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Gone for Good? Pre-funded insurance for long-term care

James Lloyd

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Contents

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Executive Summary

The UK insurance industry is one of the most successful in the world. However, the market in pre-funded long-term care insurance (LTCI) stands in marked contrast to other types of consumer insurance, and the last UK provider exited the market in 2010 citing a lack of demand. The UK is not alone in having a minimal market for such insurance: no country in the world has a market that could be described as functioning or effective when compared to other types of insurance. Why is this the case? Barriers exist on both the demand and supply-side, and some factors are unique to the UK, such as the confusion caused by universal free care available in Scotland. Various policy options have been proposed as levers to grow the size of the pre-funded LTCI market. Nevertheless, there appears to be no 'magic-bullet' solution.

To what extent can the pre-funded LTCI market help policymakers achieve key strategic policy objectives for social care? This requires viewing the market in pre-funded LTCI as a potential means to an end, rather than an end in itself. However, even if the UK were to achieve a level of take-up of around 15% for pre-funded LTCI, equivalent to France (which has the highest take-up in the world), analysis suggests that this would still result in outcomes that failed to meet many policy objectives for long-term care funding, particularly associated with catastrophic costs, fiscal pressures and means-testing. More generally, it appears that pre-funded LTCI is simply incompatible with many broader social care policy objectives such as holistic prevention, integrated care and reducing the incidence of cost-shifting.

Nevertheless, there are multiple other roles that the financial services industry could take in long-term care funding reform, particularly around delivering and servicing a state-sponsored insurance scheme for long-term care. Various case studies are available such as 'ElderShield' in Singapore and the long-term care insurance scheme of the Netherlands. Not only has the high level of coverage that has resulted from such schemes gone a long way to solving problems of long-term care funding, it has also enabled governments to introduce working-age contributions, reducing the scope of the kind of retirement means-testing in social care that has done so much to undermine the pensions industry in the UK.

The UK insurance industry is one of the most successful in the world. It is a sector characterised by high levels of choice, competition and innovation.

In this context, some stakeholders have consistently advocated a central role for the financial services industry, and pre-funded long-term care insurance (LTCI) in particular, as being the best possible solution to the challenge of how to fund long-term care in England and Wales.

This report therefore provides answers to two questions: what potential role could pre-funded insurance take in funding long-term care? To what extent can the pre-funded LTCI market help policymakers achieve key strategic policy objectives for social care?

The costs of long-term care may relate to: personal care in the home; telecare and home adaptations; personal care in a residential setting; and, the 'hotel costs' of residential care. Current public spending on social care is focused on means-tested local authority funded care and support, and non-means tested cash-based disability benefits. However, the problems with the current funding system are manifold, and relate especially to the incidence of accumulated 'catastrophic costs' among households, and fiscal pressures on public funding of care and support associated with rising demand from an ageing population.

The market in pre-funded LTCI stands in marked contrast to other types of consumer insurance. The last UK provider exited the market in 2010 citing a lack of demand, and around 36,000 pre-funded policies remain in force. However, the UK is not alone in having a minimal market in pre-funded LTCI; indeed, no country in the world has a market that could be described as functioning or effective when compared to other types of insurance.

In the USA, take-up has struggled to rise above 10% despite significant tax-breaks and other incentives deployed over several decades. Federal policymakers are instead now implementing an innovative state-sponsored national workplace insurance scheme for long-term care under the so-called 'CLASS Act' of 2010. France has achieved take-up rates of 15%, but the coverage provided is typically limited, and commentators relate the size of the market to distinctive French welfare laws, such as "l'obligation alimentaire".

Why are markets in pre-funded LTCI so small? Barriers to the development of the pre-funded LTCI market in England and Wales can be distinguished as *supply* or *demand*-side barriers. Some are common across different countries; others are unique to the UK.

Supply-side barriers include: limited profitability and market size; uncertainty

posed by longevity and morbidity risk; possible adverse selection; requirement for a new system of needs(claims)- assessments; reputation risk; IFA resistance to new brands; and, Solvency II.

Demand-side barriers include: *financial* barriers; '*exposure uncertainty*' barriers; *knowledge* barriers; *behavioural* barriers; and, *structural* barriers.

Financial barriers include: the cost of the products; the typical requirement by products for out-of-pocket payments on care; competing financial motives; precautionary saving in response to other types of household 'protection gap' besides care costs; and, households having alternative strategies for paying for care.

'Exposure uncertainty' barriers include: uncertainty over availability of informal care and consequent need for paid care; uncertainty over who to insure in a household; 'political-risk' and uncertainty over availability and shape of state support far into the future; uncertainty regarding future household wealth in relation to the means-test; and, uncertainty over future unit care costs.

Knowledge barriers include: ignorance of the risk of needing care; belief that all care is provided free by the state; and, confusion with Scotland's system of universal free personal care.

Behavioural barriers include: inertia; mental discounting of the risk of needing care; the 'positivity effect'; and, declining cognitive capacity and financial capability in the target market.

S*tructural* barriers include: complexity of products; distrust of financial services providers; obligation to obtain financial advice; shortage of qualified financial advisers; an expectation among households of 'gaming' the local authority means-test; uncertainty over adequacy of products; potential crowding out by private medical insurance; and, the implications of individual (gender) under-writing.

Various policy options have been proposed as levers to grow the size of the pre-funded LTCI market. These include auto-enrolment; compulsion; cheaper premiums secured via state-underwriting of tail-risks; the US 'LTCI Partnership' model; income-tax relief on LTCI premiums; and, a national system of assessment and entitlement for public support.

Nevertheless, there appears to be no 'magic-bullet' solution. For example, many stakeholders have proposed income-tax relief as the key to persuade individuals to insure for LTCI. However, analysis from the US

suggests only a marginal effect, and France has achieved the highest take-up rate in the world without deploying tax-relief.

More generally, even if the entire range of potential policy interventions to grow the market for pre-funded LTCI were deployed, such an arsenal of policy levers appears wholly inadequate against the entrenched demand-side barriers that exist.

As such, although various stakeholders have called for the removal of barriers to the pre-funded LTCI market, the main barriers to the development of the market appear to be the people who are supposed to buy the products.

The role of pre-funded LTCI in funding long-term care

In terms of the problems posed by the long-term care funding system in England and Wales, evaluating the appropriate role for pre-funded LTCI in funding care means asking: to what extent can the pre-funded LTCI market help policymakers achieve key strategic policy objectives for social care? It requires viewing the market in pre-funded LTCI as a potential means to an end, rather than an end in itself.

Relevant strategic policy objectives for evaluating the role of pre-funded LTCI variously relate to: outcomes of a market-based approach; long-term care funding policy objectives; social care policy objectives; and, wider public policy objectives.

However, even if the UK were to achieve a level of take-up of around 15% for pre-funded LTCI, equivalent to France, analysis suggests that this would still result in outcomes that failed to meet many of the policy objectives for long-term care funding, particularly associated with catastrophic costs, fiscal pressures and means-testing. More generally, it appears that pre-funded LTCI is simply incompatible with many broader social care policy objectives such as holistic prevention, integrated care and ending cost-shifting.

Overall, the conclusion that pre-funded LTCI is never likely to prove an adequate response to the problems posed by the long-term care funding system is neither new nor controversial.

Abroad, and within academia, the failure of pre-funded LTCI markets to achieve anything approaching adequate take-up has featured extensively in research and commentary; however, this evidence is rarely cited in the UK debate.

The failure of the pre-funded LTCI market in the UK is not a failure of the financial services industry. The issues encountered owe far

more to the characteristics and vagaries of human behaviour and cognition, than any industry shortcomings, and are common across LTCI markets abroad.

Arguably, it is actually far from clear that it is in the interests of the insurance industry for long-term care funding reform to focus on private insurance. Even under highly optimistic scenarios, the likely annual profit to be generated by pre-funded LTCI is likely to be so small as to be insignificant for many providers. Yet the implication of a policy framework built around private LTCI is that the means-tested safety-net of state support would have to persist: social care would continue to be a pillar of the UK's retirement means-testing regime that does so much to undermine pension saving.

Nevertheless, there are multiple other roles that the financial services industry could take in long-term care funding reform, besides providing consumer insurance, which would facilitate the greater financial contributions and risk-pooling that the long-term care funding system so clearly needs. As such, the crucial distinction may not be between a public versus private solution to long-term care funding, so much as a market-based private solution versus a state-sponsored approach that relies on the financial services industry in a delivery role.

The biggest commercial opportunities for the financial services industry may therefore be in delivering and servicing an innovative state-sponsored, public-private partnership, insurance scheme rather than a re-born pre-funded LTCI market. Various real and theoretical case studies are available: 'ElderShield' in Singapore; the long-term care insurance scheme of the Netherlands; the scheme arising from the US 'CLASS Act'; and, the proposal for a 'National Care Fund' in the UK. Rather than a market of tens of thousands, such public-private partnerships would result in participation levels measurable in the tens of millions.

Not only has the high level of coverage that has resulted from such schemes gone a long way to solving problems of long-term care funding, it has also enabled governments to introduce working-age contributions, reducing the scope of the kind of retirement means-testing in social care that has done so much to undermine the pensions industry in the UK.

1. Introduction

This report answers two questions: what potential role could pre-funded insurance take in funding long-term care?...

The UK insurance industry is one of the most successful in the world. It is a sector characterised by high levels of choice, competition and innovation. Around 78% of households have contents insurance and 35% have life insurance.[1]

In this context, the long-running policy debate regarding how to fund older people's long-term care has seen some stakeholders consistently advocate a central role for the financial services industry, and private insurance in particular, as being the best possible solution to this policy challenge.

Multiple potential financial products to fund long-term care can be conceived. Some are simple 'decumulation' devices (equity release). Others are 'point-of-need' products (immediate and deferred-needs annuities).

However, this report is concerned with the most important type of insurance product and the one that most stakeholders conceive of in discussion on long-term care funding: 'pre-funded insurance'. This is the form of insurance most commonly purchased by households, whether as travel insurance, contents insurance or life insurance. It is insurance that is bought before an adverse event occurs, and which pays out a lump-sum or regular income when it does.

Policy documents on pre-funded long-term care insurance rarely stretch beyond discussion of the principal products available and potential levers to grow the market. There has been limited analysis that takes an objective view of how pre-funded insurance may or may not help policymakers achieve the full range of objectives that are associated with social care policy, including those that arise from problems with the current funding system in England and Wales. In the context of the suffering imposed by the current social care funding system, this omission is important.

This report therefore provides answers to two questions:

- What potential role could pre-funded insurance take in funding long-term care?
- To what extent can the pre-funded long-term care insurance market help policymakers achieve key strategic policy objectives for social care?

This task has been made easier by recent policy documents from both the previous Labour government[2] and the current Coalition Government[3] providing a vision of the outcomes sought within the social care system for individual users and families. The areas of overlap across these documents – for example, around *prevention* and the *personalisation* agenda – paint a picture of a social care system in future broadly reflective of political consensus.

Gone for Good? Pre-funded insurance for long-term care

The rest of this report explores the potential future of pre-funded long-term care insurance in funding long-term care.

The next chapter sets out the challenge posed by long-term care funding, as well as the situation for pre-funded long-term care insurance in the UK and internationally.

The third chapter looks at the demand and supply-side barriers to the growth of the 'pre-funded' insurance market.

The fourth chapter evaluates potential policy options to grow the market in pre-funded long-term care insurance, such as the use of tax-relief and simplified products.

Chapter 5 undertakes the critical task of analysing pre-funded insurance in the context of the policy objectives

of long-term care funding and wider social care policy, particularly in the context of the suffering imposed by the current under-funded system.

The final chapter concludes by making recommendations for policymakers and the insurance industry.

Key points:

- The UK insurance industry is one of the most successful in the world. It is a sector characterised by high levels of choice, competition and innovation.
- Some stakeholders have consistently advocated a central role for the financial services industry, and pre-funded long-term care insurance in particular, as being the best possible solution to the challenge of long-term care funding.
- Policy documents on pre-funded long-term care insurance rarely stretch beyond discussion of the principal products available and potential levers to grow the market. There has been limited analysis that takes an objective view of how pre-funded insurance may or may not help policymakers achieve the full range of objectives that are associated with social care policy, including those that arise from problems with the current funding system in England and Wales.
- This report therefore provides answers to two questions: What potential role could pre-funded insurance take in funding long-term care? To what extent can the pre-funded long-term care insurance market help policymakers achieve the key strategic policy objectives for social care?

2. The Current Picture: The long-term care funding challenge and pre-funded insurance

The costs of "long-term care" may refer to a range of different costs associated with care in a home or residential setting...

The challenge of how to fund the long-term care of older people has been one of the most difficult confronting the current government, as it was for the previous government.

This chapter reviews the nature of this challenge, and outcomes in the current market for pre-funded long-term care insurance, both in the UK and internationally.

What is "long-term care" that requires funding?

Public policy debate often talks in simplistic terms about long-term care funding and its need for reform, when in fact, there are a number of specific and divergent potential costs associated with the onset of care needs, which can each be measured in terms of current average expenditure, unit cost, and an 'ideal' expenditure that would be reflective of a better-funded system. These can be distinguished as follows:

- Personal care in the home

'Personal care' refers to the different forms of help that individuals need, arising out of physical or cognitive conditions, which help them to lead their everyday lives.

Personal care differs from nursing or medical care in the fact that although personal care needs may arise out of a medical condition, trained clinicians are not required to provide personal care. As such, the majority of personal care provided across the population is by family and friends: so-called "informal" or "unpaid" care.

Need for personal care is often measured using standardised measures of impairment often distinguish activities of daily living (ADLs – walking, cooking, bathing, etc.) and instrumental activities of daily living (IADLs - preparing a hot meal, shopping for groceries, making telephone calls).

The receipt of personal care in the home by paid care workers ('home care' or 'domiciliary care') may take the form of help with bathing and using the toilet, cooking or cleaning.

