British Actuarial Journal, Vol. 20, part 1, pp. 209–224. © Institute and Faculty of Actuaries 2015
doi:10.1017/S135732171400021X

Long-term care: a review of global funding

Abstract of the Edinburgh Discussion

[Institute and Faculty of Actuaries, Sessional Research Event, 17 March 2014]

Contact
Sue Elliott, F.I.A., E-mail: susan.elliott@metlife.uk.com

This abstract relates to the following paper: Elliott S. Long-term care: a review of global funding. *British Actuarial Journal*, doi: 10.1017/S1357321714000300

The Chairman (Mr P. L. Gatenby, F.I.A.): The paper has been on the profession's website for the last week, so I hope you have read and digested it.

We have two of the authors with us, Ms Sue Elliott and Mr Stephen "Hamish" Wilson. They are both going to give short presentations on some of the aspects of the paper.

I have been working in long-term care off and on for about 25 years. Initially, I did some work as a consulting actuary, which resulted in developing a product for Commercial Union. Then, during the 1990s, I was the chief actuary of a company called PPP Lifetime, which became the leading provider of pre-funded long-term care insurance products in the UK. Now I sit on a group called "Pensions and Long-Term Care". We have a separate research group in the profession at the moment, looking particularly at how to link long-term care with pensions.

Maybe not quite so much in Scotland, but in the rest of the UK, politicians have been talking about the funding of long-term care off and on during those 25 years. We had a Health Select Committee enquiry in the mid-1990s. We had a Royal Commission in the later 1990s. Nothing much happened after either of those events. We had the Dilnot Commission a few years ago. There is a little action now. Still, Scotland apart, in the UK there is not much at this stage that is going to help people to fund for their care.

Maybe the one thing that we will have at last is some political clarity – that is, the state is not going to do much for you unless you end up needing care for a long, long time.

Out of the major countries in the world, we seem to be the furthest behind by a long way in terms of our politicians, our government and our political process seriously looking at the issue and coming up with solutions that work.

I should like to start by handing over to Ms Sue Elliott who has also been working in long-term care, off and on, for probably at least 25 years on both sides of the Atlantic.

Ms S. D. Elliott, FSA, FCIA, F.I.A. (introducing the paper): The paper is the final version of an earlier working paper we presented on 22 October 2012, from that we took feedback and incorporated it into the final paper.

We looked at six countries: France, Germany, Japan, the Netherlands, the USA and the UK. We picked these countries because of their relative success in the long-term care insurance market. I use the term "relative" with France about a 15% market penetration and the USA just under 10% penetration. The UK has <1%. There are extremes on the public versus private partnership funding. For example, the Netherlands has about 100% public coverage. However, in the countries with public programmes, there are some sustainability issues that need to be considered. They potentially have to limit some of the benefits or pull back on them.

More detail is given in section 1 of our paper, the introduction.

I will cover briefly section 2 of the paper, a geographic overview looking at the demographics and changes in health and social care expenditure, and section 3 showing the country-specific results. I will then hand over to Mr Hamish Wilson, who will give an overview of the UK, including the devolved nations. Section 5 is the conclusion, including lessons learned. Then we will open up the floor to discussion.

For the geographic overview we covered six measures: the population projections (which are common), life expectancy trends, population pyramids, dependency ratios, social changes, and expenditure on healthcare and long-term care. I am going to focus on three of those areas.

Looking at the projected population aged 65 and over (figure 2 in the paper) between 2010 and 2050, Japan has the greatest proportion in 2010, and it also has the greatest growth going into 2050, almost doubling by then. In contrast, the USA has the lowest current population aged 65-plus and the lowest growth. The range is interesting: in 2010 it ranges from 13% to 23%, almost double, and in 2050 it ranges from 21% to 40%, which is quite a significant increase. Aged 85-plus is similar. Japan has the highest proportion and the USA has the lowest. The range goes from 2% to 8% for 2010, and 5% to 12% for 2050 – quite significant increases.

The population pyramids (figures 4–6 in the paper) show how the population ages. The top of the graph gets bigger as the baby boomers move up.

Japan has the most pronounced increase and has become quite top-heavy, which could be a major reason why they are ahead in public funding for long-term care.

We cannot quite figure out the USA's population pyramid. We have looked into the data, but it still appears strange that it has not shown the same pattern. It looks like the younger group is getting older.

The dependency ratio (figure 10 in the paper) is another way to look at how the population is ageing. It measures the population aged 65 relative to the working age population. We have looked at it from 1960 to 2011, and it has increased for all countries. The working population is having to support the elderly population much more.

Japan has seen the most significant increase, an increase from 9% in 1960 to 37% in 2008, which is just over four times. Again, the USA has shown the slowest growth.

The third section of the paper looks at country-specific results – the population growth, care systems (private and public) – and lessons learnt. Mr Wilson is going to cover the UK in more detail.

