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Delivering a National Care Fund: How would a public-private partnership work?

James Lloyd

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Executive Summary

The majority of countries that have gone furthest to address problems of long-term care funding in recent decades have done so through the creation of state-sponsored insurance schemes. This paper begins from recognition of the failure of conventional consumer insurance, the need for new funding in the system and the limited appetite among fiscal policymakers to take on new public spending obligations in relation to social care. Building on the model of a *National Care Fund*, first put forward by the author in 2008, the paper asks: could a *National Care Fund* for long-term care be operated and underwritten by the private sector? How would such a public-private partnership work? Such a *National Care Fund* would fund the costs of personal care for retirees in a residential or domiciliary setting.

Taking account of various considerations, the paper develops a viable model that would see working-age individuals make contributions to a *National Care Fund*, which disperses premiums into one of several 'social investment funds', managed by the private sector. An annual 'National Care Grant' from these investment funds, reflecting notional contributions and smoothed returns from growth, would then be used to purchase community-risk rated annuities for each individual aged over 65 experiencing the onset of 3 'Activity of Daily Living' (ADL) failures, in a given year. These annuities would be sold to the *National Care Fund*, which would then make ongoing payments to claimants. As a transitional stage, policymakers could open up the Fund to contributions to today's retired cohort through various payment options.

The model would require around 250,000 community-risk rated annuities to be provided by the insurance industry each year, with an average premium of around £27,300 and average life expectancy per life insured of 3.5 years. For individuals, premiums for the *National Care Fund* would be £6825 as a lump-sum cash-payment in retirement, a charge on their estate, or as an average £14 per month premium if spread over a 40-year working career. This would result in an entitlement to £150 per week toward personal care costs to individuals who experience 3 ADL failures, which would be payable for the rest of their life. Retirees experiencing 1 or 2 ADL failures would continue to rely on informal care, Attendance Allowance, and formal care purchased using Attendance Allowance, the State Pension and other pension income.

Among those countries that have gone furthest to address the challenge of long-term care funding during the last 20 years, the majority have done so through the creation of state-sponsored insurance schemes.

Every state-sponsored insurance scheme for long-term care is different, and reflects the wider institutional and welfare-state structures operating in different countries. Some insurance schemes, like those of Japan and Germany, have been built around traditional social insurance funds run at arms-length from government. Others, such as those in the Netherlands and Singapore, comprise state-sponsored insurance schemes built around a central delivery role for the private sector.

This report is focused on the issue of *delivery*, and the feasibility of creating a state-sponsored insurance scheme for long-term care in England and Wales that is administered and underwritten by the private sector, and the insurance industry in particular.

The rationale for this approach derives from three observations: the failure of conventional consumer insurance for long-term care; the need for new funding in the system; and, the limited appetite among fiscal policymakers for taking on new liabilities in relation to long-term care funding.

Building on the model of a *National Care Fund* for long-term care, first proposed by the author in 2008, this paper explores how such a state-sponsored insurance scheme for long-term care in England and Wales could be delivered by the private sector with the potential to achieve the outcomes for the social care funding system sought by stakeholders and policymakers. The *National Care Fund* would fund the costs of personal care for retirees in a domiciliary and residential setting.

This paper therefore sets out to answer the questions: could a *National Care Fund* for long-term care be operated and underwritten by the private sector? How would such a public-private partnership work?

Various models for a public-private partnership to run a *National Care Fund* can be conceived. These would see the private sector undertaking the different components and functions of a state-sponsored insurance fund for long-term care.

The biggest challenge for insurance companies in relation to long-term care funding has traditionally been around uncertainty regarding future patterns in morbidity and longevity, which have been relatively difficult risks to ‘price’, making pre-funded insurance in particular, a challenging product to provide.

As such, some models for a public-private partnership would be problematic for private providers, for example, a scheme in which working-age contributions were converted into a per-head pre-funded insurance for care at retirement, purchased by a *National Care Fund* on behalf of individuals. Insurers would still face an average 17-year gap between the notional purchase of insurance and claims, resulting in high levels of uncertainty.

Instead, a viable model would see working-age individuals make contributions to a *National Care Fund*, which disperses premiums into one of several 'social investment funds', managed by the private sector. An annual 'National Care Grant' from these investment funds, reflecting notional contributions and smoothed returns from investment growth, would then be used to purchase annuities for each individual aged over 65 experiencing the onset of 3 'Activity of Daily Living' (ADL) failures, in a given year. These annuities would be sold to the *National Care Fund*, which would then make payments to claimants.

Crucially, these annuities would be community-risk rated rather than individually underwritten, in order to ensure that there is consistency among claimants regarding the level of support they receive.

In this way, a *National Care Fund* would look and feel like a social insurance fund to individuals, even though it would be entirely administered and underwritten by the private sector in partnership with the state.

A further option would be for the annuities purchased from the private sector to be *escalating* annuities in which the income payable rises by 3% each year, or *disability-linked* so that the income payable rose commensurate with changes in need.

The model proposed could be adapted to receive contributions from the retired generation, in addition to those of working-age, although it is unlikely that redistribution – a characteristic of social insurance funds - among this cohort would be feasible. For policymakers, opening up this model to the retired generation would involve two sets of choices: *payment options* and the *choice framework* applied to them.

The claims threshold of 3 ADL failures is roughly equivalent to a Substantial level of need under the current Fair Access to Care Services criteria used by local authorities. Setting the claims threshold at this level is reasonable given that many households can cope with Low and Moderate levels of need through the provision of informal care, and through formal care purchased from private resources. In addition, many individuals with 1-2 ADL failures will be able to claim Attendance Allowance, which is worth £71.40

at the higher rate and £47.80 at the lower rate.

Existing academic research suggests that the number of individuals aged 65+ experiencing 3 or more ADL failures is around 1 million, and the annual mortality rate in this group is 24.6%. It can therefore be assumed that around 250,000 individuals aged 65+ will experience the onset of 3 or ADL failures each year, and that they will live for an average of three and a half years. In effect, a *National Care Fund* would receive 250,000 new claims each year.

It is proposed that £150 be the target amount for a weekly benefit payable by the *National Care Fund* to individuals entitled to make a claim. On this basis, a well-funded scheme would see the average total benefit payable as 182 weeks x £150 per week, which is around £27,300.

Assuming away any 'load factor', which would anyway be low given the distinctive nature of the market in question, it is therefore possible to project that under a scenario in which a well-funded *National Care Fund* was delivered via a public-private partnership, the associated annuity market would comprise 250,000 new annuities written each year, with a standard premium of around £27,300, and policies typically in force for about three and a half years. To put this figure in context, in 2010, the total number of standard annuities written by members of the Association of British Insurers, including guaranteed, level and escalating annuities, was just over 400,000.

In creating a structure for the management of the social investment funds by the private sector, policymakers would have to give consideration to engendering competition among asset managers, appropriate investment strategies, and the necessary governance mechanisms to ensure that contribution levels were sufficient given projected levels of need and investment growth.

If it is assumed that an average per-head annuity premium of £27,300 for claimants on the *National Care Fund* would be desirable, and that one in four individuals reach the relevant threshold of need, then an average total premium from individuals would need to be around £6825, assuming contributions from the whole population. If it is assumed that 40-50 million people were participating in the *National Care Fund* at any time and that the average contribution was £6825, then the assets under management for the Fund would be worth around £270-340 billion.

It is worth noting that a number of countries have created similar investment fund structures, in order to address shortfalls in pay-as-you-go public pension systems. For example, in July 2001, France created the

Pensions Reserve Fund (Fonds de réserve pour les retraites) in order to use funds realized from privatisations of state assets to finance future shortfalls in the state pension system.

What could the government do to facilitate the involvement of the financial industry in delivering this model? Key issues would likely be the needs-assessment/gateway systems, whether participation was compulsory, and the provision of data by the government in order to help insurers price the risks involved.

It therefore appears that a *National Care Fund* operated and underwritten by the private sector would be entirely feasible. The *National Care Fund* would pay £150 per week to retirees experiencing 3 or more ADL failures. The average total premium payable to the Fund would be around £6825, which is around £14 per month spread over a 40-year career.

However, despite the complexity of this structure, it would from appear from the viewpoint of (working age) individuals to be a social insurance fund: contributions proportional to means, and a benefit payable to all entitled to make a claim.

A transitional stage involving contributions from the retired cohort would address issues of sustainability and intergenerational fairness encountered in pay-as-you-go models.

Going forward, a model built around social investment funds and community-risk rated annuities provides a suitable basis for further discussion and analysis, and represents the substantive recommendation of this report for how a *National Care Fund* for long-term care could be achieved through a public-private partnership.

Importantly, the model proposed has a high degree of in-built flexibility. It can respond to changes in patterns of morbidity and longevity. It is able to provide benefits to claimants that vary with need and inflation. The role of the 'National Care Grant' could evolve, and a portion of it could be used to fund preventative interventions proven to be cost-effective. The National Care Grant could also be used to fund support payments to informal carers, echoing a characteristic of the social insurance fund for long-term care that operates in Germany.

What would be the offer to the population under this model? Under the model proposed, which would be both cost-neutral and risk-neutral for HM Treasury, individuals would pay around £6825 into the *National Care Fund* as a lump-sum cash-payment in retirement, a charge on their estate, or as an average £14 per month premium if spread over a 40-year working career.

Retirees experiencing 1 or 2ADL failures would continue rely on informal care or pay

for the costs of formal care themselves, including from the receipt of Attendance Allowance, the State Pension and other forms of pension income. Individuals experiencing 3 ADL failures would be entitled to claim on the *National Care Fund*, and would receive around £150 per week, which would be payable for the rest of their life, and could be varied according to level of need and inflation.

As such, from the point of view of individuals, the £6825 premium would enable individuals to cap the weekly cost of care that they would have to pay for while ensuring that their income was sufficient to purchase the care they required.

1. Introduction

This report is focuses on the potential delivery of a state-sponsored insurance scheme for care, administered and underwritten by the private sector...

Among those countries that have gone furthest to address the challenge of long-term care funding during the last 20 years, the majority have done so through the creation of state-sponsored insurance schemes.

The most recent countries to take this path are: the USA, which is setting up a national workplace opt-out insurance scheme for long-term care under the aegis of the 'CLASS Act'; and Jersey, which is at an advanced stage in plans to operate a new ring-fenced social insurance fund for long-term care from 2013, with contributions from employees, the self-employed and retired people.[1]

Every state-sponsored insurance scheme for long-term care is different, and each has reflected the wider institutional and welfare-state structures operating in different countries. Some insurance schemes, like those of Japan and Germany, have been built around traditional social insurance funds run at arms-length from government. At the other end of the spectrum, reforms such as those in the Netherlands and Singapore comprise state-sponsored insurance schemes built around a central delivery role for the private sector.

The evolution of long-term care funding in England and Wales over the last decade has been very different. Although the Royal Commission on Long-term Care (1999) resulted in state-funded free nursing care throughout the UK and the partial introduction of free personal care (Scotland), reform of social care funding in England and Wales has effectively remained frozen for the last decade, with millions of people suffering the consequences of this inertia.

Delivering a National Care Fund: How would a public-private partnership work?

This discussion paper is not focused on the pros and cons of state-sponsored insurance funds as a potential model of long-term care funding in England and Wales compared to other potential models. Such an evaluation would depend on many complex design choices – the shape of the state safety-net, the design of premiums and benefits, etc. - which fall outside the scope of this report.

Instead, this report is focused on the issue of *delivery*, and the feasibility of creating a state-sponsored insurance scheme for long-term care in England and Wales that is administered and underwritten by the private sector, and the insurance industry in particular.