The average cost of home care to older people in 2008-9 was £145 per week.[4] However, such a figure reflects household and local authority rationing of expenditure, and general under-funding in the system. As an alternative way of looking at the cost of personal care, academic analysis has calculated a 'normative' cost of care which is the level of support assessed as being needed in the public system, depending only on a person's needs-related characteristics and not their financial resources. Against the scale of Low-to-Critical need levels used currently by local authorities in needs assessments, the normative levels of (formal) support (£ per week) that care should be worth are estimated to be:[5]

Level of need	£ per week
Critical	229
Substantial	151
Moderate	96
Low	10
Total	**119**

- Telecare and home adaptations

Specialist technology-based services and products that enable individuals to live in their home – telecare – have grown in use over the last decade. Telecare products can take multiple different forms, but enable the remote monitoring of real time emergencies and changes in order to manage the potential risks associated with independent living. Telecare consists of various sensors placed around the home linked to a system that allows the user to be supported by an external monitoring centre.

And may include the 'hotel costs' of residential care...

In some instances, a person may be able to continue to live independently in their own home if their home is adapted appropriately. A common example of such adaptations would be the addition of a stair-lift, or the widening of doorframes to accommodate a wheelchair.

Importantly, in the context of different forms of social care, telecare and home adaptations can be considered preventative interventions; not only enabling the meeting of current need, but the prevention of higher costs associated with other forms of care, and preventing the onset of more severe care needs.

- Personal care in a residential setting

Individuals with high-level, or specialized, care needs may move from their own homes into residential care facilities. This may be because they are unable to cope in their own home even with the provision of home (domiciliary) care. Alternatively, it may be because it is actually cheaper for individuals to receive residential rather than home care.

- Accommodation costs

These are the so-called 'hotel costs' associated with individuals living in dedicated residential facilities, such as nursing homes and care homes, and comprise costs such as rent, food, heating, laundry and cleaning.

The average expenditure on residential care for older people in 2008-9 was £498 per week, incorporating both accommodation costs and residential care costs.[6] However, this figure may be more reflective of the much lower costs for residential care negotiated by local authorities - to some extent cross-subsidized by private-payers – and so a more realistic market-price may be higher.

- Nursing care costs

In addition to the different types of social care costs described here, many individuals with long-term conditions also require nursing care. However, since the recommendations of the Royal Commission on Long-term Care in 1999, all nursing care in the UK has been free, funded via the National Health Service (NHS) or local government. There is no likely prospect of this changing in the future.

This description of the costs associated with the receipt of long-term care show that "long-term care costs" can refer to range of different types of expenditure. It is also important to emphasise the wide variations in costs associated with differing levels of need. For example, home care may be very affordable to an average household, or extremely expensive, depending on the type of care required, its volume, and the unit cost of home care in a person's geographical area.

Crucially, the average lifetime cost of long-term care varies across the population, and is substantially distorted by a 'tail-group' who need care for very long periods. This is particularly noticeable among the retired population.

The following table shows the expected lifetime cost for individuals at 65 years of age, with need of care measured by whether someone is potentially eligible to local authority support under the so-called 'Fair Access to Care Services' criteria used by local authorities to allocate support. The figures assume current levels of informal care provision, without which these figures would be higher:

Public spending on social care comprises disability benefits and local authority funded care and support...

Lifetime expected cost at 65 years[7]		
	Mean	**Median**
Female	£40,400	£30,100
Male	£22,300	£13,800
All	£31,700	£21,400

Long-term care funding in England and Wales

Any role for pre-funded insurance in funding long-term care will be determined by the nature and shape of entitlements from the state. The two principal forms of entitlement are *local authority support* and *disability benefits*.

Local authority support

At present, direct public funding of social care is undertaken by local authorities, and rationed on the basis of a *needs*-assessment and *means*-assessment.

Current guidance for local authorities in England for allocating support is contained in *Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care*.[8]

Local authorities are required to fully determine the extent of 'presenting need' regardless of whether and how they are being met. If an individual cannot perform several personal care tasks, but can do so without difficulty with the help of a carer, and the carer is happy to maintain their caring role in this way, both currently and in the longer-term, then local authorities will record such needs on a person's 'care plan', but that they are being fully met by the carer.

Entitlement to home care from local authorities is also assessed on the basis of a person's means, i.e. their income and wealth. Within certain bands of income and wealth, individuals may be charged for the care they receive. Every local authority has different rules on charging for services whether residential or home care, particularly related to income.

The upper capital limit is £23,250. If a person has more than this amount in assessable capital, they may be asked to pay the full cost (up-front or deferred) of any care organised by the local authority, whether via direct provision or through a personal budget. Capital of between £14,250 and £23,250 is assumed for the purposes of the means-assessment to provide an income of £1 per week per £250 of capital.

A critical issue is what types of household wealth qualify as 'assessable' capital. Care users can ask that any capital that is 'earmarked' for a specific purpose be disregarded in the means-test, although this is discretionary. A person's home may only be counted as assessable capital in relation to the means-test for residential as long as no spouse or eligible dependent is living there. If a person requiring care still lives in their home, it is also disregarded.

Disability benefits

The UK welfare system currently distributes cash benefits to individuals relevant to social care funding.

Disability Living Allowance (DLA) is a non means-tested, cash benefit payment for children and working-age adults who have a physical disability, mental disability, need help caring for themselves or someone to supervise them, for their own or someone else's safety, or have walking difficulties. DLA is paid to 1.4 million people at a cost to the Exchequer of £5.5bn per year.[9] However, in recognition of its complexity, cost to the Exchequer, administrative burden and insensitivity to changes in people's condition, the Department for Work and Pensions (DWP) has recently proposed replacing DLA with a new benefit: the Personal Independent Payment (PIP).[10] Entitlement to PIP will be based on individual assessments of health conditions and impairments, and will also have a Mobility and Daily Living component.

Attendance Allowance (AA) is a tax-free, non means-tested, cash benefit for people aged 65 or over who

Problems with the long-term care funding system are manifold and include the incidence of 'catastrophic' costs, and fiscal pressures on public spending resulting from rising demand...

need someone to help look after them because they are physically or mentally disabled. It is paid weekly at a higher rate of £71.40 and a lower rate of £47.80. The benefit is paid by DWP to 2.16 million people aged over 65 at a cost of £7.5bn per year.[11]

The 'state-offer' therefore comprises low-level universal entitlements and more extensive, but means-tested, local authority funded care and support.

The long-term care funding challenge in England and Wales

The key aspects of the long-term care funding challenge in England and Wales relate to how costs fall on self-funders, and pressures on entitlements funded by the state.

- Accumulated catastrophic costs

For those individuals who fall outside the scope of the safety-net of state support on account of being too wealthy to qualify, three outcomes are possible: receipt of care by family members, unmet need or the purchase of care services privately 'out-of-pocket'.

The purchase of care services privately out of pocket may comprise personal care in the home, telecare and housing adaptations, personal care in a residential care setting, and the accommodation costs associated with residential care.

An individual's ability to pay for care out-of-pocket will vary according their household income and wealth, the liquidity of their wealth, and the extent to which they can use it to generate an income.

However, 'catastrophic costs' refers not to the affordability of one week or month's worth of care for an individual: it refers to the total costs that accumulate when care of different levels of cost is required and purchased over an extended period. How 'catastrophic' such costs are to an individual is relative, and will reflect their initial income and wealth before they began paying for care themselves.

In some instances, individuals with housing wealth who are not entitled to public support, but do ultimately accrue significant care-related bills, particularly associated with residential care, may be compelled to sell their homes in order to pay for this care. It is this aspect of the incidence of catastrophic costs among the population that has in the UK frequently led to newspaper headlines describing individuals "forced to sell their home to pay for care".

- Fiscal pressures on public funding of care and support

As described above, public funding of care and support is allocated by local authorities and rationed on the basis of an assessment of needs and means.

However, despite the operation of a complex rationing system, which varies by every local authority in England and Wales, there exists considerable fiscal pressure on public spending on care and support.

In large part, this reflects longstanding trends associated with rising demand resulting from demographic change: individuals are living longer, including when in need of care. As the baby-boomer cohort moves into retirement and late old-age, the number of individuals requiring care is also increasing commensurately. However, crucially, younger cohorts are less numerous, and the ratio between the retired population and the working-age population – the so-called 'elderly support ratio' - is declining. It is this combination of rising demand and a proportionally shrinking working-age population that is imposing acute fiscal pressure on the system of public funding of care and support in the UK, including Scotland.

The last UK provider of pre-funded long-term care insurance left the market in 2010 citing a lack of demand...

For example, local authorities report an increase in their discretionary spending on adult social care service from £15.3 billion in 2007-08 to £16.1 billion in 2008-09, representing around 5% in cash terms and 3% in real terms. Over a longer term, there has been a real term increase of 13% since 2003-04 and 54% over the 10 years from 1998-99.[12]

In the wake of the wider crisis that has afflicted public spending in the wake of the post-2007 global financial crisis, the demographic factors imposing fiscal pressures on social care spending have been joined by an unprecedented fiscal crisis afflicting all public spending.

Pre-funded long-term care insurance in the UK

As described above, the principal available support for social care needs in England and Wales is means-tested, and as a result, many individuals either rely on informal care or purchase care out-of-pocket. The accumulated costs of formal care purchased privately, particularly residential care, can be very high.

It is this potential 'target market' which most discussion on the potential role of pre-funded long-term care insurance (LTCI) has focussed.

However, the pre-funded LTC market in the UK has always stood in marked contrast to the large and competitive markets that exist for other types of risks, such as contents insurance and travel insurance, in which millions of people participate. As of July 2010, no UK insurer offered pre-funded LTCI, with the final provider exiting the market citing lack of demand. This is despite the fact that around 75% of the pensioner population own their home and may therefore receive very little public support under the current means-tested system. The 'exposure' among the retired population to catastrophic costs associate with long-term care is significant and growing.

The limited demand for pre-funded LTCI is observable in market statistics. Between 1995 and 2009, new long-term care business written by Association of British Insurers (ABI) members was 1,129.[13] According to the ABI there are around 36,000 long-term care insurance policies in force at the end of the 2009 calendar year.[14] These products typically pay out a cash-benefit when someone is no longer able to perform a defined number of Activities of Daily Living (ADLs).

To put this in some historical context, when there was still a live market at the end of 2003, the ABI reported that the total number of all LTCI policies in force was approximately 46,000, of which 29,500 were pre-funded policies, 12,800 were investment-based pre-funded products, and around 3,600 were point-of-need annuities.[15] If it is assumed that all pre-funded and investment-based products were held by the 65-84 year old age-group, which numbered around 8 million in England and Wales, then the take-up rate in 2003 was around 0.005%, or half a percent.

The pre-funded LTCI market is therefore much smaller than other types of pre-funded insurance. For example, around 78% of households have contents insurance, 35% have life insurance and 10% have medical insurance.[16]

Pre-funded LTCI overseas

The UK is not alone in having a minimal market in pre-funded LTCI; indeed, no country in the world has an LTCI market that could be described as functioning or effective when compared to other types of insurance.

In the USA, take-up of pre-funded LTCI is estimated at around 10% of the over-60 population,[17] although the market is perceived to be struggling and policymakers are now implementing reform built around an innovative state-sponsored insurance scheme, under the aegis of the 2010 Community Living Assistance

Other countries have also seen low rates of take-up, such as 10% in the USA, despite considerable tax-relief and other incentives...

and Support Services Act (CLASS Act). Historical data for the US market shows, interestingly, a roughly equal take-up among men and women despite gender-based underwriting.[18] It is estimated that private LTCI products fund around 10% of all formal care expenditure in the US, with around 40% coming from the means-tested state safety-net, Medicaid.[19]

Academic analysis of the US market has found that most policies have an "elimination period," of around 30 to 100 days, during which someone must be in need of care before an insurance policy will begin pay-outs.[20] Most policies feature a maximum period of pay-outs of between 1 and 5 years, thereby limiting the exposure of insurers to the tail-risk associated with long-term care. Perhaps most interestingly, the majority of policies were found to provide payments equal to the cost of care but only up to a specified maximum daily benefit; this is despite the fact that long-term care costs have historically risen faster than inflation, and in the US, are purchased around 15 years ahead of the onset of care. One academic study of the UK market calculated that the typical purchased policy covers only about one-third (34%) of the expected present discounted value of long-term care expenditures.[21]

One argument put forward to explain the limited size of the US market is the poor value of products: academic research has estimated that for a pre-funded product purchased at 65, the 'load factor' is 0.18, i.e. the buyer will on average get back only 82 cents in expected present discounted value benefits for every dollar paid in expected present discounted value premiums.[22]

However, despite having a health system that centres around private medical insurance, the US does not represent the largest market for pre-funded LTCI by take-up: in fact, the largest market is France. Take-up of pre-funded LTCI in the French market is around 15% of the population. Commentators relate this high take-up rate to a number of distinctive factors, most notably "l'obligation alimentaire" – the material support (allowance) which is due to a close family member who is in need, to ensure his/her subsistence.

Nevertheless, despite possessing the highest take-up of pre-funded LTCI in the world, it is reported that this outcome is not perceived as a satisfactory result by French policymakers, and the social care funding reform agenda in France remains 'live' - albeit stalled by the effects of the global financial crisis - with the direction of travel reportedly being toward social insurance.[23]

Analysing the role of pre-funded insurance in funding long-term care

In the absence of a live market for pre-funded LTCI in the UK, the rest of this report explores the potential for this market to grow and the extent to which such a market could help policymakers achieve social care policy objectives.

Multiple variants of the basic model of pre-funded LTCI can be conceived, such as different levels of premium for different levels of cover, and variable payouts reflecting different levels of functional impairment.

In thinking about the potential of the pre-funded insurance market for funding long-term care, it is useful to make some distinctions. First, between potential consumers of working-age in the 'accumulation phase' of the life course (building up assets to fund retirement), and potential consumers in retirement over the State Pension Age (currently 65 years of age) who are in the 'decumulation phase', i.e. spending down wealth in retirement.

