

Caring Costs Us: The economic impact on lifetime income and retirement savings of informal carers.

A report for Carers Australia.

March 2022



Carers Australia is the national peak body representing the diversity of the 2.65 million Australians who provide unpaid care and support to family members and friends with a disability, chronic condition, mental illness or disorder, alcohol or other drug related condition, terminal illness, or who are frail aged.

Our vision is an Australia that values and supports all carers, where all carers should have the same rights, choices, and opportunities as other Australians to enjoy optimum health, social and economic wellbeing and participate in family, social and community life, employment, and education.

This report was commissioned by Carers Australia and the National Carer Network - our members, the peak carer organisations in each state and territory.



Any views and recommendations contained in this report do not necessarily reflect the views of Carers Australia or the National Carers Network



About Evaluate

Evaluate's primary goal is to identify long-term solutions to ensuring the sustainability of Australia's admirable social compact, including universal access to healthcare and education as well as the supply of aged care, housing and other social infrastructure.

Our approach is based on a traditional microeconomic toolkit, moderated by the knowledge that social services are accessed by people with a vast variety of experience, needs and resources. Consequently, Evaluate has no bias towards either public or private supply of services, noting that the different access and welfare needs of Australians typically require a mix of both. Evaluate's Principals are also familiar with a range of international markets for social services – particularly healthcare – including in a number of European and Asian countries.

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Alastair's practice is in two areas: the efficiency of social policy finance, including health, ageing, education and housing; and the dynamics of domestic and international markets, in which he has provided expert counsel on questions as diverse as competition policy, supply chain development, intellectual property regulation and the operation of free trade agreements. On the latter, he has extensive experience not only in Australia but also in China, Indonesia and other parts of Asia and the Pacific.

In the social policy sector, Alastair specialises in the development of novel modelling approaches to complex questions, bringing together microeconomic analysis with game theory. He is a member of the International Health Economics Association and has a particular focus on optimising the mix of public and private finance for health goods.

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David Cullen, Senior Consultant

Dr David Cullen is internationally recognised as one of Australia's leading health economists, with a special interest in the economics of social services, and was President of the OECD's Expert Group on the Economics of Prevention in 2014 and 2015. He has also written extensively on the problems inherent in designing both public and private long term care insurance schemes.



David is also internationally recognised as an expert in the regulation of social service markets. He represented Australia at the OECD's 2017 Global Forum on Competition, where he presented, with Allan Fels, a paper on the barriers to deregulation in markets for social services. In 2015, he was commissioned, with Henry Ergas, to provide advice to the Australian Health Ministers' Advisory Committee on improving productivity and efficiency in the Australian health care system, including through payment system reform.

He was also lead author on a paper on the Relative Efficiency of the Private Health Insurance Rebate v. Direct Public Health Expenditure, which was commissioned by Private Healthcare Australia for the Australian Government.

David is the first person to be appointed Chief Economist of the Australian Department of Health and the first person to be appointed Chief Economist of the National Disability Insurance Scheme (NDIS). He is a Fellow of the Royal Society for Public Health and a Fellow of the Royal Statistical Society as well as a Member of the Royal Society for Economics. He is Honorary Professor of Health Economics and Aged Care Policy at the National Centre for Social and Economic Modelling at the University of Canberra. From 2019 to 2021 he was Senior Advisor and Special Consultant to the Royal Commission into Aged Care Quality and Safety.

David has more than 20 years' experience in providing advice on aged care and disability care to the Australian Government and is a foremost expert on the funding and financing of aged care and disability care. In aged care, David led the development of the ten-year plan for the deregulation and micro-economic reform of the aged care industry that was at the centre of the 2012 Living Longer Living Better Aged Care reforms. He also led the Australian Government's 2011 Review of the Aged Care Funding Instrument and 2010 Review of the Conditional Adjustment Payments and was the Executive Director of the Review of Pricing Arrangements in Residential Aged Care from 2002 to 2004. In disability care, David led the 2019-20, 2020-21 and 2021-22 NDIS Annual Price Reviews as well as the 2019 Review of NDIS Therapy Pricing Arrangements, the 2019 NDIS Western Australian Market Review and the 2020 Review of Pricing Arrangements for Supported Independent Living.



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Executive Summary

This document has been prepared by Evaluate on behalf of Carers Australia. Evaluate is an independent private economic consulting practice, with a particular focus on social policy.

This paper describes the construction and outputs of a microsimulation model which looks at the economic impact of informal care on the lifetime income and retirement savings of Australian carers. It is therefore a model of opportunity cost from the carer perspective, and complements previous work undertaken for Carers Australia looking at alternative or replacement cost.

As context for the model, a comprehensive overview of the circumstances, rules and history of carer subsidies in Australia is provided, which also provides the basis for potential policy changes. In particular, it is noted that the historical rationale for carer payments was that they would substitute for care otherwise provided professionally in a nursing home (and at significantly lower cost).

Over time, this has been decoupled. Whereas at the introduction of the first carer benefit (the Domiciliary Nursing Care Benefit) it was equivalent to 33% of the Australian Government Extensive Nursing Home Benefit payable in respect of a person in an approved Nursing Home and receiving extensive care, by 1992 this had fallen to 7.9%, and is now only 6%. Similarly, whereas it was originally around 25% of the income of a couple on the basic age pension, it has now fallen to 10%. The problem for carers, and for the Government which relies on informal supply, is that: where the rewards for caring are reduced; the opportunity cost of care increases; and fewer prospective informal carers will be willing to meet demand.

The consequence of this is an increase in demand for substantially more expensive formal care, including residential care. This means that reducing the share of funding for informal care is a false saving.

The model simulates the full distribution of carer impacts in Australia, variously including observed distributions of:

- Gender;
- Age at first call to care;
- Duration of care;
- Employment status before and after caring;
- Income before caring; and
- Superannuation balance at commencement of caring.

At the mean, and at current subsidy settings, Australian carers will lose:

- \$392,500 in lifetime earnings to age 67; and
- \$175,000 in superannuation at age 67.

Some who are carers for extended periods of time will lose substantially more, with the most affected 10% losing at least \$940,000 in lifetime income, and \$444,500 in retirement savings.



Because demand for informal care is exogenous to the carer – it may be a random event, or influenced by decisions taken by the care recipient but not the carer – this financial burden is effectively randomly allocated. That it is expected to be borne by those to whom it is presented seems unjust, and inconsistent with broader public policy around welfare payments, particularly subsidies for formal aged care.

Two fiscal remedies are discussed to deal with this problem. The first is the introduction of the Superannuation Guarantee Contribution for the Carer Payment. While this would cost a little over \$700 million in the first year, its impact would be to increase mean superannuation balances by \$52,500, which would reduce age pension costs by up to \$84,000. These savings to the Australian Government in future expenditure on the age pension are significantly higher than the cost of the proposed SGC payments per person, which on average over the lifetime of all carers would only be around \$18,000.

The second option is to increase the Carer Allowance, by either:

- 150% for those who are in receipt of the Carer Allowance but not the Carer Payment, to return it to the historical measure of a 25% supplement to the couple's age pension; or
- 475% for those who are in receipt of both the Carer Payment and the Carer Allowance, to return it to one third of the average basic care subsidy for residential aged care.

The actual cost impost of these measures is highly dependent upon how a reduction in income foregone will act as an incentive to more people to care. This is described in terms of wage-elasticity of supply. If we assume a lower than observed elasticity of 0.66, then the nett cost of these measures would be \$5.3 billion. However, if an observed lower-bound elasticity of 3.09 is used, then there are potential savings of \$2.4 billion. This is because while there are large increases in direct government support for informal carers, the replacement of formal care demand provides savings at a much higher rate.



Introduction

This paper follows from prior work undertaken for Carers Australia to look at the value of informal care. The previous paper considered variously:¹

- What would be the cost of replacing all informal care with formal market services, which was valued at \$77.9 billion in 2020 (this is notably independent of accommodation costs); and
- What is the opportunity cost to the economy of informal care, which was calculated at \$15.2 billion or 0.8% of GDP.

In this paper, Evaluate seeks to answer three separate but related questions, viz.:

- What is the cost to informal carers of making the decision to care for a family member, taking into account the nett difference between carer subsidies (carer's allowance and carer payment) and income foregone?;
- What improvements to the overall incentive to care would efficiently increase the number of informal carers?; and
- What would be the fiscal cost of different options.

These questions are based on a number of observations. First, it is clear both from the ratio of replacement cost to opportunity cost in the earlier Deloitte study, that informal care is always at least nominally a saving. This conclusion also emerges from Evaluate's model

Second, the sole valuation of informal care is not replacement value. This is because:

- There is some funding for informal care (Carer Payment and Carer Allowance), so this needs to be removed from any calculation of alternative cost;
- The costs and benefits of care are not easily translated into pure income. These include:
 - Financial opportunity costs, which are the difference between income from normal work and the income from various Commonwealth subsidies;
 - Non-financial losses of utility, for example from not being able to work in a profession for which the person has trained;
 - Health costs, as carers at the mean have worse health outcomes than those who are not called to provide care. These include both psychological factors such as social isolation, and physical health differences, each of which contributes to reduced quality of life (QoL);² and
 - Countervailing benefits of being a carer, which may be described variously under the headings of: responsibility or duty; task satisfaction; joy and love.
- Each of these costs and benefits will be significantly heterogeneous in their scale and distribution, depending amongst a multiplicity of factors upon:
 - Preceding career status and expected income;

¹ Deloitte Access Economics, *The Value of Informal Care in 2020. A Report for Carers Australia*, 2020. Accessed October 2021.

² See for example: Bernard Van den Berg et al, "Well-Being Losses due to Care-Giving", *Journal of Health Economics*, 2014, 35(100), pp.123-131.



- Other socio-economic factors (is there wealth which makes income foregone less important?);
 - Age and proximity to end of expected working life, or for that matter whether someone is post-retirement; and
 - Expected duration of care responsibilities.
- Further to the above, there remains the question as to whether there is any available alternative in terms of formal substitute care, if the potential carer were to prefer remaining in work. This is a matter of universal supply constraints, which are particularly amplified in regional Australia.

In the absence of appropriate survey data on how carers subjectively value the care experience, however, the only common metric which can be used is financial impact. This is felt in two ways: first in terms of lost income during working life; and second, in the longer-term reduction in the accrual of superannuation caused by foregone income. This is an opportunity cost valuation.

Both income and superannuation measures are central to the microsimulation model developed in support of this paper.



Context and rules

Before moving to the model, it is important to clarify what are the circumstances, financial instruments and rules, which govern informal caring in Australia, as well as the cost to Government. This section outlines each of these.

Informal carers in Australia

Under the cultural mores that guided public policy in Australia in the nineteenth century and the majority of the twentieth century, families had principal responsibility for providing for the health and welfare needs of those older people who were unable to provide for themselves.³ Even today, a significant proportion of people who receive assistance with their care needs receive no formal support and are only assisted by family members and other informal carers.

