-home LTC offers greater flexibility in the provision of services and requires nominal personal contributions (Heinicke & Thomsen). Overall, the system is comprehensive in the variety of services it provides, and individuals can choose their benefits. However, the depth of benefits provided is limited, and individuals may still find themselves in a position where additional personal contributions are required.

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increasing in 2009 to close the discrepancy, and no legal system is in place to ensure regular rate changes (OECD 2011a, p. 278).

<sup>50</sup> Based on the New Zealand spot rate December 2011.

As is common among OECD countries, the value of the medical-assessment-based state contribution to care is capped: level one is when considerable care is needed; level two is for those with intensive care needs; and level three is for those with high needs. In 2012, the RAC subsidy for level three care can reach a maximum monthly amount of €1,918 (NZ\$3,241) in the case of hardship (Arntz and Thomsen 2010, p. 31).

#### 4.4.3 Long-term Care Insurance in Germany

Similar to the other social insurances schemes, the LTCI system is PAYGO, universal, non means-tested, and contribution-financed; and provides partially comprehensive cover for the claimant (Heinicke and Thomsen 2010). For those unemployed, LTCI contributions are paid from unemployment insurance (Rothgang 2010, p. 441).

Although the central Government manages the public LTCI, and there are no differences in benefits across regions (Gleckman 2010, p. 6), there are both public and private providers. Private providers must offer benefits as least as good as those in the compulsory social scheme; premiums cannot exceed the contribution required for social LTCI unless extra benefits are negotiated; and employers are still required to pay the 50% contribution on premiums. An insured can choose from two rates under private insurance: the more expensive Base Rate which doesn't require a prior medical check; and the Plain Rate, where the insured chooses suitable "building blocks" (AECURA 2009).

The mandatory LTCI, either through a public or a private provider, ensures everyone has LTC coverage and therefore there is universal eligibility. Each individual must enroll with either one of 250 statutory health insurance funds, or with a private firm, which will manage the individual's health and LTC costs (Henry J Kaiser Family Foundation 2009, p. 12). However, benefits are delivered through a single system and individuals make claims and communicate with their provider.

Both public and private provision of LTCI is governed by Government-stipulated rules and regulations. The value of the benefit depends on two factors: the type of benefit the individual chooses to receive, and the level of assessed need. The three benefit options are: cash allowances; benefits-in-kind; and institutional care (Heinicke and Thomsen Feb 2010). Each of these options has different

<b>Table 10. Summary of Age Pension &amp; Long-Term Care Provision &amp; Funding: Germany</b>	
<b>Levels of state involvement in Age Pension provision</b>	
1. Pure voluntary saving	✓
2. Tax-subsidised private saving	✓
3. Mandatory private saving	✓
4. Mandatory public saving	
5. Social insurance	✓
6. Earmarked taxes	
7. Tax-funded flat-rate universal pensions	
8. Tax-funded means-tested pensions	
9. Social assistance	
<b>In-home Long-Term Care (LTC) systems: provision and funding</b>	
Care & support: state cash allowance	Income-test
Care & support: state in-kind provision	✓
Care & support: private contribution	Income-test
Health services: state subsidy	✓
Health services: private contribution	✓
Accommodation: state subsidy	✓
Other state assistance	✓
<b>Residential Aged Care (RAC) systems: provision and funding</b>	
Care & support: private contribution	Age pension + Means-test
Health services: private contribution	✓
Accommodation: state subsidy	Means-test
Accommodation: private charge	✓
Accommodation Bond	
<b>Long-Term Care Insurance (LTCI) provision and take-up</b>	
Availability private LTCI	✓
Public LTCI - tax or compulsory levy	✓
% take-up (2011)	100%

monetary values, with the cash allowance having the smallest value, and institutional care the highest. For the cash allowance, the beneficiary receives the money and can use it at their discretion to pay for informal care services. The cash can purchase in-home care services; home renovations; services by family members; or agency-based care (Heinicke and Thomsen Feb 2010).

Those on annual incomes over €44,550 (NZ\$75,000) (Swiss Life Network 2011, p. 1) can choose between socially- or privately-provided insurance. There are two forms of private insurance: individuals above a certain income level can opt for LTCI insurance with a private provider (as above); and individuals seek private insurance for supplementary benefits not provided by social insurance. For those who opt for extra coverage and benefits, there is a private supplementary insurance where the pricing is based on risk, a form of LTCI similar to that of the US (Gibson and Redfoot 2007).

In 2011, 9% of the population had a privately-provided LTCI scheme (OECD 2011a, p. 249). An added bonus for those opting for private insurance, not available under the social LTCI scheme, is a partial premium refund for those insured who make no claim for a given period (OECD 2011e).

## 4.5 Japan

### 4.5.1 Retirement incomes in Japan

*Japan's population is aging at the fastest rate in human history (as measured by the speed with which the share of the elderly (those aged 65 or older) in the total population has increased over time) and is now virtually the most aged in the world. (Horioka, Suzuki and Hatta 2007)*

*The ratio of the aged to the working population is expected to be nearly one to one by 2050. (Yoshikawa 2012)*

Japan has, in addition to level 1: pure voluntary saving, level 2: (since 2009) tax-subsidised private saving, level 3: three PAYGO pension programmes, level 5: social insurance, and level 8: the means-tested welfare pension.

Gender	Aged 65+	Total population
Female	17,503,000	13.7%
Male	13,073,000	10,3%
All	30,576,000 (24.0%)	127,554,000 (2010)

As described by OECD's *Pensions at a Glance, 2011*, the old-age, basic pension, paid from age 65, requires a minimum of 25 years' contributions, and 40 years of contributions for the full pension. Provided a pensioner is entitled to the basic pension, the earnings-related pension is paid (in addition to the basic pension), with a minimum of one month's contribution. "The pension age is gradually being increased from 60 to 65 years (between 2001 and 2013 for men and between 2006 and 2018 for women) for the flat-rate component and from 60 to reach 65 years for men in 2025 and for women in 2030 for the earnings-related component" (OECD 2011g, p. 259).

The Ministry of Health, Labour and Welfare (MHLW) is responsible for making policy decisions and supervising the operation of the age pension programmes, while the Social Insurance Agency (SIA) administers the programmes nationally and internationally.

<sup>51</sup> Statistics Bureau of Japan (2013).



However, the Government has signalled that the SIA is to be replaced by a non-governmental public corporation, 'Japan Pension Agency' (Australian Government 2012).

Of the three employment-related PAYGO programmes, the Employees' Pension Insurance (EPI) is the largest, and is for private, salaried workers and spouses; the Mutual Aid Association (MAA) system is for government workers and their spouses; and the National Pension (NP) system is for the self-employed and everyone else.<sup>52</sup> NP participants pay flat-rate contributions to cover half the NP cost, and the central government provides a subsidy to finance the other half of the basic pension benefit payments.<sup>53</sup> EPI and MAA participants contribute through payroll taxes (with payment shared equally between employee and employer) and receive earnings-linked benefits in addition to the basic pension benefit (Kashiwase, Nozaki et al. 2012).