Second, as set out in the Introduction, it is important to bear in mind the different potential costs associated with long-term care for which pre-funded insurance could be deployed: personal care in the home; personal care in a residential setting: and, the

France is cited as having the highest take-up in the world – around 15% - but commentators relate this to distinctive French welfare laws...

accommodation ('hotel') costs of residential care.

Building on these distinctions, the next chapter examines the demand and supply-side barriers to the growth of the market for pre-funded insurance against long-term care costs, both in the UK and internationally.

Key points:

- Long-term care costs may relate to: personal care in the home; telecare and home adaptations; personal care in a residential setting; accommodation costs; and, nursing care costs.
- Current public spending on social care is focused on means-tested local authority funded care and support, and non-means tested cash-based disability benefits.
- However, the problems with the current funding system are manifold, and relate to the incidence of accumulated catastrophic costs, fiscal pressures on public funding of care and support, particularly resulting from the ageing of the population and the declining 'elderly support ratio'.
- As of July 2010, no UK insurer offered pre-funded LTCI, with the final provider exiting the market citing lack of demand.
- The UK is not alone in having a minimal market in pre-funded LTCI; indeed, no country in the world has an LTCI market that could be described as functioning or effective when compared to other types of insurance.
- In the USA, take-up of pre-funded LTCI is estimated at around 10% of the over-60 population, although the market is perceived to be struggling and policymakers are now implementing reform built around an innovative state-sponsored insurance scheme, under the aegis of the 2010 Community Living Assistance and Support Services Act (CLASS Act).
- Take-up of pre-funded LTCI in the French market is around 15% of the population, which can be related to distinctive French welfare laws - "l'obligation alimentaire". However, policymakers believe the coverage provided by the market is too low and reform remains a live topic.

3. Pre-funded Insurance: Supply and demand-side barriers to the market

Multiple supply and demand-side barriers to the growth of the pre-funded long-term care insurance market have been identified by researchers and academics...

Most consumer insurance products comprise 'pre-funded' insurance. This is insurance bought by households before an adverse event has occurred, whether theft, weather-damage to the home or ill-health while travelling abroad.

Unsurprisingly, as an 'adverse event' that can cost individuals significant amounts of money, there has been consistent interest in the potential of pre-funded insurance products to protect individuals against the risk of needing paid-care.

However, the UK market in pre-funded LTCI is now closed, with the last provider leaving the market citing a lack of demand. Abroad, take-up of pre-funded LTCI also remains low.

This chapter therefore reviews in detail the potential demand and supply-side barriers to the growth of the pre-funded LTCI market, including those that are common across different countries and those that are unique to the UK.

Supply-side barriers	
	Limited profitability and market size
	Uncertainty posed by longevity and morbidity risk
	Adverse selection
	Requirement for needs(claims)- assessments
	Reputation risk
	IFA resistance to new brands
	Solvency II
Demand-side barriers	
Financial barriers	Cost
	Requirement for out-of-pocket payments
	Competing financial motives
	Household protection gap
	and precautionary saving
	Alternative strategies for paying for care
'Exposure uncertainty' barriers	Uncertainty over availability of informal care
	Uncertainty over who to insure in a household
	'Political-risk' and uncertainty over availability and shape of state support
	Uncertainty regarding future household wealth
	Uncertainty over future care costs
Knowledge barriers	Ignorance of the risk of needing care
	Belief that all care is provided free by the state
	Confusion with Scotland
Behavioural barriers	Inertia
	Mental discounting of the risk of needing care
	'Positivity effect'
	Declining cognitive capacity and financial capability
Structural barriers	Complexity of products
	Distrust of financial services providers
	Obligation to obtain financial advice
	Lack of qualified financial advice
	Expectation of gaming the system
	Uncertainty over adequacy
	Crowding out by private medical insurance
	Implications of individual under-writing

Even under very optimistic scenarios, it is unlikely that the pre-funded long-term care insurance market would ever be extremely profitable for providers...

Supply-side barriers to the purchase of pre-funded insurance

The principal supply-side barriers to the development of the pre-funded LTC insurance market relate to potential market size, actuarial risk and structural issues:

- Limited profitability and market size

Although the exposure of the older population in particular to catastrophic costs associated with long-term care is significant, it is questionable whether pre-funded LTCI would ever represent a highly profitable market for UK insurers, raising questions as to whether it would be attractive enough for insurers to re-enter the market in sufficient numbers to ensure competition and to provide a justification for policymakers to rely on a market-based approach to long-term care funding reform.

Appendix 1 contains some thumbnail scenarios a potential provider of pre-funded LTCI might consider regarding potential take-up of pre-funded LTCI, market share and profitability.

For example, consider the following potential scenario for a UK insurer in relation to England and Wales:

- Take-up of pre-funded long-term care insurance is 10%, equivalent to the USA;
- Individuals purchase the insurance when aged 65;
- Premiums are a lump-sum with an average value of £20,000;
- An insurer has 15% of the market;
- The effective profit on the value of premiums is 10%.

On this scenario - which many would consider highly optimistic in terms of both take-up and the value of premiums – an individual provider would see an effective profit of around £21.5 million per year. In the context of the UK insurance industry, such an amount would be considered small relative to the size of other insurance markets, and would be weighed against the costs of entering the market by providers.

In short, it is far from clear, even given optimistic assumptions, that the market for pre-funded LTCI in England and Wales would ever be sufficiently large or profitable for many companies to consider it worthwhile entering the market.

- Uncertainty posed by longevity and morbidity risk

Like any form of life insurance, providers of LTC insurance confront uncertainty regarding future trends in life expectancy and *healthy* life expectancy: longevity-risk and morbidity-risk. Indeed, some academic analysis has argued that given patterns of longevity and morbidity will be affected, both positively and negatively, by trends in disability and healthcare, insurance companies confront a significant degree of uncertainty in providing pre-funded insurance for long-term care, making the product problematic.[24] For example, medical advances improving the life expectancy of the whole insured population, occurring between point of purchase and point of claim, might pose difficulties for insurers.

Historically, in the UK market for LTCI, some insurers attempted to cope with such uncertainty by selling products which allowed them to review premiums and/or benefits after an initial period, e.g. five or ten years. However, analysis of this market notes: "from a customer standpoint, the reviewable nature of the contract meant that, while costs of the protection were known at the outset, the possibility remained that, as a result of later reviews, premiums might rise significantly to a point where they were no longer affordable. This would be particularly difficult for those who were living on a fixed income, which would of course be the case in many instances."[25]

Patterns of claims far into the future may be hard to predict, making it a difficult risk to price...

- Uncertainty regarding future patterns of claims

Patterns of claims on LTCI may be affected by exogenous and unpredictable factors, such as the availability of informal care, and the extension or withdrawal of publicly funded healthcare services to cover certain types of social care need.

- Adverse selection

Some have argued that adverse-selection is a problem for pre-funded LTCI, although this remains a matter of acute contention. While individuals may be able to make guesses regarding the likelihood that they will experience certain conditions, it is much harder for individuals to know most the crucial piece of information in regard of care costs, i.e. how long they will survive with that condition.

Academic analysis of European survey data does suggest some form of adverse selection in France: body mass index as well as alcohol consumption were correlated with purchase of insurance,[26] although this does not necessarily mean that such individuals will have higher average LTC costs, which would be the outcome that would push up average premiums.

Interestingly, academic analysis of the Health and Retirement Study in the US reveals two relevant effects that appear to cancel each other out.[27] It was found that purchase of pre-funded LTCI is higher among individuals with private information about their risk-profile, and among those individuals who are risk-averse and have a 'taste' for insurance, but who are actually lower-risk. As a result, the population of people who have purchased more pre-funded LTCI than others is not a higher-risk than average, and there is no effect on premiums.

- Requirement for needs(claims)- assessments

In order to make claims, owners of pre-funded LTCI would need to assessed as to their level of qualifying need. Consumers would expect to be assessed speedily and efficiently following the onset of need, including in some instances, when individuals were preparing to leave hospital.

Insurance companies providing pre-funded LTCI could rely on the assessment of independent professionals in the social care system, such as GPs and social workers, as to a person's level of impairment, and therefore, whether they can claim on their LTCI.

However, there is variation in the quality and application of needs-assessments, which would create uncertainties and difficulties for insurers. This is exacerbated by geographical variations among local authorities in when they will carry out needs-assessments, with some deferring assessment until need has clearly reached a 'Substantial' level. Some commentators also believe that if GPs or social workers employed by local authorities were responsible for undertaking assessments, they would be incentivized to be generous to users by deliberately over-estimating their level of need. Such outcomes would create problems for insurers.

Alternatively, providers of LTCI could implement their own 'gateway' system for enabling the validation of claims through individual assessments. However, this would impose a significant up-front cost for the industry in terms of developing and training a workforce, which at some point would have to be passed on to consumers. Although, on an ongoing basis, the cost of a dedicated gateway system could be pooled among different providers, getting to such a point would require overcoming significant coordination and collective-action problems within the industry.

Solvency II and the need to engage independent financial advisers also represent some practical difficulties for potential providers...

- Reputation risk

Insurance companies may be concerned with the reputational risk associated with using their brands to market pre-funded LTCI. These risks may be particularly associated with: policies that fail to meet customer expectations, for example, because the benefit-level has fallen so far behind the unit cost of care; and, the problem of refusing claims while attempting to grow a market. Anecdotal evidence reports that providers of pre-funded LTCI in the UK previously felt compelled to adopt a highly generous stance in relation to claims-refusal in order to protect the brands of their products.

- IFA resistance to new brands

In order to sell LTCI to the public, insurance companies would have to first promote and 'sell' their products to market intermediaries: independent financial advisers (IFAs). However, advisers may typically feel comfortable recommending only a small number of brands for each product line, which are those that they know and trust. As such, to develop the market, potential providers would have to put in a lot of effort and overcome this inertia and a product history of pre-funded LTCI that is tainted in the eyes of some advisers. Although this does not represent an insurmountable obstacle, it does represent a cost that insurance companies would consider before entering the market.

- Solvency II

Although not an issue that is specific to pre-funded LTCI, it is worthwhile highlighting that the capital requirements being imposed on life insurance companies under the Solvency II regime may also inhibit enthusiasm among potential providers to developing new products and markets.

Demand-side barriers to the purchase of pre-funded insurance

The preceding analysis of the supply-side barriers to the development of a pre-funded LTCI market in the UK highlights several issues: the profitability of such a market; wariness among some insurers regarding the risks associated with long-term care; and, the structural costs and barriers associated with bringing a product to market.

Nevertheless, in the extensive academic literature on the failure of pre-funded LTCI markets, most academic studies have argued that it is demand-side barriers to market development that are the more significant.

As described above, the market in pre-funded LTCI is far smaller than what might appear to be its potential, and no UK insurers now offer pre-funded insurance for long-term care. Various policy and insurance industry commentators cite a lack of consumer demand as being the key reason for this outcome.

What then are the demand-side barriers to the growth of the pre-funded LTCI market? These can be grouped into:

- Financial barriers;
- 'Exposure uncertainty' barriers;
- Knowledge barriers;
- Behavioural barriers; and
- Structural barriers.

These are now explored in turn.

Financial barriers to the purchase of pre-funded long-term care insurance

Financial barriers that have limited the growth of the pre-funded LTC insurance are as follows:

Only a limited proportion of the older population would ever be able to afford pre-funded long-term care insurance given their income and savings...

- Cost

Pre-funded LTCI could be purchased via a lump-sum payment, regular small payments spread over an extended period, or a combination of the two. Ultimately, the cost of the premium is determined by the value of the benefit.

As a lump-sum, a reasonable likely cap on a premium for an LTCI product covering *personal* care would be £22,300 for men and £40,400 for women.[28] This is the mean lifetime expected cost of personal care for men and women aged 65, in relation to care that would qualify under the local authority 'Fair Access to Care' criteria used by local authorities, and excludes cover for accommodation costs. However, median household financial wealth, excluding pension wealth, among those households with financial wealth, is around £18,000 for the 55-64 age-group, £13,900 for the 65-74 age-group and £11,300 for the 75-84 age-group.[29] This suggests many households would find it impossible to afford comprehensive pre-funded LTCI coverage.

In fact, the experience of the UK, France and the US is that purchased pre-funded LTCI policies typically pay out benefits that only ever cover a portion of costs, and as such premiums are much lower.

For example, the actual cost of LTCI premiums reported in 2005 as typical of the UK market for a 67-year old, providing a £10,000 annual benefit with a 13-week benefit deferment period were as follows:[30]

Males
- £14,726.33 – with benefit linked to RPI;
- £7,618.70 – with a level benefit.

Female
- £19,335.30 – with benefit linked to RPI;
- £10,178.00 – with a level benefit.

Nevertheless, if the housing wealth of older households is taken into consideration, the affordability of pre-funded LTCI appears much improved. Linking pre-funded insurance to mechanisms, such as equity release products, to deploy housing wealth to fund a purchase is therefore explored in the next chapter.

The impact of cost on take-up of pre-funded LTCI appears to show a different effect in the US and French markets. Analysis of the French market finds a non-linear bell-shaped curve across the income-range for take-up, highlighting that some do not purchase the insurance because they cannot afford it, and some do not because they not need to, or are so wealthy as to have a low-level of risk aversion.[31] By contrast, take-up in the US appears to show a simple linear correlation with income.

In the UK, some have argued that policymakers should target working-age individuals for pre-funded long-term care insurance since individuals typically have a higher income during this life-stage, and there is the possibility of being able to spread payments over a longer period. In this way, it is argued, issues of affordability cease to be important. However, such arguments could only ever apply to younger working-age households, who are a low-priority group in long-term care funding reform compared to the 'baby-boomer' generation. Voluntary take-up of pre-funded LTCI would also likely be extremely low, particularly in the context of low rates of retirement saving among the working age population, i.e. for an event that has a much greater probability of occurring: retirement.

- Requirement for out-of-pocket payments

The fact that most pre-funded LTCI policies would require users to nevertheless pay for some proportion of care costs out-of-pocket is likely to be a deterrent to their purchase.