For people with a disability, about four in ten (42.0%) who receive assistance with their care needs receive no formal support and are only assisted by family members and other informal carers. For older people, about one in three (33.7%) who receive assistance with their care needs receive no formal support and are only assisted by informal carers. Even where people receive formal assistance with their care needs they also often receive informal support as well. Only about a fifth of people who receive assistance with their care needs receive no support from informal carers (20.9% of people with a disability who receive assistance with their care needs and 21.5% of older people who receive assistance with their care needs).⁴

The contribution of Australia's informal carers is significant, yet not captured in economic measures such as Gross Domestic Product (GDP), unlike that of formal carers. The replacement costs of this informal care – the cost of replacing each hour of informal care with a formal sector equivalent – would value the economic cost of the informal care provided in Australia at \$77.9 billion (in 2020). The opportunity costs of informal care – which essentially considers the replacement costs only of those informal carers who partially or fully withdraw from the labour force – would value the economic cost of the informal care provided in Australia at \$15.2 billion (in 2020).⁵ For context, these values are best understood in relation to the amounts expended by governments on direct supports for older people and people with disabilities who need assistance with their care needs. In 2020, this expenditure amounted to \$21.5 billion on aged care services and \$19.7 billion on supports for people with disabilities.⁶

This section provides detail on the informal carers who deliver this support and the support that they deliver. In 2018, around 2,646,100 people were providing informal care to older people and people with a disability in Australia. That is, about one in ten Australians (10.8% of the population) were providing informal care of some form to older people and people with a disability. This included some 861,600 people (3.5% of the population) who were primary carers.⁷

³ D Cullen, "Historical perspectives: The evolution of the Australian Government's involvement in supporting the needs of older people", Australian Department of Health and Ageing 2003.

⁴ Except where otherwise stated, the data on primary carers in this section comes from: ABS. (2019). *4430.0 Survey of Disability, Ageing and Carers (SDAC), Australia: Summary of Findings*. Tables 13.1 and 27.1.

⁵ Deloitte Access Economics, *The Value of Informal Care in 2020. A Report for Carers Australia*, 2020.

⁶ Based on: Steering Committee for the Review of Government Service Provision. (2021). *Report on Government Services 2021*. Productivity Commission: Canberra.

⁷ "A primary carer is a person is aged 15 years or over who provides the most informal assistance to a person with one or more disabilities, with one or more of the core activities of mobility, self-care or communication." ABS SDAC, 2018: [Appendix: Carers](#)" 2019. Accessed January 2021.



The share of the Australian population who provide informal care at least weekly (13.8% in 2018) is slightly higher than the average share across OECD countries (12.6%). It is significantly below the share in the United Kingdom (18.2%) but higher than the share in the USA (6.9%).⁸

Most informal carers in Australia are spouses, but adult children and in particular daughters, are also often informal carers. Almost half (46.7%) of older people who receive informal care receive that care from a spouse and more than quarter (29.6%) receive that care from a daughter. Only about one in ten (12.2%) older people who receive informal care receive that care from someone who is not a relative. For people of all ages with a disability who live in a household and who receive informal care, about eight in ten (40.5%) receive that care from a partner and slightly more than a quarter (27.0%) receive that care from a parent. Again, only one in ten (12.3%) people of all ages with a disability who live in a household and who receive informal care receive that care from someone who is not a relative.

Primary carers are overwhelmingly female (71.8% of all primary carers). They are also older, on average, than the Australian population. More than a quarter of primary carers (26.6%) are aged 65 or older. Only one in ten (11.1%) primary carers are aged between 15 and 34 – whereas this age group makes up a third (34.3%) of the population aged 15 or older. Primary carers are also more likely than the general population to have a disability themselves. Over one-third (37.4%) of primary carers had a disability in 2018, which is more than twice the rate of non-carers (15.3%). About 7.0% of primary carers reported having a profound or severe limitation themselves.

Economically, people who provide informal care are likely to earn less than those who do not. In 2018, the median gross personal income per week for people who provided no informal care was \$863 compared to \$525 for primary carers and \$729 for other informal carers. They are also much more likely to be in receipt of government pensions or allowances. Government pensions or allowances were the main source of income for 46.4% of primary carers and 26.5% for other informal carers, compared to 17.6% for people who provided no informal care. Caring also has an impact on workforce participation. For people aged 15-64, some 58.8% of primary carers were in the labour force, compared to 81.5% for people who provided no informal care and 76.6% for other informal carers. Primary carers are more likely to own their own home (37.4%) compared to people who provide no informal care (26.8%).

Note, however, that some of these economic differences are, at least in part, artefacts of the age and gender distributions of informal carers compared to the general population. These existing disparities do, however, appear to be heightened by the opportunity costs of care-giving.

Carers provide a wide range of support. Some carers provide full-time care, and in other instances formal and informal carers share responsibilities. Informal care can be a substitute for or supplement to domestic, personal care or nursing work.⁹ Carers may provide assistance to the person for whom they care with mobility issues, communication issues, medication management, personal care, household chores, property maintenance and transport. Carers also frequently provide emotional, social and financial support.¹⁰

In 2018, almost three quarters of primary carers (74.0%) reported assisting the person for whom they cared with mobility issues – for example, assisting the person to get in or out of bed or to move about. More than half reported providing assistance with self care (56.5%) – for example, assistance with bathing or toileting. More than half (54.1%) also reported providing assistance with communication.

⁸ OECD, *Health at a Glance 2021: OECD Indicators*. Paris: OECD Publishing, 2021, Figure 10.16.

⁹ F Colombo et al, "Help Wanted?: Providing and Paying for Long Term Care", OECD Publishing: Paris, 2011, p.136.

¹⁰ Carers Australia, *About carers webpage*, <https://www.carersaustralia.com.au/about-carers/>, Accessed November 2021.



Many primary carers provide a significant level of support to the person for whom they care. In 2018, more than one third (33.2% of all primary carers or 286,300 people) provided 40 hours or more of informal care each week. A further 18.4% of primary carers (158,200 people) provided 20 or more hours of informal care each week. Primary carers who live with the person for whom they care often provide even higher levels of care. Some 40.2% of primary carers who lived in the same household as the person for whom they care (274,300 people) provided 40 hours or more of informal care each week. A further 19.7% of resident primary carers (124,400 people) provided 20 or more hours of informal care each week.

Of those 377,700 informal carers who were caring for someone who had a profound core activity limitation in 2018, some 54.8% (206,800 people) were caring for more than 40 hours a week and 19.7% (74,400 people) were providing 20-39 hours of care per week. Almost two thirds of younger people aged 15-44 (64.5% or 63,200 people) who were caring for someone with a profound disability were providing more than 40 hours of care a week.

Many informal carers provide care for a significant period of time. Almost half (48.1%) of all recipients of the Carer Payment receive it for more than five years, including 21.5% who receive the Carer Payment for more than 10 years. About a quarter (26.0%) receive the Carer Payment for less than two years, including 13.3% who receive it for less than one year. On average, Carer Payment recipients receive the Carer Payment for 6.2 years. However, among those carers who receive the Carer Payment for more than ten years, the average duration is 14.4 years.¹¹

Caregiving has positive and negative effects on informal carers. The inaugural Carer Wellbeing Survey¹² undertaken in 2021 found that most carers (54.1%) found being a carer satisfying and many carers - 58.6% - felt that being a carer had strengthened their relationship with the people they cared for. However, Australia's carers are two and a half times more likely to have low wellbeing than the average Australian adult, with 55% having low wellbeing compared to only 20% of the broader population. Almost all carers reported experiencing multiple types of challenges related to their role as a carer. In particular, 67% regularly feared for the future of the people they cared for; 64% did not usually have time for themselves, more than 40% experienced negative impacts on their own health, and relationships and only 19% of carers are able to easily organize a friend or family member to help them in their carer role if they are ill or need a break. On average, carers have poorer financial wellbeing and are less likely to be employed compared to the typical Australian. This first Carer Wellbeing Survey confirmed that carers across Australia are at high risk of poor wellbeing, high psychological distress, poor physical health and decreased financial and economic security.

A recent review of the available literature found that the most important predictors of carer impact were the duration of caregiving and the dependency level of the person being cared for, in terms of both physical and mental dependency stemming from decreased cognitive capacity or behavioural problems. Some specific illnesses and role conflicts also increased caregiver impact whereas social support lowered it.¹³

Support for Carers

Because intensive caregiving is associated with a reduction in labour force attachment for caregivers of working age, higher poverty rates and a higher prevalence of mental health problems, many OECD countries have implemented policies to support informal carers with a view to mitigating these negative impacts. Two-thirds of OECD countries provide care leave, whether paid or unpaid, while

¹¹ Evaluate's analysis of: Australian Department of Social Services. (2021). *DSS Payment Demographic Data, June 2021*.

¹² Centre for Change Governance and NATSEM, University of Canberra & Carers Australia, '[Caring for others and yourself: The 2021 Carer Wellbeing Survey Final Report](#)', Accessed January 2022.

¹³ N Lindt et al, "Determinants of overburdening among informal carers: a systematic review" *BMC Geriatrics*, 2020 (20:304).



respite care remains fragmented in many countries. Two-thirds of OECD countries provide cash benefits to informal caregivers. Some countries also provide counselling and training services.¹⁴

Governments provide these supports both because they address the negative impacts of caring on carers and also because informal carers most frequently offer a cost-effective alternative to other forms of care. A recent study has examined the fiscal implications of measures to allow carers to return to the workforce by significantly increasing the availability of formal care supports. It found that while the return of informal carers to the formal workforce would significantly increase economic growth and hence the fiscal position of governments, those gains would only amount to about 14% of the costs of the additional formal care services that would be required to allow it to happen.¹⁵

The Australian Government currently provides support for eligible carers through several programs. Income support is provided through the **Carer Payment**, which provides financial help to people who are unable to work in substantial paid employment because they provide full time daily care for either someone with severe disability or medical condition, or who is frail aged. Assistance with the costs of caring is provided through the **Carer Allowance**, which is an income supplement for carers providing extra daily care for either an adult or dependent child with disability or a medical condition, or someone who is frail aged. It is also provided through the **Carer Supplement**, which is an annual lump sum payment to help with the costs of caring for a person with disability or a medical condition, and through the **Child Disability Assistance Payment**, which is an annual lump sum payment to help parents with the costs of caring for a child with a disability.¹⁶

Carers are also supported through the **Carer Gateway**, which provides counselling, peer support, coaching and assistance with skills development. Some financial assistance is also available to some carers through Carer Directed Packages, which can be used to purchase planned respite (direct or indirect), assistance with home duties that provide stress relief, covering costs related to education and training or provision of remedial or preventative health and wellbeing programs.¹⁷ Carers are also supported by limited respite services provided through some of the programs that assist the people for whom they care. These include: the National Disability Insurance Scheme for carers of people with a disability, and the Commonwealth Home Support Program and Home Care Packages Program for older people.

In 2020-21, the Australian Government expended \$9.8 billion on income support and financial assistance payments to carers. It also expended almost \$700 million respite through the Home Support Program, home care packages, and residential aged care. Some expenditure through the National Disability Insurance Scheme would also have supported respite services.

In the remainder of this section, we outline the current arrangements for the provision of income support and financial assistance to carers. In the following section we briefly trace the development of the Australian Government's role in supporting carers through income support and financial assistance.

Income support

To be eligible for the Carer Payment, a person must be providing constant care in the home to someone who either has a terminal illness or who has a severe disability, or severe illness, or is frail aged, where the illness or disability is likely to last at least 6 months and the person needs constant care in their home or in hospital

¹⁴ OECD. (2021). *op. cit.* & Colombo. (2011). *op. cit.*, pp.121-51.

¹⁵ J Geyer et al, "Indirect Fiscal Effects of Long-Term Care Insurance", Berlin: German Institute for Economic Research, 2015.

¹⁶ <https://www.dss.gov.au/about-the-department/benefits-payments> Accessed November 2021.

¹⁷ <https://www.carergateway.gov.au/> Accessed November 2021



and the carer will continue to provide care when they are discharged. Both the carer and the person cared for must also be Australian residents. Carer Payment recipients can engage in employment or study for up to 25 hours per week (including travel time) and remain eligible for payment.