Why focus on such a public-private partnership in the context of debate on long-term care funding in England and Wales? The rationale for exploring the delivery of a state-sponsored insurance scheme run through a public-private partnership derives from three observations:

- The failure of conventional consumer insurance for long-term care: as with other countries, the experience of private long-term care insurance in England and Wales is one of effective market failure. The last insurance company offering pre-funded long-term care insurance in England and Wales exited the market in 2010 citing a lack of demand. Barriers to the market, which are common to many countries and fall mostly on the demand side, are supplemented in England and Wales by unique factors such as the operation of universal free personal care in Scotland, with its effect on attitudes to long-term care insurance south of the border.[2] The limitations of any approach built upon orthodox voluntary consumer insurance for long-term care have been increasingly recognised by the insurance industry itself.

This approach stems from the failure of conventional consumer insurance for care, the need for new funding in the care system, and the limited appetite among fiscal policymakers for taking on new liabilities...

- The need for new funding in the system: the under-resourcing of the long-term care funding system in England and Wales is manifested in the incidence of 'catastrophic costs', excessive rationing, unmet need and a reliance on 'excessive' informal care provision by families. A funding system that will deliver significantly improved outcomes across these domains is required, and the core change associated with such an improvement will be a substantial increase in the volume of funding, both public and private expenditure, in the social care system. A key criterion for evaluating any model of long-term care funding is the extent to which it drives new money into the system.

- Limited appetite for increased risk-exposure within HM Treasury: the UK Exchequer is already heavily exposed to the principal risks associated with long-term care funding – morbidity-risk and longevity-risk – through current and future liabilities arising from the State Pension, public sector pensions and the NHS. There is a limited appetite among policymakers to transfer more longevity-risk and morbidity-risk from the population to the Exchequer, and any funding model for which these risks would rest with the private sector would be viewed more positively than those - such as universal state-funded free care - which would see the Exchequer take on new liabilities, the costs of which are inherently difficult to forecast. In this context, there is inevitably interest in long-term care funding models in which the risks associated with obligations to fund long-term care remain with households or the insurance industry.

Building on the model of a *National Care Fund* for long-term care, first proposed by the author in 2008, this paper explores how such a state-sponsored insurance scheme for long-term care in England and Wales could be delivered by the private sector with the potential to achieve the outcomes for the social care funding system sought by stakeholders and policymakers.

In the context of the rationale outlined above, this discussion paper seeks to answer the questions:

- Could a *National Care Fund* for long-term care be operated and underwritten by the private sector?
- How would such a public-private partnership work?

The next chapter provides some background on state-sponsored insurance schemes for long-term care, examining why they have been adopted in different countries, as well as some of the trade-offs involved.

Chapter 3 sets out some background information for exploring the questions above, including the different types of risk associated with long-term care funding, as well as different ways of pooling risk through insurance.

In Chapter 4, different potential models for structuring a *National Care Fund*, operated through a public-private partnership, are explored.

Building on the models developed in Chapter 4, the fifth chapter explores what the effective 'market' that private sector agents would confront would comprise.

Chapter 6 concludes by highlighting key messages and recommendations for policymakers.

Key points:

- Among those countries that have gone furthest to address the challenge of long-term care funding during the last 20 years, the majority have done so through the creation of state-sponsored insurance schemes.
- Every state-sponsored insurance scheme for long-term care is different, and each has reflected the

The paper builds on the model of a *National Care Fund* first put forward by the author in 2008 as a proposal to fund the costs of personal care for retirees who would otherwise receive little from the state...

wider institutional and welfare-state structures operating in different countries. Some insurance schemes, like those of Japan and Germany, have been built around traditional social insurance funds run at arms-length from government. At the other end of the spectrum, reforms such as those in the Netherlands and Singapore comprise state-sponsored insurance schemes built around a central delivery role for the private sector.

- This report is focused on the issue of *delivery*, and the feasibility of creating a state-sponsored insurance scheme for long-term care in England and Wales that is administered and underwritten by the private sector, and the insurance industry in particular.
- The rationale for this approach derives from three observations: the failure of conventional consumer insurance for long-term care; the need for new funding in the system; and, the limited appetite among fiscal policymakers for taking on new liabilities in regard of long-term care funding.
- This paper therefore sets out to answer the questions: could a *National Care Fund* for long-term care be operated and underwritten by the private sector? How would such a public-private partnership work?
- Building on the model of a *National Care Fund* for long-term care, first proposed by the author in 2008, this paper explores how such a state-sponsored insurance scheme for long-term care in England and Wales could be delivered by the private sector with the potential to achieve the outcomes for the social care funding system sought by stakeholders and policymakers.

2. Background: The trend toward state-sponsored insurance schemes for care

A growing number of countries have deployed state-sponsored insurance schemes to fund care in recent decades, including Japan, the USA, Germany, Singapore and the Netherlands...

Although widely different in their form and design, a growing number of countries have deployed state-sponsored insurance schemes to fund long-term care in recent decades.

In Singapore, employees have been making payments to 'Eldershield' since 2002. With the passing of the Long Term Care Act of 1994, Germany established mandatory social and private insurance for long-term care insurance, resulting in coverage for almost the entire population.[3] In the USA, following the passing of the Community Living Assistance and Support Services Act ('CLASS Act'), policymakers are now implementing a national workplace insurance scheme for long-term care built around auto-enrolment. With Jersey at an advanced stage of planning for the creation of a ring-fenced social insurance fund for long-term care from 2013, the arrival of a state-sponsored insurance scheme for long-term care in the British Isles appears imminent.

This chapter provides background information on why this trend is observable. It considers those factors that drive countries to pursue this broad approach and some of the challenges involved. Thumbnail portraits of some schemes found overseas are contained in Appendix 1.

Why have different countries created state-sponsored insurance schemes for long-term care?

- Overcomes failure of conventional private insurance market

No country in the world has an effective, functioning market in pre-funded long-term care insurance (LTCI). Consumer aversion and other demand-side barriers have repeatedly seen the insurance industry unable to deliver the outcomes required of long-term care funding reform by social care policymakers and governments.

Despite the extensive use of tax incentives and promotional campaigns, the US market for pre-funded LTCI has effectively stalled at a take-up rate of 10%, and policymakers are now implementing a wholly new approach built around an opt-out state-sponsored insurance scheme. In France, distinctive welfare and family laws – notably the 'obligation alimentaire' – have resulted in a take-up rate of 15% for pre-funded LTCI, which is the highest in the world. However, although take-up is high, the cover provided by benefits is typically low, and some French policymakers remain keen to explore alternative approaches.[4]

- 'Choice architecture'

Recognising the tendency of individuals to ignore the risk of needing care, and the 'transaction burden' associated with obtaining private sector LTCI – such as the need to obtain financial advice - state-sponsored insurance schemes are able to impose a 'choice architecture' that results in far higher levels of take-up or participation. This may include standardised premiums and benefits (Singapore), 'auto-enrolment' (USA) or compulsion (the Netherlands).

- Benefits of explicit ring-fencing

Given the fiscal pressures imposed by an ageing population and its implications for public spending, countries have been compelled to ask their citizens to make new, extra provisions toward the funding of long-term care, i.e. a partnership between the individual and the state.

The political challenge involved in this has been mediated by directing these contributions to a clearly ring-fenced insurance scheme rather than toward the exchequer, where voters may contributions will be shifted to fund other types of expenditure. Any state-

The benefits of state-sponsored insurance schemes for care include the opportunity to overcome market failure in consumer insurance, the benefits of ring-fencing, and the 'choice architecture' policymakers can impose...

sponsored insurance fund for long-term care ultimately represents a 'contact' between families and citizens about the role of care from outside families in supporting vulnerable individuals. Embodying this contract in the operation of an independent insurance fund may help to maintain consensus and participation around this contract.

- 'Community-risk' premiums

Some individuals would struggle to afford premiums for LTCI set proportional to their risk-profile (individual risk-rating), whether because their low income means they cannot afford the average cost of premiums, or because they are high-risk (e.g. because of a pre-existing condition), and so their premium is unaffordable.

State-sponsored insurance schemes, including those delivered by the private sector, have enabled policymakers to get around this problem by determining how premiums are set, often by imposing 'community-risk' rated premiums (premiums that reflect the average risk of the population), and where necessary, facilitating cross-subsidy between high and low-risk groups, as well as wealthier and poorer households.

However, such redistribution is not limited to state-run insurance schemes. The Dutch scheme insurance scheme, AWBZ, is an example of the private sector delivering a long-term care insurance scheme built around community-risk rated premiums. In Singapore, the privately delivered and underwritten 'ElderShield' scheme features standardised premiums and benefits. Although there is limited redistribution within the scheme, the Singaporean government has made periodic contributions to the individual social security of accounts poorer citizens, so that redistribution effectively occurs as a tax-funded subsidy.

- System integration

The design of the funding mechanisms in a long-term care system inevitably reflect the wider shape of the system and the way in which care is organised and delivered, the role of families and the interaction with health services.

An advantage of state-sponsored insurance schemes observable in multiple countries that have adopted this approach is that policymakers can carefully integrate funding streams with health systems, local government and the architecture of social care delivery.

- Commercial opportunities

The demand barriers to private sector LTCI have resulted in very limited commercial opportunities for the financial services industry. In contrast, public-private partnerships in countries such as the Netherlands and Singapore have seen companies, such as Aviva, able to compete for tenders to deliver insurance solutions that fulfil the objectives of social care policymakers, with participation measured in multiples of millions rather than the tens of thousands.

What have been the challenges associated with creating a state-sponsored insurance scheme for long-term care in other countries?

- Administration costs

The administration and transaction costs associated with a state-sponsored insurance scheme for long-term care, particularly one delivered by the private sector, may be high compared to a simple model based on 'tax-and-spend'.

- Fiscal policymaking

Fiscal policymakers are traditionally wary of any proposals that limit or reduce their control and reach

The principal disadvantage over traditional tax-and-spend funding models is the extra cost of administering a state-sponsored insurance scheme...

over fiscal policymaking, particularly involving compulsory insurance contributions from income or earnings, which are tantamount to a form of income taxation.

However, state-sponsored insurance schemes for long-term care based on compulsory contributions result in precisely this outcome. The schemes found overseas typically feature distinct governance mechanisms for setting premium and benefit levels, which could be seen as infringements of the control of fiscal decision-makers.

Key points:

- Why have different countries created state-sponsored insurance schemes for long-term care? Various factors can be identified.
- Such an approach provides a mechanism to overcome the failure of conventional private insurance market.
- Policymakers can implement a choice architecture that results in high levels of participation, which may include standardised premiums and benefits (Singapore), 'auto-enrolment' (USA) or compulsion (the Netherlands).
- In the context of ageing populations, the political challenge involved with asking citizens to make new contributions toward long-term care risk-pooling has been mediated by directing these contributions to a clearly ring-fenced insurance scheme rather than toward the exchequer, where voters worry they may be used on other types of expenditure.
- State-sponsored insurance schemes, including those delivered by the private sector, have enabled policymakers to determine how premiums are set, often by imposing 'community-risk' rated premiums (premiums that reflect the average risk of the population), and where necessary, facilitating cross-subsidy between high and low-risk groups, as well as wealthier and poorer households.
- Policymakers can carefully integrate funding streams with health systems, local government and the architecture of social care delivery.

3. Delivering a National Care Fund: Setting the scene

Exploring how a *National Care Fund* for long-term care could be administered and underwritten by the private sector requires some key concepts and distinctions to be set out...

The previous chapter looked at the trend toward state-sponsored insurance schemes to fund long-term care observable in a number of countries during recent decades.

Having set out this background context, the next chapter will look at the core question of this paper: how could a state-sponsored insurance scheme – a *National Care Fund* - for long-term care be delivered through a private-partnership?

To set the scene for answering this question, this chapter reviews some key concepts and distinctions, which are useful for exploring questions of insurance and risk-pooling.