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press

The countries are all at various stages of their demand for long-term care, and at various stages of their development. As Mr Gatenby mentioned, the UK is quite a way behind some of the other countries. Some of them have attempted to put in some universal systems. They are having some problems and are having to cut back on some of their benefits, but at least they have made the decision to take it forward.

When I say the UK, I should say "England". Scotland has made attempts with its free personal care. The Dilnot Commission is only for England.

There have been varying degrees of public and private partnerships and co-operation between the two sectors.

In France there is a personalised autonomy allowance. Local tax provides about 70% of funding. Central tax and social insurance provides about 30%. That is funded through employers, social security contributions and general tax. They use a national scale for assessments, which is something that we are aiming for in the UK. It is for dependency only. "Hotel costs" are not covered. There is no means test but the benefit is reduced for high earners with a maximum reduction of 90%.

France has introduced a "solidarity day" where employees donate a day's wages once a year to fund their care. Another incentive for France is that cost sharing for families is an important element. Germany has universal social insurance with a private opt-out. The opt-out is for high earners (about €50,000 and above), civil servants and the self-employed.

The Netherlands also has a universal system funded by social insurance, with cash and in-kind benefits, and home and institutional care. In Japan they have several insurance schemes, including medical, pensions, unemployment, occupational, accident and long-term care. In Japan providing care and public assistance to the elderly is seen as a national responsibility, which is important for the success of the Japanese system. It is compulsory and there is no means test.

In the USA the primary funding is through Medicaid, which is the system of public welfare for the poor. It provides just under 40% of long-term care. The next highest one is out-of-pocket, and then Medicare, which is another social programme but provides limited amounts of long-term care funding. Private insurance penetration is just under 10%. The Medicaid programme is funded jointly between the federal and state governments, but the bias is towards institutional care, and it is means tested.

In England long-term care is means tested, but Scotland has gone further with free personal care.

In 2009 the split between public and private expenditure was 100% public coverage in the Netherlands and France, both provide 100% public coverage, but in France, the private coverage had increased to about 15%. The UK was about 60% publicly funded. The USA was just under 60% publicly funded and in Germany it was about 71%.

France has no partnership schemes. In Germany there is no partnership, but public and private systems do exist together. In Japan it is mainly a publicly funded system. In the Netherlands there is no partnership scheme.

The USA has tried partnership schemes. In the early 1990s, they started out with the dollar-for-dollar or time-based schemes. There are still some of those around in a few states. They developed a federal

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press

long-term care insurance programme in 2003 for federal employees, service members and some families. Most recently they developed the CLASS Act, or they tried to. In October 2011, however, it was declared to be actuarially unstable or unworkable. They were allowing people in with pre-existing conditions, and some of the things that were put into the scheme were creating anti-selection. It was not deemed to be financially stable and was formally repealed in January 2013.

In the UK currently there is no partnership, although we are hoping to have one as a result of the Dilnot report.

Long-term care expenditure is a very small percentage of healthcare expenditure. The Netherlands is the highest at 28% of budget. The USA has the lowest at 7% as they are used to buying private medical insurance there and, potentially, that is why they have been more successful.

The universal insurance schemes have had varying degrees of success for Germany, the Netherlands and Japan. The contributions for Germany are roughly split 50–50 between the employer and the employee. The Netherlands has had difficulties with their costs ballooning and there is debate now about limiting the services that are provided. In Japan it is seen as a national responsibility to fund care for the elderly. Contributions are split between general tax (45%), income-related contributions (45%) and a co-payment of 10%.

The schemes are all at varying degrees of their development and demand, but they all are suffering from various difficulties in sustainability. There are some common lessons that they have learnt: focusing on care in the individual's own home; integration between nursing care and social care; using a multi-disciplinary approach, especially with respect to assessments, which can lead to cost efficiencies; making sure the individual is at the centre; getting people out of hospital; and getting people into a care home, as appropriate.

One thing that came from Japan was having a care manager at the centre of things, developing a care plan and carrying it out.

The USA repealed the CLASS Act in January 2013 when they started to look at it in more detail. When looking at the Dilnot proposals, it is good that we are going through these investigations to find out more about what they are going to mean for us. There is a lesson to learn from the USA's attempts at partnership schemes.

That was a quick summary of what is happening with the other nations. I am going to hand over to Mr Wilson, who is going to focus on the UK, and specifically different areas within the UK.

Mr J. K. "Hamish" Wilson, F.F.A. (introducing the paper): As Ms Elliott said, I am going to run through the different regimes across the UK. We call it the national care lottery because it depends really where you live in the UK. And even within England, it depends where you live.

Currently, care is means tested. If you have assets worth over £24,000, you have to meet the costs of your care yourself. Crucially, your house is included in that asset test. For somebody with a long period in care it can pretty much wipe out all their assets if they have to sell their home to fund their care. If they have $<$£24,000, there starts to be state support and, dropping down to £14,000, there is full support from the state.