The maximum rate of Carer Payment payable to an individual depends on whether or not they are in a relationship; and on whether or not they are a homeowner. These maximum rates are the same as for other income support payments like the Age Pension and the Disability Support Pension. The amount of Carer Payment payable to an individual depends on their income and assets. The amount of Carer Payment payable to a person is equal to the relevant maximum rate reduced by the amount determined by the income test or by the amount determined by the assets test, whichever is the greater reduction. The means test is the same as that which applies to other income support payments like the Age Pension and the Disability Support Pension. The income-tested reduction amount is equal to 50% of the assessable income of the individual (or the couple) above the level of the relevant income free threshold. The asset-tested reduction amount is equal to 7.8% of the assessable assets of the individual (or the couple) above the level of the relevant asset free threshold. The Carer Payment does not count as taxable income if both the carer and the person cared for are both under the Age Pension eligibility age.

In June 2021, some 300,121 people were in receipt of the Carer Payment. That is, some 1.5% of all Australians aged 16 or older were in receipt of the Carer Payment. About a third of primary carers (32.4%) were in receipt of the Carer Payment. The number of Carer Payment recipients has grown significantly in the last twenty years (from 57,816 in 30 June 2001) at an average annual growth rate of 8.6% – about six times the rate of growth of Australia population.¹⁸

Almost three quarters of all Carer Payment recipients (70.6%) are female and slightly more than half (52.9%) have a partner. Almost three quarters of all Carer Payment recipients (70.5%) are aged 45 or older, including 18.8% who are aged 65 or older. Only about one in ten Carer Payment recipients (12.4%) are aged under 35 and only 2.6% are aged under 25. Some 6.1% of all Carer Payment recipients identify as Indigenous and 35.3% of Carer Payment recipients were not born in Australia.

Almost half (48.1%) of all recipients of the Carer Payment receive it for more than five years, including 21.5% who receive the Carer Payment for more than 10 years. About a quarter (26.0%) receive the Carer Payment for less than two years, including 13.3% who receive it for less than one year. On average, Carer Payment recipients receive the Carer Payment for 6.2 years. However, among those carers who receive the Carer Payment for more than ten years, the average duration is 14.4 years.

Recipients of the Carer Payment often transition to or from other income support payments. Only 5.0% of Carer Payment recipients are in receipt of income support payments (of any kind) for less than one year and 45.0% are in receipt of income support payments for more than ten years. The average duration on income support for Carer Payment recipients is 10.9 years (18.5 years for those who are in receipt of income support payments for more than ten years).

The cost of the Carer Payment to the Australian Government in 2020-21 was \$6.5 billion – equivalent to 8.4% of the combined amount expended in the same year on the Age Pension, Disability Support Pension and Carer Payment. In the 20 years from 2001 to 2021, Australian Government expenditure on income support for carers grew in nominal terms by \$6.0 billion – an annual average nominal growth rate of 13.9%. Over the next decade (to 2032), expenditure is projected to more than double in nominal terms to \$18 billion.

¹⁸ Except where otherwise specified the data in this section are drawn from: Australian Department of Social Services, *DSS Payment Demographic Data, June 2021*, and from the annual reports of the Australian Department of Social Services and its predecessors.



However, in real terms, expenditure on income support for carers is projected to be stable over the next decade both in terms of its share of GDP (0.5%) and its share of Australian Government expenditure (1.8%).¹⁹

Financial assistance for carers

Eligibility for the Carer Allowance requires a person to be providing additional daily care and attention to someone because they have either a disability or severe illness, or are frail aged. Moreover, the carer must have adjusted taxable household (carer plus partner) income of less than \$250,000 per year. Other than the eligibility criteria, the amount of the Carer Allowance payable to a carer does not depend on their income or assets. The Carer Allowance does not count as taxable income. A carer can receive the Carer Allowance for every eligible person to whom they provide care.

In June 2021, some 623,742 people were in receipt of the Carer Allowance. More than twice as many people receive the Carer Allowance as receive the Carer Payment. All Carer Payment recipients also receive the Carer Allowance. A further 323,121 people who are not eligible for the Carer Payment receive the Carer Allowance.

The number of Carer Allowances has grown significantly in the last twenty years (from 235,041 in June 2001) at an average annual growth rate of 5.0% – more than three times the rate of growth of Australia population. Almost three quarters of all Carer Allowance recipients (73.9%) are female and almost two thirds (64.3%) have a partner. Almost three quarters of all Carer Allowance recipients (71.0%) are aged 45 or older, including 29.8% who are aged 65 or older. Only about one in ten Carer Allowance recipients (9.9%) are aged under 35 and only 1.4% are aged under 25. Some 4.2% of all Carer Allowance recipients identify as Indigenous and 32.5% of Carer Allowance recipients were not born in Australia.

The cost of the Carer Allowance to the Australian Government in 2020-21 was \$2.5 billion.

Carer Payment and Carer Allowance recipients also receive the Carer Supplement, which is an annual lump sum payment. It helps with the costs of caring for a person with disability or a medical condition. In 2020-21, 645,605 Carer Supplements were paid. The total cost of the Carer Supplement to the Australian Government in 2020-21 was \$594.5 million.

Carer Allowance recipients who are caring for an eligible child aged under 16 also receive the Child Disability Assistance Payment. In 2020-21, 162,182 Child Disability Assistance Payments were paid. The total cost of the Child Disability Assistance Payment to the Australian Government in 2020-21 was \$186.7 million.

In total, the Australian Government provided \$3.3 billion in financial assistance to carers in 2020-21. In the 20 years from 2001 to 2021, expenditure on financial assistance for carers grew in nominal terms by \$2.8 billion – an annual average nominal growth rate of 9.6%.

In summary, when both income support payments and financial assistance payments are considered, total Australian Government expenditure on carers grew in nominal terms from \$1.0 billion in 2000-01 to \$9.8 billion in 2020-21, equating to an average annual nominal growth rate of 12.0%.

¹⁹ Australian Parliamentary Budget Office, “Beyond the budget 2021-22: Fiscal outlook and scenarios”, 2021, p.43.



A brief history

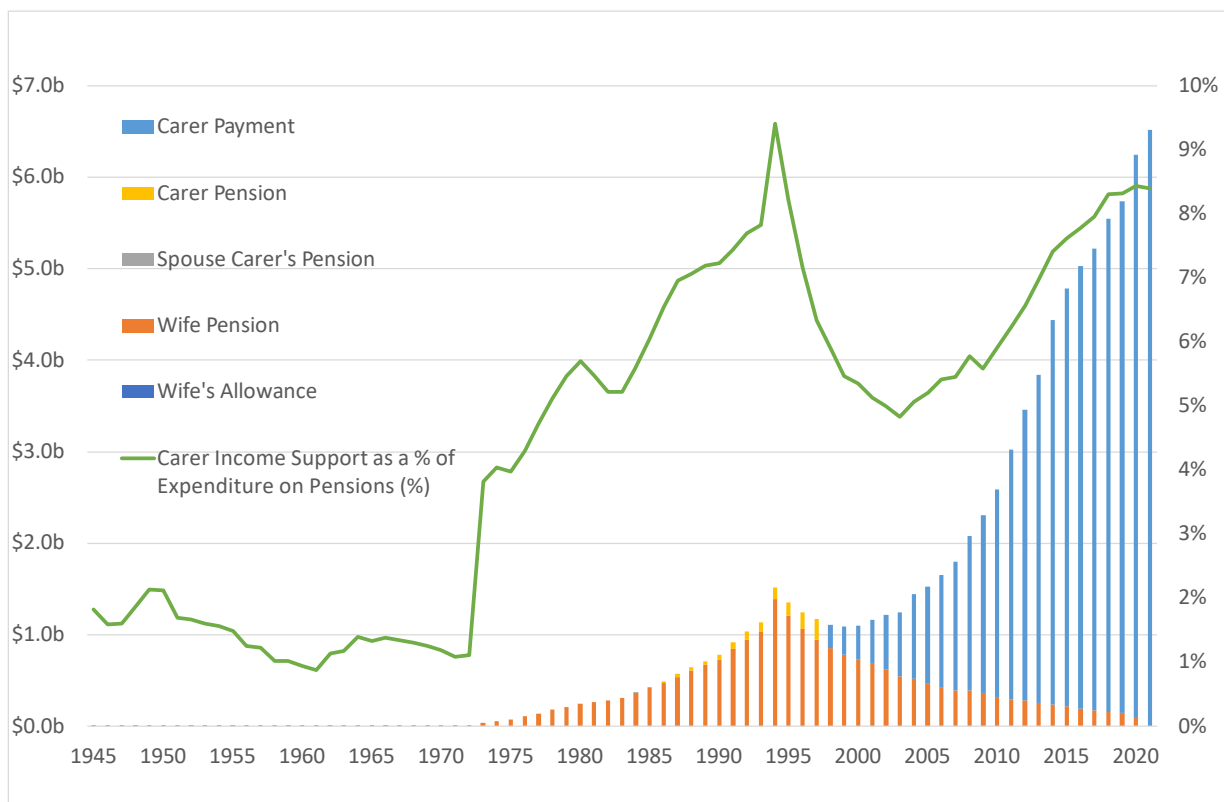
To understand the intent and application of each of the instruments described above, it is instructive to look at what preceded them, and how the arguments for informal care support have evolved over time.

Income support

The Australian Government has provided income support to carers since 1943 through a series of programs, including the Wife's Allowance from 1943 to 1972, the Wife Pension from 1973 to 2020; the Spouse Carer's Pension, from 1984 to 1985; the Carer's Pension, from 1986 to 1997; the Carer Payment, from 1998.

Figure 1 illustrates how the arrangements for income support for carers has evolved and grown over the last 75 years.

Figure 1: Expenditure on Income Support for Carers, 1943-44 to 2020-21



The Australian Government first provided support for informal carers in 1943, when the Wife's Allowance was established to provide income support to the wives of invalid pensioners and for age pensioners who were permanently incapacitated for work. Three features of these allowances provide evidence that they were intended to support wives in their role as carers rather than to act as income support payments.

First, the provision in the *Invalid and Old-age Pensions Act 1908* under which permanently incapacitated males who had reached age sixty but not age sixty-five received the age pension rather than the invalid pension was removed at the same time. Classifying these men as disabled rather than aged was arguably the obverse of the recognition of their wives as carers. Second, the recipient of the Wife's Allowance was not required to satisfy any of the eligibility tests regarding age, character, nationality or length of residence that were normally applied to income support payments. Third, the Wife's Allowance was not payable where the



husband was in a benevolent asylum or in a hospital for the insane: that is, when the wife was not required to perform her carer role.

The maximum rate of the Wife's Allowance when first established was equivalent to 15% of average weekly earnings and 28% of the maximum rate of the pension. The allowance was subject to the usual pension means test.

In June 1944, some 7,301 people were receiving the Wife's Allowance at an annual cost to the Australian Government of £332,000 – equivalent to 1.8% of the total amount expended in the same year on income support through the Age and Invalid Pensions and the Wife's Allowance. By June 1972, there were 23,690 people receiving the Wife's Allowance an annual cost to the Australian Government of \$4,534,000 – equivalent to 1.1% of the amount expended in the same year on income support through the Age and Invalid Pensions and the Wife's Allowance.

In 1972, the Wife's Allowance was replaced by the Wife Pension, which was paid at the married rate of pension and paid to the wife of an invalid or age pensioner if she was not qualified for a pension in her own right. The pension means test continued to apply. By June 1982, the number of people receiving the Wife Pension had grown to 86,637 at an average annual cost to the Australian Government of \$286.2 million – equivalent to 5.2% of the total amount expended in the same year on income support through the Age and Invalid Pensions and the Wife Pension.