Households may prefer to preserve their savings for other purposes, not least to provide protection against other types of risk confronting themselves and their family...

As described, it was a feature of the UK pre-funded LTCI market, and a current feature of the French and US market, that individuals with insurance coverage nevertheless have to pay for some care costs out-of-pocket: i.e. the level of coverage provided by the products bought is typically insufficient to cover full care costs.

For example, in France, it is estimated that dependency generates an average monthly cost of around €2,500, with the public entitlement paying €500, and private insurance typically contributing €300 on average, in the context of an average pension being worth around €1,200 per month.[32]

As described, in the UK market, benefit levels on pre-funded insurance for people in residential care were typically around £10,000 per annum, and as such, it was effectively assumed that other private income sources would be used to pay for care, with the insurance effectively positioned as a top-up.[33]

As it happens, policymakers sometimes used out-of-pocket payments as a mechanism to ration demand and, to some extent, raise revenue. However, as a feature of an insurance product, requiring individuals to dip into their own pockets upon needing to claim, could clearly act as a disincentive to purchase, especially if the level of payment required so clearly goes beyond what might be considered a normal insurance deductible.

- Competing financial motives

The limited financial resources available to households are important when it is considered that households may have competing expenditure requirements and desires. For example, households may be motivated to spend their money on leisure, to invest it, or to pay for healthcare. Alternatively, older households in particular may prefer to preserve their liquid wealth in order to be able to transfer this wealth to relatives: the so-called 'bequest motive'. The critical point is that in the context of limited budgets, households have a range of competing potential uses for their resources as well as the potential purchase of pre-funded LTCI.

- Household protection gap and precautionary saving

For many older households, exposure to the catastrophic costs of long-term care is just one aspect of an insurance 'protection gap' they may experience. For some of these risks, households may purchase insurance. However, in the context of a limited budget, households may opt instead to maintain 'rainy day' savings to act as a flexible form of insurance against multiple adverse scenarios, and the risk of paying for care out-of-pocket is only one of these scenarios: in effect, households maintain savings as pooled insurance against a number of risks. These risks may be particular to an individual household, such as the risk of the roof needing repair, or the car requiring fixing. They may also be common to many households, for example, maintaining savings against the risk that an inflation spike occurs and a household's pension income is no longer sufficient to live off.

Many older households may also maintain savings as insurance in relation to the 'protection-gap' afflicting their children and other family members; for example, an older household may maintain 'rainy-day' savings against the risk that an adult child becomes unemployed and is therefore unable to afford their mortgage.

Older households may even maintain precautionary savings against the risk of long-term care, but opt to 'insure' against this risk in a way not recognized by policymakers and the financial industry. For example, a household may insure against long-term care by maintaining a pot of savings that can be used to incentivise, reward and support potential family carers, as well as potentially pay for formal care out-of-

Many individuals hope or expect to rely on informal care when they reach the point of need, so may be deterred from purchasing insurance for this reason...

pocket.[34]

- Alternative strategies for paying for care

Households may have alternative strategies for paying for care that do not involve private sector insurance.

Household budgeting and financial planning may extend across different generations and households, and in part, be built around expectations of financial receipts. The value of inheritances received by those in the 50+ age group has increased dramatically in recent years,[35] and some may have earmarked such receipts to use to pay for care. Alternatively, some households may plan on using their housing wealth to pay for care, which they may have earmarked as a form of insurance, and prefer to gamble on whether they need care rather than insuring themselves. Academic commentators have suggested that this points to the need for linking insurance mechanisms to housing wealth.[36]

'Exposure uncertainty' barriers to the purchase of pre-funded long-term care insurance

A number of factors relating to *uncertainty* as to the *exposure* of households to long-term care costs may inhibit purchase of pre-funded LTCI. These factors are among the most ignored in policy discussion of pre-funded LTCI, but directly prevent households from forming a judgement about whether to insure. They relate to individual and household factors, as well as external factors such as care costs and potential changes in public policy.

- Uncertainty over availability of informal care

The first uncertainty affecting any potential purchase of pre-funded LTCI by a household is uncertainty regarding the availability of informal care, and potential need for formal care.

From the perspective individuals and households contemplating the risk of needing care at some point in the future, there are effectively two scenarios: care from a family member, such as partner or adult child; or, care from a paid care worker.

Although it is an under-researched topic, the last survey on the issue found that when prompted to consider the risk of needing care, most individuals would prefer to receive informal care rather than formal care.[37] Indeed, informal care provision outstrips formal care provision in terms of volume of provision and number of recipients. Among the 50+, 33.8% report receiving informal help, 3.8% receive domiciliary care purchased out of pocket (although 54% of this group also receive informal support), and 3.9% report receiving formal care paid for by the state.[38] Individuals who believe it more likely that they will receive informal than formal care are entirely correct in this belief.

In this context, and apparently having some preference for informal care over formal care, it would only be logical for individuals and households to consider the potential availability of informal care before purchasing pre-funded LTCI. Indeed, some individuals may expect and/or hope to be able to rely on informal care, even if this expectation is mistaken and does not take account the true wishes of family members. On this basis, individuals may opt not to purchase pre-funded LTCI.

However, it is very difficult for households to estimate the likely availability of informal care in the future. An extensive theoretical literature in economics and social policy has tried to map the different factors that determine participation in informal care. Variables include: survival of partnership; health of family members; proximity and availability of adult children; the opportunity cost for potential informal carers associated with reduced activity in the labour market, etc. Importantly, in deciding whether or not to purchase pre-funded insurance on the basis of whether or not informal care is likely to be available, these multiple

Households will always confront uncertainty regarding what support they will receive from the state in the future, so may struggle to calculate what their 'exposure' actually is...

variables affecting informal care provision add layers of uncertainty to the decision of whether to purchase pre-funded LTCI. Those who expect to rely on informal care may deliberately reject any opportunity to insure, as they would prefer to use their resources to support informal care provision, whether through rewarding a family carer or moving home to access informal care.[39]

- Uncertainty over who to insure in a household

Under the current means-tested system used in allocating public funding of residential care in England and Wales, a person's home will only be counted as 'assessable capital' if there is no spouse or dependent still living in a property.

Thus, for a typical retired couple who might consider purchasing pre-funded insurance against residential care costs for one or both of them, and particularly if they can only afford to insure one of them, it is unclear whether they should *both* purchase pre-funded LTCI, or just one of them, given that their home will only qualify as assessable capital in the event of *one* of them dying, or the breakdown of the relationship. This therefore raises the question of which one of them should become insured, and the difficulty of this question may deter both from becoming insured.

Any decision would be complicated by the fact that, as described above, premiums for women may be higher than that for men. One potential response from insurers would be to design a form of pre-funded 'couple's insurance' for LTC, which would insure the surviving partner.

Of course, once one partner has died, the decision for the surviving partner to insure may become clearer, and is reflected in an observation made of the UK market that insurance options typically became more "prominent" to households once one partner had died, i.e. once a house becomes potentially 'assessable capital' in a local authority means-test.[40]

- 'Political-risk' and uncertainty over availability and shape of state support

The existence of individuals with no means to pay for their own care ensures that the state will always have to provide a safety-net in funding care and support, and so will always have a role in long-term care funding, which in the future may become less, or more, generous.

A person's exposure to the risk of needing to pay for care out of pocket will be determined by the nature and shape of state support in the future.

At present state support comprises universal, non-means tested cash benefits (Disability Living Allowance, Attendance Allowance), and local authoring means-tested support, which increasingly takes the form of Direct Payments or Personal Budgets.

Considerable policy debate exists as to potential changes to both of these components of state-funded support for care needs. However, any changes would also inevitably change the exposure of households to the risks of needing to pay for care themselves. For example, a significant increase to the upper capital threshold limit in the means-test from £23,500 to £60,000 would reduce the exposure of older households to long-term care costs. An increase in the value of higher-rate Attendance Allowance from £71.40 per week to £120 per week would also reduce exposure among older households. A future government might also choose to cap the maximum that households have to pay toward care – the 'limited liability model' – which was proposed by the previous Labour government in its 2010 White Paper.

Conversely, risks may flow the other way: at the time of writing, the Department for Work and Pensions is consulting on radical proposals to replace working-age Disability Living Allowance with a so-called 'Personal Independence Payment', the implications of which are

Household wealth can rise and fall, even in retirement, so individuals may be unsure of the gap between their wealth and the threshold of means-tested state support...

unclear for individual care costs, but appear to reduce the availability of support. In addition, public support on long-term care may be downgraded in response to future fiscal crises.

As such, individuals considering the value of purchasing pre-funded LTCI must take account of 'political-risk', and to an extent, 'fiscal-risk' as a driver of politically-discretionary public spending on social care. Individuals that opt to insure themselves, potentially up to 30 years from the point of needing care, face the risk that: public support becomes less generous and that they are therefore over-exposed compared to what they had planned; or, that public support becomes more generous and that they are therefore over-protected and have wasted money.

It is important to underline the fact that under the current system, political-risk relates not just to national policy made in Westminster, but to the individual and distinct decisions on levels of support for care costs among every local authority in England and Wales. Individuals do not know the level of support that their local authority will provide up to 30 years into the future, but also, do not even know which local authority they will be living in at the point of them needing care and support.

This lack of clarity regarding the future shape of public support, as well as ongoing policy debate on long-term care funding during the last ten years, has led some commentators to argue that a market in LTCI will only develop when there is certainty and clarity from the government of the day regarding the future of state support. On this account, political and policy uncertainty inhibits the growth of the pre-funded LTCI market, and must be eliminated if a market is to flourish.

However, this line of argument is wholly spurious and has an obvious flaw: no government of the day can tie the hands of a future government regarding the future of state support. As such, 'political risk' cannot be eliminated from the long-term care funding system.

Indeed, the likely persistence of political and policy uncertainty is underscored by the low take-up of pre-funded LTCI in the UK and internationally, with its negative outcomes for the system, which would likely encourage future governments to repeatedly explore and pursue alternative funding solutions. It is unclear, and unlikely, that take-up of pre-funded LTCI could ever reach a level of coverage such that the issue of LTC funding would effectively be neutralized in political terms, and calls for reform would end. For example, despite achieving the highest level of take-up for pre-funded insurance in the world, policy debate on long-term care funding in France continues to be active and is apparently leaning away from a reliance on private sector insurance provision.[41] Because it is unable to provide a sufficient 'fix' to the problems of long-term care funding, private-sector pre-funded LTCI cannot deliver the outcomes that would remove political-risk and allow the market to develop.

- Uncertainty regarding future household wealth

A household's exposure to the risk of catastrophic care costs at any point in time can be defined as the gap between total household wealth and the threshold of means-tested state support, which currently has an upper capital limit of £23,500. The value of this gap is effectively the potential sum that individuals need to insure against to protect.

As described above, the capital threshold used to allocate means-tested public funding is effectively subject to multiple political and fiscal uncertainties regarding the future shape and form of state support. However, from the point of view of households, the size of the difference between their household wealth and the capital threshold in the means-test is also massively uncertain owing to future changes in their household wealth.

It is difficult to predict what the unit cost of care will be years into the future, and therefore, how much cover should be purchased...

For example, in 1995, a 65 year old at the point of retirement had total household wealth, excluding pension wealth, of around £98,000. Ten years later, in 2005, the equivalent figure for the then 75 year old was £185,000.[42] However, during this period, the capital threshold for means-tested public support remained around £20,000.

Thus, purchasing insurance against a future liability, which is determined by total household wealth, is subject to hugely unpredictable variations in household wealth. Not only is this variability driven by trends in house prices, the average value of inheritance transfers received in the 50+ age group by the 5% who receive such a transfer each year, have also increased substantially.[43] This means that between purchasing an LTCI policy and claiming upon it, household wealth might have increased substantially simply owing to the death of elderly parents.

In effect, the *positive* and *negative* 'investment-risk' retired households confront in relation to their housing wealth, savings and investments, all create uncertainty regarding the extent of exposure to catastrophic care costs that households confront up to 30 years into the future, creating associated uncertainty for any decision to purchase pre-funded LTCI.

- Uncertainty over future care costs

The future unit costs of personal care in the home, telecare and home adaptations, personal care in a residential care setting and accommodation costs are all very difficult to estimate up to 30 years ahead, whether because of the labour market, technology or changing practices in social care provision.

For this reason, it is effectively impossible for insurers to articulate to consumers whether any pre-funded insurance they purchase will be adequate to cover all of their care costs, or what proportion of costs they will cover.

As such, many pre-funded insurance policies for LTC in the UK and abroad, although traditionally not the USA, have only guaranteed a cash-payment, rather than a level of care.

In effect, these products ensure that the inflation-risk associated with future care costs lies with the consumer. However, no consumer can predict the likely future path in unit care costs over several decades, in stark contrast, for example, to home contents insurance for which individual households can and do calculate with great accuracy the replacement costs of household good they wish to insure. Being forced to retain the price risks associated with future changes in unit care costs is clearly a disincentive to purchase insurance, is an unattractive product feature, and stands in marked contrast to the recent trend in direct insurance for insurers to replace products rather provide cash benefits.

Although insurers could attempt to create a pre-funded product which benchmarked pay-outs to trends in unit care costs, few insurers would be comfortable attempting to forecast trends in unit care costs and to build this risk into a product.

Knowledge barriers to the purchase of pre-funded long-term care insurance

The development of the pre-funded LTCI market confronts a number of demand-side barriers relating to *knowledge* among potential purchasers.

- Ignorance of the risk of needing care

Households may lack knowledge regarding what social care is and the risk that they will need it, particularly in relation to personal care in the home. Indeed, it is worth noting that in many ways, the concept of 'social care' is largely an expert 'construct'. From the perspective of most families and households, their route into experiencing social care provision is shaped

Some households in England simply have very little knowledge of what social care is, or may think that state-funded free personal care is available, as it is in Scotland...

by specific activities: help with shopping, assistance with cooking and cleaning, etc. Even households that have experience of formal and informal care may nevertheless be confused by the concept of social care, particularly in the context of home care, and the suggestion that they should insure against its cost.