The NP scheme includes the Japanese Old Age Basic Pension, Old Age Welfare Pension, Disability Pension and Survivors' Pension, with a minimum qualifying period of 25 years. All persons residing in Japan aged 20 to 60 participate in the NP, with voluntary coverage available for Japanese citizens residing overseas. The NP is usually paid from age 65, though an early (reduced) pension can be paid from age 60 and an increased pension can be paid if deferred to at least 66 years of age. The pension is paid every 2 months, with no supplements paid for a spouse or children. While employed persons aged 60 to 69 can receive the NP (as in New Zealand with NZS), the EPI amount is suspended partially or entirely.

The NP from age 65 was set at roughly 60% of the average wage, with pension payments increased each year by the rate of inflation, although that started to reduce to 50% with the reforms in 2004 (Horioka, Suzuki et al. 2007). Because welfare costs are projected to increase 36% by 2025, equal to 24% of gross domestic product, legislators hope to limit future costs with a reform that raises the retirement age to 61 in April 2013 and to 65 by 2025 (Matsuyama 2012).

To receive age-pension benefits under the National Health Insurance scheme and the Workers Health Insurance scheme where the schemes are mandatory and coexist,<sup>54</sup> the employee must have paid into the schemes for more than 25 years (Healthhokkaido 2006). Individual who are unemployed or have not been in the workforce for the required 25 years are left considerably out of pocket as a premium is still required. This could pose a serious challenge to single mothers and widows reaching state pension age.

#### **4.5.2 The Long-term Care environment in Japan**

Between 1975 and 1995, the share of the elderly in total health-care costs in Japan rose from about 14% to 31% of GDP, and is projected to reach 50% by 2025. This surge in costs, accompanied by a surge in demand for pensions as the population aged, led to the introduction in 1990 of the "Golden Plan" to reduce the demand for medical services by improving social services for the elderly and their families and by providing LTC services that should reduce the demand for hospitalisation and thus slow the growth of medical spending (Horlacher and MacKellar 2003, p. 114).

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<sup>52</sup> Dependent spouses benefit from the EPI programmes based on their partners' contributions (Kashiwase, Nozaki and Tokuoka 2012).

<sup>53</sup> When/if contributions are temporarily insufficient to cover the payment, a reserve fund is drawn on (Kashiwase, Nozaki et al. 2012).

<sup>54</sup> Interestingly, both schemes support workers on maternity leave with benefits of 60% of wages for 42 days prior to the birth and 56 days after the birth (Healthhokkaido 2006).

The main goals for the Japanese reforms in 2000 and 2006 were to improve the quality of life for the elderly, relieve the burden of family caregivers, and deal with the growing demands of the world's highest ageing population (Campbell and Ikegami 2003, p.13). In 2006 many of the reforms successfully brought down the annual growth in costs from 8.8% in 2004 to 0.6% in 2006 (Campbell and Ikegami 2003, p. 13). However, so-called 'warehousing' in hospitals of older patients with chronic conditions (Mitchell, Piggott and Shimizutani 2008), or 'social hospitalisation' continues to use 250,000 hospital beds (one sixth of the total), and the acute shortage of RAC places remains.<sup>55</sup>

Japan's tax and transfer scheme is complex: local bodies manage LTC eligibility, but the fees associated with benefits are decided at the national level (Mitchell, Piggott et al. 2008, p.8). Retirees already subscribed to the social insurance scheme are automatically included under National Health Insurance which is funded by subsidies and premiums. Premiums are based on income, assets and the number of family members, and are partially waived for households without assets or income. The overall premium may vary slightly across the different municipalities (National Institute of Population and Social Security Research 2011, p. 27).

Those aged 65+ pay a means-tested premium when receiving LTC, based on their level of pension and other income. The central Government sets prices and premiums, and the average monthly premium is ¥2,539 (NZ\$40)<sup>56</sup> for beneficiaries with slight variation between jurisdictions (Gleckman 2010, p. 13). Premiums from those aged 40+ and retirees fund half the LTC costs, the rest is covered by local and central Government (Creighton Campbell and Ikegami 2000, p. 31). For RAC, an additional monthly fee of ¥47,632 (NZ\$750) is required; but for in-home LTC, a co-payment of only 20% is required (Gleckman 2010, p. 13).

#### **4.5.3 Long-term Care Insurance in Japan**

In April 1990, to reduce welfare spending, Japan implemented a universal (not means-tested), compulsory, contributory system of LTCI which covered care that was previously provided partly by health insurance and partly by welfare measures (Horlacher and MacKellar 2003, p. 114).

As noted, the social LTCI, providing universal coverage within a single programme and run separately from the social health insurance system, is financed from tax revenues and personal contributions on a PAYGO basis. In general, revenues are raised through a payroll tax with the rate adjustment on a three year cycle to match the growing costs of LTC (OECD 2011a, p. 278). Individuals from the ages of 40-64 years are required to pay a payroll tax of 9% towards social LTCI, the Workers Health Insurance scheme, in addition to their health insurance premium, with the tax burden split equally between the employee and employer (Gleckman 2010, p. 12).

Those absent from the work force for a period of time and the self-employed are accounted for by the state under the National Health Insurance scheme (National Institute of Population and Social Security Research 2011, p. 27). Those working less than 30 hours per week are not required to be enrolled by their employer (Healthhokkaido 2006).

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<sup>55</sup> "... the government recently announced the closure of all these 250,000 hospital beds and some 130,000 more LTCI beds used for long-stay places, producing a public outcry" (Hayashi 2011).

<sup>56</sup> Based on the New Zealand spot rate November 2011.

Benefits commence with assessed need for those aged 65 years plus (Campbell and Ikegami 2003, pp. 24 - 25). As is common with most systems, the individual is given a government subsidy, based on the externally-assessed level of dependency, on the received services. The capped value of benefits ranges from ¥44,442–¥292,045 (NZ\$700-4,600) per month (Gleckman 2010, p. 13), with costs above that borne by the individual.

As a consequence of the mandatory 20% co-payment on services, most individuals choose to under-spend the cash benefit they qualify for (Mitchell, Piggott et al. 2008, p.13). This may be seen as a strength from a fiscal spending perspective, but it discourages the elderly from

receiving the assessed level of care. Subsidies also contribute to meal costs and some accommodation costs, including electricity and water (Mitchell, Piggott et al. 2008, p. 3).

<b>Table 12. Summary of Age Pension &amp; Long-Term Care Provision &amp; Funding: Japan</b>	
<b>Levels of state involvement in Age Pension provision</b>	
1. Pure voluntary saving	✓
2. Tax-subsidised private saving	✓
3. Mandatory private saving	✓
4. Mandatory public saving	
5. Social insurance	✓
6. Earmarked taxes	
7. Tax-funded flat-rate universal pensions	
8. Tax-funded means-tested pensions	✓
9. Social assistance	
<b>In-home Long-Term Care (LTC) systems: provision and funding</b>	
Care & support: state cash allowance	
Care & support: state in-kind provision	Income-test
Care & support: private contribution	Income-test
Health services: state subsidy	✓
Health services: private contribution	✓
Accommodation: state subsidy	✓
Other state assistance	✓
<b>Residential Aged Care (RAC) systems: provision and funding</b>	
Care & support: private contribution	Age pension + Means-test
Health services: private contribution	✓
Accommodation: state subsidy	✓
Accommodation: private charge	Means-test
Accommodation Bond	
<b>Long-Term Care Insurance (LTCI) provision and take-up</b>	
Availability private LTCI	
Public LTCI - tax or compulsory levy	✓
% take-up (2011)	100%

## 4.6 England

### 4.6.1 Retirement incomes in England

The UK's three-tier retirement income system is one of the most complex in the world, with variations in provision in England, Wales, Scotland and Ireland. The focus here is on England where the pension arrangements can be categorised as levels 1, pure voluntary saving; 2, tax-subsidised private saving; 3, mandatory private saving; 5, social insurance; and 8, tax-funded means-tested pensions.