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press

Here in Scotland we have free personal care for over-65s and free nursing care for everybody. These are paid at local authority rates, so if you are in a care home and have a higher level of care than the local authority rates provide, then you need to top up the costs yourself.

There is also a national deferred payment system where you can release the equity in your house on a national scale. The local authority will fund costs of care above the free personal care and free nursing care, and then once the individual dies, the house assets are used to pay back the local authority.

In England, Dilnot reported in 2011 about the current English system and stated that it is not fit for purpose, needs reform, is unfair and depends on where you live. There is no national assessment, local authorities do things differently from each other, and information and advice about the type of care needed is poor.

For us working in the insurance and pensions industries, Dilnot pointed out that the availability of products was poor. Immediate needs annuities are the only products that are sold at the moment in the UK. If somebody moves into care they can pay a lump sum and the cost of providing that care will be paid out of the annuity. That can be bought on a deferred basis, which makes it slightly cheaper. It will start in between 1 and 5 years' time.

Dilnot recommended a £35,000 cap on care fees, and an increase in the means test threshold. It put much of the tail risk cost back on to the State.

Since then there has been a White Paper on social care funding, and the draft Care Bill. It has been announced that the Dilnot recommendations would be taken forward, although the cap would be £72,000 rather than £35,000. The £35,000 was based on 2010 costs and the £72,000 is based on 2016 costs.

In 2016, this is going to be introduced in England. The year before that, the national deferred payments scheme is also going to be introduced.

The changes in England include firstly for all people in residential care provision for them to pay a fixed amount of £12,000 towards their "hotel costs". The rationale for this is that if you were not in care there would be everyday living costs.

Then, depending on the local authority rates, there are between £30,000 and £40,000/annum care costs. This is what individuals will have to pay. The meter starts ticking towards their cap.

The means test threshold was raised up to £123,000, so if you do not own a house or other assets you may comfortably not hit the threshold. However, many houses, especially in the South of England, would be above that. So, many people will be paying the full amount as the meter starts going up towards the £72,000 cap.

Once the £72,000 is reached, in about three and a half years, the individual will spend probably more than £100,000 because of the hotel costs having to be paid on top. The state will continue to pay the care costs at the local authority rate. If you want anything above the local authority rate, you pay that yourself too. So, the individual's costs could run into hundreds of thousands of pounds for a long period in care.

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press

I will run through other changes in England. The universal deferred payment scheme is going to be changed so there are national thresholds. The Care Bill will compel local authorities to start an information service. There is much debate about whether this is compelling people to take regulated financial advice at the time of care. It seems to have settled on being information and guidance – where to get advice rather than the local authority giving you the advice.

With the cap it should mean that all care claimants need to contact the local authority, which is the only way they are going to get that meter to start ticking. It will mean that, provided people are aware of it and have been given sufficient information, people will go to the local authority and will be offered advice at that point. At the moment, if you are a self-funder, you may not contact the local authority at all until your assets run out.

A graph from the Dilnot report (figure 25 in the paper) shows the expected lifetime care of costs. There is a sizeable tail, probably 10%–15% of people would end up paying over £100,000. The Dilnot cap is protecting people from this.

I will quickly run through the devolved nations. Northern Ireland and Wales currently have pretty much the same system as England. They have not said anything yet about any changes to funding. They are still on the old lower means test and no cap. They have both introduced strategic plans. However, these are about the delivery of care not the funding itself.

In Scotland, there is a programme for change, which started in 2011, looking at a long-term strategic approach. As I mentioned earlier, the free personal care and the free nursing care is continuing.

The Scottish Care Bill last year set out on how their care system would work and improve the provision of care. This is more community based and integrates the health and social services. They believe, or hope, that integration of health and social services, and offering more local-based care at home, will lead to more sustainable funding for the future. However, the sting in the tail is a recent Audit Scotland Report has questioned the long-term sustainability of the system in Scotland. Currently, about £4.5 billion/annum is paid on care within Scotland. That is expected to rise to £8 billion by 2031, based on current prices. The government has said that its plan is going well, but the report did not give it quite as good a mark as the government did. Crucially, the government still maintains its long-term commitment to free personal care and free nursing care.

Returning to the countries that Ms Elliott covered and some lessons learnt. In France, as Ms Elliott mentioned, there has been a rapid uptake in insurance sales because the public are now much more aware of the need for care. The National Solidarity Day increases this awareness. In France, they have given empowerment to individuals for funding their care costs. That can be used to control future costs.

In Germany, you can opt out of paying the taxation required for care. If you opt out, you have to buy an insurance product instead. The insurance market has grown in Germany with this compulsory purchase upon opt-out. In the Netherlands, they have seen signs that the coverage is becoming unsupportable. It is the same in Japan. By not increasing the contributions in Japan, they have had to cut the level of provision.

