British Actuarial Journal, Vol. 19, part 1, pp. 96–115. © Institute and Faculty of Actuaries 2013
doi:10.1017/S1357321713000329
First published online 2 October 2013

Long-term care – a review of global funding models

Abstract of the London discussion

[Institute and Faculty of Actuaries, 22 October 2012]

Contact
J. K. (Hamish) Wilson, F.I.A., e-mail: hamish.wilson@hymans.co.uk

This abstract relates to the following paper: Elliott, S., Golds, S., Sissons, I. and Wilson, H. Long-term care – a review of global funding models (a working paper). *British Actuarial Journal*, doi: 10.1017/S1357321713000172

Dr D.J.P Hare, F.I.A was in the chair and asked Sue Elliott and Hamish Wilson to introduce the paper.

Miss S. D. Elliott, F.I.A. (introducing the paper): The paper we are presenting to you is a work in progress: it is not finished. The purpose of the meeting is to obtain your feedback prior to producing the final paper.

We have picked six countries either because they were relatively successful in private long-term care insurance (such as France with 15% penetration, and the US with about 10%) or for their extremes in public versus private partnership and funding (such as Germany, Japan and the Netherlands). The UK is included for the purpose of comparison.

In the paper there are six measures illustrating demand for long-term care: population projections; life expectancy trends; pyramids; dependency ratios; social changes; and expenditure on health care and long-term care.

Figure 1 shows population projections. Japan had the greatest proportion of those aged 65+ in 2010. It also has the greatest growth. The proportion is projected to almost double by 2050. By contrast, the US has the lowest current population over 65, and it also has the lowest projected growth.

The range of the proportion aged over 65 across the six countries in 2010 went from 13% to 23%. In 2050 the range has increased from 21% to 41%, which represents a quite significant change.

For those aged 85+ the comparison between countries is similar, with Japan having the highest proportion and the US the lowest. The range in 2010 is from 2% to 3%, and in 2050 is from 5% to 12%.

Figures 2, 3 and 4 show population pyramids. For each of the countries, we looked at the actual pattern in 2010 and the projected pattern in 2050. The baby boomers, aged 45-60 in 2010, move to the top of the pyramids in 2050. Japan, in figure 3, has the most pronounced effect, which is not surprising given their low birth rates and high life expectancy. The US, in figure 4, has a different pattern from the other countries.

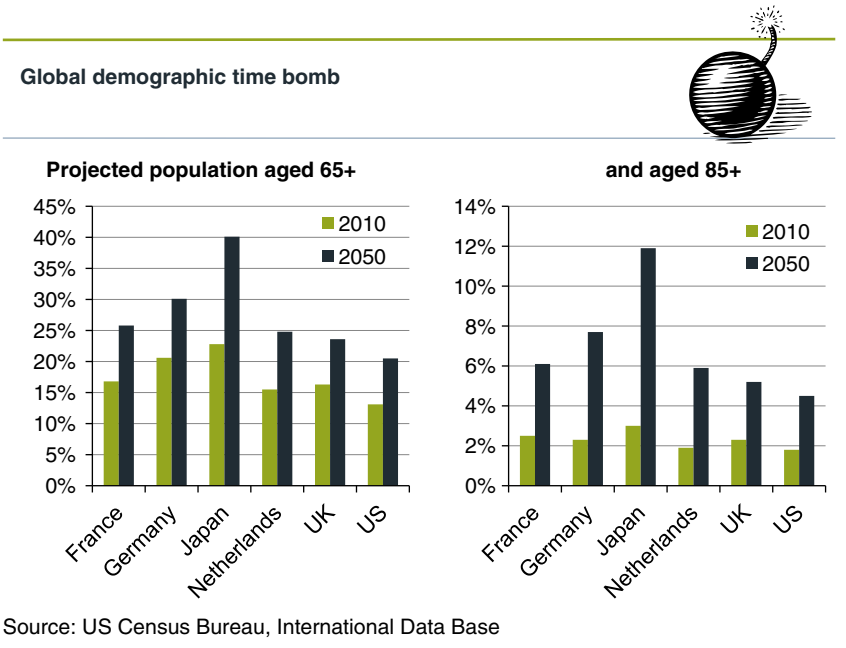

Figure 1. Global demographic time bomb

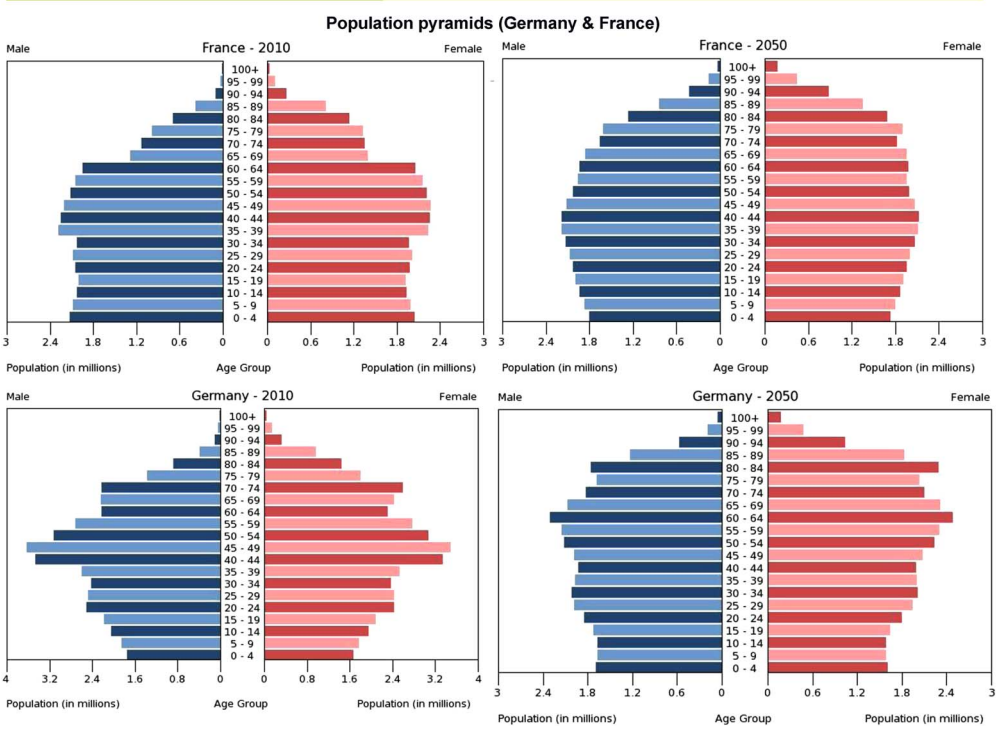

Figure 2. Population Pyramids (Germany & France)