The Basic State Pension (BSP) is in two parts. The first part (level 2) is a flat-rate, PAYGO pension payable from age 65 (men, rising to 67 by 2026)<sup>57</sup> or age 60 (women, also rising to age 67 by 2026) as long as National Insurance contributions have been paid or credited for

<b>Table 13. Population of UK 2011: age 65+, gender<sup>57</sup></b>		
<b>Gender</b>	<b>Aged 65+</b>	<b>Total population</b>
<b>Female</b>	5,458,235	8.7%
<b>Male</b>	4,027,721	6.4%
<b>All</b>	9,485,956 (15.1%)	63,100,000 (2011)

<sup>57</sup> See [http://en.wikipedia.org/wiki/Demographics\\_of\\_the\\_United\\_Kingdom#Age\\_structure](http://en.wikipedia.org/wiki/Demographics_of_the_United_Kingdom#Age_structure).

<sup>58</sup> Concurrent with these changes, the default retirement age in the UK was fully abolished in 2011 by new legislation that stops employers from compulsorily retiring workers once they reach the age of 65.

90% of the working years (OECD 2011a).<sup>59</sup> The BSP is proportionately reduced with shorter coverage periods, and is not paid if the person is entitled to less than 25% of the full pension. The BSP is payable overseas but may not be CPI-adjusted if the person resides outside the European Economic Area.<sup>60</sup>

The second part is the Pension Credit (level 8), an income-tested top-up, payable to men and women aged 60 or older (rising gradually to age 67 from 2010 to 2026) who reside in the UK and whose income is below prescribed levels (OECD 2011g, p. 317). The Pension Credit can be paid abroad only temporarily.

The State Second Pension (S2P) (level 5) is an additional Defined Benefit (DB) PAYGO pension based on an individual's indexed earnings and payable to men from age 65 and to women from age 60 (rising gradually to age 65 from 2010 to 2020). The S2P is payable abroad, but like the BSP, is CPI-adjusted only if the person resides in a European Union country or in a country that has an appropriate reciprocal agreement.

The level 2 voluntary, heavily subsidised, occupational DB and Defined Contribution (DC) retirement saving schemes typically receive contributions from both employers and employees, with benefits usually withdrawn as annuities. Also, individual schemes such as Stakeholder Pensions may be arranged privately or through employers. These can contract out of the S2P, and both employer and employee pay reduced National Insurance contributions to recognise the reduced state entitlements. From 2012, an auto-enrolment, state-administered, workplace pension saving DC system of Personal Accounts (the National Employment Savings Trust or NEST), will be gradually added (level 3). The present S2P will be simplified and made more redistributive by being flat-rate rather than earnings-related.

Restructuring of the state pension after April 2017 into a simple flat-rate amount is set out in the White Paper, *The single-tier pension: a simple foundation for saving* (2013). The single-tier pension will be set above the basic level of means-tested support (the Pension Credit Standard Minimum Guarantee, currently £142.70 (NZ\$258.351)<sup>61</sup> per week for a single pensioner); and the current legislative requirement to increase the basic State Pension at least in line with average growth in earnings will also apply. The single-tier pension will replace the S2P, contracting out, and additions such as the Category D pension and the Age Addition; and will close the Savings Credit element of Pension Credit for pensioners reaching State Pension age after implementation.

The single-tier pension will require 35 qualifying years of National Insurance contributions or credits for the full amount, and will have a minimum qualifying period of between 7 and 10 years. Those with more than the minimum but fewer than 35 qualifying years will receive a pro-rata amount. It will be based on individual qualification, without the facility to inherit or derive rights from a spouse or civil partner. People will continue to be able to defer claiming their state pension and receive a higher weekly pension in return (Department for Work and Pensions 2013, p. 8).

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<sup>59</sup> As a result of the Pension Act 2007, qualifying years for the full state pension was reduced from 44 to 30 years for people reaching the state pension age after 2010; and reduced if the person is caring for a child or elderly or disabled relative, incapacitated or job-seeking (OECD 2011h, p. 317).

<sup>60</sup> See UK Government link: <https://www.gov.uk/state-pension-if-you-retire-abroad>; and Dale, St John et al (2009) at <http://docs.business.auckland.ac.nz/Doc/WP-2-09-New-Zealand-superannuation-and-overseas-pensions-Issues-and-principles-for-reform..pdf> for a discussion of reciprocal social security agreements.

<sup>61</sup> Based on spot rate March 2013.

#### 4.6.2 The Long-term Care environment in England

*Ever since the failed 1999 Royal Commission, England has been attempting to reform its long-term care funding system. More than a decade later, significant changes to the means tested arrangements are yet to be introduced, whilst the pressure to achieve long-term reform mounts... (Fernandez and Forder 2012, p. 346)*

The current LTC system comprises a variety of systems, with responsibility for health and social policy devolved to the administrations for England, Scotland, Wales and Northern Ireland. There are key differences in the funding and provision of social care, for example, Scotland introduced free nursing and personal care, while the other countries introduced only free nursing care.

The LTC system relies heavily on informal care provided mainly by close relatives, although there is a wide range of providers of formal care in the public, voluntary (not-for-profit) and private (for-profit) sectors. Direct payments (cash alternatives to services) enable people to employ their own carers or use for a wide range of purposes (Comas-Herrera, Wittenberg and Pickard 2010, p. 387).

There is a national system for means-testing and charging for RAC, while local authorities determine the local system for charging and means-testing for LTC (Comas-Herrera, Wittenberg et al. 2010, p. 387). Responsibility for assessing local needs rests with primary care trusts (PCTs) and local authorities, which are responsible for assessing population needs for social care, commissioning services, setting local eligibility criteria and assessing individuals against those criteria.

*Health care, including nursing care in all settings, is free at the point of use, and is funded mainly from general taxation. Most social care (except for personal care for older people in Scotland) is means-tested and is funded by a combination of central taxation, local taxation and user charges. Disability benefits, by contrast, are not means-tested and are funded from general taxation. This means that the system is complex and not easily understood. (Comas-Herrera, Wittenberg et al. 2010, p. 387)*

Under the means-tested safety-net programme, co-payments towards LTC are required from those with assets above a low threshold. Demand exceeds the available funding, and local authorities differ in the standards and quantity of care provided, thus those who qualify for state support find the system unclear and unpredictable (British Government 2009, p.8). Suggestions have been made that a national single-system would produce greater fairness (Dilnot, Warner and Williams 2011, p.2).