- Pre-funded insurance

In the context of long-term care, pre-funded insurance is insurance bought before the onset of need. The risk-pool therefore contains some individuals who will go on to experience care needs and make a claim and some who will not. For example, many households buy pre-funded 'contents insurance' but only those that experience some unfortunate event, such as theft, will make a claim. Pre-funded insurance for long-term care operates in the same way: different individuals pay into a risk-pool and some of those individuals will make a claim when they require care.

'Asset-management' is frequently involved in running a pre-funded insurance scheme because of the time-gap between when individuals pay into a risk-pool and when they may make a claim. Asset-management could be particularly important for pre-funded long-term care insurance if individuals insured themselves when they were relatively young – e.g. aged 40 – and only claimed upon the insurance in old-age, e.g. when they were aged 80. For example, if a large number of 40 years olds purchased pre-funded long-term care insurance each paying a £10,000 premium, but only began making claims upon it at the age of 80, this money would have to be invested and managed for 40 years by the providers of the insurance.

Recognising this time-gap, some consumer pre-funded long-term care insurance products in the UK did previously incorporate an 'investment' component, i.e. they functioned as savings products when individuals paid into them with contributions invested in the stock market, before being converted into an insurance. Perhaps inevitably, these products hit a problem when stock-market values plunged in the early 2000s, and as such, the products were phased out and lost favour.

- Annuities

An annuity is an insurance product that pays out a regular income until the death of the annuitant (buyer) in return for a lump-sum premium paid at the point of purchase. Life annuities are the foundation of the UK's defined-contribution pension system. However, many different forms and variations of a basic life annuity are possible, and a number of variants have been deployed in relation to health and social care needs.

Immediate needs annuities

In the social care system, a type of life annuity called 'immediate needs annuities' (INAs) can be bought for individuals in residential care. These are an insurance product for the costs of residential care that is purchased at the 'point-of-need', i.e. after a person has already experienced the onset of care needs and has moved into residential care. A person with care needs purchases an immediate needs annuity with a lump-sum payment, such as £80,000, and the annuity pays out a regular income until death, whether that occurs after 10 months or 10 years. An immediate needs annuity provides a person with protection from longevity-risk, i.e. uncertainty regarding how long they

The key risks associated with insuring for long-term care are longevity-risk and morbidity-risk, which occur at both the population and individual-level...

will live for and what their total accumulated residential care costs will be.

In England and Wales, immediate needs annuities have only been sold in relation to the costs of residential care when individuals have substantial levels of need. They have also typically been individually-underwritten, i.e. on the basis of a case-by-case individual assessment of health condition and need.

Disability-linked annuities

A further type of annuity relevant to social care is the 'disability-linked annuity' (DLA). These would typically be purchased using defined-contribution pension savings at the point of retirement, but before the onset of care needs. The key feature of a disability-linked annuity is that the annual income ('annuity rate') increases in line with someone's care needs.

Impaired-life annuities

Although falling outside the social care system, the UK annuities market also offers 'impaired life annuities' (ILAs). These are annuities offered to individuals with existing significant medical problems who therefore have a diminished life expectancy. ILAs are individually-underwritten, and because they take account of a person's lower life expectancy, enable such annuitants to secure a higher income than if they were purchasing an orthodox life annuity.

The variable design of annuities

In addition to the different types of annuity described above, it is also worthwhile noting other key potential features of annuities, in relation to the benefits (income) payable. Annuities may be:

1) Level – the same sum is paid out monthly until death regardless of changes in need or the costs of care;
2) Index-linked – the sum paid out changes in line with a pre-agreed index which could be inflation or changes in unit care costs;
3) Escalating – the sum paid annually increases by a pre-agreed measure, e.g. 3%.

- Longevity-risk

Longevity-risk refers to uncertainty regarding life expectancy. At an *individual*-level, longevity-risk refers to uncertainty regarding how long a particular person will live for. At a *population*-level, longevity-risk is uncertainty regarding the life expectancy of a society or particular group or cohort within it, for example: how long will individuals currently aged 65 live for?

- Morbidity-risk

In the context of social care, morbidity-risk refers to uncertainty regarding the onset of physical and cognitive impairments that cause a need for care and support, and how those impairments evolve. It is important to distinguish between *individual*-level and *population*-level morbidity-risk.

Individual-level morbidity risk is uncertainty regarding whether an individual person will need care and if they do, how their care needs will increase. At a population-level, morbidity-risk refers to uncertainty regarding what proportion of the population will require care, and what their level of need will be. For example, what proportion of the population will experience 3 or more Activity of Daily Living (ADL) failures in a given year, and how many will go on to experience 5 ADL failures?

Population-level longevity-risk and morbidity-risk for long-term care have traditionally been challenging risks for the insurance sector to 'price'...

- Investment-risk

Investment-risk simply refers to the risk that the market value of stocks and assets, whether shares, bonds, property or other assets, can go up and down.

- Accumulation vs. decumulation phase

The 'accumulation phase' is the working-age period of the life course before retirement in which individuals accumulate wealth to fund their retirement. The 'decumulation phase' occurs from the point of retirement when individuals decumulate or 'spend-down' their wealth to provide an income to fund consumption.

In debate on long-term care funding reform in England and Wales, the particular challenges posed to the current system are focused on the baby-boomer generation, i.e. individuals who are arriving at, or have begun, the decumulation phase. This is significant because having passed through the accumulation, working-age stage of their life, this cohort has less scope to make contributions to a long-term care insurance scheme from income.

Insurance, risk and long-term care

It is worthwhile making some observations about different types of risk and insurance, in the context of insurance schemes for long-term care.

Uncertainty and the challenge of pricing the risks for long-term care over a long period

On some measures, it is easier for insurance companies to handle risks if the insurance is provided in relation to a shorter than a longer period. For example, if someone purchases pre-funded long-term care insurance at the age of 40, which will provide cover for the rest of their life, the 40-year time gap between purchase and the likely onset of care needs creates significant difficulties for insurers as trends in morbidity and longevity could vary enormously during this period, and insurers would struggle to assemble meaningful data in order to determine premiums and benefit levels for such insurance. Put another way, the bigger the time gap between purchase of insurance and likely onset of need, the harder it is for insurers to 'price' this risk. This issue was reflected in the historic design of pre-funded long-term care insurance products in the UK, some of which were built around an initial investment component, and others which gave the insurers the right to review premiums and benefit levels every five to ten years.

Longevity-risk and the insurance industry

The UK insurance industry, with a highly developed life annuity market, has significant experience in handling longevity-risk. However, there is much less capacity and experience in handling morbidity-risk, particularly in relation to pre-funded insurance, in which insurers would attempt to project social care-related trends in morbidity in the population into the future.

The advantage of compulsion for insurers

Compulsory forms of insurance have advantages for insurance providers. This is because when a whole 'population' participates in insurance, this results in a balance of different risk-profiles within an individual insurer's risk-pool. If insurance is voluntary, this increases the potential for adverse selection, i.e. because some high-risk individuals know more than the insurer about their risk-profile, more of them may purchase insurance than low-risk or average-risk individuals. This results in the cost of benefits to the insurer increasing, and in some circumstances, makes it untenable to offer insurance.

Nevertheless, the UK insurance sector does feature a highly developed life annuity market, and considerable experience of handling longevity-risk...

Key points:

- How could a state-sponsored insurance scheme – a *National Care Fund* - for long-term care be delivered through a private-partnership? To set the scene for answering this question, it is worthwhile to make some distinctions and observations.
- When a time-gap occurs between the purchase of insurance and claims upon it, asset-management may have to be undertaken by providers, and this may be particularly true for pre-funded long-term care insurance. For example, if a large number of 40 years olds purchased pre-funded long-term care insurance each paying a £10,000 premium, but only began making claims upon it at the age of 80, this money would have to be invested and managed for 40 years by the providers of the insurance.
- Various types of annuities are relevant to long-term care funding, including: immediate needs annuities which are bought at the point of needing residential care; and, disability-linked annuities which are bought with pension saving but for which the value of the income paid increases when care needs arise.
- The key 'risks' relevant to long-term care are longevity-risk and morbidity-risk, which can be conceived of at both the population-level and the individual-level.
- In relation to long-term care funding, the biggest challenge for insurance companies has traditionally been around uncertainty regarding future patterns in morbidity and longevity, which have been relatively difficult risks to 'price'.

4. Delivering a National Care Fund: How would a public-private partnership work?

The principal innovations associated with the *National Care Fund* model are around the time of payment, flexibility in payment options and choice architecture...

Having identified in the previous chapter some key concepts and observations on the operation of insurance for long-term care, it is now possible to explore some different potential models for a National Care Fund delivered via the private sector, which would fund personal care in a residential or domiciliary setting.

The analysis set out here effectively begins with the three observations put forward in the Introduction:

- The failure of conventional insurance;
- The need for new funding in the system;
- The limited appetite for increased risk-exposure within HM Treasury.

In this context, a funding model is required that is able to bring significant new funding into the long-term care system without transferring more risk from the population to HM Treasury. A state-sponsored insurance scheme administered and underwritten by the private sector could be achieve one way to achieve this.

A National Care Fund

This report builds on the proposal for a *National Care Fund* in England and Wales, which is a model originally put forward by the author in 2008,[5] but subsequently developed and refined by multiple further reports and working-groups.[6]

The *National Care Fund* model is of a pre-funded state-sponsored insurance fund for the costs of personal care in domiciliary or residential settings. The model has various distinctive features, but importantly, could be run as a public-private partnership or entirely by the state.

The distinctive features of the *National Care Fund* represent a response to the long-term care funding challenge in England and Wales, and the particular context found, especially the unprecedented housing wealth of the older population.

The key innovations in the model are:

1) Time of payment: most state-sponsored insurance schemes for long-term care are built around working-age payments. However, recognising the context of the long-term care funding challenge in England and Wales, the *National Care Fund* model proposes contributions by individuals from the State Pension Age onwards, i.e. in the 'decumulation phase'. Nevertheless, this would not prevent a *National Care Fund* from eventually receiving contributions from working-age individuals in the 'accumulation phase' when circumstances were appropriate, i.e. a phased transition to an accumulation phase model.[7]
2) Flexibility in payments: rather than a single payment option, such as income-based contributions, the model seeks to give individuals maximum flexibility and choice in when and how premiums are paid, with the options of contributions from income, lump-sums, or deferment of payment (with interest) until after death in the form of an estate charge.
3) Auto-enrolment: recognising that compulsory contributions would be politically difficult to implement, but a voluntary scheme would struggle to achieve sufficient take-up levels, the model proposes auto-enrolment as a middle-way. This could comprise a 'hard' version: individuals are automatically enrolled and if they do not opt out or opt for early 'pre-payment', the premium would be charged on their estate. Alternatively, a 'soft' version of auto-enrolment could be applied, i.e. 'mandated choice', in which individuals are *compelled* to make a choice about whether to participate. This could occur, for example, as part of

To explore how a *National Care Fund* could be administered and underwritten by the private sector, this chapter develops options based on a simple accumulation phase model...

the process of claiming the State Pension for the first time. However, neither approach would rule out a gradual transition to full compulsion if and when this became politically feasible.

The underlying rationale for the distinctive features of the *National Care Fund* model is to provide a non-taxation mechanism for deploying into the long-term care funding system the housing wealth of the older cohort, which a number of social care policy analysts have identified as a largely 'untapped' source of wealth to fund new risk-pooling mechanisms for long-term care.

Like schemes in the USA and Singapore, the *National Care Fund* model is an 'opt-out' long-term care insurance scheme, but one focussed initially on retirees. However, as described, this would not stop a *National Care Fund* scheme subsequently receiving contributions from working-age cohorts, in effect moving closer to the USA and Singapore schemes.