Interestingly, research into the French market for pre-funded LTCI – the world's most developed – did find that take-up was higher among those individuals who have experience of providing informal care, as well individuals who have been recently hospitalized or suffered a serious illness,[44] suggesting knowledge is a factor in determining take-up of pre-funded LTCI.

Public ignorance and confusion over what social care is has led some stakeholders to suggest that pre-funded LTCI should be focused on the costs of residential care, which is easier to boost awareness of. However, as a strategic response to the challenge of long-term care funding, this raises a number of problems, which are explored in subsequent chapters.

- Belief that all care is provided free by the state

Households may mistakenly believe all personal care is paid for by the state, i.e. that a system of universal free state-funded care operates in England and Wales. For example, qualitative research with older people on paying for long-term care found "considerable confusion around who currently pays for care, with many believing the state funds this as it does the universal health system, or that it had previously funded it."[45]

This mistaken belief may in part reflect the existence of universal, free at the point of need, healthcare in the shape of the NHS. It may also reflect the inevitable intersection and overlap between free healthcare and means-tested social care support.

Crucially, there will always be a significant proportion of individuals, including many wealthy individuals with an expensive house but a dependent still living there, who receive free care funded by the state. As such, it is not difficult to find apparently wealthy individuals who receive 'free personal care' funded by the state, thereby exacerbating confusion.

- Confusion with Scotland

It is worth underlining that a potentially distinct and significant barrier to the development of a pre-funded LTCI market in England and Wales is the provision, since 2003, of universal free personal care in Scotland.

Political scientists have long noted how devolved systems of governance have unexpected effects, including the shaping and influencing of parallel policy debate in other regions. Political scientists recognise that the policy adopted by one devolved government within a country – such as Scotland - will always limit and shape the potential policy options adopted by another nation next door, particularly one sharing a common language, currency, taxes and central government.

The existence of free personal care in Scotland arguably represents a 'textbook' example of this effect. As such, the Scottish system may result in households in England and Wales:

- Believing that personal care is also free for them;
- Expecting personal care to become free as it has in Scotland;
- Feeling that it is unfair that they should have to insure given the available entitlements in Scotland, and therefore refusing to do so;
- Planning on moving to Scotland, declaring a Scottish bloodline, or deploying other mechanisms, to benefit from entitlements available on the other side of the border.

As behavioural economists observe, individuals may engage in 'mental discounting' in relation to the risk of needing care in the future...

It is a striking characteristic of debate on long-term care funding in England and Wales that there has been very limited consideration given to how the presence of universal free personal care in Scotland may influence public perceptions and expectations.

Behavioural barriers to the purchase of pre-funded long-term care insurance

Behavioural economics has had a growing influence on policymaking in recent years, particularly in relation to understanding financial behaviour and decisions. Various commentators have cited behavioural factors as being important to explaining the low demand for pre-funded LTCI. Potential behavioural barriers can be grouped as follows:

- Inertia

As with many types of financial behaviour, individuals may display simple inertia in relation to the risk of needing long-term care and the option to purchase insurance.

- Mental discounting of the risk of needing care

Studies in behavioural economics have noted the tendency of individuals to engage in 'mental discounting' in relation to the risk of events that might happen in the future. As such, when asked to consider insuring against an event that might occur several decades in the future, such as the risk of needing long-term care, individuals may discount the risk of this event occurring, and make a choice about whether to insure on this basis.

- 'Positivity effect'

A psychological aspect of ageing is the 'positivity effect' in which the brain subconsciously excludes 'negative information' in an attempt to regulate the emotions, and avoid stress and its harmful effect on the body.[46] In the context of the difficult choices required from older people regarding the risk of dementia and disability and associated need of long-term care, this psychological aspect of ageing may make it hard for older people to properly address the issue of their long-term care provision. The positivity effect may underpin the tendency, widely noted, that individuals do not like to talk or think about potentially depressing topics, such as the prospect of spending several years of their life unable to look after themselves or live independently in their own home. Qualitative research with older people on this issue has unsurprisingly found that the topic was "both frightening and depressing".[47]

- Declining cognitive capacity and financial capability

Financial capability – the skills of a person relevant to financial planning and financial activity – has been shown to increase with age as individuals accumulate financial experience.[48]

However, although far from a universal nor predictable process, ageing is on average associated with declining capacity in relation to different types of cognitive functioning. Data from the English Longitudinal Study of Ageing[49] provides reliable evidence for the 50+ age-group in England and Wales of age-related declines in literacy, numeracy and interpretive ability.

The relevant implications of declining cognitive capacity associated with ageing are several. First, it may be harder for older people to understand complex financial products, including pre-funded LTCI. Second, declining cognitive capacity among the older population may reduce the effectiveness of competition in any future pre-funded LTCI market, as individuals struggle to comprehend the differences between complex and variable products.

Some households may plan on 'gaming' the means-test for public support: moving wealth around until they qualify for public support...

Structural barriers to the purchase of pre-funded long-term care insurance

Structural barriers to the growth of the pre-funded LTCI market include:

- Complexity of products

Various commentators have observed that pre-funded LTCI represents a complex product by the standards of other forms of insurance, and this complexity may be a deterrent to purchase.

- Distrust of financial services providers

An important legacy for LTCI has been distrust in providers of long-term care insurance, owing to some historic problems around premiums and claims.

In addition, policymakers and the financial industry acknowledge that distrust of financial services providers is a wider problem for consumer engagement across all financial products.

- Obligation to obtain financial advice

When it was still available, pre-funded LTCI required consumers to obtain independent financial advice. However, for some consumers, the need to obtain independent financial advice is itself a barrier to purchasing insurance. First, because this imposes a time burden on individuals, as well as a financial cost when individuals must pay for the advice. Second, some individuals may distrust the value or objectivity of independent financial advice.

- Lack of qualified financial advice

The number of independent financial advisers (IFAs) qualified to advise on LTCI products is so low as to be a major impediment to the development of the market.

- Expectation of gaming the system

Households may not opt to purchase pre-funded insurance because they are aware of the means-test for public support and plan on gaming this system by transferring and spending down their assets sufficiently as to be able to qualify for public support. This may be particularly true for households with levels of wealth just above the level of the current means-test. However, there is also anecdotal evidence that a number of solicitors and IFAs also give advice to families on how to game the current system, suggesting that even wealthier households may be actively engaged in deliberate deprivation, or believe that they will be able to game the system, and will opt not to purchase pre-funded LTCI on that basis.

- Uncertainty over adequacy

Households may not purchase LTCI because they struggle to frame the likely probability of needing care, the cost of care, and what level of coverage is adequate. For example, imagine an average 65 year-old couple consider the following choice that an insurance company might provide to them regarding pre-funded LTCI:

- Silver-level coverage: £40 per month for a payout of £300 per month on critical needs.
- Gold-level coverage: £80 per month for a payout of £700 per month on critical needs.

To choose between these two options, individuals would need to form a judgement of what they believe to be an adequate level of cover. However, given uncertainty over need, it is extremely difficult to make a judgement as to what might be an acceptable level of cover, and on that basis, feel confident enough to purchase LTCI.

The private medical insurance market may already have 'captured' those households with sufficient resources and risk-aversion to be potential purchasers of long-term care insurance...

- Crowding out by private medical insurance (PMI)

Within the 50+ age-group, there may be only a limited number of households who are sufficiently risk-averse and have financial resources that they would consider purchasing pre-funded LTCI. However, this is also a key target market for private medical insurance (PMI). As such, in the context of limited household budgets, it may be that PMI has to some extent 'crowded-out' the LTCI market.

- Implications of individual under-writing

Men and women have substantially different risk-profiles in relation to long-term care, with women more likely to need care for longer periods. As such, an actuarially fair LTCI premium for a woman will, other things being equal, be more than for a man.

Although individually underwritten gender-based premiums are acceptable to consumers in fields such as house insurance and travel insurance, it is not clear that this would be considered popular and acceptable for LTCI. This is because as an activity, formal care closely intersects with informal care provision as social care, as well as childcare, both of which are predominantly undertaken by women, with associated costs, such as loss of earnings. As such, gender-based premiums for pre-funded LTCI may be a barrier to the growth of the market as women may question the fairness of being required to pay more than men.

Comment

This review of supply and demand-side barriers to the growth of the pre-funded LTCI market reveals a wide-range of potential factors that may limit the growth of the market. LTCI will be unaffordable to many households. For those who can afford it, uncertainty shrouds who to insure in the household, what their exposure will be in the future, and whether England and Wales will instead become like Scotland. Many will prefer to gamble on being able to rely on informal care, and anyway, do not wish to visit an IFA to learn more about the product. For those with higher levels of financial capability who may be more inclined to purchase insurance, private medical insurance might appear a more important product to purchase. Many may not understand what social care is, and among those that do and have a good knowledge of the current system, the option of moving assets around in order to be able to access state support may appear preferable to paying for an insurance, particularly as many feel that having paid taxes throughout their life, they are entitled to public support anyway.

As such, the failure of the market in pre-funded insurance for long-term care should not be seen as the fault of the UK insurance industry: it reflects universal demand barriers and some factors unique to the UK.

In the context of these multiple demand-side barriers to the growth of the pre-funded LTCI market, various commentators and organisations have proposed policy interventions with the objective of overcoming these barriers and increasing take-up. These ideas are explored in the next chapter.

Key points:

- Barriers to the development of the pre-funded LTCI market can be distinguished as *supply* or *demand*-side barriers.
- Supply side barriers include: limited profitability and market size; uncertainty posed by longevity and morbidity risk; adverse selection; requirement for needs(claims)- assessments; reputation risk; IFA resistance to new brands; and, Solvency II.
- Demand-side barriers include: *financial* barriers; '*exposure uncertainty*' barriers; *knowledge* barriers; *behavioural* barriers; and, *structural* barriers.
- *Financial* barriers include: cost; requirement for out-of-pocket payments; competing financial motives;

household protection gap and precautionary saving; alternative strategies for paying for care.

- *'Exposure uncertainty'* barriers include: uncertainty over availability of informal care; uncertainty over who to insure in a household; 'political-risk' and uncertainty over availability and shape of state support; uncertainty regarding future household wealth; and, uncertainty over future care costs.
- *Knowledge* barriers include: ignorance of the risk of needing care; belief that all care is provided free by the state; and, Confusion with Scotland.
- *Behavioural* barriers include: inertia; mental discounting of the risk of needing care; 'positivity effect'; and, declining cognitive capacity and financial capability.
- S*tructural* barriers include: complexity of products; distrust of financial services providers; obligation to obtain financial advice; lack of qualified financial advice; expectation of gaming the system; uncertainty over adequacy; crowding out by private medical insurance; and, the implications of individual under-writing.

4. Policy levers to increase take-up of pre-funded long-term care insurance

Multiple 'policy levers' to grow the size of the pre-funded long-term care insurance market have been proposed...

In light of the demand and supply-side barriers to the development of the pre-funded LTCI market, commentators and analysts have proposed a number of potential policy responses in order to address these issues and boost take-up. This chapter reviews and evaluates some of these proposals.

Potential policy levers
Auto-enrolment
Compulsion
Community-risk rated underwriting
Cheaper premiums secured via state-underwriting of tail-risks
US 'LTCI Partnership' approach
Matched contributions to premiums
Income tax relief on LTCI premiums
Educating households about the burden of informal care
Benefit-blind needs-assessments
Vouchers
Product simplification and standardisation
Standardised premiums and benefits
'Over-the-counter' distribution
Inheritance tax-breaks
Liquidity instruments to improve affordability
A national system of assessment and entitlement
Group-level insurance

- Auto-enrolment

In the wake of current UK pension reform, and plans to automatically enrol employees into workplace pension schemes, it has been proposed that working-age individuals could also be auto-enrolled into pre-funded LTCI. This could be wrapped into pension reform: individuals simultaneously enrolled into a pension scheme and an LTCI product. Alternatively, auto-enrolment for LTCI could occur separately, as part of an individual or group-based policy.

Besides the fact that auto-enrolment of employees in this way would represent a long-term solution for today's working-age cohort, rather than a short-term solution to under-funding for the current retired generation, this proposal confronts a number of problems.

First, much of the working-age population is already resistant to the idea of pension saving, and may reject pension saving altogether if it is tied to the 'distant and scary' prospect of needing long-term care in old-age.

Second, under EU legislation on forced selling, it would arguably be illegal for employers or the government to automatically enrol individuals into a private-sector insurance product that they may not definitely benefit from, i.e. may not claim upon. Auto-enrolment in pensions has only been possible thanks to the fact that workers will definitely benefit: the money taken from employee's salaries remains their money. However, copying the auto-enrolment process that is being applied to pensions across to private-sector pre-funded LTCI would likely prove illegal.

- Compulsion

Confronted with low take-up of pre-funded LTCI, a number of stakeholders have suggested that pre-funded LTCI should be made compulsory. Such a move would be a radical, politically-brave step in the UK: at present, the closest equivalent to compulsory insurance is motor insurance for those individuals who choose to be drivers. Many members of the public may reject the mandatory purchase of private sector insurance for all citizens as an infringement of liberty. Nevertheless, it is worth noting that the compulsory purchase of medical insurance has, with caveats, become a feature of US healthcare policy debate.

To reduce the cost of premiums, the state could guarantee to fund all costs beyond a certain threshold of expenditure – such as £80,000 – but it is precisely the fear of uncapped expenditure which is a key potential driver to purchase insurance...

The proposal confronts a number of questions and problems.

First, in relation to retirees, it is unclear how compulsory purchase of insurance would be feasible, given the limited income and liquid savings of many older households. Without serious cuts to their household expenditure and well-being, which would be widely resisted and rejected, many would not be able to afford the insurance, whether as lump-sums or regular premiums. Many individuals who are exposed to the risk of paying for care owing to being owner-occupiers, but who nevertheless have a very low income, would be forced to make unacceptable cuts to household spending in order to pay for a private-sector LTCI policy.

Second, for working-age cohorts, even assuming a community-risk rated premium of around £10 per week, many households would struggle to afford the premium.