Institutional or RAC is comprised of nursing care and accommodation costs. The National Health Service (NHS) provides 'free' nursing care to those independently assessed as needing RAC, funded by the 152 different local authorities (Dilnot, Warner et al. 2011; Older People and Dementia Branch Oct 2009, p. 4), at the standard Registered Nursing Care Contribution cost of £108 (NZ\$210)<sup>62</sup> per week (Alzheimer's Society 2011, p.1). Those individuals unable to pay the remaining costs are fully funded by the Government.

The means-tested RAC-funding system relies on an individual's ability to make co-payments towards their care, based on assets and any pension income (Dilnot, Warner et al. 2011). Individuals qualifying for assistance also receive a Personal Expenses Allowance (PEA) of £22.60 (NZ\$45) per week (Dilnot, Warner et al. 2011, p.26). Those

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<sup>62</sup> Based on the New Zealand spot rate November 2011.

with capital above the upper threshold of £23,250 (NZ\$45,300) are expected to pay the full weekly charges for accommodation and care (Disability Alliance Apr 2011). As there is no assistance for this group, they are likely to draw down or minimise their assets until they qualify for means-tested assistance with capital below the lower savings threshold of £14,250 (NZ\$27,800). The personal contribution takes into account personal income, pensions (Alzheimer's Society 2011, p.2), and the private home if no dependents are residing in it (British Government 2009, p.19).

Those with assets between £14,250 and £23,250 (NZ\$27,800-\$45,300) are required to contribute an additional £1 (NZ\$1.95) per week for every £250 (NZ\$490) of assets above £14,250 (NZ\$27,800) (Dilnot, Warner et al. 2011, p.34).<sup>63</sup> An individual is expected to draw down their capital to the minimum threshold before the Government contributes beyond the NHS standard contribution (British Government 2009, p.16).

Funding for LTC and RAC comes mainly through general revenues. NHS costs the state £49 billion a year (NZ\$93.52 billion) (Dilnot, Warner et al. 2011, p.57), but measuring the entire state cost for LTC and RAC is more difficult as the services and benefits are distributed through multiple providers. Funding for social care also comes from local taxation and user charges, and where separate budgets are decided, social care is commissioned by local authorities based on grants from central Government (OECD 2011a, p.228). Overall, England's estimated annual spend on the elderly is £140 billion (NZ\$267.19 billion) (Dilnot, Warner et al. 2011, p.57).

That spending is set to increase. In March 2013, the chancellor announced that a modified version of proposals laid out in the Dilnot Review would be brought forward to 2016, including introduction of the single tier pension, and capping the maximum lifetime amount anyone will have to pay for RAC at £72,000, rather than the £75,000 proposed by the health secretary or the £35,000 proposed by Dilnot (Watt 2013). In addition, the means-test threshold for RAC will be raised from £23,250 to £123,000, but people will still have to pay for their board and lodging, limited to a maximum annual cost expected to be about £10,000 (Papworth 2013).

The *Care and Support White Paper* (2012), among other changes, proposes to: establish a new housing fund (£200 million over five years) to support development of specialised housing for older and disabled people; support local authorities with start-up funding of £32.5 million to develop online information about local care and support options; introduce a national minimum eligibility threshold; train more care workers to deliver high-quality care, and double the number of care apprenticeships to 100,000 by 2017; legislate to give people an entitlement to a personal budget as part of their care and support plan, perhaps via direct payments; and invest a further £100 million in 2013/14 and £200 million in 2014/15 in joint funding between the NHS and social care to fund better integrated care and support (Department Of Health 2012, pp. 11 - 12).

Implementation of the proposals is another issue.<sup>64</sup> By capping RAC costs at £72,000, the Government is hoping the insurance market will offer LTC insurance products.

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<sup>63</sup> England also has a non-means-tested benefit for the severely disabled aged 65+ called the Attendance Allowance where an individual's disability is not specifically age-induced (British Government 2009, p.16).

<sup>64</sup> The new policy, expected to cost an extra £1bn a year by 2020, is expected to be funded partly by a new freeze on the inheritance tax (IHT) threshold at the current rate of £325,000 for individuals until 2019 together with previously announced changes to national insurance and pensions. If IHT, frozen since 2009, increased in line with inflation every year until 2019 it would reach £420,000 (Papworth 2013).

Buying a policy that covers that potential £72,000 cost might appeal to someone who wants to protect themselves against having to sell their home to pay for their future social care costs (Papworth 2013).

### 4.6.3 Long-term Care Insurance in England

There is no LTCI available. The 2011 Dilnot Report argues that unlike health care, LTC costs cannot currently be collected into a risk pool to protect individuals from exposure to high costs because there is no provision of universal support, there is no market for private protection (Dilnot, Warner et al. 2011, p.13), and the level of uncertainty makes it unprofitable and impracticable for the private sector to offer an LTCI product (Dilnot, Warner et al. 2011, p. 30). The report also rejected a full social insurance scheme as an option: care packages cannot remain comprehensive enough to cover the full scope of LTC costs and remain flexible to future changes in costs as this requires too large an amount of public expenditure (Dilnot, Warner et al. 2011, p. 30).

In the current system: “care is free only to those who cannot afford to pay for themselves, ... with substantial local variation in access and means-testing for home care” (Comas-Herrera, Wittenberg et al. 2010, p. 375). However, the British Government recently announced that it will make in-home personal care free to those with the highest needs (Comas-Herrera, Wittenberg et al. 2010, p. 375).

Since the 2011 Dilnot Report, two White Papers<sup>65</sup> and a progress report on funding reform by the Department of Health’s Commission on Funding of Care and Support have been published. The Commission argued that in most areas of life where a large financial risk is faced, insurance can provide protection, yet there are very limited options for someone wishing to protect themselves against the risk of high LTC and support costs (Department Of Health 2012, pp. 10 - 12).

The Commission’s proposed changes to the funding system include, as noted above: financial protection

<b>Table 14. Summary of Age Pension &amp; Long-Term Care Provision &amp; Funding: England</b>	
<b>Levels of state involvement in Age Pension provision</b>	
1. Pure voluntary saving	✓
2. Tax-subsidised private saving	✓
3. Mandatory private saving	✓
4. Mandatory public saving	
5. Social insurance	✓
6. Earmarked taxes	
7. Tax-funded flat-rate universal pensions	
8. Tax-funded means-tested pensions	✓
9. Social assistance	
<b>In-home Long-Term Care (LTC) systems: provision and funding</b>	
Care & support: state cash allowance	✓
Care & support: state in-kind provision	Means-test
Care & support: private contribution	Means-test
Health services: state subsidy	✓
Health services: private contribution	
Accommodation: state subsidy	Means-test
Other state assistance	✓
<b>Residential Aged Care (RAC) systems: provision and funding</b>	
Care & support: private contribution	Age pension + Means-test
Health services: private contribution	✓
Accommodation: state subsidy	Means-test
Accommodation: private charge	Means-test
Accommodation Bond	
<b>Long-Term Care Insurance (LTCI) provision and take-up</b>	
Availability private LTCI	
Public LTCI - tax or compulsory levy	
% take-up (2011)	0%

<sup>65</sup> See <http://www.dh.gov.uk/health/2012/07/scfunding/>.

through capped costs and an extended means test; introduction of a universal system of deferred payments for residential care, and introduction of a national eligibility threshold for adult care and support; provision of a clear, universal and authoritative source of national information about the health and care and support system; legislation to extend the right to a carer's assessment and provision of carers' entitlement to public support; and publishing a framework for improved integration between health and care (Department Of Health 2012, pp. 6 - 7).