Options for a National Care Fund run through a public-private partnership

Using the *National Care Fund* model as a basis, this chapter explores in how a public-private partnership could be used to deliver a state-sponsored insurance scheme for long-term care.

For the sake of simplicity, the models below are developed on the basis of 'accumulation phase' contributions, with mandatory contributions paid from earnings. Subsequently, potential 'decumulation phase' versions are explored. However, in exploring the trade-offs in designing such a scheme, it is easier in the first instance to assume a basic accumulation phase model.

It is important to underline from the beginning the fact that each of the models developed below assume that from a 'user-perspective' the *National Care Fund* would appear to operate as a single entity into which they pay premiums, and which pays benefits as and when claims are validated. As such, the various potential structures for a public private partnership described below would, in effect, operate 'behind-the-scenes' and not be visible to users.

- Model 1: Accumulation phase pay-as-you-go *National Care Fund*

In this model, working-age individuals make contributions into a single insurance fund that is operated by an insurance company, which pays benefits to all older people requiring care. In effect, this would be a classic social insurance fund outsourced to the private sector.

However, from the point of view of insurance companies, no company would be able to operate an insurance fund for the whole population under existing regulation and capital requirements, nor to obtain reinsurance. In effect, the *scale* of such a scheme would be too risky for any individual company to take on.

In addition, as a pay-as-you-go (PAYG) scheme, issues of *intergenerational fairness* and *sustainability* arise if the current working-age generation were expected to fund the benefits of current retirees. Sustainability may also be problematic if the older generation is proportionally large compared to the size of the working-age population - sometimes referred to as the 'elderly support ratio' - as is the case in England and Wales.

The box below summarises how the different risks are allocated in this model. Individual longevity and morbidity-risk refers to these risks in relation to the individuals receiving insurance payments from the *National Care Fund*.

One option would be for individuals to contribute to social investment funds managed by the private sector, which buy insurance on behalf of individuals at the age of retirement...

Model 1	
Type of Risk	**Who holds the risk?**
Investment-risk	N/A in a PAYG scheme
Population morbidity risk	Working-age cohort
Population longevity risk	Working-age cohort
Individual longevity risk	Working age-cohort
Individual morbidity risk	Working age-cohort

'Funded' National Care Fund with investment-risk smoothing component

Recognising problems of *intergenerational fairness* and *sustainability* associated with PAYG insurance funds, the next models instead feature a *funded* design, in which contributions are adjusted to reflect income and earnings, but in which there is no transfer from the working-age cohort to the retired generation. The models also separate the structure into an investment/accumulation component and an insurance component.

To put this approach in context, it is worth observing that some UK insurance companies did historically offer long-term care insurance products built around individuals paying into an investment vehicle during their working-life, which then converted into a pre-funded long-term care insurance policy at the point of retirement. Such products posed two problems for policymakers. First, the products were characterised by excessive investment-risk, creating unpredictability regarding how much the investment pot would be worth at the point of retirement, and how much insurance against long-term care costs could therefore be purchased.

Second, from the point of view of policymakers, such a product was also flawed by its limited suitability given variations in earnings across the working-age population, and the fact that individuals with low earnings or spells outside of the labour market would either not use such products, or would have very small pots to convert into an insurance policy, akin to current problems of under-saving into defined-contribution pensions.

The next models therefore introduce the idea of a 'social investment fund', which does two distinct things. First, it applies asset-management techniques to smooth out investment-risk, so that annual returns available for distribution are very similar year-to-year, reflecting long-term trends in return on capital and interest rates, rather than fluctuations in asset prices.

Second, by paying out a single annual bonus – referred to in the model as a 'National Care Grant' - that can be divided up among the population equally, redistribution would effectively occur via the investment fund. In effect, although contributions would be proportional to means, the amounts allocated to individuals as a share of annual National Care Grant would be the same.

This model therefore introduces the concept of the *National Care Fund* as an *aggregator* in relation to premiums and benefits.

- Model 2: Social investment fund + pre-funded insurance

In this model, a *National Care Fund* features a social investment fund into which individuals make contributions. Given the inclusion of a redistribution component, mandatory contributions would be necessary.

Each year, the social investment fund makes a large annual cash bonus payment reflecting the notional,

However, this would still leave an average 17-year gap between the purchase of pre-funded insurance from the private sector and the typical onset of need...

equalised contributions of individuals retiring in that year and investment growth, called the National Care Grant.

This National Care Grant is then used to purchase pre-funded long-term care insurance for each individual at the point of retirement. The insurance is not individually-underwritten, and instead, the effective premium paid for each policy is a 'community-risk' rated premium.

It is important to underline again that these operations would all occur 'behind the scenes' from a user perspective, with all individuals making payments into a *National Care Fund*, contributions that are proportional to earnings, but with the same amount of cover provided to all individuals. Indeed, from the point-of-view of individuals, the scheme would still look like a 'social insurance' fund – contributions are proportional to means – even though the individual functions of the scheme were undertaken by the private sector.

This form of 'social' or 'collective' insurance would effectively redistribute within a cohort so that those individuals with limited earnings or spells of unemployment are not under-insured compared to wealthier individuals, resulting in something closer to universal coverage.

For example, every working-age individual might pay 2p for each pound of their earnings, so that higher-earning individuals effectively contribute more. However, at the point of retirement, every individual would have the same notional amount attributed to them, e.g. £10,000, which is then used to purchase a pre-funded long-term care insurance policy on their behalf.

However, this model would confront several problems if it were to be delivered by the private sector.

First, the *scale* of such a single large investment fund would be challenging for any private sector company to take on. Second, the absence of *competition* in relation to the management of the social investment fund would arguably lead to poor incentives and under-performance. To get around these problems, it would therefore be desirable for multiple social investment funds to operate side-by-side, with a central management function of the *National Care Fund* dispersing contributions among the investment funds, and amalgamating annual Care Grants from each fund into a single National Care Grant.

However, even if multiple investment funds were deployed, a third problem would still exist: although such a compulsory scheme would help insurance companies in the provision of pre-funded long-term care insurance by eliminating scope for adverse selection, the time-gap between the purchase of insurance for individuals at 65, and the potential onset of need, which may be several decades into the future, would leave private sector providers still confronting both investment-risk, as well as uncertainty regarding future patterns in morbidity and longevity, in relation to individuals aged over 65. To put this in perspective, the average healthy life expectancy of someone aged 65 (i.e. before the onset of high-level care needs) is around 17.3 years.[8]

In short, although the model overcomes some of the problems with a funded social insurance fund for long-term care delivered by the private sector, it would nevertheless remain very challenging for private sector partners to engage with. In effect, too much *investment-risk* and *morbidity-risk* would rest with private sector companies, who would have to take a very cautious approach in setting benefit levels. Although premiums and benefits for new retirees could be adjusted by providers each year, the core insurance book would nevertheless be challenging for providers given the potentially long gap between when the

A more promising approach is for an annual, smoothed bonus payment from social investment funds to be used to buy life annuities on behalf of all individuals reaching a defined threshold of need each year...

insurance contract is written and when it may be claimed upon.

Model 2	
Type of Risk	**Who holds the risk?**
Investment-risk	For contributions - the working-age population. For insurance - the insurance providers.
Population morbidity risk	Insurance providers.
Population longevity risk	Insurance providers.
Individual longevity risk	Insurance providers.
Individual morbidity risk	Insurance providers.

'Funded' National Care Fund with social investment funds + annuities

In order to overcome the problems of Model 2 identified above, Model 3 introduces a new component to overcome these problems: annuities.

As described in previous chapters, the most frequently used type of annuity product in relation to long-term care is an immediate needs annuity.

Immediate needs annuities (INAs) are purchased at the point-of-need after someone has entered residential care. An INA may be a 'level annuity' - which pays out the same amount year on year until someone dies – or an 'escalating annuity', which pays out more each year relating to a fixed percentage (e.g. 3%) or tracks an inflation-measure (index-linked). Most immediate needs annuities are sold on the basis of individual risk-assessments, i.e. premiums and benefits are proportional to a person's age, health condition and medical history.

The critical feature of annuities in the context of long-term care funding is that it is much easier to project the life expectancy of individuals with substantial care needs than those without, and the associated longevity-risk is therefore easier for insurers to price. Therefore, replacing pre-funded insurance with annuities in this analysis would improve feasibility from the point of view of private-sector providers.

- Model 3: Social investment funds + individual immediate needs annuities

In this model, working-age individuals make contributions to a *National Care Fund*, which disperses premiums into one of several social investment funds. As above, annual Care Grants are paid by the social investment funds and amalgamated into one National Care Grant.

However, unlike models above, rather than pre-funded insurance, the National Care Grant is instead used to purchase an INA for every individual experiencing a defined level of care needs – for example, 3 ADL failures - with the same amount notionally allocated to each person. Unlike existing INAs, the annuities would also be bought for individuals in receipt of domiciliary care.

The operators of the *National Care Fund* would estimate how many individuals would be entitled to make a claim in any given year and divide the National Care Grant on that basis. Individual-underwriting would be undertaken in relation to the INAs, so that the amount each individual receives depends on their age, health condition and medical history.

It is worthwhile to pause again and consider how such a scheme would operate from the point of view of individuals: contributions would be made into the *National Care Fund* proportional to earnings. At the point of need, individuals would be assessed and

To ensure consistency and coherence in the income payable to individuals via the *National Care Fund*, these annuities would have to be 'community-risk' rated rather than individually underwritten...

subsequently told how much they will receive with different individuals receiving different amounts.

As such, the flaw for this model is the variable amounts that individuals receive, resulting from individual risk-assessments. Two key issues are worth identifying. First, it is likely that many care users would struggle to understand the reason for differences in payment, and may consider it unfair.

Second, variations in the income available to individuals of a similar need profile would also be potentially disruptive to the supply-side of the social care system, particularly independent care providers, as they attempt to develop and supply services to individuals. It is easier for the market in care services to develop and operate if individuals with similar impairments have similar levels of means to purchase support.

Model 3	
Type of Risk	**Who holds the risk?**
Investment-risk	Population
Population morbidity risk	Population; any shortfall resulting from an unexpected excess of claims would have to met by the investment funds.
Population longevity risk	Population; trends in longevity would be priced into the benefits payable from annuities.
Individual longevity risk	Annuity providers.
Individual morbidity risk	As a simple level-annuity that paid out a flat-rate income, individual claimants
	would hold their own morbidity-risk.

- Model 4: Social investment funds + 'community-risk' immediate needs annuities

In order to overcome the problem identified above associated with differential benefit levels payable to individuals through the use of individually-underwritten immediate needs annuities, this model introduces the concept of an immediate needs annuity purchased using a community-risk rated premium. In short, individuals would not be individually assessed, and the income they receive would be reflective of 'community-risk' of all individuals entitled to make claims, rather than their individual risk-profile. This product is referred to as a 'community immediate needs annuity' or CINA.

The use of CINAs would effectively mean that individual morbidity-risk is pooled among those entitled to make a claim on the *National Care Fund*, e.g. individuals assessed as having a standard level of need - such as 3 Activity of Daily Living (ADL) failures.

As above, the model would see working-age individuals make contributions to a *National Care Fund*, which disperses premiums into one of several social investment funds. The annual amalgamated National Care Grant from these funds is then used to purchase CINAs for every entitled individual in retirement who has made contributions and experiences a defined level of care needs in a given year, with the same amount made available to each person. However, in the absence of individual risk-assessments – in effect, applying a community-risk rating – the amount received by each individual care user is the same.

From the point of view of individuals, contributions would be made into the *National Care Fund* proportional to earnings. However, every individual whose need entitles them to make a claim would

These annuities could also be 'index-linked' to provide protection from inflation, and 'disability-linked' so that the income payable rises in line with care needs...

receive a regular income, with the amount received the same among all recipients, and not linked to their individual risk-profile (or contributions). Indeed, from the point of view of individuals, this model would appear to be a pure social insurance fund: contributions proportional to income and benefits linked to a defined level of need.