The Australian Government did not provide income support explicitly to carers until 1983. At that time, a Spouse Carer's Pension was introduced for the husbands of severely handicapped age or invalid pensioners or rehabilitation recipients who required constant care and attention either permanently or for an extended period. The pension was only paid if care was actually provided by the husband in person and in the matrimonial home. Moreover, the pension was cancelled if the husband failed to provide care, for whatever reason, for more than twenty-eight days in any calendar year. The husband also could only receive the Spouse Carer's Pension if he was ineligible for any age, Invalid or service pension. The rates and conditions were the same as for the Wife Pension, which was already available to the wives of age, invalid and service pensioners. At the end of the first year of the Spouse Carer's Pension, some 1,721 carers of income support recipients received the pension at an annual cost of \$6.9 million.

The Spouse Carer's Pension was renamed the Carer Pension in 1985. In June 1986, some 103,382 people were in receipt of the Wife Pension and 5,020 were in receipt of the Carer Pension. The total annual cost to the Australian Government in that year was \$495.8 million – equivalent to 6.5% of the amount expended in the same year on income support through the Wife, Age, Invalid and Carer Pensions.

Eligibility for the Carer Pension was gradually widened on three fronts – namely, the characteristics of the carer and their relationship with the person they care for, the characteristics of the person being cared for and the nature of the care provided. First, recipients of the pension/payment have not been required to be a relative of the person cared for since 1985. They are also no longer required to live in the same house as the person cared for.²⁰ Recipients of the Carer Payment are able to participate in employment, education or training for up to twenty five hours per week and can take up to sixty-three days off from caring each year.²¹ Second, the person being cared for is no longer required to themselves be in receipt of an income support

²⁰ Carers have been able to live in a neighbouring house since 1991 and anywhere since 1993.

²¹ Carer Pensioners were first able to participate in employment, education or training in 1993. In 1997, the number of hours that the carer could participate in these activities was doubled. The number of days for which a carer could cease caring was increased to forty-two in 1993 and to sixty-three in 1997.



payment.²² Third, the constant care and attention requirement was replaced in 1988 by the requirement that personal care in connection with bodily functions (including eating, toileting and medication) or constant supervision to prevent injury to the person being cared for or others was required.

From 1995, no new people were able to receive the Wife’s Pension. Instead, new applicants needed to meet the eligibility criteria for the Carer Pension. From 1997, the Carer Pension was renamed the Carer Payment.

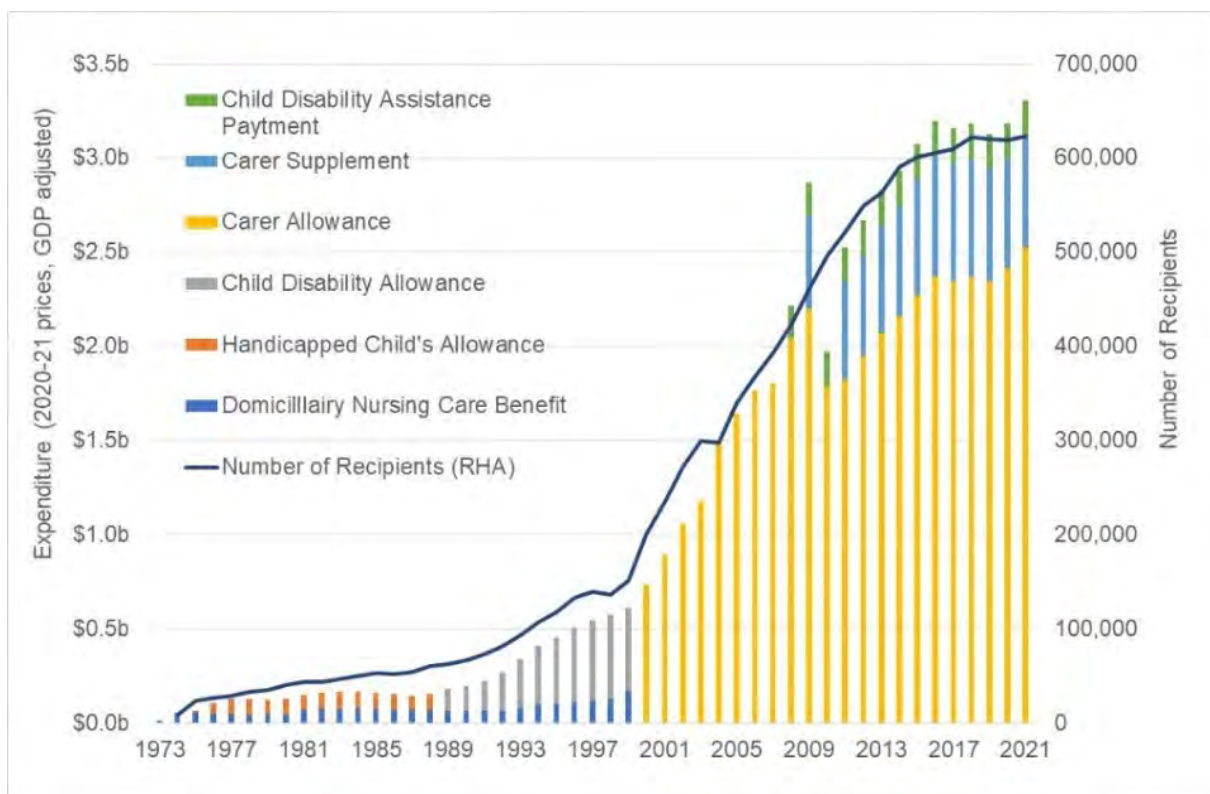
In 1943, the maximum rate of the income support payment for carers was equivalent to 15% of average weekly earnings and 28% of the maximum rate of the pension. In 2021, the maximum rate of income support for carers, which is now equivalent to the maximum rate of the Age/Disability Support Pension, was equivalent to 27.8% of average weekly ordinary time earnings for singles and 21.0% for members of couples.

Financial assistance

The Australian Government has provided financial assistance with the costs of caring to carers since 1972 through a series of programs, including the Domiciliary Nursing Care Benefit, from 1972 to 1997; the Handicapped Child’s Allowance, from 1974 to 1987; the Child Disability Allowance, from 1987 to 1999; the Carer Allowance, from 1997; the Child Disability Assistance Payment, from 2008; and the Carer Supplement, from 2009.

Figure 2 provides further details on how the level of financial assistance provided to carers by the Australian Government has grown over the last fifty years.

Figure 2: Expenditure on Financial Assistance for Carers, 1972-73 to 2020-21



Note: RHA is right hand axis

²² In 1991, the eligibility criterion was extended to include severely handicapped people in receipt of any income support payment. This criterion was further widened in 1996, when the Carer Pension became payable even where the person receiving care was not receiving a security payment.



It is evident here that the past decade, and particularly the past five years, have been a period of relatively modest growth compared to the preceding two decades.

The Commonwealth introduced the Domiciliary Nursing Care Benefit in 1972 at the same time as the Wife's allowance was phased out. The benefit was designed to support those carers who had responsibility for the provision, in their home, of the professional nursing care and supportive services required by an older relative on a continuing and regular basis. Through this benefit the Commonwealth sought to assist carers and to provide an incentive towards home care as an alternative to institutional care. The benefit was paid to the carer, with eligibility criteria applying to both the carer and the person they cared for. The statutory criteria for eligibility for the benefit were that the person being cared for had to be sufficiently ill or disabled to be approved for admission to a nursing home under the *National Health Act 1953*. A doctor's certificate was used to establish entitlement. The person being cared for also had to be at least sixty-five²³ and had to be related to the carer who received the benefit. Finally, the carer had to provide adequate nursing care of the person in the home in which both the person and the carer lived. A registered nurse had to certify that they visited at least twice weekly.

The rationale for the benefit was to provide assistance with the costs of home care for people who would otherwise be admitted to a nursing home. As the benefit was not intended to be an income support payment, no income or assets test was applied to it and it was not considered to be taxable income. Initially, the rate of the benefit was set at \$28 per fortnight. The rate was such that it provided a 25 per cent supplement to the income of a couple whose only income was from the Age Pension. The rate remained fixed until 1980, when it was increased to \$42 per fortnight. It then remained fixed again until 1993, when it was raised to \$52 per fortnight. After 1993, the rate was indexed annually by the CPI.

The real (CPI-adjusted) value of the financial assistance payment for carers was significantly eroded over time. Between, 1972-73 and 1998-99, the real value of the Domiciliary Nursing Care Benefit decreased by 60.8 per cent. The decline in value is even more marked when compared to the cost of long term institutional care. When the benefit was first introduced, its value was equivalent to 57.1% of the average Nursing Home Benefit. By 1998-99, its value was equivalent to 7.9% of the average Residential Care Subsidy and to around 5% of the average Australian Government subsidy paid for high level (nursing home) residential care. However, the other support programs that were by then available to carers and the people they care for must be taken into account in assessing the effect of this apparent decline. Through these programs, like the Home and Community Care Program and the National Respite for Carers Program, significant levels of additional support were now available to carers and the people for whom they cared.

In 1974, the Handicapped Child's Allowance of \$10 per week was introduced for parents or guardians caring for severely handicapped children under the age of 16 years who were at home and in need of constant care and attention on a permanent or long-term basis. The allowance was not taxable, nor was it subject to an income test. In 1977, eligibility for the Handicapped Child's Allowance was extended to persons caring for children who were substantially, rather than severely, handicapped. In 1987, the Handicapped Child's Allowance was replaced by the Child Disability Allowance. The new allowance was payable at the rate of \$144 per month.

At the time of the introduction of the Handicapped Child's Allowance, the amount of the allowance was slightly more than two-thirds (71.4%) of the amount of the Domiciliary Nursing Care Benefit. By contrast, the rate of the new Child Disability Allowance was equal to 171% of the rate of the Domiciliary Nursing Care

²³ From 1979, the lower age limit was reduced to sixteen.



Benefit. In 1998, the rate of the Domiciliary Nursing Care Benefit was aligned with the Child Disability Allowance. In 1999, the two payments were combined into the Carer Allowance. The rate of the Carer Allowance is indexed on 1 January each year in line with movements in the CPI.

When the Carer Allowance was first introduced (as the Domiciliary Nursing Care Benefit) its value was equivalent to:

- 25% of the income of a couple whose only income was from the Age Pension;
- 93% of the Australian Government Personal Care Subsidy payable in respect of a person in an approved Aged Person's Hostel;
- 57% of the Australian Government Basic Nursing Home Benefit payable in respect of a person in an approved Nursing Home; and
- 33% of the Australian Government Extensive Nursing Home Benefit payable in respect of a person in an approved Nursing Home and receiving extensive care.

The value of the Carer Allowance has significantly decreased in real time since its introduction and is currently equal to just:

- 10% of the income of a couple whose only income was from the Basic Age Pension;
- 6% of the average Australian Government Basic Care Subsidy payable in respect of a person in an approved Aged Care Home; and
- 1.5% of the average amount payable in respect of a person with a disability living in shared accommodation.

This is a significant decoupling of carer support from government's broader willingness to pay for formal care, or for income support at retirement. There is no coherent policy argument for this, and it appears manifestly unjust. This issue is discussed further below.



Some brief reflections on justice

Exogenous risk

The decision to provide informal care, as noted earlier, is based on a range of factors, including both financial and non-financial costs and incentives, as well as the presence or absence of alternatives. Evaluate acknowledges that this study is a somewhat utilitarian approach, seeking to understand financial impact as the mean, and does not deal with the human complexity of the decision to care.

At the same time, the challenge for governments, is to balance reasonable rewards for informal care with the broader goal of fiscal responsibility.