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

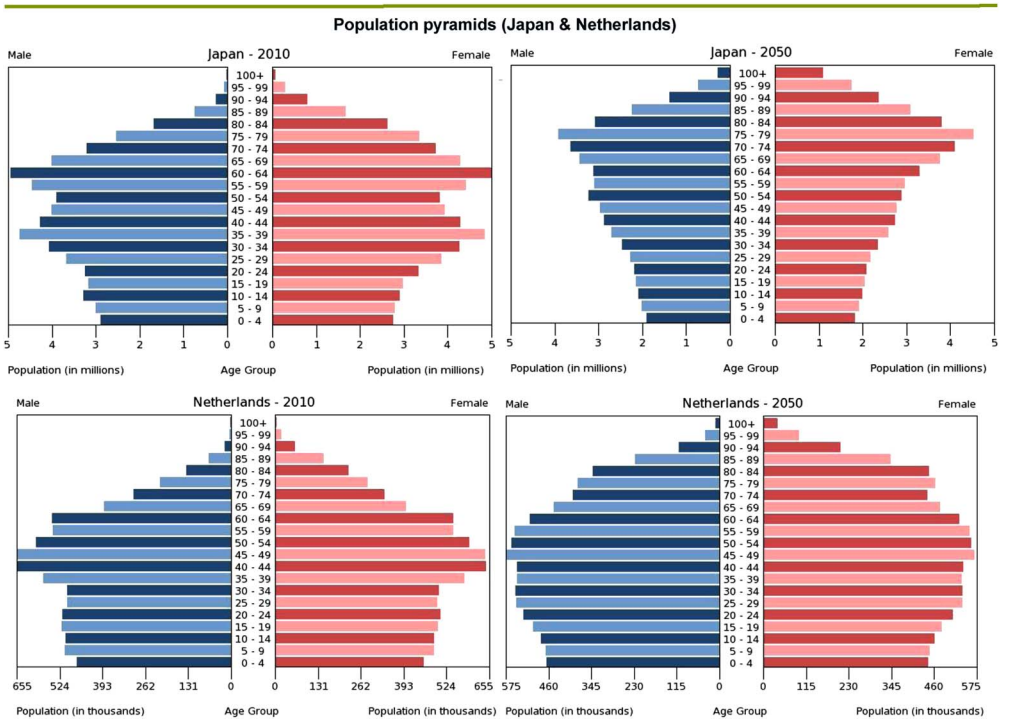

Figure 3. Population Pyramids (Japan & Netherlands)

Figure 5 shows dependency ratios. The dependency ratio is the ratio of those aged 65+ divided by the population aged 15 to 64, so it shows the number of older people who are supported by the working age population. For all six countries it has increased over time from 1960 to 2011.

Again, Japan shows the most significant increase from 9% in 1960 to 37% in 2008. And the US has shown the slowest growth.

Figure 6 gives a summary of the current public and private systems for each of the six countries studied.

Starting with France, where 70% of the cost is from local government funding with the balance of 30% from central tax and social insurance. There is a national scale for assessing an individual's needs, but it only covers dependency and not hotel costs, which are the individual's responsibility. So, for those of you who have been following the proposals of The Commission on Funding of Care and Support, chaired by Andrew Dilnot here in the UK, the cap we are hearing about does not cover the hotel cost.

The main US programme is Medicaid. It is their safety net. 39% of the funding comes from Medicaid which is jointly funded through the federal government and the states. It has a bias towards institutional care and it is means tested and focused on people of limited income, which is similar to the position in the UK.

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

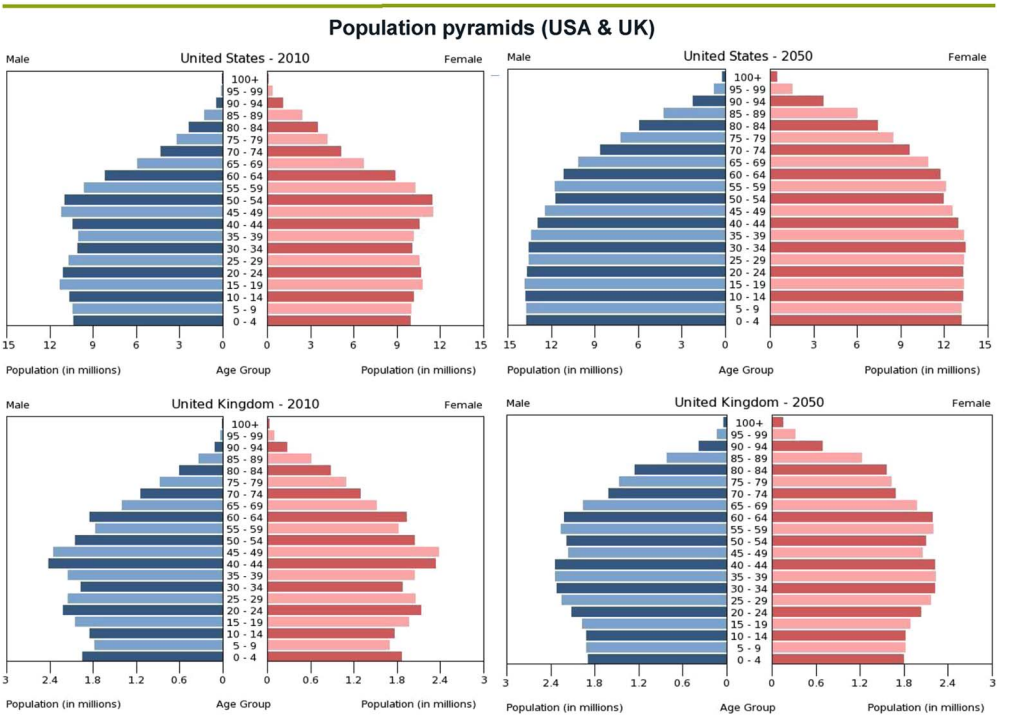

Figure 4. Population Pyramids (USA & UK)