Third, if individuals were expected to pay individually risk-rated premiums, affordability problems would increase substantially: for example, women, including those with child-rearing responsibilities outside of the labour market would have to pay more than men, as would those with certain conditions or disabilities. Most forms of compulsory insurance and risk-pooling see the effective premiums that individuals have to pay highly regulated. It would be unprecedented for the state to impose on individuals the higher insurance costs associated with their individual risk-profile in the form of mandatory private insurance.

If, to address affordability issues, compulsory insurance only applied to those in work, this would create issues around exposure and coverage for those with periods out of the labour market, whether due to unemployment, ill-health, caring or child-rearing responsibilities.

Wider structural issues for a system of compulsory pre-funded LTCI would also arise. Insurers would likely seek to target the most 'profitable' risks, excluding higher-risk individuals, meaning some individuals may not be able to obtain insurance, despite it being compulsory to purchase it.

- Community-risk rated underwriting

As described in the previous chapter, in order to charge 'actuarially fair' premiums, private insurers would have to charge women, and potentially some other groups, higher premiums. To address this problem, regulators could stipulate that insurers could only charge community-risk rated premiums for LTCI.

However, this would mean that either: men would have to pay more than their actuarially fair premium, and may therefore reject participation; or, women's premiums would have to be subsidized from other – presumably public – resources. However, some might argue that the explicit subsidy of LTCI for – most likely wealthy – women who opt to insure is not an effective use of public spending on social care, given many would have resources to pay for care out-of-pocket.

Nevertheless, this issue may be have to be revisited: at the time of writing, the European Court of Justice is examining the legality of gender-based life insurance premiums and annuity pricing. An eventual ruling that gender-based premiums were illegal would have a significant effect on the whole UK life insurance industry.

- Cheaper premiums secured via state-underwriting of tail-risks

In order to reduce the cost of pre-funded LTCI, it has been proposed that the state should guarantee to fund all care costs beyond a certain threshold, measured in accumulated care costs (e.g. £80,000) or time (experience of critical-level need for two years). By

The US 'Partnership' insurance model was designed to encourage take-up, but appears to have been inefficient as a form of public spending...

effectively covering the 'tail-risk' of potential LTCI costs that individuals confront, individuals would only have to purchase, for example, £80,000 of cover, which would lower the premiums that households have to pay and improve the affordability of products, as well as addressing some key concerns of potential LTCI providers around uncertainty and risk.

However, this proposal suffers a distribution problem and an incentive problem. The distribution problem relates to the fact that if the state guarantees to fund all care needs of someone who has required, for example, £80,000 of social care expenditure, this provides little 'cover' to individuals with around £80,000 or less in assets, who would have to run down all of their wealth to qualify for public support, but for whom, with only £80,000 of total wealth, LTCI premiums would represent a substantial amount. In short, the cover provided by this 'limited liability', as a proportion of household wealth, would be of greater benefit to wealthier households.

The incentive problem relates to the fact that fear of 'catastrophic costs' is itself arguably the most powerful potential driver for encouraging households to purchase LTCI. If the state removes this fear by undertaking to fund all care for individuals with high volumes of accumulated need, many individuals may then prefer to gamble on whether they will require up to £80,000 of formal care, and opt not to insure themselves. In short, any encouragement to self-insure provided by lower premiums would be counteracted by a reduction in the fear-based motivation to insure.

- US 'LTCI Partnership' approach

In the context of pre-funded LTCI, the 'Partnership approach' refers to a policy introduced in the US in the 1980s by four states, and expanded in the 2000s with around 27 states now participating.

As in the UK, US citizens only become eligible to state-support once they have spent down their assessable wealth and assets to a threshold: $2,000 (excluding main residence, car and certain other types of personal property).

Under the Partnership for Long-Term Care programme, an individual buys a government-approved LTCI Partnership policy. Upon making a claim on the policy, for every $1 paid by the policy, the effective means-test for state-support also increases by $1. For example, someone who had received $100,000 in pay-out as benefits to fund care from a Partnership LTCI would then be able to claim state-support when their assets had reached $2,000 plus $100,000, i.e. $102,000. If someone had received $150,000 in benefits from a Partnership LTCI, the means-test for accessing state-funded support would then be $152,000.

In many ways, the Partnership for Long-Term Care model can be seen as an elegant approach to encouraging individuals to purchase insurance, and access a level of publicly funded asset protection that is proportional to their wealth. The generosity of the policy could be increased or decreased by changing the ratio of increase in the means-test threshold proportional to the amount received as benefit.

As an alternative form of pre-funded LTCI, problems with the 'Partnership' LTCI model include many highlighted above, including cost, affordability, complexity and behavioural barriers. By raising the means-test to higher levels, it is unclear whether the Partnership LTCI also encourages more people to engage in gaming (deliberate deprivation). The US experience also suggests that Partnership LTCI is not a 'game-changer' for boosting take-up: in the four states that initiated the program in the 1980s, only 218,000 policies were purchased over nearly 20 years.[50] Some argue the policy is also regressive by directing public spending toward wealthier households.

The cost of introducing tax-relief would be difficult to justify given under-funding in the social care system...

However, perhaps the biggest drawback of the policy is cost: Partnership LTCI represents an explicit public subsidy for the purchase of private insurance, provided to people who may well have purchased LTCI anyway (a 'dead-weight' cost). Although Partnership LTCI was promoted as a way of saving the state money, the findings of a study by the US Government Accountability Office are worth quoting at length:

> "the Partnership programs are unlikely to result in savings for Medicaid, and may increase spending. The impact, however, is likely to be small. About 80% of surveyed Partnership policyholders would have purchased traditional long-term care insurance policies if Partnership policies were not available, representing a potential cost to Medicaid. About 20% of surveyed Partnership policyholders indicate they would have self-financed their care in the absence of the Partnership program, and data are not yet available to directly measure when or if those individuals will access Medicaid had they not purchased a Partnership policy. However, illustrative financing scenarios suggest that an individual could self-finance care— delaying Medicaid eligibility—for about the same amount of time as he or she would have using a Partnership policy, although GAO identified some circumstances that could delay or accelerate Medicaid eligibility. While the majority of policyholders have the potential to increase spending, the impact on Medicaid is likely to be small because few policyholders are likely to exhaust their benefits and become eligible for Medicaid due to their wealth and having policies that will cover most of their long-term care needs."[51]

- Matched contributions to premiums

As a variant of the 'Partnership LTCI' model deployed in the US, one alternative would be for the government to match the value of household expenditure on the premiums of pre-funded LTCI policies up to a certain cap, as a form of incentive. For example, for every £10 spent on LTCI premiums by households, the government could match this with an extra £10 paid toward the premium, or at a lower rate of generosity, such as £5 or £2.

The challenges for this model are around cost to the Exchequer, potential dead-weight cost of individuals who would have insured anyway, the directing of public subsidy to wealthier households that can afford LTCI, and potential public hostility to the government being seen to subsidise the insurance industry.

- Income tax relief on LTCI premiums

One proposal for encouraging take-up of LTCI is for premiums to be granted income tax-relief. Besides some challenging technical issues for how this would work in practice, the idea confronts a number of problems.

First, such tax-relief would present an upfront cost to the Exchequer that would be difficult to justify in the context wider under-funding of the social care system and competing claims on public spending.

Second, retirees have lower incomes, so pay much less income tax from which tax-relief could be granted.

Third, there is significant uncertainty regarding how effective such a move would be in encouraging take-up, particularly given widespread shortfalls in UK pension-saving across the population, despite a long-established and entrenched tax-relief regime. In the US, both the federal government and at least 34 states provide tax credits or deductions for the purchase of long-term care insurance, which in theory can amount up to around $3,180 deductible premiums.[52] However, academic studies of US states that provide tax breaks for LTCI purchase and those that do not find a very limited impact on rates of take-up.[53] [54] For example, Goda (2010) found that the "average tax subsidy raises coverage rates by 2.7 percentage points, or 28%. However, the response is concentrated among

The government could try to educate households about the potential costs of needing care, but households are generally averse to thinking about this risk...

high income and asset-rich individuals, populations with low probabilities of relying on Medicaid."[55]

Finally, it is worth noting that in France, the world's most developed pre-funded LTCI market, take-up of 15% has been achieved without any use of tax incentives.[56]

- Educating households about the burden of informal care

Analysis of the French market suggests that purchase of LTCI is associated with living with a partner and the number of children in a household, as well as having a higher probability of receiving informal care in the future.[57] One interpretation of this is that the purchase of LTCI in the French market is driven by a desire to protect relatives from the burden of informal care-giving. This points to one potential avenue for the government and/or industry to promote the take-up of pre-funded LTCI: education about the implications of requiring care. However, the effectiveness of any such public education campaign would remain hugely uncertain. As noted in the previous chapter, governments confront an uphill battle in this regard since large swathes of the population would prefer not to think about the risk of needing care, or may be confused by the availability of free personal care to people in Scotland, and to individuals with a partner remaining in their home.

- Benefit-blind needs-assessments

It has been proposed that take-up of pre-funded LTCI would increase if benefits, i.e. payouts from the insurance, were entirely disregarded in the means-test used in local authority community care assessments. The rationale for this proposal is the hypothesis that individuals are disincentivised from purchasing pre-funded LTCI by the thought that they would just be disqualifying themselves from social care support they should receive from the state.

Although it is unlikely that many households have such a detailed knowledge of local authority community care assessments as to be de-motivated from purchasing insurance on this basis, the principal problem for this proposal is that it effectively encourages wasteful use of public expenditure: individuals are implicitly encouraged to make claims on public resources despite being in receipt of an insurance pay-out.

- Vouchers

As a prompt to encourage households to purchase pre-funded LTCI, it has been proposed that the government could send individuals a voucher that could be redeemed against the value of an LTCI policy. This could be timed, for example, at the point that individuals claim the State Pension for the first time. The rationale is that such a voucher would prompt individuals to think about insuring for long-term care, encourage individuals to find out about options, and be perceived as a 'gift' from the government.

The problems for the proposal include: uncertainty regarding its effect on take-up, as well as cost.

- Product simplification and standardisation

To address concerns that pre-funded LTCI is too complex a product for consumers, it has been proposed that regulators should impose simple, standardised product features, so that consumers would find them more understandable.

However, the potential effect on take-up of any simplification and standardisation of products is unknown. Standardising products also reduces the scope for providers to innovate in product features and characteristics, which is a key rationale for relying on a market-based approach to insurance for long-term care.

Alternative 'distribution systems' could be tried, such as the Post Office or other 'over-the-counter' channels...

- Standardised premiums and benefits

To further simplify pre-funded LTCI, it has been proposed that they become highly regulated products with standardised premiums and benefits across different providers. However, this form of regulation would effectively eliminate the basis for competition between providers, and would likely make the market unattractive to some insurance companies, as competition would effectively be built on scale, efficiency of back-office functions, etc.

- 'Over-the-counter' distribution

Recognising that the requirement to visit an IFA is a major impediment to the use of pre-funded LTCI, it has been proposed that alternative, 'over-the-counter', distribution channels be explored, in conjunction with the use of highly regulated products. For example, the Post Office represents a trusted brand to many older people, has a national network, and already sells branded financial products delivered by third-party companies. High street banks would also appear a suitable site for distribution.

- Inheritance tax-breaks

Although it is always important not too read across too much detail from overseas examples to the UK, it is nevertheless interesting to note that a study of the French market using European household panel survey data found that an individual who has a high inheritance to leave to his children is more likely to purchase LTC insurance, i.e. suggests that LTC insurance is purchased in order to preserve the inheritance.[58]

Tapping into this behaviour, it may be possible to design some form of IHT-relief to encourage the purchase of pre-funded LTCI. However, the behaviour found in the French market should not be separated from the wider design of the system: one academic commentator links demand for pre-funded LTCI to the effectiveness of the power of French local authorities to part of people's estates.[59]

- Liquidity instruments to improve affordability

Recognising that many older households would struggle to afford pre-funded LTCI from income or savings, but nevertheless have substantial housing wealth, it has been proposed that financial services products could be used to overcome this liquidity problem, mirroring proposals for state-sponsored approaches to this dilemma.[60]

In particular, it has been suggested that there is a missing product on the market: a back-to-back equity-release with pre-funded LTCI product. This would represent a complex product for both consumers and providers. Indeed, providers would have to navigate morbidity-risk, house-price risk and capital market liquidity-risk. Nevertheless the real challenge for such a product would be consumer demand: both products in isolation have struggled to win favour with consumers, and combining them might create a product that was doubly unpopular.

- A national system of assessment and entitlement

As described in the previous chapter, local authority variations in assessments and entitlement to support is an important factor in creating uncertainty for individuals around what their potential exposure to long-term care funding costs actually is. As such, various stakeholders have argued that a pre-requisite for the development of a market in pre-funded LTCI is a shift to a national – and predictable – system of assessment and entitlement to publicly-funded care and support.

As a model for funding long-term care, pre-funded LTCI is not the only that requires a shift to a national system of assessment and entitlement. However, the

A national system of assessment and entitlement for public support might make it easier for households to calculate their exposure, but given the cost and upheaval of such a reform, policymakers would want certainty that the problems of long-term care funding would be fixed...

problem with such a shift is that it would entail very significant and expensive transition costs, involving a major reorganisation of local government financing, potentially including reform of Council Tax. However, for such an upheaval of local government to occur, and for necessary stakeholder support, various actors would need to be confident that undertaking such reforms would actually lead to a fully-funded social care system. However, in the context of the wide-ranging demand-side barriers afflicting pre-funded LTCI, such a model can offer no such guarantee. If central government proposed to impose such a reform, only to 'sit on its hands' following reform in the hope that an LTCI market would develop, it is likely that key stakeholders essential to achieving such a significant reform would withhold their support and cooperation.

- Group-level insurance

A further proposal to increase take-up of pre-funded LTCI is to use the workplace through the development of 'group-based' pre-funded LTCI schemes. Group-insurance has been key to the private medical insurance market. However, there is little evidence in the UK of an appetite among employers to become involved in LTCI, nor that this is a type of insurance demanded from employees as part of their compensation. As such, group-level insurance is unlikely to boost take-up for pre-funded LTCI.