There is a particular problem here though, insofar as it is not just that the impact of caring is heterogeneous, but that from the carer's perspective, demand is strictly stochastic: while there may or may not be choices which ultimately contribute to the care recipient's needs, there is no decision in the potential carer's life which leads to demand for them to leave the workforce.

The consequence of this is that demand for carer payments is in the first instance exogenous to the person providing the care. While they are asked to make a decision as to whether or not they should make the sacrifices required to become carers, the actual demand is independent of that decision.

In turn, this means that the principal beneficiaries of the current regime of carer subsidies are respectively:

- The recipient of care, who is the source of demand; and
- Government, which is able to pay a substantially discounted rate for the care provided.

The nature of demand here means carer subsidies should be conceived of quite differently from other welfare payments. In particular: this is nothing like a work-leisure trade-off which is imagined to drive some demand for unemployment and associated benefits; and at their current levels, carer subsidies provide no incentive to reject paid work.

These observations are central to Evaluate's view that the current prices of carer subsidies are simply unjust, and more closely resemble penalties than incentives. Because demand is randomly allocated, and choice is constrained by supply gaps,²⁴ the fiscal motive is being unjustly pursued without proper regard to its impact on those called to care.

To draw an analogy, this is in practice equivalent to determining individual tax imposts by lottery, presenting some Australians with much greater demands on their income than others, and ignoring the individual impacts of such a policy. This is particularly at odds with how care is funded via government funding of formal providers, whether residential, ambulatory, or through the Medicare Benefits Schedule.

Funding Drift

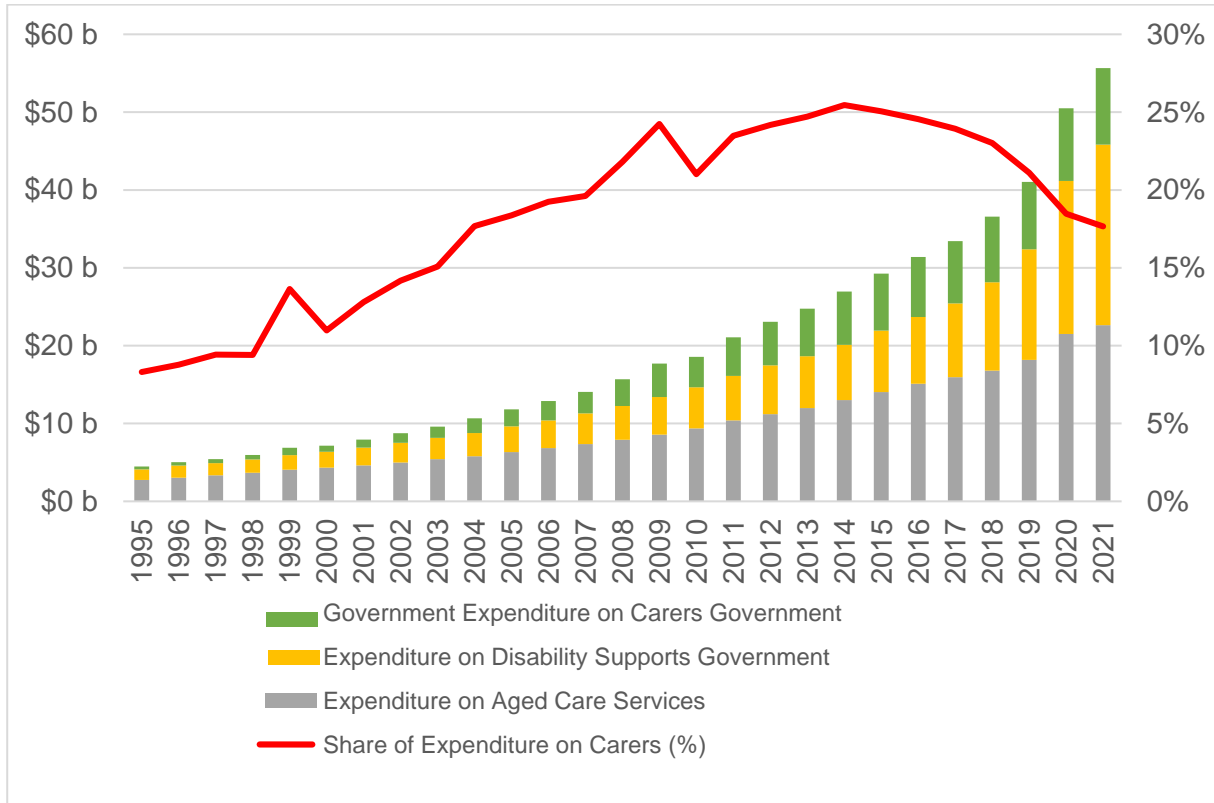
The injustice described above is exacerbated by what Evaluate would term 'funding drift'. While there has been a substantial growth in government expenditure on care over recent years, this has been predominantly consumed in the formal care sector, without improving the lot of informal carers at the same rate. This section illustrates some of the changes in funding over time discussed earlier.

²⁴ See for example: <https://www.australianageingagenda.com.au/research/research-points-to-local-solutions-for-aged-care-workforce-shortages/> Accessed November 2021.



While prior figures have shown how expenditure has grown over time, it is also instructive to look at how it has fared compared to investments in formal care services. The following chart illustrates this issue, showing how government expenditure on care has grown in recent decades, while the share allocated to informal care has fallen:

Figure 3: Government expenditure on care: 1995-2021

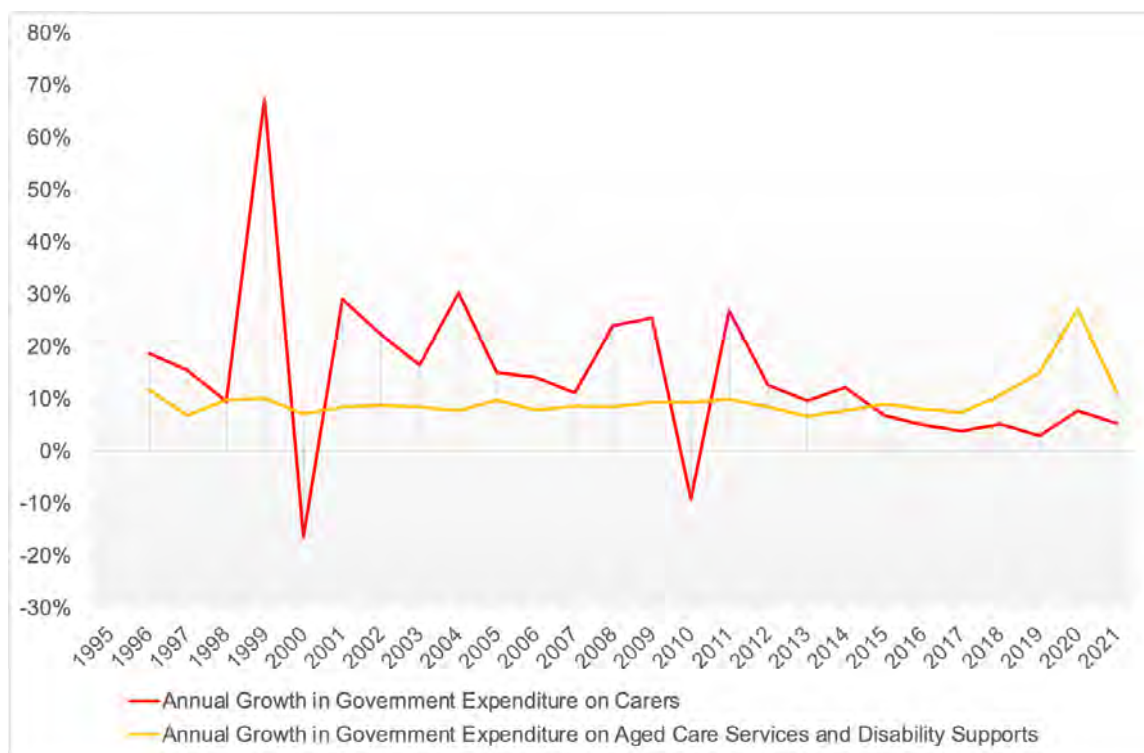


The red line illustrates how carers' income as a share of government expenditure has fallen since a peak in 2014. While this suggests an increase in the efficiency of informal care from the government's perspective, it should also lead to long-term inefficiency in the allocation of funding: where the rewards for caring are reduced, the opportunity cost of care increases, and fewer prospective informal carers will be willing to meet demand.

The consequence of this is an increase in demand for substantially more expensive formal care, including residential care. This means that reducing the share of funding for informal care is a false saving. This issue is further illustrated in Figure 4.

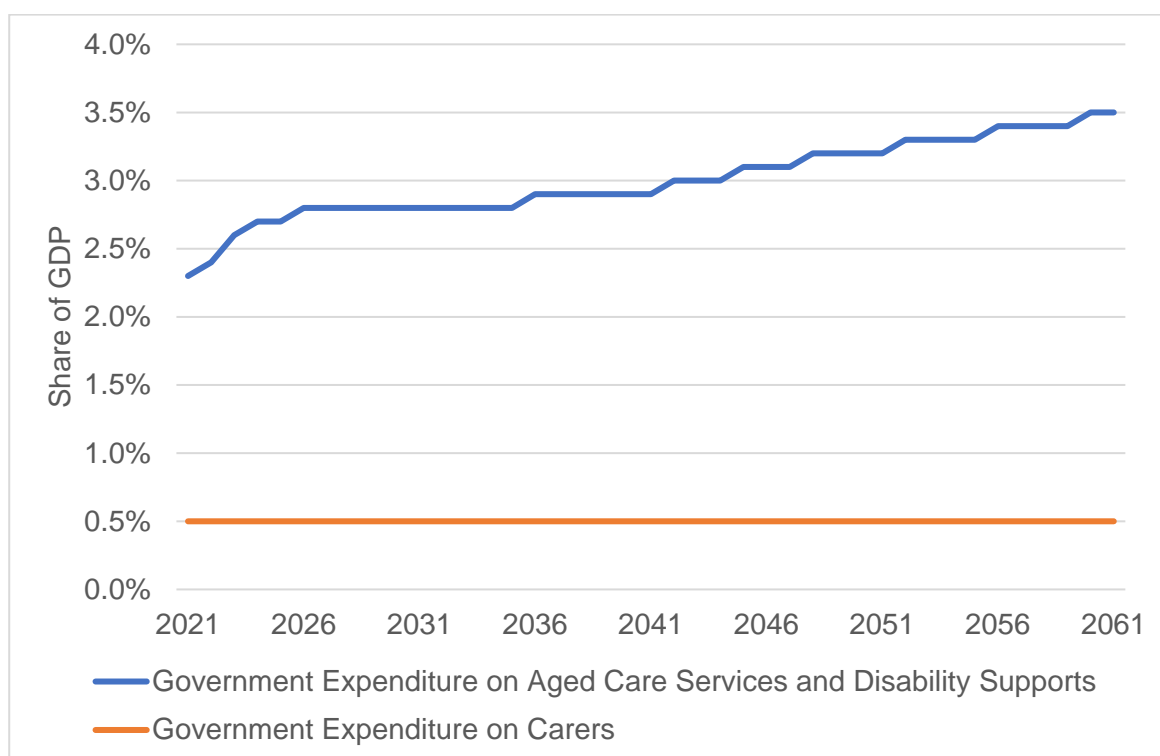


Figure 4: Growth in carer support v. overall public investment in carer income support since 1995



It is not clear whether the turn in 2014 is a deliberate government policy, but its efficiency must be questioned. Of particular concern is that the growth in care expenditure as a percentage of GDP is not intended to be reflected in any rate of growth on informal care expenditure over the next four decades:

Figure 5: Expected growth in care and carer funding to 2061



This flatline projection in forward estimates, maintaining informal care supplements at 0.5% of GDP again increases the perceived efficiency of informal care at the cost of overall efficiency in the care system.