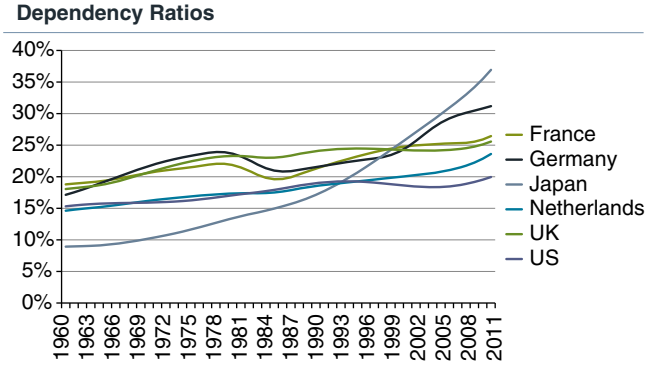

Figure 5. Dependency Ratios

Figure 7 shows data from OECD statistics of the public versus private expenditure on long-term care from 2009. The data indicated that France and the Netherlands are totally publicly funded and we will have to dig into that further before completing the final paper. We know France is not all publicly funded and that they do have a private insurance market. The discrepancy could be because of the date when the data were collected. In 2007 we believe the private market was 1% and about 15% in 2010. The reason for the big increase has been widespread media discussions which have increased public awareness about the risks and the funding gap. Also, group insurance is quite large in France.

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

Global LTC public financing

Country	Funding Source	Eligibility & coverage	Benefit types
France	Local & central tax & social insurance	Universal, reduced for high incomes	Cash and in-kind, home & institution
Germany	Social insurance with private opt out	Universal	Cash and in-kind, home & institution
Netherlands	Social insurance	Universal	Cash and in-kind, home & institution
Japan	Social Insurance	Universal	In-kind home & institution
USA	Income tax, medicare premiums & congress funds	means tested and minimum paying eligibilities	Post acute care in nursing homes
UK	Income tax and local tax	Minimum safety net, income and assets based test	Cash and in-kind, home & institution

Figure 6. Global LTC public financing

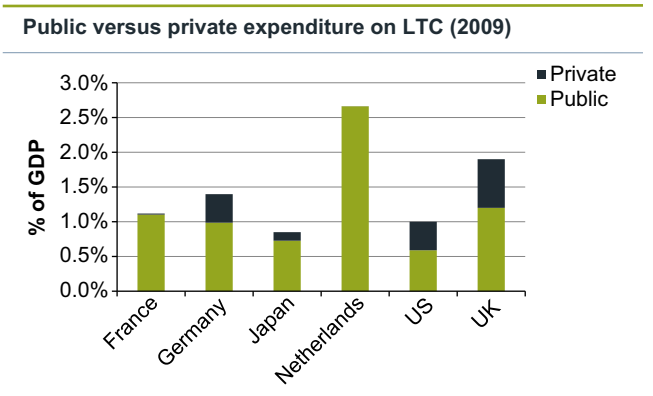

Figure 7. Public versus private expenditure on LTC (2009)

The other ones: Japan is 86% publicly funded; Germany, 71%; the US 59% and the UK is around 60%.

Figure 8 shows the split between healthcare and long-term care in 2009. The lowest expenditure on long-term care was the US, and the highest was the Netherlands.

Finally, Figure 9 shows some details for those countries which have universal schemes: Germany, the Netherlands and Japan.

In Japan what is making them different is that providing care and public assistance to the elderly is seen as a national responsibility. The benefits are set by national government but it is all run locally, which is similar to the UK.

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

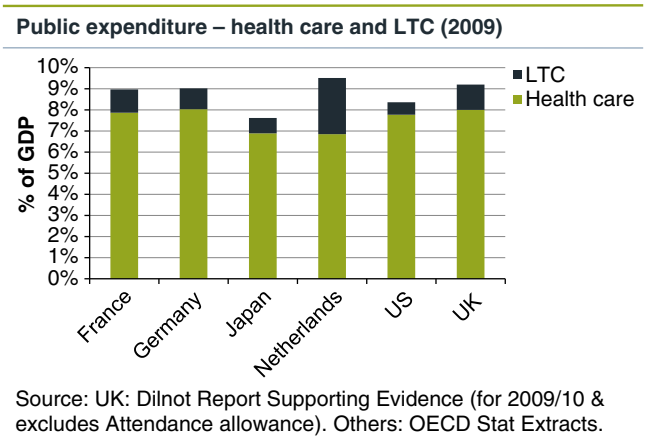

Figure 8. Public expenditure – health care and LTC (2009)

Universal insurance schemes in detail

Country	Insurers / Purchasers	Financing Source	Contributions
Germany	National LTC insurance funds	Payroll and income-related contributions (100%)	1.95% payroll tax (additional premium of 0.25% for those with no children
Netherlands	Regional Care offices	Payroll and income-related contributions Means-tested co-payments	% payroll tax, max Euro 330 per month
Japan	Pay as you go municipality run	General tax 45%, income related contributions 45%, co-payment 10%	Ages 40-64 ~ 1% payroll tax. Age 65+ ~ 30 USD per month

Figure 9. Universal insurance Schemes in detail

Mr J. K. Wilson, F.I.A. (introducing the paper): Just before I go onto lessons learned, I will just add a comment about Scotland. What we showed for the UK was predominantly the position in England and the devolved nations of Wales and Northern Ireland. In Scotland there is free personal care for everybody over age 65 and free nursing care for everybody, depending on eligibility for the need for care. There is no financial test.

However, in Scotland you are not entitled to attendance allowance if you are receiving free personal care, and you are also not entitled to NHS separate nursing care that you would be in England. So arrangements in Scotland are not quite as different from those in England as some have stated.