Model 4	
Type of Risk	**Who holds the risk?**
Investment-risk	Population
Population morbidity risk	Population; any shortfall resulting from an unexpected excess of claims would have to met by the investment funds.
Population longevity risk	Population; trends in longevity would be priced into the benefits payable from annuities.
Individual longevity risk	Annuity providers.
Individual morbidity risk	Individuals in receipt of benefits.

In effect, this model would be a classic social insurance for long-term care, as currently operated by Germany and Japan, but administered and underwritten by the private sector.

The most critical feature of this model is that by allocating the risks associated with long-term care in a particular way, the feasibility for the insurance industry of engaging in a delivery role increases, both in relation to the investment and annuities components. In particular, by transferring longevity-risk of the lives insured to the private sector, the model transfers to the insurance industry, and by extension the capital markets, the key risk, which the private sector is most able to handle.

'Funded' National Care Fund with social investment funds + options for annuities

Given that Model 4 appears to provide a workable basic model for a *National Care Fund* delivered via a public-private partnership, the next models vary the type of annuities applied in order to achieve certain goals or desirable outcomes.

- Model 5: Social investment funds + 'disability-linked community immediate need annuity'

Applying community-risk rated immediate needs annuities in Model 4 means that all individuals claiming on the *National Care Fund* would receive similar benefits.

However, it would be desirable for benefits payable to be more closely linked to changes in a person's condition. For example, for one benefit level to be payable upon 3 ADL failures, (e.g. £150 per week) and more to be payable upon 5 ADL failures (e.g. £230 per week). In short, it would be desirable for community-risk immediate needs annuities to incorporate a feature of disability-linked annuities, i.e. benefits that are proportional to need. In the absence of this function, individuals with care needs would be left with the risk that their needs may increase and remain at a high level for longer periods, but their insurance benefits would not increase commensurately.

As described above, disability-linked annuities are a type of annuity product bought using defined-contribution pension savings, the income for which increases in line with level of need. A contrived name for an immediate needs annuity product bought using community-risk rated premiums that varied the income payable proportional to need would be a 'disability-linked community immediate needs annuity'. Annuity

To transfer more morbidity-risk to the private sector, these annuities could be purchased on the basis of 'block-contracts'...

providers would have to take account of not just population morbidity-risk, but how patterns of need evolve across the population of individuals requiring care.

Incorporating this type of product, Model 5 would operate in the same way as the previous model: working-age individuals would make contributions to a *National Care Fund*, which disperses premiums into one of several social investment funds. The annual amalgamated National Care Grant is then used to purchase a disability-linked community immediate needs annuities for every individual experiencing a defined level of care needs in a given year, with the same amount made available to each person, but with benefit levels proportional to need.

Model 5	
Type of Risk	**Who holds the risk?**
Investment-risk	Population
Population morbidity risk	Population; any shortfall resulting from an unexpected excess of claims would have to met by the investment funds.
Population longevity risk	Population; trends in longevity would be priced into the benefits payable from annuities.
Individual longevity risk	Annuity providers.
Individual morbidity risk	Annuity providers.

However, as set out in the previous chapter, multiple types of annuity are possible. As well applying a variable income proportional to need, the annuities bought by a *National Care Fund* could also be index-linked or escalating in nature, in order that recipients would be given protection against inflation or rises in unit care cost. However, it is worth observing that these features are arguably less important than for traditional life annuities, as most annuitants have a much shorter life expectancy.

- Model 6: Social investment funds + block-purchased community immediate needs annuities

This final model seeks to transfer a further risk to the private sector: population level morbidity-risk.

The models above have all assumed that the operators of a *National Care Fund* scheme would purchase individual annuities for each person that experienced 3 ADL failures in a given year. In part, such an approach would reflect the fact that the individuals in question would reach this threshold at different points during a 12-month period reflecting, for example, needs resulting from inclement weather.

However, this would still leave the operators of the *National Care Fund* – and by extension, the population - holding considerable morbidity-risk. If the number of individuals entitled to make claims during one year was more than expected, there would be a funding shortfall. If the number was less than forecast, there would be a surplus.

Model 6 therefore seeks to transfer more of the population-level morbidity risk to annuity providers by proposing the 'block-purchasing' of community immediate needs annuities, in which a provider undertook to pay an annuitised income, proportional to need, to a fixed percentage of the population experiencing a given level of care needs in a year.

Each such block-contract might cover 20% of the population. So, for example, insurance companies would be guaranteeing payment of needs-related benefits to 20% of the individuals that experience 3 or

The model developed here could be opened up to contributions from the retired cohort, whether via lump-sum payments, contributions from pension income or as a charged deferred on to people's estates...

more ADL failures in any given year, regardless of how many individuals do experience 3 ADLs. Insurance companies would be taking on some of the population-level morbidity-risk: uncertainty regarding how many individuals will experience 3 ADL failures in that year. However, as trends in morbidity would vary over time, annuity providers would price the benefits payable proportional to trends in morbidity. Nevertheless, the risks associated with year-to-year fluctuations in patterns of morbidity across the population would rest with the annuity providers.

Model 6	
Type of Risk	**Who holds the risk?**
Investment-risk	Population
Population morbidity risk	Annuity providers
Population longevity risk	Population; trends in longevity would be priced into the benefits payable from annuities.
Individual longevity risk	Annuity providers.
Individual morbidity risk	Annuity providers.

Decumulation-phase payment options

Having developed some novel models for how a *National Care Fund* could be operated by the private sector in relation to accumulation phase contributions, it is now worthwhile reflecting on decumulation phase contributions.

As described above, the original *National Care Fund* model recognised that the key problem for policymakers were those cohorts in England and Wales who have retired or are at the point of retirement. This therefore raises the question of how a *National Care Fund* would operate that was open to decumulation-phase contributions? In effect, two sets of choices are relevant: *payment options* and the *choice framework* applied to them.

Three potential payment options could be given to individuals:

- A lump-sum payment at retirement, for example, through the taking of the 25% tax-free lump-sum from pension saving;
- Contributions from retirement income;
- The option to defer payment entirely in the form of an estate-charge.

The choice framework applied to premiums could be:

- Voluntary;
- Soft-compulsion, e.g. 'mandated choice', which overcomes inertia by compelling individuals to make a choice regarding participation;
- Compulsion.

In addition, the payment options and choice framework can develop over time. For example, contributions may be voluntary in a first phase, 'mandated choice' in a second phase and compulsory in a final phase.

Unlike an accumulation phase model, in which redistribution could occur via a flat-rate contribution from earnings, commensurate with income tax, redistribution in a decumulation phase would be likely to be much more complex to achieve. This is because:

- There are wide variations in the proportion of income and assets that individuals possess;
- Both retirement income and assets can fluctuate greatly at different points in retirement.

For these reasons, whatever payment options or choice framework were applied for the retired cohort in relation to a *National Care Fund*, 'flat-rate' premiums,

However, it is unlikely that any redistribution within this cohort would be feasible...

rather premiums proportional to income and wealth, would be more feasible.

Whatever payment options and choice framework were applied to a decumulation phase model of a *National Care Fund*, there would be no fundamental barrier to applying them in the context of an operating structure featuring social investment funds and 'community-risk' immediate needs annuities. As such, this type of model could be applied to the long-term care funding system in England and Wales.

Nevertheless, policymakers would have to give consideration to when premiums were paid, the scope for investment growth and the risk profile of participants in the determination of premium levels.

Key points:

- Various models for a public-private partnership to run a *National Care Fund* can be conceived.
- However, some models would be very problematic for private providers, for example, a scheme in which accumulation phase contributions were converted into a per-head pre-funded insurance for care at retirement; insurers would still face an average 17-year gap between the notional purchase of insurance and claims.
- Instead, a viable model would see working-age individuals make contributions to a *National Care Fund*, which disperses premiums into one of several 'social investment funds', managed by the private sector. An annual 'National Care Grant' from these investment funds, reflecting notional contributions and smoothed returns from growth, would then be used to purchase immediate needs annuities for every individual aged over 65 experiencing the onset of 3 'Activity of Daily Living' (ADL) failures each year, i.e. a standardised threshold of need. These annuities would effectively be sold to the *National Care Fund*, which would then make payments to claimants.
- Crucially, these annuities would be community-risk rated rather than individually underwritten, in order to ensure that there is consistency among claimants regarding the level of support they receive.
- In this way, a *National Care Fund* would look and feel like a social insurance fund to individuals, even though it would be entirely administered and underwritten by the private sector in partnership with the state.
- A further option would be for the annuities purchased from the private sector to be *escalating* annuities in which the income payable rises by 3% each year, or *disability-linked* so that the income payable rose commensurate with changes in need.
- The model proposed could be adapted to receive contributions from the retired generation, and not just those of working-age, although it is unlikely that redistribution among this cohort would be feasible. For policymakers, opening such a model up to the retired generation would involve two sets of choices: *payment options* and the *choice framework* applied to them.

5. Scoping the premiums, benefits and market of a National Care Fund

If the needs-threshold for claiming on the *National Care Fund* were set at 3 'Activity of Daily Living' failures, then around 250,000 people each year would be entitled to make a claim, with an average life expectancy of 3.5 years...

The previous chapter explored some potential operating models for a National Care Fund delivered through a public-private partnership.

This chapter adds further detail by examining the levels of benefits and premiums that would apply to a *National Care Fund*, and on that basis, what would be required of the private sector. For the sake of simplicity, the chapter focuses on Model 4 outlined in the previous, which incorporated social investments funds and the purchase of community-risk rated immediate needs annuities by the operators of the *National Care Fund*.

This chapter first looks at what the implications of this model would be for the annuity market. It then examines potential structures for the operation of the social investment funds. The chapter ends with an exploration of what could be done by the government to develop the markets in question.

Individual Annuity Market

What would be the size of the individual annuity market that would result from the model proposed?

The number of lives insured

To answer this question, it is first necessary to consider what level of support will be required and therefore how many individuals will make claims.

It is proposed that individuals would be able to claim upon the *National Care Fund* once they had been assessed as having experienced 3 ADL failures, which would be equivalent to a Substantial level of need, under the current Fair Access to Care Services criteria.

The rationale for this approach is that:

- Many households are in fact able to cope with Low and Moderate levels of need through the provision of informal care, and through formal care purchased from private resources;
- Many individuals with 1-2 ADL failures will be able to claim Attendance Allowance, which is worth £71.40 at the higher rate and £47.80 at the lower rate.

In this context, it is reasonable to limit the claimants on the *National Care Fund* to retirees with 3ADLs failures or above. This is also the needs-threshold applied in the Singaporean 'Eldershield' state-sponsored insurance scheme.

Existing academic projections from the Personal Social Services Research Unit suggest that the number of individuals aged 65+ with 3 or more ADL failures is around 1 million, with the number rising slightly over the next 25 years.[9] The same projections suggest that the annual mortality rate in this group is 24.6%.

On the basis of these figures, we can deploy rough assumptions that around 250,000 individuals aged 65+ will experience the onset of 3 or ADL failures each year, and that they will live for an average of three and a half years.

The value of benefits and premiums

Having established estimates of how many individuals would be entitled to claim on the *National Care Fund* and their average life expectancy, the next question is what individuals will receive, assuming a scenario in which the *National Care Fund* was adequately funded and the income received by claimants was sufficient to meet their needs.

Estimating what income individuals require for different levels of need is a complex question, which must take account of forecasts and variations in the unit costs of care.

If the initial target income to be payable by the Fund were to be £150 per week, each annuity purchased by the Fund would have to have a premium of around £27,300...