Comment

This chapter has explored a range of potential policy interventions to increase take-up of pre-funded LTCI in England and Wales.

This review suggests that there is no 'magic-bullet' solution. For example, many stakeholders have proposed income-tax relief as the key to persuade individuals to insure for LTCI. However, evidence from the US suggests a marginal effect, dead-weight cost, and France has achieved the highest take-up in the world without deploying tax-relief.

More generally, even if the entire range of potential policy interventions to grow the market for pre-funded LTCI were deployed, such an arsenal of policy levers appears wholly inadequate against the entrenched demand-side barriers identified in the previous chapter. Various stakeholders have called for the removal of barriers to the pre-funded LTCI market; however ultimately, the main barriers to the development of the market are the people who are supposed to buy the products.

Key points:

- Various policy options have been put forward as levers to grow the size of the pre-funded LTCI market.
- These include auto-enrolment; compulsion; cheaper premiums secured via state-underwriting of tail-risks; the US 'LTCI Partnership' model; income tax relief on LTCI premiums; and, a national system of assessment and entitlement.
- Nevertheless, there appears to be no 'magic-bullet' solution. For example, many stakeholders have proposed income-tax relief as the key to persuade individuals to insure for LTCI. However, evidence from the US suggests a marginal effect, dead-weight cost, and France has achieved the highest take-up in the world without deploying tax-relief.
- More generally, even if the entire range of potential policy interventions to grow the market for pre-funded LTCI were deployed, such an arsenal of policy levers appears wholly inadequate against the entrenched demand-side barriers identified in the previous chapter.
- Various stakeholders have called for the removal of barriers to the pre-funded LTCI market; however ultimately, the main barriers to the development of the market are the people who are supposed to buy the products.

5. Evaluating the role of pre-funded insurance in funding long-term care

The potential role of pre-funded long-term care insurance in funding care must be evaluated against various criteria...

The previous chapters have reviewed pre-funded LTCI, the experience of UK and overseas markets, the demand and supply-side barriers to the growth of the pre-funded LTCI market, and potential policy levers that could be deployed to boost take-up.

However, as described in the Introduction, a key objective of this report is not just to examine the state of the pre-funded LTCI market in the UK and internationally, and measures that could be taken by policymakers. This report also seeks to answer the question:

- To what extent can the pre-funded long-term care insurance market help policymakers achieve key strategic policy objectives for social care?

Exploring this question is absolutely critical for analysing the potential role of pre-funded LTCI in the funding of long-term care. It requires viewing the market in pre-funded LTCI as a potential means to an end, rather than an end in itself; a viewpoint that many commentators have struggled to adopt. Multiple different settlements are available to policymakers as a potential response to the long-term care funding challenge in England and Wales, and the advantages and disadvantages of giving pre-funded LTCI a central role can only be understood when the market is set in the context of the full range of outcomes that policymakers have identified as objectives in the domain of social care.

Relevant strategic policy objectives variously relate to:

- Outcomes for a market-based approach

What is the rationale for a market-based approach? For example, will a market result in choice, competition and innovation in supply?

- Long-term care funding policy objectives

To what extent will pre-funded LTCI address the problems arising out of the long-term care funding system in England and Wales. For example, to what extent can a market in pre-funded LTCI eliminate 'catastrophic costs' from the system, relieve fiscal pressure on the state, as well reduce the incidence of means-testing?

- Social care policy objectives

Would a market in pre-funded LTCI help or hinder systemic reforms in the social care system associated with personalisation, prevention, integrated care and the elimination of cost-shifting?

- Wider public policy objectives

For example, what would a market in pre-funded LTCI mean for incentives to save for retirement, or how to the UK adapts to meet the costs associated with an ageing population?

These broad policy objectives are described in detail in Appendix 2. A key failing of previous literature on the role of pre-funded LTCI in funding care has been to simply ignore these wider social care policy objectives. However, the *outcomes* that would result from a funding settlement that relied on pre-funded LTCI are by far the most important consideration in policy discussion.

The rationale for market-based approach to pre-funded insurance for LTC

There is no clear public policy rationale for a market-based approach to risk-pooling for long-term care.

To what extent could the pre-funded long-term care insurance market eliminate 'catastrophic costs' from the social care system?...

- Market potential

In light of the demand and supply-side barriers identified above, and taking account of overseas case-studies, it appears very unlikely that a deep and competitive market in pre-funded LTCI will ever develop in England and Wales. There is no immediate prospect of this situation changing, and analysis of potential policy levers to change this outcome does not reveal any option like to increase take-up. For example, income tax-relief on contributions would be unlikely to increase take-up by anything other than a nominal amount.

- Choice and Innovation

Although choice and innovation in product design have been notable and successful outcomes in the fields of home insurance, travel insurance, etc., the complexity of decisions around purchasing LTCI, and the declining cognitive capacity of much of the target market for pre-funded LTCI products means that high levels of choice and innovation arguably represent *undesirable* outcomes, that might actually depress rates of take-up.

- Effect on public spending

The absence of risk-pooling in relation to LTC costs, and the extremely small size of the pre-funded LTCI market, have actually created extra costs for the Exchequer, in terms of increased NHS and local government spending. There is very little prospect of growth in the take-up of pre-funded LTCI, and as such, relying on pre-funded LTCI will have no positive on public spending.

Pre-funded LTC insurance and the objectives of LTC funding policy

- Catastrophic costs

In relation to the incidence of *catastrophic costs*, demand-side barriers to pre-funded insurance have prevented their elimination from the social care system. If England and Wales were to achieve a level of take-up of 15%, equivalent to the most successful market overseas – France – the incidence of catastrophic costs within the system would remain highly problematic, and continue to be a 'headache' to politicians.

- Sufficient funding in the system

As a policy mechanism to drive more money into the social care funding system, given the low take-up of pre-funded insurance, there is little scope for pre-funded insurance to drive fundamental increases in the wealth, and the proportion of GDP, spent on care. As such, outcomes in the system would continue to be unacceptable in many cases.

- Fiscal pressure

Could pre-funded insurance relieve *fiscal pressure* on public funding of support? The scope for the market to relieve fiscal pressures would be defined by the extent to that individuals with pre-funded insurance would *not* fall back on the state, when otherwise they would have done.

However, evidence suggests that take-up of pre-funded LTCI will always be highest in households that would be unlikely fall back on state support in the majority of cases. As described above, this was a finding of an official review into Partnership Long-term Care Insurance in the US.

The existence of a voluntary insurance market would necessitate the continuation of a state safety-net, with associated means-testing and all of its effects on household behaviour...

As such, were England and Wales to achieve take-up of pre-funded LTCI equivalent to the US or France, this would have provide very little relief to fiscal policymakers.

- Means-testing

Even under an optimistic growth scenario for pre-funded LTCI, the operation of a state-funded safety-net for those who have not insured, and/or cannot afford to pay for care themselves would nevertheless be required. Given that even under optimistic scenarios, millions of households would not be able to afford pre-funded LTCI or would have no actuarial incentive to purchase it owing to their limited wealth, a growth in the pre-funded LTCI market would not reduce the use of means-testing in the social care system, with its associated effects on savings incentives and popular resentment.

- Sustainability

In terms of *financial sustainability*, a market in pre-funded LTCI would be dependent on whether individuals could afford such insurance in the future.

As described above, it is far less clear whether relying on a market in pre-funded LTCI would be *politically sustainable*, given that take-up rates would never be likely to sufficiently reduce the incidence of catastrophic costs and other problems within the system, and thereby 'dampen down' calls for reform.

- Transferring risk to the capital markets

Given the high exposure of the UK Exchequer to longevity risk in the context of an ageing population, there is a preference among policymakers for models of long-term care fund that provide a mechanism to transfer associated risks to the capital markets. However, the low-take up of pre-funded LTCI limits the scope for the transfer of longevity risk and morbidity risk associated with social care to be transferred to the capital markets.

Pre-funded LTCI and wider social care policy objectives

The 'supply-side' of the social care system has been characterised by significant change in recent years, as policymakers endeavour to achieve personalised, efficient and flexible social care delivery. These changes represent major reforms individually, and collectively, have seen significant sunk-costs expended. As such, evaluating the role of pre-funded LTCI in funding long-term care requires careful consideration of such insurance would interact such reform and the outcomes sought.

- Integrated care

Would promoting pre-funded LTCI help or hinder the *integrated care* agenda that exists between health and social care? This agenda is driven by a set of objectives around *user*-integration and *provider*-integration.

From the perspective of the user, integration would depend on the extent to which insurance industry claims and benefit payouts were integrated with the processes of local authorities, the NHS and care providers. One scenario could see local authorities, residential and domiciliary providers able to establish that a person is insured, automatically initiate and process a claim, and initiate transfer payments. A contrary scenario would see the management of this process entirely left to the individual or their family.

The impact of pre-funded LTCI usage on provider-driven integration is difficult to assess. Insurance companies would become another organisation that would have to incorporated into joint-working, alongside NHS bodies, local authorities and care providers. If insurance companies were unwilling to

It is not clear that a reliance on private insurance would advance the frontier of knowledge and practice around prevention...

use public needs-assessment procedures to validate claims, information would have to be coordinated from insurers to other relevant bodies.

- Prevention

Would the advancing frontier of *prevention*, characterised by research and growing investment in preventative interventions, be supported or undermined by making pre-funded LTCI the centre of a new funding settlement on LTC? The crucial consideration here is that although insurance companies clearly have an incentive to invest in prevention – just as providers of private medical insurance subsidise gym membership – crucial holistic preventative interventions at the community level are only ever likely to result from local authority spending.

In relation to 'holistic' prevention at a community level, research into different types of preventative interventions, such as the (Partnerships for Older People) POPPs programmes has revealed a key challenge around incentivizing and coordinating local authorities to invest in prevention. Underpinning this challenge has been the fact that many of the cost-savings accrue to the NHS. By extension, it would be insurance companies would benefit significantly from local authority investment in prevention if this reduced the incidence of morbidity in the population, effectively creating a misaligned incentive structure for local authorities. Although over time, insurance premiums might be competed down to reflect lower morbidity in the population, this would be a long process, and would be reliant on the operation of competitive insurance market.

In relation to preventative interventions in the home, such as telecare and home adaptations, which prevent the worsening of need, it has been suggested that insurance companies may be more effective than public agencies at initiating the use of such products and services by households. However, there is no evidence to support this. In particular, there is an absence of consumer research as to how households would feel about exchanging a cash benefit received upon claiming an LTCI policy for products and services. Although the insurance company may have an interest in lowering expenditure, the default position of many consumers is to maximise the value of the benefit they receive from an insurance policy.

- End to cost-shifting

A key feature of the social care system in England and Wales is cost-shifting between NHS bodies, local authorities, families and care providers. Cost-shifting is a rational response by budget-constrained actors in a social care system in which responsibility, contracts and obligations can be blurred.

As a new set of actors operating in this picture, insurance companies would also confront an incentive framework encouraging them to attempt to shift costs on to other actors. As such, a regulatory framework would be required to police the behaviour of companies, monitor the fulfilment of contracts, etc. In short, the greater use of private pre-funded LTCI would likely add to the potential scope of cost-shifting in the social care system and require extra resources to address it.

- Carers' outcomes

To the extent that households not entitled to public support purchase pre-funded LTCI, this may reduce the burden on informal carers.

- Distribution and efficiency

Some key objectives of reforms to the design and delivery structures of the social care system in recent years have been around improving the distribution of resources and the efficiency of their use. Several comments can therefore be made.

Relying on pre-funded long-term care insurance would prevent policymakers from introducing 'matching contributions' for state support – an idea that continues to generate interest...

First, to the extent that a market of any size in pre-funded LTCI requires a supporting infrastructure, for example, of claims validation, this will have to be funded by the state or by households themselves via the cost of insurance premiums. In the wider context of the under-funded social care system, such extra costs could be seen as wasteful and unnecessary, if alternative funding model did not incur such costs by using existing assessment mechanisms, such as GPs and social workers.

In terms of distributional efficiency within the system, a compelling idea that has been proposed in the UK policy debate to improve efficiency is that of 'matching contributions' toward care costs in order to ration demand.[61] On this approach, for every £2 of out-of-pocket payments on care, the state would contribute £1. This model seeks to encourage households to consume public resources efficiently by putting a 'price' on the public support received.

Although perceived to pose difficult administrative challenges, there remains a keen interest in deploying the model of matching contributions in the UK social care system. However, the implementation of matching contributions would be entirely incoherent with the usage of pre-funded insurance. This is because as a demand-management mechanism, matching contributions only function in the context of a budget-constrained household. However, if a household had insured itself for LTC, then at the point of making a successful claim and receiving cash benefits, the household ceases to be budget constrained and could deploy its benefit payouts to maximise the payments it receives from the state. In short, 'matching contributions' are incompatible with the operation of a pre-funded LTCI market. If policymakers were to pursue a market-based insurance model for long-term care funding, this would rule out matching contributions, despite the ongoing and considerable interest in the approach among policy analysts.

- User outcomes

The low take-up of pre-funded LTCI that would exist, even under an optimistic scenario regarding take-up would make little impact on improving user outcomes in the social care system.

- Personalisation

The use of pre-funded LTCI would appear to be coherent with the personalisation agenda, and its principal vehicle, Personal Budgets, as both are built around cash entitlements.

Wider public policy objectives and the role of pre-funded LTC insurance

As a policy model to fund long-term care, it is important to evaluate pre-funded LTCI against policy objectives that fall outside of the domain of social care, but which nevertheless comprise important strategic policy objectives for government.

- Incentives to save for retirement

The current long-term care funding system in England and Wales is widely recognised to disincentive retirement saving through the operation of means-testing.