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

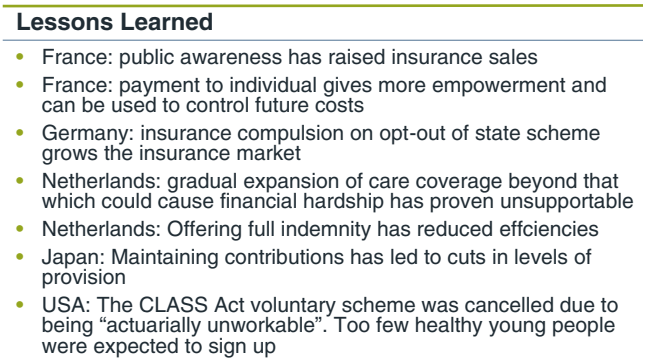

Figure 10. Lessons Learned

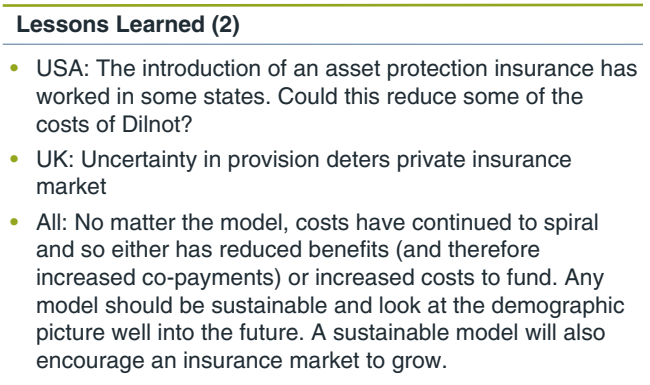

Figure 11. Lessons Learned (2)

Figures 10 and 11 cover the lessons learned from those countries we have covered in the paper.

For the UK, we are now in a position where we may be introducing Dilnot's proposals. There has been some noise about that and it is looking more likely. A real lesson learned from every other country is that any proposal has to be sustainable, especially if we want to grow an insurance market and ask insurers to become involved.

So, before we start the discussion, as authors, we should maybe take a step back from where the paper has been heading. Through research, we have found that there are a lot of papers that look at global funding methods. As an actuarial profession, perhaps we should be looking at something different, rather than just repeating the message from other papers.

We should like to engage everybody in this discussion. Ideas might include for us to do some model validation of the Dilnot costings, adding some stress test scenarios to see how sustainable it might be. Or, we could consider what is most likely to grow the private insurance market.

In addition, Figures 12 and 13 give some prompts for topics which may follow in the discussion.

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

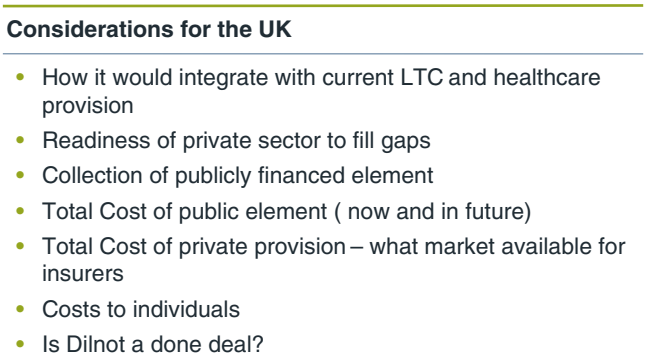

Figure 12. Consideration for the UK

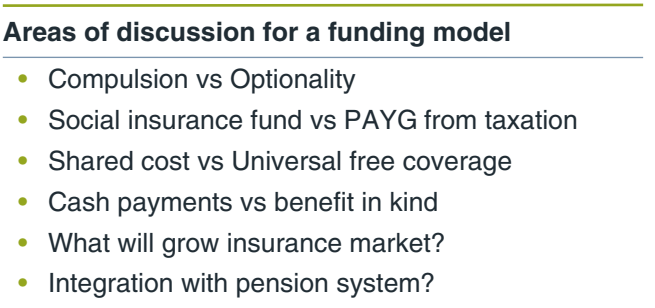

Figure 13. Areas of discussion for a funding model

Mr I. J. Kenna, A.I.A.: The most significant part of the paper is Section 5.1.6: "Graph 9 indicates that financial sustainability is the most important policy priority for long-term care systems in the OECD"

However, no mention is made of exactly what level of care is to be provided by the financially sustainable long-term care system.

Funding methods are dictated by general financial conditions.

At present, interest rates are being kept low and large amounts of extra money are being printed. This indicates pay-as-you-go rather than long-term funding methods.

Coming now to the health deficit, a limit of life of 100 corresponds to a net continuous deterioration in health of about 5% per annum combined with one small drop just before death at age 100.

In the United Kingdom, for the past 60 years, the limit of life, measured by the age of the oldest inhabitant, has never gone above 115 years.

At the same time, people have generally been living longer than they used to, thanks to advances in care and medical science. These advances keep people alive but do not significantly extend their capability for work. The longer they live, the more they consume.

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

The gross health deficit has gone up over the years. The obesity ratio is always on the increase. Care and medical science have been improved continuously. As a result, net deterioration in health has been kept down.

The gross health deficit is occasioned by a number of factors: poor diet; lack of exercise; and pollution.

Diet in the United Kingdom is rich in cooked fat and oil and other harmful substances. Bacon remains the UK's most popular foodstuff.

As regards exercise, less manual work is being done. People used to walk or cycle to the bus stop or to the railway station. The advent of the private car has reduced these forms of exercise.

Pollution is everywhere. Fine particle air pollution is more penetrative to the lungs than coal-fired air pollution. You can blow your nose and blow the coal-fired air pollution out of your nostrils. The oil-driven fine particle pollution goes straight down to the lungs. I quote the Chinese experience for that, as set out in numerous issues of Beijing Review. They should know because they have fine particle air pollution all over Beijing and other Chinese cities at the present moment.

Long-term care costs can be brought down, provided something concrete is said and done about poor diet, lack of exercise and pollution. This will increase the limit of life. The limit of working life will also increase. Consumers will become producers.

As an item of interest: The UK's oldest inhabitant, Grace Jones, was 112 years and 302 days old on October 4th, 2012. There is a case for regularly publishing details of the oldest inhabitants in various countries in The Actuary. Such details are of limited value to the actuarial profession as mere anecdotes. As indicators of the limit of life they are invaluable.

Mr P. W. Wright, F.I.A.: Is private long-term care insurance a class of business which will be particularly affected by the requirement in Europe for gender-neutral pricing? Will it affect either the value for money that can be offered by private insurers or, alternatively, the soundness of the insurance company offering any long-term care products?

Miss Elliott: On the gender neutral issue, yes, those regulations will apply. The only products available at the moment in the UK insurance market are immediate needs annuities. They are all subject to individual, case-by-case, underwriting and there is a question on whether the individual nature of that process could ease the gender neutral issue. Obviously, we cannot use a male table and a female table for rates. But due to the very nature of the immediate needs annuities, you look at the life expectancy for each individual case rather than access a table.