Analysis from the King's Fund has proposed normative levels of formal support for different levels of need, drawing upon the Department of Health's FACs criteria.[10] The 'normative' level of support is the level of support it is assumed a person requires, irrespective of their financial situation. The figures proposed by the analysis are as follows:

Normative levels of formal support under benchmark care packages:[11]

Need level	Mean level of support (£s per week)
Low	10
Moderate	96
Substantial	151
Critical	229

(Source: Humphries R et al. (2010) *Securing Good Care for More People*, The King's Fund, London)

It can therefore be assumed that all individuals with 3 ADL failures, which is roughly equivalent to a Substantial level of need, require at least £151 per week. However, if it is assumed that all such individuals claim and receive Attendance Allowance at the higher rate, then the average income required would be £79.60.

Although the figure of £79.60 could be used as a target for a normative benefit level for claimants on a *National Care Fund* who have 3 ADL failures, many individuals experience more than 3 ADL failures, so the income of £79.60 per week would be insufficient.

It is therefore proposed that the target amount for a weekly benefit payable by the *National Care Fund* to individuals entitled to make a claim, who would have experienced at least 3 ADL failures, would be worth around £150 per week. It is worth noting that in the model of a public-private partnership to run a *National Care Fund* currently being examined, it would be feasible for disability-linked immediate needs annuities to be deployed, so the risk of 'over-payment' proportional to need does not need to be of concern.

So, it can be assumed that average life expectancy for someone aged 65+ who has experienced 3 ADL failures is three and a half years, and the *National Care Fund* would seek to pay a benefit of £150 per week. On this basis, a well-funded scheme would see the average total benefit as 182 weeks x £150 per week, which is around £27,300.

Assuming away any 'load factor', which would anyway be low given the distinctive nature of the market in question, it is therefore possible to project that under a scenario in which a well-funded *National Care Fund* was delivered via a public-private partnership, the resulting annuity market would comprise 250,000 new annuities written each year, with an average premium of around £27,300, and policies typically in force for about three and a half years.

Comparison to current annuity market

How would such a new market compare to the current UK annuities market? In 2010, the total number of standard annuities written by members of the Association of British Insurers (ABI), including guaranteed, level and escalating annuities, was just over 400,000.[12]

How does the £27,300 premium compare with the existing life annuity market? The majority of pension annuities sold – around 60% - are from pension pots worth less than £30,000.[13] As such, the insurance industry has significant experience of annuitizing premiums of this size. It is also worth observing that although providers would clearly benefit from new data becoming available, a basic life annuity for which average life expectancy is three years and a half would be a relatively straightforward risk for providers to price.

The purchase by the *National Care Fund* of 250,000 community-risk rated life annuities each year compares to a current market of around 400,000 new policies written each year...

The tender offer to providers

With an annual National Care Grant to dispense, the administrators of the *National Care Fund* scheme would seek to procure 'community immediate needs annuities' from private sector annuity providers. How would the transaction between a *National Care Fund* and annuity providers occur?

One approach would be for the Fund to seek to obtain these annuities as 'block-purchases' - e.g. 50,000 policies at a time – in a blind auction among providers. In effect, the tender to insurance companies would be: "In exchange for £1.365 billion, the *National Care Fund* would like to purchase community-risk rated life annuities for 50,000 people who will experience the onset of 3 Activity of Daily Living (ADL) failures during the next year. What annuity rate would you be willing to offer?"

An alternative procurement mechanism would be for the *National Care Fund* to effectively organise a flexible 'blind auction' in which providers would offer to annuitize a given number of lives – 10,000, 20,000 etc. – and the *National Care Fund* would take up these tenders until the annual quota was fulfilled, opting for the highest annuity rates on offer.

It is important to underline that the annuities contracts would be sold to directly the *National Care Fund*, rather than to the individuals whose lives are being insured. As such, there would be no reputation risk involved for companies, and no need to set up distribution channels, promote the product to Independent Financial Advisers, or similar challenges associated with bringing an annuity product to the open market.

Comment

This analysis suggests that in terms of both capacity and expertise, the model proposed would be feasible for the insurance industry to deliver. The only remaining question would be whether annuity providers would participate in the market? There would clearly be potential for providers to profit from the market. Since the *National Care Fund* would be undertaking a blind auction to identify the best tenders available, the business would necessarily be placed with the providers offering the best rates who were able to achieve an acceptable return for shareholders. As such, given the potential for such profit, it is reasonable to expect that annuity providers would engage.

National Care Fund Social Investment Funds

This section explores the investment funds component of a *National Care Fund*. As described above, the key operational requirement of the investment structure would be to pay out an annual National Care Grant reflecting (equalised) contributions and investment growth, with the value of the National Care Grant reflecting long-term rates of return on capital but not fluctuating year-on-year, in order to prevent disruption in the social care system on the supply-side.

This section considers a number of related issues concerning contributions, investment strategy, competition, etc.

- Competition

For a variety of reasons, the assets of a *National Care Fund* under management would benefit from being placed with multiple asset managers, in order to benefit from differentiated investment strategies and types of assets, as well as to ensure competition among the asset managers. Placing all of the Fund's assets with a single asset manager would impose an unacceptable level of 'manager risk'.

In designing the structure of the social investment funds to be managed by the private sector, policymakers would need to take account of investment-strategy, competition, and the feedback and governance mechanisms that will determine contribution levels...

- Investment-strategy

It is beyond the scope of this paper to explore and propose an investment strategy for a *National Care Fund*. The key objective would be to minimise year-on-year changes in the value of the National Care Grant, which would trend upwards or downwards reflecting medium to long-term trends in return on capital, but not annual fluctuations in asset prices. The second objective would be growth. Policymakers could explore how existing sovereign wealth funds and pension reserve funds overseas have addressed these objectives.

- Determination of contribution levels

A critical feature of the investment structure underpinning the *National Care Fund* is that it would not be required to guarantee to deliver a particular rate of return or the value of the annual National Care Grant. In this sense, the liabilities of the investment funds are not fixed or pre-determined.

However, a governance structure would be required to oversee the feedback mechanism between the value of future projected National Care Grants reflecting returns on investment and contributions, projected trends in longevity and morbidity (i.e. trends in need), and future trends in average unit care costs.

Many state-sponsored insurance funds have had to review premium and benefit levels repeatedly after their launch, reflecting on-going changes in demand and funding; effectively, the converse to public spending decisions in systems based on taxation and public spending.

A particular feature of state-sponsored insurance funds is that by seeking to resolve such choices through a distinct governance process, such decisions can be de-politicised. As such, an open and transparent governance mechanism could be used to pronounce on what contribution levels would be required to achieve given outcomes in the future, taking accounts of available data and projections.

- The value of the funds under management

If it is assumed, from the analysis above, that an average per-head premium of £27,300 would be desirable, and that one in four individuals reach the relevant threshold of need, then an average contribution would need to be around £6825, assuming contributions from the whole population. If it is assumed that 40-50 million were participating in the National Care Fund at any time and that the average contribution was £6825, then the assets under management for the Fund would be worth £273 billion - £341 billion.

Would the asset-management industry have the capacity to undertake the management of such a level of investments? Since the assets under management for the Fund would grow incrementally over time, the asset management industry would be able to scale up the necessary capacity as required. Indeed, if some of the assets were allocated passive investment strategies, this would limit the need for more asset management capacity.

Comment

This section has explored issues relating to the investment-structure underpinning a *National Care Fund*. The analysis suggests that the total assets under management would be no more than around £350 billion. There would be clear merits to using different and competing asset-managers, and there is no superficial reason to think that the asset-management industry would not be able to scale-up as appropriate to undertake this function.

A number of countries have created similar investment fund structures to the model proposed here in order to

To facilitate the involvement of the private sector, the government could transfer administrative and official data on longevity-risk and morbidity-risk into the public domain...

address shortfalls in pay-as-you-go public pension systems. For example, in July 2001, France created the Pensions Reserve Fund (Fonds de réserve pour les retraites) in order to use funds realized from privatisations of state assets to finance future shortfalls in the state pension system.

However, occupying a grey area between public and private assets, such state investment funds confront 'political-risk' manifest in the threat of 'raids' by governments. In response to fiscal pressures confronting many developed countries following the global financial crisis of 2008, France, Ireland and Hungary have all used a portion of previously ring-fenced pension reserve funds to meet immediate obligations or other shortfalls.[14]

However, in relation to a state-sponsored insurance scheme into which individuals were encouraged to contribute, such a raid would clearly be catastrophic for public confidence in the scheme. As such, the legal status of the *National Care Fund* investment funds – literally, the strength of the 'ring-fence' - would be critical as protection against potential raids by future governments.

What can the government do to facilitate the involvement of the insurance industry?

This section provides a few pointers regarding what the government could do to facilitate private sector involvement in the model of a *National Care Fund*, delivered through a public-private partnership, that has been developed here.

- Assessment/gateway systems

Perhaps the most important and critical function the government would have to undertake would be to ensure an accurate, consistent, reliable and transparent gateway system for individuals to make claims on a *National Care Fund*.

Such a system, which might involve GPs, local authorities or social workers in an assessment role, would have to be accurate and consisten over time in assessing individuals with physical or cognitive impairments, and whether or not they have experienced 3 or more ADL failures.

- Compulsion

As described above, compulsory insurance models are preferable for insurers because compulsion eliminates the scope for adverse selection and ensures a balanced risk-pool.

Implementing compulsion in relation to a state-sponsored insurance scheme would make it considerably easier for private sector companies to take on delivery roles in relation to such a scheme.

- Data

In order to help insurers and reinsurers price the longevity and morbidity-risk associated with a *National Care Fund*, the government could make a deliberate effort to put as much relevant administrative and government data into the public domain as possible relating to these risks. Such data may currently be held by local authorities, government departments, local health bodies and social care providers.

Key points:

- What would the model of a public-private partnership developed in the previous chapter mean for the private sector? A *National Care Fund* could set a claims threshold of 3ADL failures, which is roughly equivalent to a Substantial level of need under the current Fair Access to Care Services criteria used by local authorities. This is reasonable given that many households can cope with Low and Moderate levels of need through the provision of

A further key factor would be ensuring a consistent, reliable and predictable assessment system for validating claims on the *National Care Fund*...

informal care, and through formal care purchased from private resources. In addition, many individuals with 1-2 ADL failures will be able to claim Attendance Allowance, which is worth £71.40 at the higher rate and £47.80 at the lower rate.

- Existing academic research suggest that the number of individuals aged 65+ with 3 or more ADL failures is around 1 million, and the annual mortality rate in this group is 24.6%. On the basis of these figures, it can be assumed that around 250,000 individuals aged 65+ will experience the onset of 3 or more ADL failures each year, and that they will live for an average of three and a half years.
- It is proposed that the target amount for a weekly benefit payable by the *National Care Fund* to individuals entitled to make a claim, who would have experienced at least 3 ADL failures, would be worth around £150 per week. On this basis, a well-funded scheme would see the average total benefit as 182 weeks x £150 per week, which is around £27,300.
- Assuming away any 'load factor', which would anyway be low given the distinctive nature of the market in question, it is therefore possible to project that under a scenario in which a well-funded was *National Care Fund* delivered via a public-private partnership, the resulting annuity market would comprise 250,000 new annuities written each year, with an average premium of around £27,300, and policies typically in force for about three and a half years. To put this figure in context, in 2010, the total number of standard annuities written by members of the Association of British Insurers, including guaranteed, level and escalating annuities, was just over 400,000 in total.
- In creating a structure for the management of the social investment funds by the private sector, policymakers would have to give consideration to engendering competition among asset managers, appropriate investment strategies, and the necessary governance mechanisms to ensure that contribution levels were sufficient given projected levels of need and investment growth.
- If it is assumed that an average per-head annuity premium of £27,300 for claimants on the *National Care Fund* would be desirable, and that one in four individuals reach the relevant threshold of need, then an average contribution would need to be around £6825, assuming contributions from the whole population. If it is assumed that 40-50 million were participating in the *National Care Fund* at any time and that the average contribution was £6825, then the assets under management for the Fund would be worth £270 billion - £340 billion.
- It is worth noting that a number of countries have created similar investment fund structures to the model explored here in order to address shortfalls in pay-as-you-go public pension systems. For example, in July 2001, France created the Pensions Reserve Fund (Fonds de réserve pour les retraites) in order to use funds realized from privatisations of state assets to finance future shortfalls in the state pension system.
- What could the government do to develop facilitate the involvement of the insurance industry? Key issues would likely be the assessment/gateway systems, whether participation was compulsory, and the provision of data by the government in order to help insurers price the risks involved.