Ms Elliott mentioned the CLASS Act in the USA. They did their sums before introducing the system and worked out that it was not sustainable, and so cancelled it. The USA has also seen movements in the insurance market with a bigger uptake of private provision.

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press

In the UK there is not much of an insurance market because there is continued uncertainty. It is good for England that the Dilnot proposals are being introduced but will a change of government change it again?

What we can learn from all these countries is that costs continue to spiral. To introduce a new model, you have to look at the sustainability and the future demographic picture.

Mr P. A. P. McDade, F.I.A. (opening the discussion): Has the Scottish government given any consideration to a cap on the fees and raising the means test, as has been proposed in England?

Mr Wilson: All they have done so far is reiterated their commitment to the current system of free personal care and free nursing care. There have not been any noises about trying to introduce a Dilnot-like proposal. So just a reminder: by having this free personal care and free nursing care, there is no need to introduce a cap. It is free.

Mr McDade: My personal experience based on a relative is the so-called free personal care covers less than one-third of total costs of a nursing home.

Ms Elliott: It could be that the hotel costs are not covered.

Mr McDade: That's posssibly correct.

Ms Elliott: There are nursing costs, personal care and hotel costs. We know in England that the hotel costs are quite significant. Hence the cap from Dilnot is not really a cap. It is only covering the social care costs and not the hotel costs.

Mr McDade: Just to put some figures on it, my experience is that the total costs of a nursing home is about £30,000/annum. The Scottish government's contribution is about £10,000 or £11,000. The rest is being met by my relative. A cap would be useful in the long term.

Ms Elliott: It would probably help with Dilnot. Although they call it a cap, it is not really a cap. We are trying to educate the politicians about what it is.

Mr W. D. B. Anderson, F.I.A.: The real difficulty with long-term care is effecting behavioural change in both the individuals' and the politicians' minds.

You must have given much thought to how you get people conceptually to buy in to some form of insurance pre-payment scheme or social insurance scheme. The French Solidarity Day is France's way of getting people to think momentarily about this. What other approaches are there to engage the population in a meaningful discussion and take people away from these terrible discussions about individuals when they need long-term care?

My relative has been in a home for about 10 years suffering from Parkinson's disease and that has wiped out all his personal assets. He did not prepare for this.

Ms Elliott: As part of the Care Bill the government has promised a national awareness campaign. Perhaps they can learn some lessons from the French market, where they have increased the awareness. As an industry we want to influence what that awareness campaign is going to cover.

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press

One of the key things is to make sure that people understand what the proposals mean. Right now there is so much confusion around it and this is a problem. People believe what they read in the *Daily Mail*.

People say, "It is capped at £72,000. We do not have to worry about it". But when you get into the detail, they do.

We are hoping that the awareness campaign will help. One thing from a personal perspective is that we have dignity ambassadors in the UK. Perhaps we need a care ambassador – somebody that people can relate to, getting away from the negative side of things. There might be some figureheads, such as Michael Parkinson, that we could use for a campaign. Then we can focus on the caring side and not just the downside.

We have learnt from other countries that are a long way ahead of us. It is quite depressing but we are where we are; we have tried to move forward.

The Chairman: In the 1990s, when we used to sell pre-funded long-term care insurance, we sold mainly through a direct sales force. When our sales people were in front of prospective customers, they used to end up selling some sort of funding arrangement in probably 60% or 70% of the cases. When you sit down in front of people, put the facts in front of them, it becomes a logical purchase.

What was difficult was finding the leads – generating the interest from people in the first place. Part of the problem is that most people still do not realise that this is not now covered by the NHS. Originally, older people were looked after in geriatric wards in hospitals as part of the NHS.

The people who are aware are either those who have read the *Daily Mail*, I guess, or those who have had experience close at hand. Anybody who has had to go through it with a relative realises how much care costs, and those people are going to be more aware that if there are funding vehicles around, then it might be worth buying into one or at least investigating it.

The problem was that there was never any clarity about what government was going to do. This was a big issue when we were selling policies and products in the 1990s. There was always a question coming back from the prospective customer, "What happens if the government changes the system? What happens if it suddenly decides to fund care for all? What happens if it puts some sort of compulsory system in place?". Consequently, we had to put elements in the product that would allow a change to be made if the system changed.

One of the good things about the Care Bill is that it is putting clarity into the system. Unfortunately, it is still a means-tested complicated system. The cap is complicated; as well as the distinction between personal costs, social costs and hotel costs. We are involved in the process and understand what it all means. But the average person does not understand the distinction between all these different costs. It will only help promote a financial services solution, if there is an awareness campaign by the government.

As Ms Elliott said, we are hoping that is going to happen. However, one of the last big awareness campaigns was Switch to Pensions in the 1980s. That was about personal pensions and it went wrong for the government. I am not sure how far the government is going to be prepared to go to help raise awareness about long-term care.