I am not sure whether there was a question from Mr Kenna. He talked about the importance of the level of care. The key point in section 5.1.6 was around fiscal and financial sustainability. The top four factors are: financial sustainability; home care; quality of services and the level of care; and integration of health and long-term care. These are key factors for the UK market.

I do take the point about diet, exercise and pollution. They will impact on any health care product, not just long-term care.

But, if the people we are seeing are living beyond 100, and given that some products do not have a maximum age, you could have people who are in a very disabled state. If they have reached 99 and are very healthy, they could live for 10 more years. We have to think of the pricing implications of those scenarios.

Mr Wilson: I agree with Mr Kenna that there has been no evidence of the extension of mortality in the UK, but rather the compression of mortality. We are seeing much of the gains in longevity being socio-economically related. There is a big gain still out there to be had by those in lower socio-economic classes or those with worse diets.

Mr I. Sissons, F.I.A.: The question of the level of care raised in the first question is an interesting one. Clearly, you could deliver a very poor level of care and the financial implications would obviously result in a lower cost. Those sort of considerations are more political considerations and not, perhaps, ones in which the Actuarial Profession have a detailed say.

The role of the Actuarial Profession is very much around the financial implications and the sort of modelling that we can bring to bear. Long-term care is complex subject. It covers a wide range of different aspects including prevention. We need to concentrate on where we can make an impression. We cannot necessarily look at everything.

Mr C. Redman, F.F.A.: Looking at the very good paper, it is interesting to note the similarities between Japan and Scotland. This might seem a strange thing to say, but both countries have a system of funding that has been going for over a decade and they have built up a lot of experience. Japan's universal insurance scheme started in 2000 and is essentially unaltered since that time. Scotland has ten years of experience. Yet both of these systems were ridiculed, in some quarters, when they were introduced: that they would not work; that they were misconceived; and unsustainable.

But both have worked and have gone along relatively unamended. You could look at both the systems now and say "Are they sustainable?" The answer is probably not without some adjustment over the longer term.

Problems of "sustainability" are often used as an excuse by governments not to take action to introduce schemes to fund long term care. But what do we mean by "sustainability", and how do we achieve sustainability?

It seems to me if a scheme were sustainable for 20 years, given what we know about the future, that would be a reasonable period. We cannot assume that any scheme will be sustainable for 50 years or 100 years without significant amendment.

The question is: how do we make schemes sustainable? If we looked at pensions, if we have pension schemes with adjustable pension ages, they are much more sustainable than those without. It would be helpful to look at Dilnot and consider what features, such as adjustable caps, could be introduced to cope with changing economic and social conditions and make a national scheme more sustainable.

Social problems are solved because there is a will to do something regardless of the constraints. I am always amazed, looking back to the 1940s, that we had the Beveridge Report in 1942, the Education Act in 1944, the start of the Welfare State and the introduction of the National Health Service.

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

All of these things happened at a time when there were severe economic problems. We were fighting a war in the early 1940s and were reliant on Marshall Aid after the war when the UK was essentially bankrupt.

You can do something, even in poor economic conditions. The question is do you want to do something? How high is providing care up your list of priorities? This is the issue with Dilnot. It is a report that has very, very wide support from virtually all of the voluntary organisations and lobby groups involved with the elderly. Perhaps it should be seen as a done deal. But we need to make it happen.

So how can we produce further information that would help the implementation of the Dilnot recommendations to solve many of the problems related to funding care in the UK for an increasing number of elderly?

Ms S. G. Golds (student): I was looking at the Netherlands. Their system started in 1968. At that point it was decided that responsibility for care of the elderly would be the responsibility of the state, whereas childcare is very much the responsibility of the family. It did start as covering catastrophic costs.

It was a very idealistic system. It covered such things as making sure that the elderly were integrated socially, that they were not isolated, and things have been added along the years and changed. I would just say that it has been a system in a constant state of flux and re-examination. For them, the budget is set every few years. If the economic situation cannot cover what they were providing, they adjust it.

Maybe the lesson learned from that is that, as Mr. Redman was saying, you cannot plan for 50 years ahead, so you have to accept that there will be changes.

Miss Elliott: From the perspective of how the Actuarial Profession can help with Dilnot and its implementation, we have written to Jeremy Hunt, the new Health Secretary, and Norman Lamb, the new Social Care Minister, putting forward our skillsets. Mr. Sissons mentioned modelling and funding, etc.

We are waiting to hear back. We do not want to miss the boat and we want to add to the debate where we can. They are setting up groups of key stakeholders and we want to make sure that we are one of those key stakeholders.

We had some discussions before the Dilnot recommendations. Mr. Sissons and I went to the Department of Health to discuss the matter prior to the publication of the recommendations in July of last year.

On the partnership concept and its sustainability, the details may change over time, but the essence is realising that one partner cannot fund it all, and that there has to be buy in from both sides. Otherwise it becomes unsustainable, and there has been mention of the position in Japan and Scotland.

Parterships have been tried in four states in the US, with limited success.

Mr Sissons: I think that Mr Redman hit the nail on the head. The Dilnot recommendations had central estimates of the cost and the modelling around those central estimates. Estimating and modelling are a close fit to the core competencies of our profession.

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

There was also mention of sustainability with reference to Japan having been stable for about 20 years. Some of the countries we looked at had, in their minds, sustainable models that would last for several decades yet had to be adjusted after a very short time. We need to understand why those countries made what appeared to be sensible decisions at that time, but in practice they did not turn out that way.

Prof. M. R. Hardy, F.I.A.: Living in Canada gives you an interesting perspective on social cohesion, because our nearest neighbour has very different ideas on cost and the value of providing government supported benefits to a broad swathe of the population. What we know from studying longevity is that social class is a major determinant of how long you live, how well you will be, what your care needs will be. We should, perhaps, use different models and parameters for people from lower income groups than for people from higher income groups.

This applies particularly when you are considering the integration of private benefits and state benefits. We want to avoid the situation where the state benefits are being disproportionately paid for by an income class that may not benefit so much. This is a problem, for example, with proposals to increase state retirement age, or for government incentives for using reverse mortgages. That is not very useful if you have never owned a home.