6. Conclusion

On the basis of the model developed here, it does appear that a *National Care Fund* for long-term care could be administered and underwritten by the private sector...

This paper has explored and evaluated the scope for creating a state-sponsored insurance scheme for long-term care in England and Wales, delivered through the operation of a public-private partnership.

This paper set out to explore the questions:

- Could a *National Care Fund* for long-term care be operated and underwritten by the private sector?
- How would such a public-private partnership work?

The analysis set out over the preceding chapters suggests that a *National Care Fund* operated and underwritten by the private sector would be entirely feasible. The analysis suggests that the best model for such a scheme would be built around multiple 'social' investment funds making annual, smoothed Care Grants, which would be amalgamated into a single National Care Grant and used to purchase a community-risk rated immediate needs annuity for every individual experiencing a defined level of need in any given year. The *National Care Fund* would pay £150 per week to retirees experiencing 3 or more ADL failures. The average total premium payable to the Fund would be around £6825, which is around £14 per month spread over a 40-year career.

However, despite the complexity of this structure, it would from appear from the user's viewpoint to be a social insurance fund: contributions proportional to means, and a benefit payable to all entitled to make a claim. In effect, the analysis in this report has shown how a 'classic' social insurance fund could be operated and underwritten by the private sector. A transitional stage involving contributions from the retired cohort could be used as a mechanism to facilitate contributions from the older cohort, thereby addressing issues of sustainability and intergenerational fairness encountered in PAYG models.

Going forward, a model built around social investment funds and community-risk rated immediate needs annuities provides a suitable basis for further discussion and analysis, and represents the substantive recommendation of this report for how a *National Care Fund* for long-term care could be achieved through a public-private partnership. However, the success of any final scheme would of course depend on choices relating to the multiple design-features of state-sponsored insurance schemes for long-term care, some of which are set out, as background information, in Appendix 2.

The insurance industry would clearly be a key stakeholder in responding to this model. Crucially, in the absence of a significant market in long-term care insurance in England and Wales, the commercial opportunities represented by the model developed in this paper would be far greater than anything derived from an orthodox private insurance market.

Importantly, the model proposed has a high degree of flexibility built-in. It can respond to changes in patterns of morbidity and longevity. It is able to provide benefits to claimants that vary with need and inflation. The role of the National Care Grant could evolve, and a portion of it could be used to fund preventative interventions that have been proven to be cost-effective. The National Care Grant could also be used to fund support payments to informal carers, echoing a characteristic of the social insurance fund for long-term care that operates in Germany.

What is the National Care Fund 'offer'?

Throughout this report, the analysis has emphasised how the *National Care Fund* scheme would appear from the point of view of individual citizens. It is therefore appropriate to end the report by spelling out the 'offer' to the population.

For individuals, in exchange for a £6825 premium or £14 per month spread over a 40-year career, individuals would be entitled to a £150 per week income upon experiencing 3 Activity of Daily Living failures...

Under the model proposed, which would be both cost-neutral and risk-neutral for HM Treasury, individuals would pay around £6825 into the *National Care Fund* as a lump-sum cash-payment in retirement, a charge on their estate, or as an average £14 per month premium if spread over a 40 year working career.

In return, retirees experiencing 1 or 2 ADL failures would continue rely on informal care or pay for the costs of formal care themselves, including from the receipt of Attendance Allowance, the State Pension and other forms of pension income.

Individuals experiencing 3 ADL failures would be entitled to claim on the *National Care Fund*, and would receive around £150 per week, which would be payable for the rest of their life, and could be varied according to level of need and inflation.

As such, from the point of view of individuals, the £6825 premium would enable individuals to cap the weekly cost of care that they would have to pay for while ensuring that their income was sufficient to purchase the care they required.

Viewed in terms of need, individuals and their families would effectively be insuring via a *National Care Fund* against no longer being able to cope through reliance on informal care, benefit payments and pension income alone. The *National Care Fund* would provide insurance against not having enough money to purchase the care you need, or having to rely on a family member even when you are no longer able to undertake multiple Activities of Daily Living; it caps the responsibilities of carers. Because the *National Care Fund* would operate at arm's length from the Exchequer, individuals would have total confidence that the money they contribute would be there for them when they needed it.

Conclusion

As revolutionary as some of the ideas in this paper may seem in a UK context, they should not be considered as such. Most countries that have successfully responded to the challenge of long-term care funding reform have done so through the creation of a state-sponsored insurance scheme.

No potential model for funding long-term care in England and Wales is perfect. Each involves risks, trade-offs and potential pitfalls that may occur over time. A key risk for the model proposed is that an extended period of low or negative economic growth would reduce the value of the social investment funds, the value of the National Care Grant and the benefits payable to claimants. However, this investment-risk can be seen as the functional equivalent of 'fiscal-risk' in tax-based funding models, in which sluggish economic growth cuts the value of the tax-base and reduces revenue. However, one advantage of the *National Care Fund* model is that whereas fiscal-risk is linked to primarily to the performance of the national economy, the investment-risk of the *National Care Fund* would be linked to the performance of the global economy, and in that sense, could be seen as a better response to the risks for the long-term care funding system posed by variations in the performance of the national economy. However, it is important to remember that even under the *National Care Fund* model explored here, public spending would continue to represent a very significant part of national expenditure on social care, so this effect would be limited.

Clearly, a public-private partnership to deliver a state-sponsored insurance scheme for long-term care would impose extra transactional, legal, administrative costs over and above a purely public operated scheme. However, the interest in keeping the risks associated with long-term care insurance off the balance-sheet of the Exchequer should not be underestimated. As such,

By setting the needs-threshold at this level, individuals and families would continue to rely on informal care and retirement resources for low and moderate needs, and would effectively be insuring against no longer being able to cope when needs become more substantial...

the effective 'premium' that taxpayers and society would have to pay for a public-private partnership is the price of transferring the risk to the capital markets. Ultimately, it would be up to the private sector to make the case to the government as to how it could deliver an insurance scheme and the advantages of pursuing this approach.

Key points

- The analysis set out over the preceding chapters suggests that a *National Care Fund* operated and underwritten by the private sector would be entirely feasible. The *National Care Fund* would pay £150 per week to retirees experiencing 3 or more ADL failures. The average total premium payable to the Fund would be around £6825, which is around £14 per month spread over a 40-year career.
- However, despite the complexity of this structure, it would from appear from the user's viewpoint to be a social insurance fund: contributions proportional to means, and a benefit payable to all entitled to make a claim. In effect, the analysis in this report has shown how a 'classic' social insurance fund could be operated and underwritten by the private sector. A transitional stage involving contributions from the retired cohort could be used as a mechanism to facilitate contributions from the older cohort, thereby addressing issues of sustainability and intergenerational fairness encountered in PAYG models.
- Going forward, a model built around social investment funds and community-risk rated immediate needs annuities provides a suitable basis for further discussion and analysis, and represents the substantive recommendation of this report for how a *National Care Fund* for long-term care could be achieved through a public-private partnership.
- Importantly, the model proposed has a high degree of in-built flexibility. It can respond to changes in patterns of morbidity and longevity. It is able to provide benefits to claimants that vary with need and inflation. The role of the National Care Grant could evolve, and a portion of it could be used to fund preventative interventions that have been proven to be cost-effective. The National Care Grant could also be used to fund support payments to informal carers, echoing a characteristic of the social insurance fund for long-term care that operates in Germany.
- What is the offer to the population? Under the model proposed, which would be both cost-neutral and risk-neutral for HM Treasury, individuals would pay around £6825 into the *National Care Fund* as a lump-sum cash-payment in retirement, a charge on their estate, or as an average £14 per month premium if spread over a 40 year working career.
- Retirees experiencing 1 or 2ADL failures would continue rely on informal care or pay for the costs of formal care themselves, including from the receipt of Attendance Allowance, the State Pension and other forms of pension income. Individuals experiencing 3ADL failures would be entitled to claim on the *National Care Fund*, and would receive around £150 per week, which would be payable for the rest of their life, and could be varied according to level of need and inflation.
- As such, from the point of view of individuals, the £6825 premium would enable individuals to cap the weekly cost of care that they would have to pay for while ensuring that their income was sufficient to purchase the care they required.
- As radical as some of the ideas in this paper may seem in a UK context, they should not be considered as such. Most countries that have successfully responded to the challenge of long-term care funding reform have done so through the creation of a state-sponsored insurance scheme.

Appendix 1: Case studies of state-sponsored insurance schemes

This section provides some thumbnail case studies of how state-sponsored insurance schemes have been deployed in Singapore, the Netherlands and the USA.

- Exceptional Medical Expenses Act/AWBZ (Netherlands)

The Dutch long-term care insurance scheme - Algemene Wet Bijzondere Ziektekosten (AWBZ) - was established in 1986 to provide insurance against previously uninsurable health costs such as nursing or residential care.

AWBZ is a 'pay-as-you-go' (PAYG) social insurance scheme, but is run and administered by the private sector. Critically, although private insurers manage the AWBZ scheme, they do not bear financial risk.[15]

The AWBZ scheme provides coverage for the whole population, irrespective of age, income or employment status. The scheme funds institutional, domiciliary nursing and personal care for individuals with physical, cognitive, developmental disabilities and long-term mental illness.[16] It is reported that around 3.6% of the population of the Netherlands are in receipt of benefits from the AWBZ scheme.[17]

Contributions to AWBZ are set as a percentage of income over a minimum threshold. The average contribution for someone on average income is €320 per month. Tax-payers not in employment make their contributions via their tax assessments. Some revenue from general taxation is also directed to the AWBZ scheme.[18]

Interestingly, AWBZ includes a demand-management mechanism: individuals receiving benefits from AWBZ may also be liable for income-related co-payments for institutional or home care.[19]

- ElderShield (Singapore)

ElderShield is an affordable national long-term care insurance scheme, created by the Singapore government in 2002. Singapore has one of the most distinctive welfare systems in the world, and some background information is required to put the ElderShield scheme in context.

At the core of Singaporean welfare system is the Central Provident Fund (CPF), a publicly run pension saving scheme set up in 1955, which is compulsory for all citizens, tax-exempt, and guaranteed a risk-free interest of 2.5%. Each CPF account contains an 'Ordinary Account' for making approved purchases (education, homes); a 'Special Account', for both life insurance and pension saving; and a Medisave Account for hospital expenses. The Medisave account represents 6-8% of an individual's wages, which are earmarked for the medical benefits of the contributor. On top of Medisave, Medishield is a low-cost, individual medical insurance scheme for high-cost hospital bills, into which individuals are auto-enrolled, i.e. it is a voluntary opt-out scheme. The Singaporean government occasionally uses budget surpluses to top-up the value of these various schemes to benefit the less well-off; in 2001, the government paid two years' worth of MediShield premiums for all Singaporeans aged 61 and over.[20]

In response to the ageing of the Singapore population and rising demand for social care, the government initially created an ElderCare Fund in 2000 to provide direct funding to organisation providing social care to those in need.[21]

Subsequently, in 2002, the government created the ElderShield scheme, which is an affordable insurance scheme for long-term care, which individuals make payments into from their Medisave accounts.