Theoretical considerations

Dealing with heterogeneity

Because the model presented in this paper focuses strictly on the financial impacts of a decision to provide (or not provide) informal care, there are essentially five forms of heterogeneity present for those presented with that decision. These are:

- The age at which a person is first presented with demand for informal care;
- The duration over which care is provided;
- The gender of the person (as Australian incomes are unevenly distributed);
- Future work patterns after care;
- The current and expected future income of the person (so what is foregone); and
- What other resources (wealth) the potential carer may have to defray the impact of income losses.

A number of observations are made on each of these. However, as a preliminary note, Evaluate has only looked at informal care demand which reduces capacity to work: while there are many more carers who will provide informal care on weekends or during evenings while otherwise working, this group is not bearing the financial opportunity cost of care to the same extent, and any benefits will be significantly affected by income testing.

First, the age at which a person first becomes a carer has two significant impacts. One is that – as with any age – it is an interruption to career progress. However, the earlier this interruption occurs, the more significant the lifetime impact in terms of income, as the carer will always be one step behind their expected uninterrupted or ‘normal’ career trajectory. The cumulative effect of this is that total lifetime income will be reduced not only by the cost of the career break, but by an ongoing discount against all future work.

The associated issue is that as the value of superannuation payments are subject to compound interest or other compounding market factors, loss of any superannuation contributions at an earlier age will have a more significant impact at the point of retirement.

Consequently, the model looks principally at lifetime income and superannuation effects depending on age called to care for an extensive range of age cohorts across normal working life, up to age 65.

Duration of care provided further compounds these effects. The longer the interruption, the more income which may be immediately foregone, but equally the greater the discount to future earnings compared to a normal trajectory. Similarly, the longer the interruption, the more profound the impact on retirement savings due to longer periods without superannuation contribution.

Accordingly, the model contains an observed distribution of care duration for each age group, from brief calls to care, through to the remainder of a person’s working life. On this, Evaluate assumes that expected duration of care is not a factor affecting decision to care per se: the argument here is that for any individual prospective carer, there is a frequent decision not only as to whether to initially provide care, but whether to continue in that role.



With respect to gender, for each age group, the model has two streams: one female and one male. This is not simply relevant to income, but also has implications for future work patterns.

The issue of future work patterns is particularly important. While at the mean, the decision to care is typically accompanied by a significant financial loss, this is unevenly distributed. Accordingly, there is a distribution in the model where those who care and then cease providing informal care, follow a range of trajectories. These are based on observed patterns of employment, and take into account that for some who choose not to meet the demand for informal care, they may in any case face significant periods of unemployment.

A consequence of this is that across the total distribution, there are some people who, despite the immediate cost of care, may be better off in the long term, as caring is a better financial outcome than unanticipated unemployment.

The current and expected future income are what is fundamentally at stake in the decision to provide care, or to reject the call. This financial fulcrum leads to highly asymmetric impacts, which can be illustrated by considering three different examples:

- An extensively educated and highly-remunerated mid-career professional who would be making a very substantial financial sacrifice in order to leave work and provide informal care;
- An unskilled worker at any career stage whose financial loss from agreeing to informal care would be much smaller; and
- An early retiree or long-term unemployed person, whose trade-off is predominantly the opportunity cost of leisure, rather than any measurable financial impact.

The impact of these differential effects on the individual care decision with respect to prevailing prices of informal care is discussed later in this paper: but within the model there is again a very broad distribution of potential sacrifices to be considered.

It is presumed that - *ceteris paribus* with respect to other costs and benefits of care – those who face a lower financial opportunity cost in terms of both income and retirement savings are more likely to meet demand for informal care. Returning here to the question of justice, this would suggest a compounding effect on persons living in lower socio-economic circumstances, which for those individuals, would be a peculiar form of intergenerational burden. Given that some care demand – particularly that stemming from certain chronic diseases – is asymmetrically distributed, this will also compound the financial impact on poorer Australians.

Finally, there is the question of other resources (wealth) which may affect the care decision. While this is acknowledged, it is not included in the model, though it will have some impact on means testing and income testing (the latter due to investment yield).

The individual decision to care

The model described above provides an extensive simulation of the impact of agreeing to care, but does not fully answer the question about how people address that financial impact. As noted, the cost of caring is highly asymmetric, despite means- and income-testing. This asymmetry is illustrated in extensive detail in the model appended to this report.

Focusing on these costs, and the individual decision to provide or not provide informal care in the face of such economic sacrifice, takes us away from the replacement cost approach, toward a focus on opportunity cost.



Opportunity cost itself is a measure of the relative injustice accorded to informal carers, who bear these losses (foregone income and retirement benefits) directly, but it is not a complete story. As discussed, a comprehensive analysis of the costs and benefits of caring need to take into account other factors, such as carers' health, and the vicarious utility carers may receive from improvements in the health and happiness of those for whom they care.

This then brings us to the contingent valuation approach, which argues that the proper valuation of informal care lies subjectively with actual and prospective informal caregivers. The questions to be asked respectively:

- At what price are informal caregivers willing to accept the responsibility to care for a loved one?; and
- Conversely, what are informal carers willing to pay in order to purchase services which obviate demand for their care services?

These 'willingness to accept' (WTA) and 'willingness to pay' (WTP) measures implicitly capture all the non-financial dimensions of the care equation, as discounts and multipliers.

For our purposes, the WTA measure is the important one, but in any case, the most compelling recent research suggests that WTA and WTP are at close to parity.²⁵ This is an important observation, because unlike formal care, informal care is not provided on a limited-hours basis: when assessing their own WTP for a marginal hour's reduction in care provided, carers will take into account the total cost of providing care (WTA) and the continuous demand on their time.

Importantly, this continuous demand aspect of informal care strongly argues that the correct comparator in a replacement cost sense is not episodic ambulatory care, but comprehensive residential care. The key to this argument is the recognition that while informal carers may not be constantly providing direct care, they are nonetheless constantly available.

Three measures and three elastic bands

All of this leads us to three measures for the valuation of informal care with respect to an individual or average carer. These are variously:

1. The replacement cost for continuous informal care, which is what may be saved if one more care recipient can be cared for at home. This is the alternative price of residential care. Importantly, this is not a basis for aggregating the total value of informal care currently provided, but is the basis for potential savings from an increase in the rate at which those called to provide informal care meet that demand;
2. Opportunity cost, which is the principal study of this paper and its associated model, expressed in terms of income and retirement savings foregone. This permits discussion on how much would need to be spent to improve the short- and long-term lots of individual carers; and
3. Contingent valuation, which is the individual or average carer's WTA price.

Each of these is used in the following calculations. The last is the most challenging, as it requires a detailed survey of the preferences of actual and potential carers, which is not currently available. However, there are useful indicative factors in the available literature.

²⁵ Bernard van den Berg et al, "The economic value of informal care: a study of informal caregivers' and patients' willingness to pay and willingness to accept for informal care", *Health Economics*, 2005 (14).



The WTA price is most important because it allows for analysis of comparative government funding, to derive some measure of elasticity: this is done by looking at how increases in carer funding – and conversely reductions in the nett impact of caring – affect the rate at which prospective carers will meet care demand.

This is not a well-studied phenomenon. However, a compelling survey-based study from 2010 observes two elasticities, viz.:²⁶

1. A wage-elasticity of informal care for men at -1.8, which means that a 10% increase in available wages would lead to an 18% reduction in the provision of informal care by men; and
2. A much greater wage-elasticity of -3.6 for women, which means that a 10% increase in wages would lead to a 36% reduction in informal care provision by women.

The counter-hypothesis which may be made here is that a 10% reduction in wages should shift the dial in the other direction, increasing willingness to provide care by a similar margin. Accordingly, an increase in carer subsidies by the equivalent of 10% of mean wages should have the same effect, as it reduces income foregone by the same amount.

These calculations are based on data from the Health and Retirement Study carried out at the University of Michigan.²⁷ This is a longitudinal study of 20,000 Americans, who act in an economy with very different wage structures, health protections and alternative care prices compared to Australia. Consequently, rather than importing these factors to Australia, Evaluate's main conclusion are that it is reasonable to assert both:

- A substantial negative wage elasticity for informal care provision; and
- Translating this to our data, a substantial positive elasticity for reductions in income foregone, through increases in carer subsidies.

In particular, it is reasonable to assume that an expected elasticity of 0.67 will prevail with respect to modest changes in carer income.

Of course, elasticity for any population only occurs at the mean. While demand for care is fairly randomly distributed across the population, as noted above potential carers may have radically different circumstances. We might describe three different bands of elasticity, where changes in potential subsidies have different levels of incentive effect, due to their variation as percentages of income foregone:

1. Potential carers who are retired or otherwise expect extensive periods of unemployment, for whom any increase in subsidy is effectively a windfall, and will not affect supply;
2. Those at the mean, who make marginal decisions on price as to whether they will meet demand for informal care; and
3. Those with higher incomes whose willingness to supply care is not elastic to small percentage changes in prospective income foregone, but more likely dependent on non-financial factors.

This means in turn that there is one group who will supply regardless of an increase in the carer subsidy, because it is not defraying income foregone, and another group for whom such increases will not increase supply.

²⁶ Olena Y Nizalova, "The wage elasticity of informal care supply: Evidence from the health and retirement study", Institute of Labor Economics: IZA Discussion Paper No. 5192, 2010

²⁷ <https://hrs.isr.umich.edu/about> Accessed November 2021.



On the initial group, some policymakers may see any increase in funding as waste, as it has no incentive effect. In the first instance, this ignores any questions about justice, and also ignores how much more efficient that informal care is compared to the alternative price of formal care. There will still be savings, even if informal care prices are substantially increased.

On the latter, while there is no cost, there is also no effect.

However, at the mean of this distribution, the expected elasticity is sufficient that significant changes to carer payments may be made in a way that is close to fiscally neutral. This is central to the policy options discussed further below.



Micro simulation results

Evaluate estimates that, on average, a primary carer will, as a result of their decision to become a primary carer, face a real reduction in their lifetime earnings during their working life of about \$393,000 and a real reduction in their superannuation balance at age 67 of about \$175,000 (see Table 1 below).

Table 1: Financial Impact of Decision to become a Primary Carer

	Average	10th percentile	25th percentile	Median	75th percentile	90th percentile
Impact on superannuation balance at age 67	-\$175,500	-\$444,500	-\$216,000	-\$90,500	-\$39,000	-\$19,000
Impact on lifetime earnings to age 67	-\$392,500	-\$940,000	-\$497,500	-\$233,000	-\$107,500	-\$48,500

This is based on a comprehensive microsimulation which considers the impact of informal care demand for 10,000 Australians, taking into account:

- An observed distribution of different ages when a person is first called to care, between 18 and 65;
- Different pathways and impacts for male and female carers;
- The decision to care or not to care;
- An observed distribution of care durations; and
- An observed distribution of alternative economic pathways for individuals, whether or not they choose to care.

The impact of becoming a primary carer is highly variable (see 6 and 7). For a given gender and age, it is primarily determined by the carer’s annual income and superannuation balance at the time that they become a primary carer, and by the length of time that they remain a primary carer. A quarter of people who become primary carers will face a real reduction in lifetime earnings of more than \$497,500 and a real reduction in their superannuation balance at age 67 of more than \$216,000. One in ten people who become primary carers will face a real reduction in lifetime earnings of more than \$940,000 and a real reduction in their superannuation balance at age 67 of more than \$424,500.