I do think that, wherever the public side ends up, this is such a rich area for the private insurance market. The paper's focus is more on the public side, but let us remember that insurance design is at its best in terms of our public contribution when we create transparent products, fairly priced, that meet a real need in society. That is clearly an area where we have a lot of opportunity. Right now, we are looking to create products based on risk-pooling rather than investment spreads, so developing this market could be particularly timely.

Mr R. B. Colbran, F.I.A.: I was disappointed in Mr Sissons' earlier response about level of care. It seems to me that you cannot separate the costing from what you are achieving. It seems vital to look at this holistically and ask: are we providing a satisfactory level of care and what does it cost to provide a level that we would accept for our own parents or even ourselves?

If we (the actuarial profession) do not have the resources then maybe we have to team up with somebody who has.

I noticed, in figure 7, what a high proportion of GDP the Dutch are prepared to spend on long-term care. I have only been into one care home in Holland but the level of provision was absolutely amazing. You can see what they are achieving with the money.

The Dutch, as surely the authors will know, have their village for dementia sufferers. I know it is only a one-off but the level of care for they are aiming is truly remarkable – whereas I go into a care home in this country and still feel the pattern is a lounge full of old ladies sitting around nodding. We are just not achieving something that we can regard as acceptable.

The Chairman: I just wonder at this point, Miss Elliott, if it would help if you were to clarify what questions you are trying to answer in your paper.

There have been very helpful questions during the discussion about the quality of care and how much should a system attempt to fund. There are other questions about how you would go about modelling the different parameters which influence such a system.

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

In particular, have you got one question you are trying to answer or are you trying to cover a broad range of actuarial help for the Dilnot Commission proposals?

Mr Wilson: I think we started off trying to cover a broad range. As I said, we have to step back as a profession and ask what we can give that is of most value, rather than simply repeat inputs from other areas.

We can challenge the model. We can put some actuarial rigour into the model. We can validate the model and we can apply stress tests. We can change the benefit design to negate areas where the system becomes unsustainable.

We do these things all the time when we are designing long-term products. Can we not apply that rigour to the public financing element? To me, that is the key question.

Secondary to that is that we are in an insurance industry. What insurance products can we design alongside the system to try to close the gap that is left? It is clear that there is not a groundswell of opinion in England, in particular, to finance long-term care completely from public funds.

Miss Elliott: In my capacity as Chair of the Health and Care PEC, rather than as an author, I would say that in health and care there is such a social aspect to the issue which must be taken into account when considering those issues. We have to be very careful, therefore, in making comments on those issues, since doing so can easily take us outside our remit.

Talking about the level of care, we realise that the level of care and the quality of care are going to impact on the modelling, and on the cost, etc.

The Chairman: I think that is very helpful.

One of the questions I am hearing is that, if the Actuarial Profession is going to prepare some actuarial material that would help the country consider these issues, should we just restrict ourselves to actuarial modelling, or should we be going further, working with other organisations to clarify the choices in levels of care and methods of meeting the need? In doing so we would consider those methods that exist in other parts of the world, and also those which currently only exist in people's imagination?

Mr D. J. Grenham, F.I.A.: I found the paper slightly confusing or confused. On the one hand it presented different models from around the globe. On the other hand, in the UK, we have Dilnot. The suggestion in the paper is that we should look at a variety of models to decide what to do, and from where to learn lessons, even though in the UK we currently really only have one option.

I was therefore not really sure the points the authors were trying to make.

In trying to market the role of actuaries in long term care we have to start from our core skill set. There are certain things about the data relating to long term care where we can potentially add a lot of value.

Actuaries could also help to assess the potential impact of behavioural change on any new policy introduced. Another factor to take into consideration is that demographic projections for long term

care should not just project the number of people in old age but also the number of potential carers. What is happening to the working age population and increases in women's participation in the labour force will affect the number of women not working and therefore potentially available to provide care.

When we move into the asking about what society should provide, there is going to be such a wide range of possible answers that the profession may not want to go there.

Finally, picking up a previous comment about costs or funding of care in the Netherlands, the Netherlands is perhaps the furthest forward in assisted suicide and maybe there is a connection. Maybe they have high funding and very nice nursing homes but they have also legalised assisted suicide and there may be increasing cost pressures which influence end of life decisions.

Ms M. J. Cornall, F.I.A.: I was on the original long-term care working party about 20 years ago. I was so young at the time that I thought I would never need long-term care and my parents would never need long-term care. Now, 20 years later, my mother is in a situation where she does now need long-term care, and in another 20 years it may well be me!

When we formed the first long-term care working party, we concentrated on statistical modelling. We modelled mortality and a simple multi-state model for morbidity taking into account both length and seriousness of illness. Although we were aware that this was a complex situation, speaking now with the benefit of practical experience, I can see just how difficult this is to model.

Illness is not like mortality. Disability is far more complex. In the case of dementia it is possible for individuals to be physically able but actually unable to cope by themselves. Although severely physically disabled individuals may be able to manage with home help several times a day, there are people with dementia who would appear able and well to outsiders like you and me, but they need constant supervision because their actions are so random and they could wander. Currently NHS continuing healthcare assessments require high degrees of physical disability and someone with severe dementia is unlikely to qualify unless they also have a severe physical disability. So all those actuaries thinking they can buy insurance cover for their long term care, may well find themselves with dementia but excluded from payouts.

Of course modelling techniques have moved on significantly over the last 20 years with more use of stochastic techniques, so it should be possible to improve the models used. However sophisticated models cannot address which part of society is going to fund the long term care. At the end of the day those with insufficient funds are funded by the state. This comes into clear focus in practice when you are actually buying long term care for someone and you realise that most other residents in the home are paid for by the state. The insurance industry needs to question whether it is a form of mis-selling to sell something which would otherwise be provided by the State.

In summary, I am trying to say that the Actuarial Profession should be heavily involved in the debate over long term care because we are one of the few professions which is technically able to do the modelling. However we need to realise that there are political and social difficulties around how to finance this fairly, either through the State or insurance, particularly for dementia cases.

Good luck! Let's hope we make more progress in the next 20 years than we did in the last 20!

The Chairman: That was a volunteer for the working party!

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

Mr P. G. Scott, F.I.A.: Just a couple of points. First, on the question of how far should the health PEC push the boundaries in researching this area, I would encourage you to keep pushing, to keep trying to stretch out, because I think that this is an area where we really can add value to the debate. If you reach the point where someone really screams that you have gone too far, you have probably gone just about far enough.