It appears that pensioners will be encouraged to buy private insurance to cover them up to the new limit, currently £72,000. Individuals may also be offered the choice of taking a lower lump sum when they retire, and converting the rest into care protection insurance. Importantly, it will not be implemented until 2015 or later, and will still require individuals to pay care bills up to the level of the cap (Ross and Winnett 2013).

## 4.7 United States

### 4.7.1 Retirement incomes in the US

Social Security, the publicly provided pension benefit, requires a minimum of ten years' contributions for eligibility, has a progressive benefit formula based on the best 35 years of earning, and has a 50% dependants' addition for married couples (where partner has smaller entitlement) and for qualifying dependent children (OECD 2011i, p. 322). The pension age of 66 in 2008 is increasing to 67 by 2022. Early retirement is possible from age 62, subject to an actuarial reduction. There is also support for voluntary pensions for higher earners, and a means-tested top-up payment for low-income pensioners, Supplemental Security Income (SSI).

Applying the spectrum of state involvement in retirement income provision, the US has levels 1, 2, 4, 5, and 9: pure voluntary saving, tax-subsidised private saving through 401(k)s, Individual Retirement Accounts (IRAs) and other occupational schemes,<sup>66</sup> mandatory public saving via payroll taxes, social insurance, and social assistance, SSI. Despite population ageing (see Table 15), until the GFC eroded the assets of many Pension Funds,<sup>67</sup> projected future income shortfalls for age pensions did not create an immediate financial problem for Social Security as since the 1980s, income has exceeded benefits annually, allowing the system to accumulate an interest-earning trust fund. However, the Old Age and Survivors Insurance (OASI) trust fund is either projected to be exhausted by 2044 (Hines Jnr and Taylor 2005), or regarded as substantively illusory (Blocker, Kotlikoff and Ross 2008).

Qualifying for the means-tested SSI depends on working and paying Social Security taxes (although SSI is funded from the U.S. Treasury general funds).

<b>Gender</b>	<b>Aged 65+</b>	<b>Total population</b>
<b>Female</b>	23,000,000	7.5%
<b>Male</b>	17,500,000	5.7%
<b>All</b>	40,400,000 (13.1%)	308,745,538

People who have worked long enough may be able to receive Social Security disability or retirement benefits as well as SSI. Only 9% of those aged 65+ received just the SSI, a

<sup>66</sup> The system takes its name from subsection 401(k) of the US Internal Revenue Code.

<sup>67</sup> In the US (and Spain) the value of money in pension funds has fallen by between 1% and 2% per cent a year over the last decade; in the same period in the UK the average annual return on pension funds has fallen by 0.1% a year; whereas returns on pension funds in Chile increased by an average of 5% a year, 4% in Poland and 3% in Germany (Hall 2012).

<sup>68</sup> See Department of Health and Human Services (2012).



further 5% received SSI and some Social Security (Office of Retirement and Disability Policy 2012).

Social Security replaces only about 40% of pre-retirement income for the average worker, so private pensions, savings and investments are important (Social Security Administration 2011). Private pensions, savings and investments are also generously tax-favoured. For example, all earnings on these funds not only are tax-deferred but could be tax-free upon a qualified distribution.<sup>69</sup>

#### **4.7.2 The Long-term Care environment in the US**

In 2009, with nearly 10 million citizens estimated to require assistance, the US public and private expenditure on LTC services and support was between US\$203.2 billion and US\$243.3 billion (NZ\$265.7 to NZ\$318.1 billion) (Frank 2012, p. 333).<sup>70</sup>

The US has a means-tested safety-net scheme for LTC, with two coexistent programmes: Medicare and Medicaid. Their purposes are different: Medicare is primarily for the aged and the disabled, and operates as social health care insurance for acute health care but it does not cover all medical expenses or the cost of most long-term care.<sup>71</sup> Medicaid is a Federal-State health insurance program for low-income and needy people including children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments; it is a means-tested social health insurance system designed for those with acute or LTC needs.

The Medicare programme is funded by a 2.9% payroll tax, and those who have not contributed can pay a monthly premium (Henry J Kaiser Family Foundation 2010, p.14). For those struggling to pay premiums and co-payments, Medicare-Aid is an alternative within the programme of Medicare where people with monthly income below US\$908 (NZ\$1,140) receive help in covering premiums, co-payments and deductibles (North Carolina Division of Medical Assistance Aug 2011).

While it is mandatory that each state offer benefits including Medicaid and Medicare, many of the services and the eligibility criteria are discretionary, and decided at state level (OECD 2011a, p.228). Each state also has a different limit for asset-tested Medicaid support around the US\$2,500-3,000 (NZ\$3,073-3,688) level, excluding such assets as the family residence, a car, and some other personal items (Medicare Mar 2011). The majority of Medicaid's aged care expenditure goes to skilled nursing facilities (RAC) rather than to home health care services (LTC) (Congress Of The United States 2004).

Medicaid bears the greatest cost burden for delivering RAC benefits. In 2003 it paid 46% of nursing home care costs, where Medicare paid only 12.4%, private insurance paid 7.7%, and 27.9% was private payments (O'Brien 2005, p.1). A current problem for the government with two co-existing systems is the potential cost that arises from people having dual eligibility and benefiting from both programmes: in 2008 this was 9.2 million

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<sup>69</sup> Tax-deferred retirement savings, the second-largest tax expenditure in the US after exclusions for employer-sponsored health insurance, were expected to cost the federal government about US\$142 billion in foregone tax revenue in 2011. See [http://www.americanprogress.org/issues/2011/01/te\\_011911.html](http://www.americanprogress.org/issues/2011/01/te_011911.html), and <http://www.voxeu.org/index.php?q=node/7287>.

<sup>70</sup> Based on the New Zealand spot rate November 2011.

<sup>71</sup> Higher-income beneficiaries (around 5% of people with Medicare) pay higher premiums for medical insurance and prescription drug coverage. See U.S. Social Security Administration: <http://www.socialsecurity.gov/pgm/medicare.htm>; or Centers for Medicare and Medicaid Services: <http://www.cms.gov/>.

individuals (Centres for Medicare and Medicaid Services Sept 2011, p.1). The process for someone getting institutional care is for Medicare to pay for the first 20 days of nursing care and for the next 21-100 days a daily maximum co-payment is required up to the amount of US\$137.50 (NZ\$170) per day (Henry J Kaiser Family Foundation 2010, p.5).

Individuals in RAC may keep up to US\$50 (NZ\$61.47) per month of their income towards personal needs, and the rest is contributed towards their care (North Dakota Department Of Human Services April 2011). Beyond the 100 days, the individual must rely on Medicaid if they have insufficient funds. In this way Medicare does not fund LTC but is involved where short-term care is required (Medicare Mar 2009).