Figure 6: NPV Impact on Superannuation Balance at Age 67

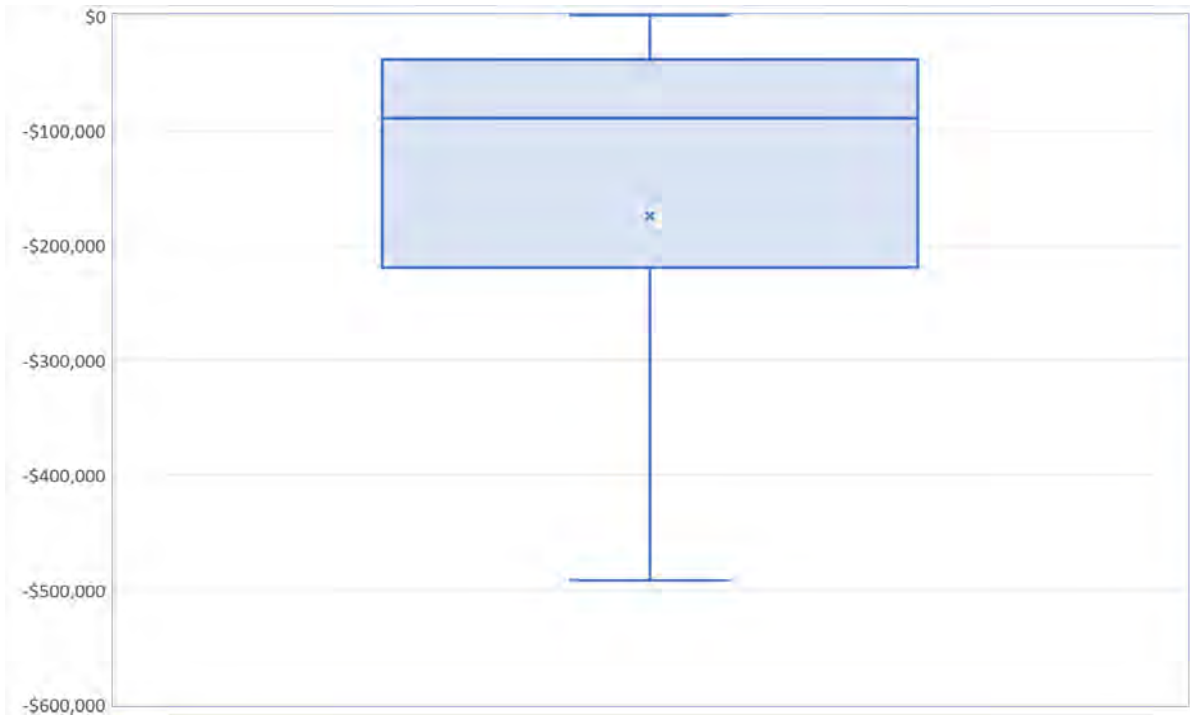


Figure 7: NPV Impact on Lifetime Income to Age 67

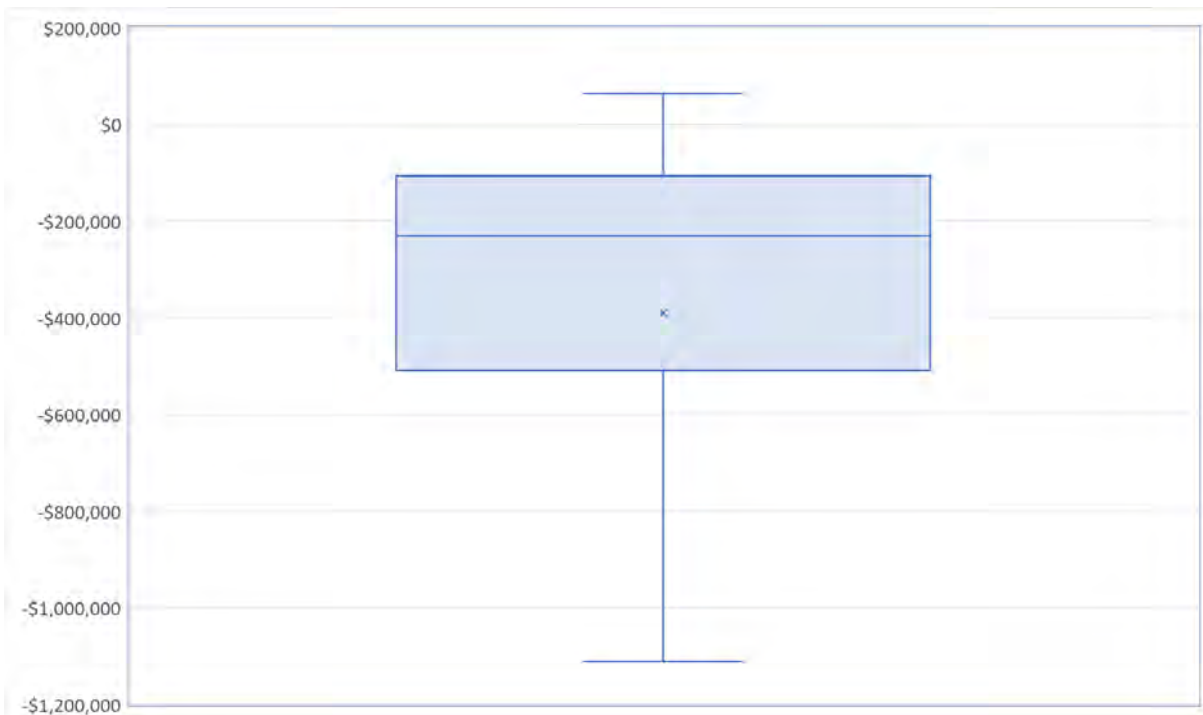


Table 2 sets out the results of a regression analysis that illustrates how the impact of becoming an informal carer on the superannuation balances at age 67 depends on their gender, the age at which they become an informal carer, the number of years for which they are an informal carer and their annual income at the time they become a primary carer. Table 3 similarly sets out the results of a regression analysis that illustrates how the impact of becoming an informal carer on the lifetime income to age 67 also depends on their gender, the age at which they become an informal carer, the number of years for which they are an informal carer and their annual income at the time they become a primary carer.



Table 2: Regression analysis of the impact of caring on superannuation balances at age 67

Multiple R	0.80
R Square	0.64
Adjusted R Square	0.64
Standard Error	135361
Observations	10000

	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>Significance F</i>
Regression	4	3.26E+14	8.16E+13	4451.876	0
Residual	9995	1.83E+14	1.83E+10		
Total	10000	5.09E+14			

	<i>Coefficients</i>	<i>Standard Error</i>	<i>t Stat</i>	<i>P-value</i>
Intercept	-629,338	7466.408	-84.2892	0
Gender	-117,022	4581.866	-25.5403	0
Age	12,435.3	126.2012	98.53548	0
Years caring	-17,717.6	252.2476	-70.2388	0
Income pre caring	0.312324	0.113425	2.75357	0.0059

Table 3: Regression analysis of the impact of caring on lifetime income to age 67

<i>Regression Statistics</i>	
Multiple R	0.78
R Square	0.62
Adjusted R Square	0.62
Standard Error	285,914.4
Observations	10001

	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>Significance F</i>
Regression	4	1.31E+15	3.28E+14	4011.161	0
Residual	9995	8.17E+14	8.17E+10		
Total	10000	2.13E+15			

	<i>Coefficients</i>	<i>Standard Error</i>	<i>t Stat</i>	<i>P-value</i>
Intercept	-822,151	15770.81	-52.1312	0
Gender	-253,613	9677.979	-26.2052	0
Age	21,899.79	266.5667	82.15502	0
Years caring	-39,636.3	532.8063	-74.3915	0
Income pre caring	-3.84224	0.239581	-16.0374	0



On average, the superannuation balance at age 67 of a person who becomes a primary carer is reduced by about \$17,700 for every year that they are a primary carer. Similarly, their lifetime earnings are reduced by \$39,600 for every year that they are a primary carer. The results are every different for men and women, reflecting their differing annual incomes and superannuation balances at the time they typically become a primary carer. On average, men who become primary carers will have their superannuation balance at age 67 reduced by about \$117,000 more than women who become primary carers. Similarly, their lifetime earnings to age 67 are reduced by about \$254,000 more than women who become primary carers. In the main, this is a function of both gender-based wage disparity and gender-based work patterns in Australia.

The coefficient of the age variable is positive and significant in both regressions. In other words, the younger a person becomes a primary carer the greater the impact that their caring will have on both their superannuation balance at age 67 and their lifetime earnings to age 67. On average, a person who becomes a primary carer at the age of 35, say, and who then remains a primary carer for the same number of years as a person who becomes a primary carer at age 45, will have a superannuation balance at age 67 that is \$124,400 lower than the other primary carer. While a person at 45 is likely to forego more immediate income than a person at 35, the more significant factor here is the loss of early superannuation, which means foregoing substantial growth in retirement assets.

The level of a person's income before they become an informal carer also has a statistically significant effect on the impact of becoming a personal carer on superannuation balances at age 67 and lifetime incomes to age 67. Not surprisingly, the higher paid a person is before they become a primary carer the larger the impact that the caring will have on their superannuation balances at age 67 and lifetime incomes to age 67.

Any reduction in superannuation balance at age 67 can have flow on impacts of government expenditure in retirement. Indeed, depending on the other assets and income held by the individual, a reduction in superannuation balance at age 67 of \$175,000 would increase eligibility for age pension by about \$20,400 per year. Given that life expectancy at age 67 is currently 20.5 years (weighted for the gender balance of the population of informal carers), this equates to an average lifetime increase in expenditure by the Australian Government on the Age Pension for each primary carer of about \$279,500.



Potential policy solutions

Policy Option 1 – Government pays Superannuation Guarantee Contribution on the Carer Payment

This scenario examines the impact of the Government paying into the superannuation accounts of primary carers based on the amount of Carer Payment that they receive.

Against current policy, this change would have a significant impact on the superannuation balances of primary carers at age 67. On average, the policy would increase those superannuation balances by about \$52,500. For one in four primary carers it would increase their superannuation balance at age 67 by more than \$66,000. For one in ten carers it would increase their superannuation balance at age 67 by more than \$122,500 (see 4).