I have been focusing my mind on this question of how we grow the insurance market in this country, by which I mean how we grow the private insurance market. We have a degree of public insurance today. We perhaps do not like it because it includes people having to sell their houses to pay for their part of the public system. But we have a partial public system.

As far as private insurance is concerned, I start by looking at the history. As the authors said, when you look today there is not much more than immediate care annuities available in the market. If, however, you look back 15 years, there were some innovative products developed in this marketplace. I know my old shop had some products whereby not only could people pre-fund care, but they could choose the level of care: there was a gold, a silver and blue product, which provided different levels of benefits.

It was not a lack of actuarial design or even actuarial pricing for the product. The demand has never been there. When we debate this question of what would make a successful private insurance market, we have to look at the question of demand. In one sense, I think that it is extremely challenging. In our society we are not really saving enough for the living years, so trying to persuade people to save for the dying years is extremely difficult.

I wonder whether in this country we are going to have to open up the debate again about the fiscal approach to premiums for this type of insurance. We know from history in the days of private medical insurance, the over 65s could obtain tax relief on their premiums. There was a much, much bigger market which almost collapsed when the tax relief was taken away.

I wonder whether further work for the working party may cover both international comparisons and history in this country. For me, if we want to stimulate this market, the market is going to be people in their 60s and in their 70s, who are starting to worry about costs for their care. The question is how do we motivate them to invest in a quality insurance product?

Mr P. A. C. Seymour, F.I.A.: I started in the long-term health care business about 20 years ago. I remember standing up, just to echo what we have just heard, and saying "What chance have we in creating a long-term care market?" That is when the reinsurers were all keen on it. We could not get people to do enough about their pensions.

To put that in perspective, the Rowntree Enquiry pointed towards a social insurance fund. To make it sustainable, it pointed towards having a non-government body that determined what contribution rates ought to be. We called them in-flight corrections, as we were trying to keep the ship afloat.

The point is really that the cost of long term care is 2% or thereabouts. The cost of pensions is 20% or thereabouts. Look where we are now on the subject of pensions! I really do think, and I am just echoing what Mr. Scott said, that to create an insurance market in this country is going to be extremely hard.

By the way, we were also talking about partnership deals back then. Will Dilnot happen or not? It seem clear that the insurance companies would like it to happen because there is an insurance

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

market that would fit in quite well with the proposals. But I do not know whether it will happen—I think pensions are more important.

Mr P. H. Simpson, F.I.A.: I was one of those reinsurers who, 15 or 20 years ago, were trying to help develop the market. I think that if you are going to look at the private long-term care insurance market, such as it is, you are probably going to split it into three segments. The richest people will probably pay-as-you-go for a high standard of care. There is always, hopefully, going to be some form of safety net for the poorest in society. It is really to the middle segment that the industry can best address itself.

Again, looking back about 15 years ago to some of the innovative product designs that were talked about, at that time one of the more interesting ones looked at utilising a pension pot to buy an annuity which would increase its pay-out when the annuitant became ill and was unable to perform the tasks of daily living.

At least at that time, I believe, one of the problems with that product design was that under the tax laws you could not buy an annuity out of a tax exempt pension pot whose potentially variable payments out were contingent on such an event, which is a pity. Obviously, the two largest pools of resource people in this middle segment have tended to have are their pension pot and their house.

Again, so far as I am aware, that has not changed. We seem to be suffering from some tax and HMRC limitations on product design.

We effectively have a long-term care insurance industry at the moment. It is called equity release. Just by default. When people get to advanced age, they run the risk of outliving their assets. I know that, historically, there have been issues and stigma related to equity release. Some of the more modern products overcome those issues. There still is a fairly negative mind-set regarding equity release products, particularly among the older generation. Some of the survey feedback suggests that the younger generation are happier to spend the equity in their house rather than leave it as an inheritance for their children.

A major issue has also been alluded to: the uncertainty around how the state and the insurance industry interact. 15 years ago things very much got kicked into the long grass. We had the Royal Commission on Long-Term Care. Its findings got sidelined and never really developed. Now we have Dilnot.

Until we have some certainty about how the private and state sectors will interact, it is going to be very difficult for the long-term care industry to grow in any way other than, perhaps, for products like equity release, which is probably not the ideal way of addressing the specific problem of the funding for old age care.

Ms A. Misterka (student): There was talk about private insurance. My question is: is it possible to widen the research regarding people who migrate from country to country?

Everybody has been talking about the UK only. There could be a wider demand from people who have emigrated, for example from France to the Netherlands, or from the Netherlands to the UK. I did not see any research about the cover for such people who probably will not have a house or annuities for the future. They may not be covered by any other country, if they were not living in the European Union, for example.

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

Mr Seymour: I forgot to say something about the modelling point. Following the very first paper that the Institute introduced with Steve Nuttall and others, we were invited by the Select Committee for Health to talk about this subject and we were projecting long-term care costs.

I said to the people there: "We could have a relatively benign scenario where the cost goes up by 2030, let us say, two times in real money, or we could have an equally possible scenario where it goes up by a factor of eight in real money."

They turned to me and said "You are useless", which is a lesson in itself, but I said "I am sorry, the message I am trying to give you is this: you need a robust system that will cope with variable scenarios in the future." Tonight's word is "sustainable" rather than "robust" .

The trick is getting across the idea of sustainability. Earlier, I spoke of it in terms of the Rowntree recommendation, a sort of off-line quango to set rates of contribution, and it was compulsory, and all those things that probably do not play very well any more. I do not think people understand how potentially variable the outcomes are over long, long periods of time. Maybe we could get that message across in a better way.

Mr D. L. Grimshaw, F.I.A.: It has been a very interesting debate. There are a lot of points that I could echo but I will not.

One point I have not heard which always concerned me when, like Mr Simpson earlier, I was promoting long-term care insurance as a reinsurer several years back, was the fact that the claim triggers under private insurance vehicles may not match up with the care needs. It was always a concern in my mind, and it is one that remains, if you put forward private insurance as a solution, that I could have perfectly genuine care needs but not quite fail the specified activities of daily living. There is an important mis-match there that has the potential to undermine the private insurance vehicle.