Medicaid assesses the level of care needed, and if institutional care is necessary, Medicaid requires a co-payment from the individual's monthly income with the balance covered by subsidy. Recovery for expenses may be sought from the estate after the person dies (North Carolina Division of Medical Assistance Aug 2011). Medicaid does not include a person's family home among their 'countable' assets, whether or not a spouse is living there (O'Brien 2005, p.6). A spouse remaining at home can keep all of their own income and there is also 'spousal impoverishment protection coverage' which allows the spouse to keep up to half of their total assets depending on the state's level of protection (O'Brien 2005; North Carolina Division of Medical Assistance Aug 2011).

Research quantifying the differences in state benefit rules, coverage and spending shows the state annual average spend per low-income individual can range from US\$4,000 (NZ\$4,920) to as little as US\$1,300 (NZ\$1,598), a wide disparity that results in inequitable benefit distribution (Holahan and Liska 1997, p.2). Another key difference among states is the use of disproportionate shared hospital payments (DSH), a financial arrangement that allows federal subsidies to be reinvested into hospitals that service a disproportionate share of low-income individuals (Holahan and Liska 1997, p.2-3).

The US rules do not appear to restrict benefits based on whether someone has been out of the workforce for a period of time. Medicare hospital insurance is part A of the coverage and generally doesn't require a premium; but for part B, medical insurance, a premium is required for each year a person is enrolled, including a penalty payment for any break in enrollment (Medicare 2008).

The risk to an individual is that they lose employer-sponsored insurance and become eligible for public coverage only if their assets are below the set minimum (Holahan, Garrett and Institute 2009, p.2). There is the opportunity to buy into the employer's coverage through obtaining a COBRA<sup>72</sup> but this can be very expensive (Holahan, Garrett et al. 2009, p.2). The fact that there is social insurance for the poor, largely funded by general revenues and user contributions rather than a compulsory universal premium, means individuals can be insured under the public system regardless of their employment histories although this provides no protection of assets.<sup>73</sup>

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<sup>72</sup> The US Consolidated Omnibus Budget Reconciliation Act (COBRA), Continuation of Health Coverage, gives workers and their families who lose their health benefits the right to choose to continue in their group health plan for limited periods under circumstances such as job loss, reduction in the hours, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102% of the cost to the plan. See <http://www.dol.gov/dol/topic/health-plans/cobra.htm>.

<sup>73</sup> Countries with universal social insurance tend to provide some protection for a base level of assets.

Research shows that few retirees are without current health care coverage, either through a plan from a former employer, insuring through a spouse's plan, or a private policy, nevertheless reliance on the Medicare system is heavy, use of COBRA is light, and coverage for LTC expenses is lacking with most intending to self-insure (Salter, Harness and Chatterjee 2011, p. 91), although this is not a workable solution for those with limited access to assets. Two of the most disturbing research findings are: "the number of retirees, particularly with large amounts of investable assets, who plan to spend down their assets to qualify for Medicaid"; and conversely: "the number of retirees who haven't thought about meeting these expenses" (Salter, Harness et al. 2011, p. 91). "Almost any government health insurance policy is partial in care and cost" (Steuele 2013), and the worst case may be that these retirees do not fully understand the rules for qualifying for Medicaid and may spend down assets and still not qualify.

#### 4.7.3 Long-term Care Insurance in the US

The Federal Government started to offer LTCI for employees, retirees and family members in 2002, thus creating the largest private insurance market for LTCI (OECD May 2011, p.248). However, in 2003 private insurance still covered less than 10% of the total RAC costs (O'Brien 2005, p. 1), primarily for recovering from specific medical events rather than causes related to old age. Despite some growth, the private LTCI market remains small, and as of 2004, only 10% of individuals aged 60 plus own a private LTCI policy (Brown and Finkelstein 2008b), and only 4% of total LTC expenditures for the elderly were paid by private LTCI (Li and Jensen 2011, p. 34).

Factors contributing to the small size of the LTCI market in the US include the availability of Medicaid benefits; a misperception that general health insurance also covers LTC; the unaffordability of LTCI policies; and potential moral hazard and adverse selection problems in the market for LTCI (Li and Jensen 2011, p. 34). While the publicly funded Medicaid is means-tested and requires the wealthy to deplete their wealth before they can access it (Brown and Finkelstein 2008b), its accessibility means it still has a crowding-out effect on private provision.

Other problems include uncertainty of health costs: 45-60% of all stays in RAC last less than a year, but

<b>Table 16. Summary of Age Pension &amp; Long-Term Care Provision &amp; Funding: United States</b>	
<b>Levels of state involvement in Age Pension provision</b>	
1. Pure voluntary saving	✓
2. Tax-subsidised private saving	✓
3. Mandatory private saving	
4. Mandatory public saving	✓
5. Social insurance	✓
6. Earmarked taxes	
7. Tax-funded flat-rate universal pensions	
8. Tax-funded means-tested pensions	
9. Social assistance	✓
<b>In-home Long-Term Care (LTC) systems: provision and funding</b>	
Care & support: state cash allowance	
Care & support: state in-kind provision	Means-test
Care & support: private contribution	Means-test
Health services: state subsidy	✓
Health services: private contribution	Means-test
Accommodation: state subsidy	Means-test
Other state assistance	✓
<b>Residential Aged Care (RAC) systems: provision and funding</b>	
Care & support: private contribution	Age pension + Means-test
Health services: private contribution	✓
Accommodation: state subsidy	Means-test
Accommodation: private charge	Means-test
Accommodation Bond	
<b>Long-Term Care Insurance (LTCI) provision and take-up</b>	
Availability private LTCI	✓
Public LTCI - tax or compulsory levy	✓
% take-up (2011)	10% (age 60+)

11-21% last 5 years or longer (Brown and Finkelstein 2008b, p. 7). Other limiting factors are the “elimination period” of 30-100 days that a person must be in care before insurance benefits will be paid out; the maximum “benefit period” of up to 5 years; and a price that is higher than actuarially fair (Brown and Finkelstein 2008b).

A potential solution to the crowding-effect (Brown and Finkelstein 2008b) is to have an option for people to supplement Medicaid coverage by private partial insurance, already achieved in four states with a Partnership for LTC. The US federal government offering of LTCI since 2002 for employees, retirees and family members does not cover many risks related to old age (Georgetown University 2003, p. 5). Currently only 15 - 18 million Americans own LTCI, so few Americans know someone who has benefited from LTCI, and they are reluctant to purchase something unfamiliar (Grote 2011, p. 23).<sup>74</sup>

Although buying LTCI at an earlier age can reduce the lifetime costs as the cost of LTCI rises with each year of ageing, newer LTCI policies are increasingly expensive, and older policies endure large rate increases for the same coverage. There are also problems for insurers: in 2010, the leading LTCI companies in the US paid more than \$10.8 million in daily claim benefits, a 53% increase in payments from 2007, when the same companies paid \$7 million in daily benefits (Grote 2011, p. 23).