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press

Ms Elliott: In this round of the debate for long-term care the engagement that the Department of Health has had with the industry has been quite good – getting us on board, listening to us, both as a profession and as an industry. The Department has asked the Institute and Faculty to join its current task force on the deferred payments scheme, to review the guidance, etc., that it is drafting. We have worked quite actively as a profession to become involved with the Department of Health.

Mr P. Turnbull, F.I.A.: I have some questions. Why is public funding good? Governments try to address all the problems of the ageing population on a pay-as-you-go basis but we now have a big unsustainability problem. Everybody is worried about how a shrinking workforce is going to fund these older populations. I am not convinced that the State system is necessarily the answer. I would want to see much more hard cash funding.

Why is the cap and means testing a good idea? One potential view would be that it simply is guaranteeing a minimum inheritance for the heirs of the elderly person. Why should current taxpayers pay to make sure that specific people receive an inheritance? The population seems to like that as an idea but I am not sure that it makes much sense.

Politicians and the current Scottish independence debate are destructive in this. Politicians are worried about suggesting that benefits are going to be cut or costs are going to be increased. Such a suggestion would be bad news and the *Daily Mail* will pick up on that. Fundamentally, that is what needs to happen. Roger Black, who presented here in Edinburgh on the topic of Scottish independence, noted the issue of escalating costs likely to be incurred in respect of the elderly section of the Scottish community and the lack of clarity on how this issue is to be managed.

How can you do anything about this as an individual unless you know exactly what is going to happen?

I note that pensions are already poorly funded and private provision is nowhere near where it ought to be. I am not sure why we might expect to encourage significant private provision for long-term care costs given the existing state of pension provision.

The Chairman: From my perspective, the answer to your questions is slightly different for the current older population. People in their 70s, 80s and 90s may be closer to needing care than people in their 40s, 50s and 60s.

Most concern about long-term care appears to be for the older generation, partly because they are the people who thought that it was all going to be provided by the state. Part of the answer to the question is, "Why should we care about them? Why should we not just let them pay for it themselves?". And part of it is fairness. What did they expect to receive when they started paying their National Insurance contributions in the 1940s and 1950s? Many expected to have their care paid for – any sort of healthcare paid for.

It is a different solution for people who are young.

I am glad that we are doing some work as a profession now. If you were designing a system for income in retirement now I would not call it a pension – but an income in retirement to cover all income needs in retirement, not just a level income or a level income in real terms, but maybe an income that can fluctuate because there may be different needs at different times in retirement.

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press

We need to encourage the younger generation to save enough for their retirement in the first place. The systems for saving for retirement can be made more flexible so that they can include an increase in income for those unfortunate people that need expensive long-term care. It should not be too difficult to build that into the system. It is not too difficult to fund for, if you start early enough.

One of the problems with the cap is that it does not provide people with a solution. It just says that in certain circumstances, if you spend this much money, then some part of your care costs will be paid for in the future by the state. But you still have to find some other funding mechanism, as we showed in the presentation, for quite large amounts of money.

I have a question for those of you working in insurance companies. How many people working in insurance companies and for financial services providers have looked at or are looking at developing long-term care funding solutions? I imagine that it is quite a small number.

Ms Elliott: If I may just add to that, the cap itself does not introduce new products. All it does is divide the source of the funding between public and private.

100% public funding is not what we are looking for in the UK. There needs to be some type of partnership between public and private funding. We have seen that the systems that are 100% universal are having sustainability issues. The amount that you have to pay for care under the Care Bill is not going to change, except for inflation.

To respond to the question about clarity: unfortunately, what sounded quite simple when the Dilnot proposals came out has become very complicated.

At the Institute and Faculty of Actuaries, as Mr Gatenby mentioned, we are looking at other ways of saving for care needs, potentially using pensions. The Pensions and Long-Term Care Working Group are working on a paper looking at pensions as a way of funding for care needs, whether that be via a disabled life annuity, changing regulations or allowing greater flexibility in pensions. But if people do not have enough for a regular pension, how are they going to have additional savings for care needs? When you reach pension age, do you have a financial check that is set up automatically so that you start thinking about your care needs?

This paper initially is going to the Department of Health and should be published in April 2014. In the paper there is a model on which we have been working that does projections to assess the potential implications of the Dilnot proposals, the cap and the means test.

There is a lot of work going on in the profession. There is no short answer. It is going to take some time. It has been 25 years now.

The Chairman: I can see in another 25 years we will still be saying, "When is something going to happen?".

Ms Elliott: Looking at some of the systems of other countries, perhaps they have taken a leap of faith in trying something different, in Japan, Germany and the Netherlands. They have problems, but at least they have taken a step forward.