In its first iteration, ElderShield provided benefits for 60 months to cover a portion of a person's long-term care costs. Subsequently, the benefit payable and term length have increased to 72 months. In 2007, an extra higher level of cover was made available for those wishing to pay more for more cover. ElderShield is payable to those who are not able to do at least 3 of six defined ADLs.

Singaporean citizens with Medisave accounts are automatically enrolled into ElderShield at from the age of 40, i.e. it is an opt-out scheme. The ElderShield premium is determined at the age of entry, does not increase with age, and is payable annually until the age of 65. Premiums can be paid from Medisave or using cash.[22]

The Singaporean Ministry of Health currently has appointed three private insurers to run ElderShield: Aviva; GreatEastern and NTUCIncome.

- Community Living Assistance and Support Services Act/CLASS Act (USA)

The Community Living Assistance and Support Services Act (CLASS Act) is a new policy innovation in the USA. The Act was passed in 2010, and at the present time, the details of the scheme are still being finalised by policymakers. As such, it remains to be seen how this state-sponsored long-term care insurance scheme will operate in practice, i.e. will it be entirely administered by the Department of Health and Human Services (the overseeing federal government department), or will its operation deploy a public-private partnership in the delivery of core-functions of the scheme, such as distribution of benefits? The Act does provide for the establishment of the CLASS Independence Fund in the U.S. Treasury with the Secretary of the Treasury to serve as the managing trustee. Nevertheless, other core functions may be undertaken by the private sector, and the overall design of the scheme is still evolving as policymakers reach the implementation stage.

The CLASS Act can be seen as a response by federal policymakers to the failure of the private pre-funded long-term care insurance market in the USA to achieve a take-up rate beyond 10% despite government marketing campaigns, tax-incentives and the adoption by over 30 states of the 'Partnership' long-term care insurance scheme. However, given that the CLASS Act does not seek to provide total coverage – benefits will only ever cover a limited proportion of care costs – others have viewed the Act as a complement to the private insurance market.

The scheme will provide individuals with care and support needs with a cash benefit to purchase non-medical services that enable them to remain in the community. The objective of the CLASS Act is to provide finance for support services that do not require individuals to become impoverished and turn to Medicaid to access these services (i.e. means-tested support).[23]

The CLASS Act scheme is a work-place long-term care insurance scheme, i.e. contributions are made from pay-slips. Employers will be given the option to automatically enroll employees in the CLASS program and to deduct CLASS premiums from employee wages. Employees may then elect to waive enrolment in the CLASS scheme, i.e. opt-out. The Act requires the government agencies to establish an alternate enrolment process for individuals whose employers do not elect to participate, who are self-employed, or who have more than one employer.[24] Individuals who meet certain conditions may voluntarily enrol in the CLASS programme: they must be age 18 or older, receive taxable wages or self-employment income, and be actively employed.

Interestingly, premiums for the scheme are not individually underwritten in relation to gender or health condition, but are in relation to age. Once a person has

enrolled, their premiums cannot be increased. Nominal premiums of $5 will be payable by individuals who have an income below the federal poverty level, and to those aged 18 to 21 who are full-time students and actively employed.[25]

To claim benefits under the CLASS scheme, individuals must have a functional limitation of 2 ADLs or more, which is certified by a licensed health care practitioner that it is expected to last 90 days or more.[26] In order to be eligible to claim benefits, a person must have been enrolled and paid premiums for five years, as well as to have a minimum level of earnings sufficient for them to be credited with one quarter of social security coverage.

Benefits will be payable as cash, and there is provision in the Act for increasing their value in line with increases in unit care costs. The Congressional Budget Office and other analysts have projected that the scheme will pay an average benefit of about $75 per day.[27]

As academic reviews of overseas long-term care insurance schemes have noted, the most consistent feature of new long-term care funding models is that they continue to be refined, updated and reformed years after implementation, to reflect perceived shortcomings, sustainability issues and changes in the delivery of social care.[28] As such, it is reasonable to expect that US federal policymakers will make changes to the CLASS Act insurance scheme in years to come, which may include restricting benefits, increasing premiums, as well as mandatory participation by employees or by employers in relation to auto-enrolling their workforces.

Clearly, a key factor in determining the success of the CLASS programme as a voluntary insurance scheme is levels of participation. This will depend on how many employers choose to automatically enrol employees into CLASS, and how many employees subsequently remain enrolled and do not opt out.

Appendix 2: Design choices for a state-sponsored insurance scheme

A state-sponsored insurance scheme to fund long-term care delivered via a public-private partnership could take various different forms and policymakers confront many design choices. Inevitably, these are complex decisions with multiple trade-offs involved reflecting a range of political, practical and financial priorities.

This section examines the design choices involved in implementing a state-sponsored insurance scheme run through a public-private partnership.

- Age of contributions

Contributions to a state-sponsored insurance scheme could take-place at different ages, whether in the 'accumulation phase' (pre-retirement) or 'decumulation phase' (post-retirement.

In the US, the Community Living Assistance Services and Support Act (CLASS Act) will enable employees to make contributions from the age of 18. In the Netherlands, every citizen with taxable income over the age of 15 pays. In Japan, contributions into *Kaigo Hoken* begin at 40 and continue into retirement. The proposal for a *National Care Fund* in the UK debate, recognising the significant housing wealth of older people, proposed letting individuals make payments from the point of retirement or as charges from estates, i.e. enabling people to make payments from 65, with further payments from estate if preferred or required.

- Choice framework

Contributions into a state-sponsored insurance scheme could be on a purely voluntary basis, compulsory, or reflect a 'middle-way' approach, such as 'soft-compulsion' or 'auto-enrolment'.

In terms of acceptability, a purely voluntary choice framework would pose the smallest political challenge, but would risk low-levels of participation. Compulsory participation confronts the opposite challenges.

The feasibility and practicality of any choice framework applied is highly dependent on the age and nature of contributions. Compulsory payments from earnings would be relatively easy to implement as multiple other types of payslip taxes and contributions already exist.

Importantly, voluntary and compulsory enrolment mechanisms do not have to be conceived of as permanently exclusive. A state-sponsored insurance scheme could initially be characterised by voluntary participation, which would transition gradually to compulsion over time, possibly via 'auto-enrolment', as public acceptability of participation increased.

- Setting of premiums

Unlike private insurance, which typically involves individually risk-rated premiums that are set according to a person's individual risk-profile, public-private partnerships for funding care have typically seen the state use its powers to determine the cost of premiums to reflect broader policy aims, such as universal coverage and affordability, with contributions set proportional to the principle of 'ability-to-pay'.

The nature of premiums into a state-sponsored insurance scheme can take different forms. A 'flat-rate' premium might see everyone pay the same annual cash amount unless individuals are of extremely low income. Progressive premiums could see individuals pay a proportion of their income, e.g. 1%, so that the total amount paid by wealthier households is more.

- Form of benefits

Benefits from a state-sponsored insurance fund could take the form of cash or care. Put another way,

individuals could receive cash that they use to purchase care, or services funded by the state-sponsored insurance scheme directly provided to users.

However, across the majority of social care systems in developed countries, the trend is toward cash-based systems, although exceptions remain such as Japan's insurance fund, which provides all benefits in the form of services.

The trend toward cash is particularly observable in the UK, reflecting the personalisation, choice and control agendas in social care policy, embodied in documents such as *Putting People First*.[29] As such, most UK policy debate in relation to state-sponsored insurance schemes has conceived of the benefits comprising cash-payments.

- Benefit structure

Key design choices relate to the benefit structure applied to a state-sponsored insurance fund for long-term care, i.e. what individuals receive and when proportional to different levels and types of need.

Many social care funding systems use a standardised measurement of physical and cognitive impairment against which insurance claims or public entitlements are measured. These could be purely functional, e.g. Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs). Alternatively, depending on how the provision and availability of informal care is incorporated into 'needs-assessments', some form of standardised risk-assessment tool may be deployed, such as those used currently by local authorities in England and Wales.

Benefits could begin payment at a low level of need, e.g. one ADL, or could start at a higher level, such as 3 ADLs. Benefits could be set so as to pay for 50% of care costs for a given level of need, 75%, 100% or some other level. The proportion of care costs paid for could also vary by level of need (e.g. 25% of costs for 2 ADLs, 50% of costs for 3), or could involve a fixed cap on how much individuals would have to pay out of pocket. A wide variation in the effective coverage provided by different state-sponsored insurance schemes overseas is observable.

Benefits could pay out indefinitely, i.e. until someone recovers or dies. Alternatively, they could pay out for no more than a fixed period, such as 72 months, which is the limit applied to the ElderShield scheme in Singapore.

Depending on the design of the scheme, benefits could be payable to all age-groups, or just individuals over the state pension age. There are arguments for and against such an approach.[30]

- Demand management mechanisms

In order to ration and manage demand for the resources of a state-sponsored insurance scheme for long-term care, various additional mechanisms could be applied. In particular, policy tools such as 'co-payments' and 'matching contributions' could be used to ration the demand of households for funding from an insurance fund proportional to their financial resources (ability to pay) and the availability of informal care.

A 'co-payment' usually sees users expected to make some fixed out-of-pocket contribution in order to receive a cash entitlement. Matching contributions also require that individuals pay an amount toward the cost of care themselves in order for them to receive the benefit payable from the insurance scheme. However, with matching contributions, the benefit received is proportional to the amount spent by the user out-of-pocket. The ratio between the amount paid 'out-of-pocket' toward care and the amount received as an insurance benefit can vary, e.g. 3:1, 1:1, 1: 2, etc. Another proposal has been for 'matching care

contributions' in which the generosity of the matched contributions varies to reflect the proportion of someone's care needs met through informal care.[31]

The importance of demand management mechanisms should not be underestimated: most countries that have implemented state-sponsored insurance schemes have had to review premiums and benefits on a regular basis. This has not necessarily resulted from the withdrawal of informal carers; rather, it may has tended to reflect trends in morbidity and longevity.

- 'Carer-sighted' vs. 'carer-blind'

Long-term care funding systems vary in how funding and entitlements vary to take account of informal care provision, i.e. care provided by family and kin. A pure 'carer-blind' system would disregard any informal care provision in determining someone's eligibility to funding. A 'carer-sighted' system sets levels of entitlement and support proportional to the availability and provision of informal care.

In England and Wales, the mechanism used to allocate public funding by local authorities is 'carer-sighted'. However, guidance for local authorities places strong emphasis on ensuring that informal care provision is voluntary and sustainable in assessments of need.[32]

One approach in relation to a state-sponsored insurance scheme for long-term care is for informal carers to receive a cash payment in lieu of the informal care they provide, albeit at a level that does not represent a salary payment. In Germany, the long-term care insurance fund makes pension contributions on behalf of informal carers.[33]

- Types of cover

Pay-outs from a state-sponsored insurance fund could variously be used to pay for: personal care in the home; telecare and home adaptations; personal care in a residential setting; and, the 'hotel costs' associated with residential care.

- Brand

The 'brand' of a state-sponsored insurance scheme would clearly be critical in shaping public attitudes and participation. Public support for reform, as well as subsequent participation, may be engendered by carefully designing the brand and name.

In Singapore, the name chosen for the national insurance is ElderShield. However, building on this brand, policymakers have deployed two levels of cover – ElderShield 300 and ElderShield 400 – which in turn is provided by three companies who also deploy their own brnads: Aviva, GreatEastern and NTUCIncome. As such, reflecting a standardised product, the three companies share the usage of the ElderShield brand, even as they provide the insurance under their own brand.

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