Currently, the cheapest access to LTC coverage is often through employer-sponsored plans that include lifetime discounts, underwriting concessions, and tax advantages that are unavailable to individual policyholders. Employers who purchase LTCI for themselves and/or their employees can deduct a portion of their premiums, a tax advantage especially valuable for shareholders, partners, and limited liability companies (Grote 2011, p. 25). Other ‘safe’ paths to save on LTCI are options in traditional plans such as waiver of the elimination period for home care, waiver of the shared care benefit for couples, or waiver of the inflation-protection rider; and new ‘hybrid’ products. The two basic hybrid products are annuities with LTC riders, and life insurance with LTC riders. However, people with employer-sponsored or hybrid plans “tend to have coverage that is not as rich as those who own individual LTCI” (Grote 2011, p. 26).

Another option, LTC Partnership Programs are now available in more than 30 states, up from 4 states in 1987. In this agreement between the public and private sectors, those LTCI policyholders who exhaust their LTC benefits have the option to go on Medicaid without spending down all of their assets (Grote 2011, p. 27).

The Community Living Assistance Services and Supports Act (CLASS) is a potential step forward in the provision of LTC and LTCI, although premiums and benefits are yet to be finalised.<sup>75</sup> In the voluntary CLASS programme, working individuals are projected to have an average of \$150 to \$240 a month (based on age) automatically deducted from their paycheck. After paying premiums for a minimum of five years, those who have remained enrolled in the programme are covered if they require LTC. Cash reimbursement benefits are speculated at somewhere between US\$50 and US\$75 a day (Grote 2011, p. 27). Perhaps one of the most useful aspects of the CLASS programme may be that it brings greater attention to the need to plan for future LTC costs (Springfield, Hardock and McMurtry 2010, p. 51).

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<sup>74</sup> In 2010, in the relatively small market for LTCI, 31% of new individual claims were for home-care services, 30.5% were for assisted living, and 38.5% were for skilled nursing home care (Grote 2011, p. 24).

<sup>75</sup> The US Secretary of Health and Human Services must release the details of the plan by October 1, 2012 (Grote 2011, p. 26).

## 5 Other complexities of LTC and LTCI

As well as cost and classification, measurement, and local social and economic contexts, the demand and supply sides of LTC and LTCI provision are affected by perverse incentives, gender, ethnicity, and geography.

*Perverse incentives* are a problem in the LTCI market. Private LTCI significantly increases the use of formal LTC services, especially among very disabled seniors (Li and Jensen 2011, p. 48). However, further important findings are that private LTCI does not deter informal care-giving which reduces the costs to the state of LTC; and “private LTCI enables moderately disabled older adults to avoid or at least postpone nursing home entry” (Li and Jensen 2011, p. 48), making it possible for them to remain at home.

Factors preventing the growth of LTCI products include a lack of clarity about what people can expect from the state, as well as public sector provision producing the ‘crowding out’ of private provision. For example, it is argued that the US’s publicly funded, means-tested Medicaid (an imperfect substitute for LTCI) has a crowding-out effect on private provision (Brown and Finkelstein 2008b).

In the UK, one recent recommendation is to encourage a broader base of public support by reforming the current means-testing system so that most people would qualify for some assistance (Mayhew, Karlsson and Rickayzen 2010, p. 502). In the proposed model, rather than requiring individuals to run down all their assets before they become eligible for state support, almost everyone would be required to make some out of pocket contribution towards costs, with the gap between entitlement to support and the actual cost of LTC to be filled by insurance and other products.

*Gender* poses another set of issues. In New Zealand, as in most of the developed world, women live longer than men though the gap is reducing. Data from Statistics New Zealand (2007, p. 2) show that the population group aged 85+ are predominantly female, and European. However many women are ignorant of the fact that women usually outlive men, and still expect their spouse/partner will care for them if they can’t care for themselves (King 2011).

Bittinger (2011, p. 28) argues that women need planning and educational resources, and insurance options, because while women retiring today are increasingly financially independent, they face financial challenges. The norm has been intermittent work histories, lower hourly rates than their male counterparts, and part-time employment with few benefits. The consequence is that women generally have lower savings and fewer assets, and this in turn has implications for women’s access to LTCI.

It is likely that women in New Zealand would replicate US data (Bittinger 2011; Grote 2011) showing that six in ten women do not know how they will meet their LTC costs:

*Since women outlive their spouses by approximately five years, it is more likely that financial assets will be depleted, thereby putting women at a higher risk for financial hardship or even bankruptcy due to LTC expenses.* (Bittinger 2011, p. 27)

Where LTCI is based on unisex rates, single women pay the same as single men, despite living five years longer on average (Grote 2011, p. 26). However, not all jurisdictions are gender-neutral. The US Department of Health and Human Services has an online

National Clearinghouse for LTC information. Under Annuities, which are available from insurance companies to help pay for LTC services, it states:

*How much you receive in income each month depends on the amount of your initial premium, your age, and gender. Since women tend to live longer than men, women generally receive a smaller monthly payment over a longer period of time than do men of the same age. (Department of Health and Human Services 2012)*

In contrast to the US's actuarial approach, France's LTCI model is not gender-differentiated and has achieved comparatively greater success (Browne 2011, p. 5).<sup>76</sup>

For *indigenous populations* in many countries, including New Zealand, LTC provision is complicated by poorer health outcomes, lower savings and fewer assets (Ministry of Health 2007; Ministry of Health 2010; Ministry of Health 2011). Although older people are fairly evenly distributed across socioeconomic deprivation quintiles, the distribution of older Māori is skewed toward the high deprivation end of the scale: Māori at age 50 have shorter life expectancy than non-Māori females and males: 16% of Pakeha women survive past age 65, versus 3.6% of Maori women (Department of Public Health 2008).<sup>77</sup>

*Geography* can make a difference to the dependency ratio, access to LTC, and affordability of LTCI. In New Zealand, the highest percentages of those aged 65+ as a proportion of the local population are in the lowest socio-economic areas, for example, Northland, Bay of Plenty, and Taranaki (Statistics New Zealand 2007), yet there is a current lack of provision of institutional LTC in regional settings: 87% of LTC facilities are located in urban areas, with only 13% in non-urban areas (Grant Thornton 2010). Regional disparity implies that, as well as regional differences in the capacity for labour to provide either RAC or in-home LTC, the lowest socio-economic regions, with the highest proportion of the population aged 65+ and thus the greatest need, will be least able to afford LTCI.

## 6 Discussion

As shown throughout this paper and its supporting research: even for the native-born, it is difficult to track the terrain across any country's total age environment, particularly income provision and in-home and in-institution (LTC and RAC) care and support for general health or well-being. The incidence of the economic costs is of concern as it largely determines intergenerational equity. Increasing numbers of ageing residents cannot depend on decreasing numbers of taxpayers to fund a comparatively generous PAYGO system of 'entitlements', including a universal age pension and in-home care and support.

Cost is the most critical issue driving international interest in LTCI. New Zealand's trend of ever-increasing gains in longevity at older ages (Jackson 2011) adds urgency to the search for ways to meet the costs of the large baby-boom cohort that will swell the ranks of those over 85 by mid-century (Dale and St John 2011). In 2010, New Zealand had 1.3% of LTC costs provided for by private insurance but 92% from general government

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<sup>76</sup> The French Insurers' Federation describe LTCI as a major success because in a population of 49 million aged under 60 years (plus 14 million 60+), 5 million have some form of private LTCI (Browne, 2011, p. 5).