Mr A. T. Pfaff, F.F.A.: It strikes me that we are looking at two issues. One issue is covering basic needs and how that is funded. Having had an elderly parent who has gone through the care system

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press

that covers only basic needs, I would say that the other issue is that there is a difference between basic needs and what might be called "quality of life". We do not want just to park people in care homes to die.

So, there should be some form of a push to develop long-term care products. There is a market for that, regardless of what caps are, to cover that excess beyond basic needs costs, so people can have a good quality of life in retirement.

Ms Elliott: The annuities that are available can be used as a top-up. If you have your basic needs covered by the state, and if you want to have a better quality home, or a better quality of life, then you can use an annuity for a top-up. Although the average premium could be about £100,000, you do see policies with premiums of, say, £20,000 or £50,000. So you could use that. That is at the time of need of care. It is not planning for it, but at point of crisis.

Mr Pfaff: There is a definite market for the life assurance and pensions providers. As the baby boomers age, the companies in which to invest are hearing aid and spectacles companies. There is some truth in that. Maybe the life assurance industry needs to wake up to the fact that there is a market out there for these products.

Ms Elliott: As a profession we have joined up the practice areas of pensions, healthcare and life to look at this issue, which is a good step. We are getting other parts of the industry to do so too, not just the Actuarial Profession.

Mr Wilson: I am slightly more pessimistic. There is a need for pre-funding products, but whether there is a demand is another question.

Many people are not aware of the need. There are many other demands on their money. People are not paying enough into their pensions or do not have sufficient life insurance cover.

As an industry, we should start to look at these products. The working party will go a long way but I am pessimistic about who is going to buy them.

Ms Elliott: From recent work that has been done, using the pensions environment and equity release, there are also pre-funded like insurance products. These were around but did not sell very well because people did not want to buy them.

The USA market sells many pre-funded products, but the benefits are quite limited. The benefit periods are, on average, about 5 years. What do people do after the 5 years are up? But it makes it more affordable. In the French market they have pre-funded but they also have group risk policies. Funding is set up through the employer with employees paying the premiums. Group risk is another area to look into to encourage people to think about it earlier.

Mr H. B. McKee, F.F.A.: The paper covers the issues at a macro level within each population. Insurers are much more interested in the micro level: "Will the individual buy it?". When you bring the two together we reach a point where it is possible to design products that could be sold – bearing in mind how under-insured the UK population is for fairly standard covers, which they might buy far less in advance, and that pension funding is not particularly good – the people buying are likely to be high earners and they might well be the people who would say, "I am well off and if I need to fund long-term care, I will do so when the need arises".

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press

What might be beneficial as a next stage of the work is some form of segmentation of the population to try to achieve some perspective on the overall macro picture. If you broke it down into four of five different segments and how they might behave, then what position would you generate?

Even if insurers came up with products, it would not make any real difference to the overall need, whether there is public funding or public action to make it compulsory. If you do not make it compulsory, then the reality is that this will be way down the chain of things for which people pay. Even if you reach the point where they have to make a contribution at the point of need, then in reality, how many people at this point have £20,000 or £50,000 or £100,000? It becomes a tiny portion of the population, leaving the state to sponsor or arrange care for the vast majority of people.

Ms Elliott: The pensions paper that we have talked about starts that segmentation process. One of the sections breaks it down by income and wealth and what potential financial solutions would be suitable for them. Also, looking at particular solutions, which target would you look at, what size of pension pot, etc.?

As a profession, we are also doing some work with another organisation about the segmentation of its database. We are going to try to help it set up that segmentation to do some consumer research. It was started through the ABI and the Department of Health – the quick response teams that were set up. We did start some consumer research with some companies that want to take it further and get a better feel for the type of products people are looking for and what they would be willing to pay. We said, "This is what you would receive, but you have to take a 10% reduction in your pension". No way! So you can build beautiful products, but nobody will buy them. We are stuck. I take your point, though, that doing that segmentation is the key next step.

The Chairman: I would agree with you that the only way to encourage many people to buy into insurance, at least to cover some of the costs, is for there to be compulsion. We have seen in France, which has a compulsory scheme for certain benefits, that it has led to a number of people buying insurance. In Germany, again, there is a scheme. People have opted out and bought some insurance. Having a compulsory scheme for some level of benefit does seem to encourage people to use insurance.

However, instead of making some level of benefit compulsory, we have a cap system that says the state will cover some of the long tail of the loss. Most people will not understand what that means and is not going to encourage them to start buying insurance. I agree that some form of compulsion would certainly help the financial services industry to develop products to cover the rest.

I do not think that it will happen and do not see, certainly in England, that there is any political interest in providing a certain level of benefits for all.

Mr Wilson: The problem is that compulsion is political. The politicians are motivated by their votes. We have seen with pensions that there is, perhaps, an opportunity for compulsory contributions. But they never took that brave move. I doubt very much that they would make the move here.