Table 4: Impact of Policy Option 1 – Superannuation on Carer Payment

	Average	10th percentile	25th percentile	Median	75th percentile	90th percentile
Impact on superannuation balance at age 67	\$52,500	\$8,000	\$14,500	\$30,500	\$66,000	\$122,500

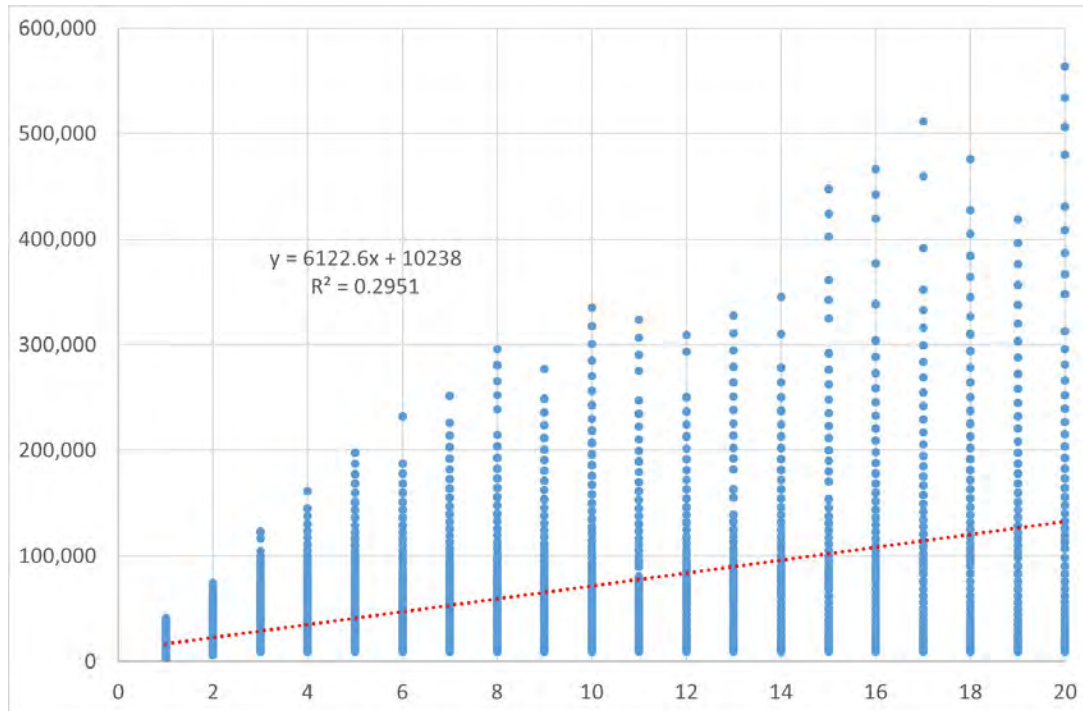
Based on the 2021 budget,²⁸ for the 2022-23 financial year, given an expected total expenditure on the Carer Payment of \$6.780 billion, and at an SGC rate of 10.5%, the first-year cost of this measure would be \$711.9 million. While this is not insignificant, it pales next to projected expenditure increases for formal care services. Per the discussion below, on a lifetime cost basis, there is an actual saving from this measure.

On average, this change in policy would close the superannuation deficit that arises from making the decision to become a primary carer by about 37%. Moreover, as Figure 8 shows, the impact of the policy increases in relative as well as absolute terms the longer a person is a primary carer. Of course, in absolute terms the increase in the superannuation balance because of this policy change would be much higher for those who cared for longer. The regression analysis reported above, showed that, on average, each year of caring reduced the superannuation balance at age 67 by \$17,800. A person who cared for one year would have a superannuation balance at age 67 that was \$7,200 higher than it would otherwise be as a result of this policy (which would offset 27.8% of the loss in superannuation that they suffered because they became a carer). A person who was a carer for twenty years would on average have a superannuation balance at age 67 that was \$99,000 higher than it would otherwise be as a result of this policy (which would offset 40.7% of the loss in superannuation that they suffered because they became a carer).

²⁸ <https://www.dss.gov.au/about-the-department/publications-articles/corporate-publications/budget-and-additional-estimates-statements-budget-2020-21/portfolio-budget-statements-2020-21-budget-related-paper-no-112> Accessed November 2021.



Figure 8: Relative Impact on Superannuation Balance of Policy Option 1, \$ by Years of Caring



As noted above, any change in the superannuation balance at age 67 has a potential impact on the amount of age pension for which a person can be eligible. Increasing a superannuation balance at age 67 by about \$52,500 has the potential to reduce age pension costs to the Commonwealth over the person's remaining lifetime by up to \$84,000. This is significantly more than the costs of paying superannuation on Carer Payments, which would cost the Commonwealth only \$18,000 over the carer's lifetime.

While it is true that for many carers the age pension savings that would be realised because of the increase in the superannuation balance would be less than the maximum possible of \$84,000 (because those carers have other income and assets at retirement) it is most likely true (given that 66.7% of age pension are in recipient of the full age pension and that only 14.7% of age pensioners have their pension entitlement determined by the assets test) that the savings in age pension generated by the higher superannuation balances would on average more than offset the additional expenditure by the Commonwealth on superannuation contributions.

Policy Option 2 – Increase the Carer Allowance

This scenario examines the impact of the Government increasing the level of Carer Allowance. This change lever has been chosen in preference to an increase in the Carer Payment because the Carer Payment is an income support payment and its settings align with other income support payments. The Carer Allowance, on the other hand, is intended to compensate the primary carer for the financial impact of the decision to be a carer and so is the appropriate policy instrument to adjust that compensation.

In this regard, it should be noted (as discussed above) that when the Carer Allowance was first introduced (as the Domiciliary Nursing Care Benefit) its value was equivalent to:

- 25% of the income of a couple whose only income was from the Age Pension;
- 93% of the Australian Government Personal Care Subsidy payable in respect of a person in an approved aged person's hostel;



- 57% of the Australian Government Basic Nursing Home Benefit payable in respect of a person in an approved Nursing Home; and
- 33% of the Australian Government Extensive Nursing Home Benefit payable in respect of a person in an approved nursing home and receiving extensive care.

The amount of the Carer Allowance is currently equal to just:

- 10% of the income of a couple whose only income was from the Basic Age Pension; and
- 6% of the average Australian Government Basic Care Subsidy payable in respect of a person in an approved Aged Care Home; and
- 1.5% of the average amount payable in respect of a person with a disability living in shared accommodation.

The following policy option is considered in this scenario:

- Increasing the Carer Allowance by 150% for those who are in receipt of the Carer Allowance but not the Carer Payment to return its relativity to 25% of the income of a couple whose only income was from the Basic Age Pension; and
- Increasing the Carer Allowance by 475% for those who are in receipt of the Carer Payment to return its relativity to 33% of the average Australian Government Basic Care Subsidy payable in respect of a person in an approved Aged Care Home. This would acknowledge the need for high-intensity care.

The impact of these possible changes on the lifetime earnings of primary carers at age 67 are set out in Table 5 in absolute terms.

Table 5: Impact of Policy Option 2 – Increase the Carer Allowance

	Average	10th percentile	25th percentile	Median	75th percentile	90th percentile
Impact on lifetime earnings to age 67 of a 150% increase in the Carer Allowance	\$31,500	\$5,000	\$10,500	\$25,500	\$46,500	\$67,000

On average, increasing the Carer Allowance by 475% would offset 31.0% of the loss in lifetime income to age 67 that a primary carer would face as a result of the decision to become a primary carer. Moreover, one in four primary carers would recover more than 55% of the loss in lifetime income to age 67 that they would face because they became a primary carer.

Alternatively, increasing the Carer Allowance by 150% would only offset 9.6% of the loss in lifetime income to age 67 that a primary carer experiences. Only one in ten primary carers would recover more than 25% of the loss in lifetime income to age 67 that they would face because they became a primary carer.

The direct costs of increasing the Carer Allowance in the first year from the 2022-23 estimate of \$2.445 billion²⁹ (noting that 48% of Carer Allowance recipients receive the Carer Payment) would be:

- \$1.907 billion for a 150% increase in the Carer Allowance to return it to parity with 25% of a couple’s basic age pension, for those who are in receipt of the Carer Allowance but not the Carer Payment; and

²⁹ Ibid., combination of Adult and Child Carer Allowance budgets.



- \$5.575 billion for a 475% increase in the Carer Allowance to return it to parity with 33% of the formal care price for an aged care resident, for those who are in receipt of the Carer Payment.

These are certainly expensive options, though they have the effect of reinstating some measure of relationship between carer subsidies and other pensions and care expenditure. While they are far from complete, either would significantly assist in reducing the financial burden which is randomly and exogenously allocated to those called to care.

Finally, the expenditure projected above is not entirely incremental, because as carer income increases, more people presented with demand for informal care will choose to provide that care.

Given the elasticities of demand discussed above it is likely that the number of people willing to be primary carers would increase as a result of the increase in the Carer Allowance. If we use a low wage-elasticity supply for care of 0.67, this will increase the number of carers who would qualify as Carer Payment recipients by 16.8% and of carers who only qualify for the Care Allowance by 5.3%.

This would in turn lead to:

- An increase of \$9.925 billion in overall expenditure, including the 475% and 150% increases for existing carers; but
- Savings from new informal carers in lieu of replacement formal care of \$4.569 billion;
- Meaning that the nett cost of these measures would be \$5.357 billion.

This is assuming a much lower wage-elasticity rate than that recorded in the literature. Evaluate has selected a low nominal rate because of the observed heterogeneity discussed at length above. While much higher elasticities are observed from survey of existing carers, it is likely that those currently choosing not to care are less responsive to changes in relative wages.

If however we were to use the male lower bound observed elasticity of 1.8 then the increase in carers would be 45.4% for Carer Payment recipients and 14.3% for Carer Allowance only recipients.

The consequence of this would be a net cost of these measures of only \$1.744 billion.

Finally, following the observation that 71.8% of carers are female, then a weighted average of the lower elasticity bounds of 1.8 for males and 3.6 for females gives us a figure of 3.09.

If this were to prevail, then we could expect the increase in carers to be 77.9% and 24.6% respectively. This would in turn provide net savings of \$2.369 billion.



Table 6: Summary of Sensitivity testing of Policy Option 2 – Increase the Carer Allowance

Average Income forgone because of caring	\$392,500			
Average Income returned by measure	\$99,000			
Share returned	25.2%			
Assumed Elasticity of Supply	67%	100%	180%	309%
Impact on Supply of Carer Payment Recipients	16.8%	25.2%	45.4%	77.9%
Impact on Supply of Carer Allowance only Recipients	5.3%	8.0%	14.3%	24.6%
Current 2022-23 Estimate				
Carer Payment	\$6.8b	\$6.8b	\$6.8b	\$6.8b
Carer Allowance paid to Carer Payment recipients	\$1.2b	\$1.2b	\$1.2b	\$1.2b
Carer Allowance paid to other carers	\$1.3b	\$1.3b	\$1.3b	\$1.3b
Extra Payments to existing recipients of payments				
Carer Payment	-	-	-	-
Carer Allowance paid to Carer Payment recipients	\$5.575b	\$5.575b	\$5.575b	\$5.575b
Carer Allowance paid to other carers	\$1.907b	\$1.907b	\$1.907b	\$1.907b
Payments to new Carers attracted by higher payments				
Carer Payment	\$1.140b	\$1.710b	\$3.078b	\$5.284b
Carer Allowance paid to Carer Payment recipients	\$1.135b	\$1.702b	\$3.064b	\$5.259b
Carer Allowance paid to other carers	\$0.169b	\$0.253b	\$0.456b	\$0.782b
Total new payments to carers	\$9.925b	\$11.147b	\$14.079b	\$18.808b
Direct services replaced by new Carers	\$4.569b	\$6.853b	\$12.336b	\$21.176b
NET COST TO GOVERNMENT	\$5.357b	\$4.294b	\$1.744b	-\$2.369b
MEMORANDUM ITEMS				
Direct services replaced by all carers	\$46.745b	\$49.029b	\$54.512b	\$63.353b
Total Payments to Carers	\$19.150b	\$20.372b	\$23.304b	\$28.033b



Further Calculations

The model which underpins this paper is a functional microsimulation which can produce alternative selected data, and can test the impact of other funding measures on both lifetime income and superannuation effects.

As examples:

- If there is a concern about the impact on a particular cohort, e.g. women between the ages of 45-55, parameter-specific impact data can be produced; or
- If there is interest in testing the adjustment another element of carer subsidies, or using a different multiplier on the Carer Allowance, this can equally be produced by the current model.

Similarly, changes in eligibility rules or other regulations can be modelled, by translating them into financial impacts and their distributions.

As a standard measure, the model should be updated as actual policy measures are implemented, or adjustments are made to prices, e.g. for annualised CPI increases.



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