Mr D. Simmons, F.I.A.: Looking at compulsion versus optionality, the thought that I have is that there is compulsion for the state. The state cannot just abandon people who cannot care for themselves. Therefore maybe some form of compulsion of funding, perhaps akin to employees being automatically enrolled in to the National Employment Savings Trust, might be an appropriate thing to think about.

Miss Elliott: Thank you for all your questions.

The first point is about waiting to see what happens on Dilnot. Regardless of Dilnot, there is still a need. Dilnot is not covering the hotel costs, and for the sector that we are looking at from an insurance perspective, a lot of that need is going to be amongst medium wealth earners. They, potentially, are going to be looking for better quality homes than you would get from a local authority-funded bed. So the hotel costs could be quite significant. That is something, as a profession and as an industry, we have to try to help the government to understand.

The next point is about products: the disability linked annuity. There was some clarification issued by HMRC in discussions with the ABI in September. It is not as clear as we would like it to be, but at least it is a step forwards and it is indeed to be tested.

Equity release and care: yes, I agree with that. It is potentially a good solution for domiciliary care in your own home. Again, I know the profession has done work on equity release before. We could

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

combine equity release and care and we could work together to review risks associated with the combination.

We did not really focus on private insurance that much in the paper. It might take a separate working party to look at the potential for the profession to add value in the private insurance area. We are not here to design the products, but we can add the funding element, the risk assessment, the data collection, etc.

Dilnot: extending out from central modelling only to cover new scenarios with different variability. I think that is something we should really push for. I have made a note for myself to follow that up and see whether we have had any responses from Jeremy Hunt and Norman Lamb.

I take on board the country to country integration. I had not thought about that.

Mr Wilson: Thanks, Miss Elliott. You have just about covered everything. There was a question on awareness. Part of Dilnot was around large-scale public awareness. We are all going to become aware of the issue over the next 10 to 20 years. It is going to be happening all around us as our parents and more and more people are in need of long-term care. We have to try to bring that awareness forward so that the public know that they have to take action.

France seems to have done something that has worked. We can maybe learn from France and the national solidarity day. Over the last couple of years we have all had an extra bank holiday. Maybe next year we can give up a day's work and a day's pay?

On the fiscal regime, I totally believe that in countries where they allowed other types of insurance to obtain tax relief, like Australia, it has worked. It has grown the market. To allow long-term care to obtain tax relief would be a very good move.

Ms Golds: I thought that was a very interesting point around the differences that wealth and income have on people's long-term care needs in the future. I would point out that with a system like the Netherlands, although it is universal in theory, in practice the co-payments are so high for the higher earners that they self-fund. Also in Germany there is the opt-out, so in reality it is not universal.

France has had a lot of success in educating the country and there has been a large increase in private coverage. Education of the public has to be key here. People are often not aware of the issue until it affects a family member and they see the effects and the cost. People's children have to be engaged. The idea of your parents having to sell their house to pay for their care is never popular. Preventing this is quite an incentive, upon which a market could be built.

Mr Sissons: I was interested in the number of times that the word "modelling" was mentioned. I found that very encouraging.

There were a couple of points upon which I wanted to pick up. The phrase "living years and dying years" crept in. Anyone who has a physical disability regards themselves as still in the living years. It may become a little difficult when you have mental incapacity. But in general people who are still alive think of themselves as in the living years. That, I think, is where the differentiation between pensions, the normal income while you are living, and long-term care, the income that you need when you are in a state of needing care, is a boundary which is not a clear one. We have tended, in

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press

society, to create boundaries that actually do not exist. Income needs in retirement are to see you through the rest of your living years.

On the question of incentives: Mr Grenham commented that he found the paper a little bit confusing as to what we were actually trying to achieve. One of the things that we were looking at was the reason why systems had come out in different ways in different territories. Incentives are often one of the key factors.

Maybe we did not draw that out sufficiently in the paper. That was certainly one of the underlying intentions. Dilnot just happens to be the proposition that is on the table at the moment in the UK. The paper was not aimed specifically at Dilnot. But we cannot ignore it. It is the flavour of the month.

I could not hear Mr Grimshaw's question clearly enough to reply. But I think it was about the differentiation between the assessment of care needs under an insurance policy and the state.

Under the new proposals for the single assessment, if the insurance industry is willing to use that as a basis for providing cover, those sorts of differentiation should not be as strong as they were in the past.

I thought the point about immigration/emigration is a very valid one. It does go right through the heart of the subject, not just in terms of the inter-generational strains that are introduced when you have people in different territories but we rely very heavily on immigration to provide the staff for care homes in the UK. It is a multilayered question and certainly one that I think bears looking at in more detail.

The Chairman: Thank you very much, authors, and thank you very much to the participants.

The plan of our colleagues is to finalise the paper. I do not know when that is going to be because I think that there are so many different ideas to come out from this evening that there is quite a large piece of work to be done. I suspect if anybody from the audience wants to volunteer, or who have colleagues who would like to volunteer, their help would be gratefully received.

To me there were four broad headings that struck me from our discussion. We talked a lot about modelling the funding costs. There is a lot of data from different countries that could be used to show the consequences of the pyramids for funding costs, etc. Also, not just for the mean, but the tails of the distribution. What is the variability in this? There is the arithmetic consequences of assumptions but then there is also the sensitivity around those assumptions. What do the assumptions represent in terms of changes in the population or changes in lifestyle, or whatever?

We talked quite a bit about funding options and the consequences: how are you going to cover all of this cost? We have talked about incentives from fiscal treatment. Also, we covered how people will react to different cost structures that are put in place. There is plenty of volatility there, and options to model.

We have also talked about history. Some people have given us the benefit of previous working parties and previous experiences. That is worth capturing.

What man learns from history is that man does not learn from history, so said Napoleon. But our motto is reason from experience. That is the motto of the Institute and the Faculty. What we can learn from the past may well be very helpful in the future.

Then we had the point about what we could learn from other countries, both in terms of terms of the movement of population, but also their experiences; what drives behaviour and what drives different designs.

Ringing in my ears is Mr. Scott's comment that if anybody feels you have gone too far, you have probably gone to the right place.

As you can tell, many of us have enjoyed reading the paper. We are grateful to the authors for what they have done and we are looking forward to the next instalment. Please join with me in thanking our speakers.

https://doi.org/10.1017/S1357321713000329 Published online by Cambridge University Press