<sup>77</sup> These data are reflected in recent research from the US indicating that mortality differentials by socioeconomic status are measurable, and have generally widened from around the 1950s or 1960s through the 1990s (Waldron 2007).

(OECD 2011a, p.231). Estimated government expenditure on LTC in New Zealand by 2021 is \$2 billion (Grant Thornton 2010). While New Zealand shows little if any urge to reform the sector, LTC and LTCI are undergoing reform in most Western countries in response to the changing demographics: ageing populations, looser family ties, increasing female labour-market participation, and increasing costs. Given the changing demographics and the comparatively privileged position of the baby-boom generation, issues of intergenerational equity and the potential for intragenerational funding of LTCI cannot be ignored (See, for example St John, Dale et al. 2012).

The looming public costs are exacerbated by eroded private savings post GFC. As the numbers of those aged 65+ increase in most countries (see Table 1), the need for reform in this sector intensifies, and interest in LTCI increases.<sup>78</sup>

In France, wide coverage in the press of national debates around the search for solutions to the LTC risks of an ageing population has increased the general public's awareness, and supported the development of private LTCI. The growth of the French market is also explained by insurers offering policyholders cash benefit products, providing greater freedom of choice of care service and service provider (Courbage and Roudaut 2011, p. 23). In addition to choice, for the aged individual and for their family, financial security and the consequent peace-of mind is a significant benefit of LTCI.

Japan, recognising that their frail older populations were growing, their traditional resources for care were declining and their existing fragmented long-term care programmes were increasingly seen as costly, inefficient, and unfair, introduced comprehensive long-term care insurance (Campbell, Ikegami and Gibson 2010, p. 94). Research in Germany found the perception of financial security in the case of LTC needs increased in all segments of the population after introducing compulsory LTCI (Zuchandkea, Reddemannb, Krummakerb and Graf von der Schulenburga 2010, p. 641).<sup>79</sup>

The primary goal of comprehensive LTCI in Germany and Japan was to meet needs, however, controlling costs remains vital for sustainability: "having prices fixed by the government is most important, but it is not enough" (Campbell, Ikegami et al. 2010, p. 92). Both countries have difficulty recruiting and maintaining skilled staff;<sup>80</sup> both countries suffer from excess demand, and long waiting lists, instead of the hoped-for decreased demand for residential care, and the anticipated decreased costs (Campbell, Ikegami et al. 2010, p. 93).

Private insurance products for LTC and LTCI, where they exist, tend to be limited and circumscribed. "Suppliers of long-term care insurance are affected by the uncertainties of future costs and demands including the inflation risk which makes it a difficult product to price as a single premium product." (St John and Dale 2011, p. 14) Exclusions for higher risk purchasers are likely, and the risks of getting it wrong in the face of multiple uncertainties are high, thus significant loading charges are likely to make the insurance unduly expensive (Fenn 1999).

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<sup>78</sup> See, for example, Frank (2012), Fernandez and Forder (2012), Greenhalgh-Stanley (2012), Chon (2013).

<sup>79</sup> In Germany and France, although *health* insurance covers the full risk of being in need of LTC, *LTCI* only covers basic needs, and individuals are still expected to contribute towards their care. If they are unable to do so, social welfare is their last option (Arntz and Thomsen 2010, p. 29).

<sup>80</sup> In both countries, this is a low-wage industry (Campbell, Ikegami et al. 2010, p. 93), despite the need for an appropriately skilled workforce.

For such reasons, the UK Royal Commission on LTC (Dilnot, Warner et al. 2011) concluded that private insurance without state intervention is not ever likely to become significant. The Government has responded in 2013 by constructing an environment conducive to insurance products by capping private contributions to RAC (currently at £72,000) (Watt 2013).

The Australian Productivity Commission (2011) suggested that state intervention via a social insurance approach to aged-care funding in Australia would complement both the Medicare Levy and the SG which are already in place and have proved to be 'popular' taxes with the community (Productivity Commission 2011, p. 120). As Barr (2010, p. 317) observed:

- ... while compulsion makes politicians nervous, it has economic advantages, including:*
- *It recognises the evidence from behavioural economics that people do not always make decisions in their own self-interest.*
  - *It avoids adverse selection, since good risks cannot opt out and bad risks cannot choose to buy inefficiently large amounts of cover.*
  - *A system that is compulsory allows some redistribution; thus it is possible to charge a contribution to x per cent of earnings, respecting ability to pay.*

In a system that is a mix of state and privately funded health care, the roles for government to realise the potential for privately funded LTCI products include: facilitating their introduction and providing regulation and appropriate incentives; clarifying the role of the state, and expected state entitlements based on a unified assessment system; making it easier to get advice and direction regarding provider services in the private, voluntary and statutory sectors; and, importantly, covering risks that the market cannot, such as excessively long durations in care (Mayhew, Karlsson et al. 2010, p. 503).

Despite the increasing urgency, few countries have succeeded in providing protection for LTC costs. These market failures entail both individual and public costs. Without LTCI it is likely that capital will be run down too early by those who live a long time, and the costs of supplementary income top-ups, LTC, and other age-related health expenditures will fall on the current working-age population, either through higher taxes or as the families concerned meet the costs of their parents either directly or through receiving lower bequests (St John and Dale 2011). The introduction of means-testing as a solution to the LTC problem can result the proliferation of mechanisms to disguise income and wealth, and other inappropriate divestment of assets. An important criticism of New Zealand's approach to financing LTC thus concerns the implications for intergenerational equity (St John and Dale 2011).

In New Zealand, with no compulsion to annuitise, limited tax incentives in the accumulation phase (KiwiSaver), and no Government interest or encouragement, the market for LTCI remains thin or non-existent (St John 2009).



## Glossary

**ADL:** activities of daily living

**DB:** Defined Benefit pension – pension based on employee's earnings history, tenure of service and age

**DC:** Defined Contribution pension – payment based on individual contributions

**LTC:** in-home and residential long-term care

**LTCI:** long-term care insurance

**PAYGO:** pay as you go system of funding benefits

**RAC:** residential aged care

### Australia

**CACPs:** Community Aged Care Packages

**EACH:** Extended Aged Care at Home

**EACHD:** Extended Aged Care at Home Dementia

**HACC:** Home and Community Care

**SG:** Superannuation Guarantee

### France

**APA:** Cash payment funded from the Government's general budget for health and social services. The amount is determined by need, and abated against income.

### Japan

**EPI:** Employees' Pension Insurance, the largest scheme, for private, salaried workers and spouses

**MAA:** Mutual Aid Association for government workers and their spouses

**NP:** National Pension system for the self-employed and everyone else

### England

**BSP:** Basic State Pension

**NHS:** National Health Service

**PEA:** Personal Expenses Allowance

**S2P:** State second pension, contributory

**NEST:** National Employment Savings Trust

**PCT:** primary care trust

### US

**401(k):** tax-subsidised private retirement savings

**OASI:** Old Age and Survivors Insurance

**COBRA:** Consolidated Omnibus Budget Reconciliation Act, Continuation of Health Coverage

**SSI:** Supplemental Security Income

**CLASS:** Community Living Assistance Services and Supports Act

### New Zealand

**DHB:** district health boards

**NZS:** New Zealand Superannuation

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