Mr J. S. R. Ritchie, F.F.A.: I have a couple of questions and observations on the long-term private insurance problem. When I was involved in looking at this in the past, there was a statistic that stuck in my mind, which was that the chances of someone who is healthy today ever needing to go into a nursing home was, roughly one in three for a woman, and one in four for a man.

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press

So my first question is: is that still roughly the statistic that applies today? If it is then there is a problem. If you know that something is almost certain to happen, people are likely to fund for it or make a provision. If you know that something is possible but unlikely – for example, your house burning down – then you can protect yourself through pure insurance for a very modest cost. The trouble with a one-in-three or one-in-four probability is that it is in the middle of that spectrum. It is neither almost so certain that you pre-fund it, nor so unlikely that you seek pure insurance. It is because it is in the middle of the spectrum between pure funding and pure insurance that you have an additional difficulty.

Secondly, is there a concern that the possibility of creating a market here has had the waters muddied by the problems that we have had with critical illness insurance and the associated definitions? There has been much publicity about companies not paying out when the policyholder felt that a genuine claim had arisen. Relating this to the risk of going into a nursing home, I would assume that the individuals themselves would only go into a nursing home as a last resort. There would not be moral hazard. That might not be true for the person's family. They might be quite keen if they thought that there was insurance available to cover the cost. They might be subject to the moral hazard rather than the individuals themselves.

Mr Wilson: Taking your second question first, the claims trigger is a real challenge for the development of insurance products. The person will be assessed by the local authority. There will be people in that person's home probably trying their best to find the financial solution for them. Setting an insurance claim trigger based on this personal discussion is going to be difficult.

Ms Elliott: Do you have any experience, Mr Gatenby, from your PPP days, of the pre-funded market, where we did have claims definitions?

The Chairman: We paid claims when people reached a certain level of disability. It was not about going into a nursing home. In fact, the reality is that most people would like to stay at home for as long as they can. They would prefer to have a package of care services in their home. We were a bit naive in the early days of the products. I remember that under the very first products, we likened failing two out of a list of six activities of daily living (ADLs) to going into a residential home, and failing three to going into a nursing home.

The reality is that it was nothing like that. You could have people failing five ADLs who could stay at home. You had other people who might only be failing one who, for other reasons and circumstances, needed to go into a nursing home. It is not an exact science about whether somebody needs to go into a home or not.

The only way you can make insurance work is relating it to people reaching a certain level of disability and, when they reach it, make the payments. Those payments could be used for care at home or a residential care home.

In the USA, some of the products are more about going into nursing homes. It is not the way to make it work in the UK and possibly US because most people want to stay at home. It is often an event, such as becoming incontinent, which triggers going into a nursing home. Incontinence is not necessarily one of the ADLs. You can fail the others and can be looked after, but once you reach that stage, you would go into a care home.

It also depends on whether there is a spouse or other family members still living with the person that needs care. There are so many factors that can determine when somebody might need to go into a

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press

care home. You have to link the products to reaching a certain level of disability and then make payments. You can make the products more complicated by making higher payments at different stages of disability, which is what we did with our product in the 1990s.

Ms Elliott: The current product that is on the market, the immediate needs annuity, would not suffer from this problem because people are already in care, or going into care, whether that be in a care home or in their own home. To satisfy the HMRC requirements for the tax benefits, you have to be at a certain level of disability expected to be permanent. If you do not satisfy that, then you do not receive the tax-free payments.

At present it is not an issue, but if we are having to compare, as Mr Wilson said, local authority assessments with insurance products, we could be open to criticism or debate. It is something that we need to watch out for.

The Chairman: In relation to your statistic, I think the answer is that those numbers probably are still the same for the proportion of people that need to go into a nursing home, or the proportion of people reaching that level of disability.

Mr Wilson: About 25% of people do not pay any care costs and about 25% will pay more than £50,000. This is in respect of people aged 65. So 25% of 65-year-olds are not expected to incur care costs.

Mr J. E. Gill, F.F.A.: I have a couple of comments on what might spark an insurance market. You may be familiar with the bumper sticker: "Be kind to your kids because they will be choosing your care home". The reality is, as the paper illustrates, that they will not. They will take whatever the government gives them, which in 20 or 30 years' time will not be a nice choice if we believe what the numbers in the paper are telling us. So the ability to offer some modicum of choice is probably the best that an insurance product can offer.

I also recognise and agree with the authors the requirement to have some kind of partnership between private insurance and public funding. One of the things of which we should be cognisant is that, of that partnership, one side at the moment seems to get away with financial promotions material that would not be acceptable from private insurance: capped, but it is not a cap; free, but it is not free. But if we can give some modicum of choice, we might have an angle for the public to engage with the insurance products.

Mr J. Hastings, F.F.A.: This paper strikes at two areas, one of which is the policy debate and advice, and the other area which is where provision might come from, for example, the involvement of insurance companies.

One statistic I came across in the paper – I only came across it for France – was the number of years of healthy living in retirement. I do not know whether the breakdowns are available for other countries. Many actuarial statistics can tell you people's expectation of life. However, the healthy life element and the unhealthy life element are important parts of which it would be helpful for the wider public to be aware.

I wondered to what extent long-term care solutions depend on cultural differences between countries. Long-term care is a global problem, but the solutions will probably be influenced

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press

geographically by the culture of individuals. That may have some influence on the approach taken, the concept of the social element the government provides and the private provision.

I fit into the category of someone who is reasonably well remunerated. I am shortly about to stop working and at that stage I will no longer have my company's medical benefits. The question is: should I pay for those medical benefits or am I prepared to take a risk that I can tolerate paying for a certain amount of medical benefits myself, and should only insure the catastrophe cost of a treatment that is elective and very expensive? I think that it helps that I can go to an insurance provider to cover that catastrophe cost.

It may well be the case that I would want to do the same for long-term care provision. I do not know whether I would definitely need the provision, but if I do need it, I will be able to finance some of it myself. If I can insure the excess, that will give me more comfort than would otherwise be the case.

It occurs to me that what I really need is the equivalent of a hotels website, where I can assess whether I want one star, two star or three star treatment. I can look up the user reviews as to which of these provisions is ideal for me. It may be that the way to engage the public on this is to build up some sense of the cost of alternatives on a website where you can see what you can get for what you spend and how much long-term care is likely to cost.

I mentioned the cultural differences between countries. I am aware that it is not unusual in the USA to go into "senior living", which is not necessarily the same as going into healthcare.

For the UK the proposed deferred payment scheme is likely to be something of a disaster as I cannot see the benefit of a situation where, in a country that is very short of housing accommodation, I would move out of a house that would then lie unoccupied, potentially unheated and deteriorating, while I live in a care home for three and a half years before my house can be sold following my death. Is this in any way a sensible approach? It would seem to me preferable to take that equity and re-invest it into some form of senior living accommodation, based around healthcare, where I can continue to live with as much long-term care as I need provided and paid for. At least I would be in an environment where both I and my accommodation would be looked after. Further, when I no longer have need of that accommodation, it can be sold and transferred to somebody else.

Creating the equivalent in the UK of senior living that allowed gradual transfer into long-term care, and which could be built around a nursing unit that can also service the wider community, would work much better for the protection of housing equity. It would also get older people out of large houses and into smaller, more suitable accommodation. That would be a more universally beneficial approach in the UK.

Mr Wilson: There are statistics on healthy life expectancy. It is apparent that, whereas life expectancy has increased, healthy life expectancy has not increased at the same rate. That means that your unhealthy years are growing significantly.

Ms Elliott: There are some websites such as Care Homes UK on which you can do a search for care homes. All of them in England have to be registered through the Care Quality Commission. You cannot necessarily see a rating, but there are descriptions of them. There are similar websites for Scotland, Wales and Northern Ireland. I used to work for Just Retirement and, as a provider, we had

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press

to make sure that a care home was registered. We had to check those various websites and became quite familiar with them. They cover home care providers as well.

On the UK deferred payment scheme, I cannot see why it is called "universal" when there are eligibility criteria. That does not mean "universal" to me. The Department of Health is currently working on guidance notes for the deferred payment schemes. There are issues around upkeep on the home, etc., if you are not living there. Things like that would be built into the guidance.

I take on board some of the things you have said. I have been asked to join that task force on behalf of the Institute and Faculty. I have just reviewed the paper and I will add your comments to mine.

Mr C. Taylor, F.F.A.: To me, it boils down to a few questions: why should the government – any government – do anything about this? Re-election suicide comes to mind. Why try to solve the problem today? Why should individuals buy as well? Is there a better quality of life in your 40s and 50s or 80s and 90s? It is not just about using an internet site, but visiting the home, not just to see it, but to feel it and smell it as well.

Why should insurers and consultants develop these products if there is not a government to support them or there is little demand? Maybe if we can answer those questions we can decide on action.

Mr Turnbull: Picking up on the senior living point, I am aware of a number of schemes in Scotland where assisted living accommodation is being developed quite quickly. Is this a developing area? Is this a useful solution?

Ms Elliott: It is one of the potential accommodation to which people could go. I am not certain how much is available. I think that the best solution is what the USA has developed with its continuing care retirement communities. You start out in a bungalow but, as your care needs increase, you can move to other accommodation within the same community. We have one in the UK with Joseph Rowntree.

Unfortunately, we do not have the land to be able to develop such communities on a much wider scale. You could do it on a smaller scale by staying in the same community with the same people and eventually you might need full care. Something like that would be quite beneficial. People do not feel that they are just being shoved into a care home.

The Chairman: It remains for me to express my thanks to all of you who have participated in this evening's discussion and to thank the authors of the paper.

https://doi.org/10.1017/S135732171400021X Published online by Cambridge University Press