By deploying a private market approach to insuring against long-term care, as opposed to the many, more collectivist alternatives deployed in other countries, this would necessitate the continuation of means-testing as part of the state-funded safety-net for social care. As such, pre-funded LTCI would effectively institute means-testing as part of the UK retirement 'savings proposition', disincentivizing pension-saving, and potentially undermining the enormous sweep pension policy reforms currently ongoing.

It is not clear that pre-funded insurance against specific types of costs – such as the cost of residential care – is an attractive approach in the wider context of social care policy...

- Equity

As a financial product that would likely only be affordable to wealthier households, the policy option of pre-funded LTCI would not advance equity across the population. It is important to consider this in terms of outcomes following the onset of care needs, but also equity of access to the opportunity to protect against catastrophic costs of long-term care.

Pre-funded insurance for specific care-related costs

The above analysis has explored how pre-funded LTCI, as a generic product, would interact with social care policy objectives. However, various proposals have been put forward that would see pre-funded LTCI focus on specific related costs. These ideas are now explored.

- Pre-funded insurance for residential over domiciliary care

Some commentators in the long-term care funding debate have proposed insurance products that focus on the costs of residential care, but not domiciliary care.

However, as has been identified by commentators, the problem with such a model is that it would create a set of incentives that might see care recipients move into residential care earlier than is necessary, in order to eliminate the costs of domiciliary care. Depending on individual situations and who was paying for domiciliary care, the care user, their family and local authorities may all be incentivised to attempt to shift costs to the insurance company in this way.

A further problem with insurance that focuses on residential care is that most individuals do not like to contemplate the prospect of moving into residential care, and prefer the idea of remaining in their own home. As such, an insurance product that is specifically built around residential care will potentially find it harder to achieve take-up than one that insures against the cost of care in someone's own home and thereby enables people to remain 'independent'.

Qualitative research with older people has found a belief that any long-term care insurance "should pay for every aspect of care. If there were limited funds, personal care and help around the home were prioritised above care home fees. Participants' thinking was that these two options allow people to stay at home for longer, which is preferable to going into a care home."[62]

- Pre-funded insurance for the accommodation costs of residential care

One proposal put forward is that given it is the 'hotel costs' of residential care which have the largest potential for causing 'catastrophic costs', pre-funded insurance models should focus on this segment of long-term care costs. On this approach, policymakers and the financial industry should focus on developing insurance products that provide protection against the accommodation costs of residential care, rather than personal care costs.

Besides the fact that in the wider social care system, it is investment in prevention and home care that ultimately reduces a person's need for residential care and therefore provides a compelling target for new resources, there is also an important insurance argument against this proposal.

At present, individuals are typically only exposed to expensive accommodation costs if they are the surviving partner, they have moved out of their own home, which is now unoccupied by a dependent, and qualifies as 'assessable capital' under local authority means-testing rules. Many people in residential care, whose homes do not comprise assessable capital, are

The long-term care funding system must flexible and adaptable to changing patterns of care provision, such as 'housing with care'...

effectively 'insured' or 'covered' by the state. However, even when this is not the case, the argument can be made that as a considerable stock of wealth, typically amounting to over £100,000, housing wealth can *already* be seen as functioning as a form of insurance against the costs of housing, including accommodation costs associated with residential care.

Indeed, it would arguably be wholly illogical to encourage households with housing wealth to insure against accommodation costs, but remain exposed to the costs of personal care.

Importantly, this argument applies not just to private-sector pre-funded LTCI, but to other long-term care funding models effectively built around pre-funded risk-pooling, including tax-based models and social insurance.

A further argument concerns the growing role of 'housing with care' and different forms of specialist accommodation that are positioned between domiciliary care and residential care. This growing sector is viewed as being particularly effective at securing potential cost-savings based on prevention that can be secured through a holistic, 'whole-environment' approach.

As such, it would arguably be undesirable to encourage individuals to take out an insurance product that assumes the receipt of residential care, when intermediate housing with care solutions may be more appropriate in the future. A pre-funded insurance product for accommodation costs would effectively remove the flexibility which social care policy analysts consider desirable for giving individuals access to cost-effective intermediate housing solutions.

Comment

In the absence of a market in pre-funded LTCI, such insurance products clearly cannot be used by policymakers as a solution to problems associated with the long-term care funding system in England and Wales.

However, even if the UK were to achieve a level of take-up of around 15% for pre-funded LTCI, equivalent to France, the above analysis suggests that this would still result in outcomes that failed to meet many of the policy objectives for long-term care funding, particularly associated with catastrophic costs, fiscal pressures and means-testing. More generally, it appears that pre-funded LTCI is simply incompatible with many broader social care policy objectives such as prevention, integrated care and ending cost-shifting.

In many ways, these outcomes explain why there has been such apparent miscommunication between the financial services industry and social care policymakers. What might appear to represent a success from the point of view of the insurance industry, for example, a take-up rate of 15%, would in fact represent a disastrous failure from the perspective of social care policy.

Key points:

- Evaluating the appropriate role for pre-funded LTCI in funding long-term means asking: to what extent can the pre-funded long-term care insurance market help policymakers achieve key strategic policy objectives for social care? It requires viewing the market in pre-funded LTCI as a potential means to an end, rather than an end in itself.
- Relevant strategic policy objectives for evaluating the role of pre-funded LTCI variously relate to: outcomes for a market-based approach; long-term

care funding policy objectives; social care policy objectives; and, wider public policy objectives.

- Even if the UK were to achieve a level of take-up of around 15% for pre-funded LTCI, equivalent to France, analysis suggests that this would still result in outcomes that failed to meet many of the policy objectives for long-term care funding, particularly associated with catastrophic costs, fiscal pressures and means-testing.
- More generally, it appears that pre-funded LTCI is simply incompatible with many broader social care policy objectives such as prevention, integrated care and ending cost-shifting.

6. Conclusion: Toward a new public-private partnership to fund long-term care

Even if England and Wales were to achieve take-up rates for pre-funded long-term care insurance of 15% equivalent to the international leader – France – this would still result in a severely under-funded social care system...

This report has set out to explore the potential role of pre-funded long-term care insurance in funding long-term care.

The report has set out to answer two questions:

- What potential role could pre-funded insurance take in funding long-term care?
- To what extent can the pre-funded long-term care insurance market help policymakers achieve the key strategic policy objectives for social care?

The approach taken has been distinctive: rarely, if ever, are financial products for long-term care evaluated in the context of the broad array of policy objectives for social care funding, delivery and wider public policy. All too often, consideration of this question is excessively narrow, simply positing the amount that individuals pay on care, potential insurance products, and speculation on how the market can be grown. An objective of this report has been to show just how inadequate and unacceptable such a simplistic approach is.

Pre-funded long-term care insurance

The conclusion that pre-funded LTCI is never likely to prove an adequate response to the problems posed by the long-term care funding system is neither new nor controversial. In the UK context, the Royal Commission on Long Term Care noted in 1999: "Left to grow without intervention, there seems little reason to think that private insurance will become more important in the UK than it has become . . . in America."[63] These comments are arguably more pertinent today than they were twelve years ago.

Abroad, and within academia, the failure of pre-funded LTCI markets to achieve anything approaching adequate take-up has featured extensively in academic research. A consistent and surprising feature of the UK debate is how little this evidence is cited. Indeed, some commentators have appeared to lack the necessary analytical tools and framework to be able to understand why individuals do not purchase pre-funded LTCI, despite it superficially appearing that it would be in their interests to do so. The irony of this has been embodied in the successive forecasts that the market for pre-funded LTCI will grow to be highly valuable; in the UK today, there is no market for pre-funded LTCI.

However, the failure of the pre-funded LTCI market in the UK is not a failure of the financial services industry. The issues encountered owe far more to the vagaries of human behaviour and inevitable interaction with the state safety-net, than any industry shortcomings, and are common across LTCI markets abroad. It is not the fault of the insurance industry that pre-funded LTCI fails to provide the outcomes that social care policy needs. Across products such as contents insurance, travel insurance and life insurance, the UK insurance industry has been highly effective and successful in policy terms, whether measured by choice, efficiency, innovation, and the pooling of risk across the population. There is no prospect of long-term care insurance joining this list.

There can be now no intellectual justification for suggesting that pre-funded LTCI can be an adequate policy response to the UK's long-term care funding challenge. All too frequently, proponents of pre-funded insurance for long-term care have focused on what individuals *could* and *should* do. However, these are irrelevant for policymakers, who can only concern themselves with what individuals *actually* do. If debate is to move forward, and a settlement achieved, all stakeholders need to recognise this distinction.

Importantly, even if the UK were to achieve take-up rates of 15% for pre-funded LTCI, as high as the current international outlier - France - this would still represent a strategic policy failure for the social care system, which would continue to feature catastrophic

Those who regard the effects of being 'uninsured' for long-term care as a matter of 'individual responsibility', ignore the fact that the resulting costs frequently fall on taxpayers...

costs, under-funding, calls for reform, and unacceptable human suffering. Policymakers have struggled to convey to some stakeholders that even a take-up rate of 25% for pre-funded LTCI would represent a policy failure and it is hoped that this report will help some stakeholders to understand why this is the case.

The limits of individual responsibility

One response from stakeholders to the absence of demand for pre-funded LTCI has been to argue that individuals are rational, and if they choose not to insure themselves, that is their decision and responsibility, and it is not the role of the state to push individuals to insure.

However, this 'individual responsibility' argument is undermined by the fact that the absence of risk-pooling in relation to long-term care creates direct costs to the state. Unlike the case of contents insurance, in which uninsured individuals who are robbed have to meet the costs of replacing their goods themselves, the consequences of individuals being unprotected from the costs of social care – uninsured and outside the coverage of local authority needs-assessments – frequently results in direct costs to the state, notably in terms higher hospital admissions and labour withdrawn from the labour market in order to provide informal care. These extra costs have to be borne by the taxpayer. To put it another way, for long-term care, relying on 'individual responsibility' leads to 'collective cost'.

Is a private sector long-term care insurance market in the interests of the insurance industry?

It is rarely commented - but important to underline - that it is far from clear that it is actually in the interests of the insurance industry for long-term care funding reform to focus on private insurance. As noted in previous chapters, even under highly optimistic scenarios, the likely annual profit to be generated by pre-funded LTCI is likely to be so small as to be insignificant for many providers. Yet the implication of a policy framework built around private LTCI is that the means-tested safety-net of state support would have to persist: social care would continue to be a pillar of the UK's retirement means-testing regime that does so much to undermine pension saving.

The UK insurance industry effectively confronts a choice: would it prefer to see the near abolition of retirement means-testing as part of efforts to fix pension-saving incentives, or would it prefer government to focus on boosting take-up of pre-funded LTCI. This question is underlined by the fact that, at the time of writing, measures to abolish Pension Credit and raise the value of the State Pension have moved centre-stage in pension policy, as part of wide-ranging measures to fix the UK's pension-savings problem. It would be illogical, ineffective – and perhaps inconceivable - for the government to pursue such an enormous and costly reform, only to leave means-testing as a core feature of the social care system. As counter-intuitive as it may seem, there is a clear and compelling argument that for the insurance industry as a whole, its interests lie in the government adopting a comprehensive approach to long-term care funding reform that will provide a route-map to the abolition of means-testing in the social care funding system. To fix the UK's pensions problem, policymakers and the financial industry need to work in collaboration. Long-term care funding reform built around means-testing and pre-funded LTCI cannot be part of this.

It is also worth pointing out that fixing the long-term care funding system, particularly through mechanisms that enable older households to deploy their considerable housing wealth, may also encourage these households to engage and spend on other types of goods and services, including financial services. Many older households do maintain liquid savings as a form of insurance in case informal care is required, or

There are multiple other roles that the financial services industry could take in a reformed long-term care funding system, besides providing pre-funded long-term care insurance...

formal care has to be paid for out-of-pocket. Taking away the fear around future care needs and provision, may encourage older households to use their liquid wealth to insure against other major risks associated with the 'protection gap' afflicting the older population, to the benefit of the insurance industry.

Toward a New Future for Financial Services in Funding Long-term Care

So far, this report has only focused on consumer-facing 'direct insurance' from the financial services industry: insurance products sold via independent financial advisers.

But, there are multiple other roles that the financial services industry could take in long-term care funding reform, besides providing consumer insurance, which nevertheless facilitate the greater financial contributions and risk-pooling that the long-term care funding system so clearly needs. As such, the crucial distinction may not be between a public versus private solution to long-term care funding, so much as a market-based private solution versus a state-sponsored approach that relies on the financial services industry in a delivery role.

For a variety of reasons owing to fiscal constraints, demographic change, and the need to give older people trust that their contributions will be ring-fenced, the role of taxation and public spending in a new settlement on long-term care funding reform may be limited.

As such, and as found in other countries, the biggest commercial opportunities for the financial services industry may in fact be in delivering and servicing an innovative state-sponsored, public-private partnership, insurance scheme, rather than a reborn pre-funded LTCI market. Various real and theoretical case studies are available: Eldershield in Singapore; the scheme arising from the US Community Living and Assisted Support Services Act (CLASS)[64]; and, the proposal for a National Care Fund in the UK.[65] Rather than a market of tens of thousands, such public-private partnerships would result in participation levels measurable in the tens of millions. Those countries that have gone furthest in addressing problems of long-term care funding in recent decades have done this through the use of state-sponsored insurance schemes, delivered through public-private partnerships.

Although not a perfect analogy, another potential example of such an approach that is increasingly cited in social care debate is that of the UK's NEST (National Employment Savings Trust): a state-sponsored pension fund whose core functions will be carried out by the private sector on the basis of competitive tenders. Indeed, although branded as a pension fund, NEST is in many ways more of a commissioning agency, and is involved with many UK insurance 'household names'. Discussion of a "Nest for care" is not entirely appropriate: the problems of long-term care funding system focus on the baby-boomer generation, not younger workers. However, the approach embodied by NEST does clearly sign-post a potential new avenue for UK policymakers to explore in relation to long-term care funding, and one which may hold out much greater business opportunities for the financial services industry.

As such, the financial services industry may yet play a very significant role in funding long-term care, but not one that people may expect. Given consumer behaviour and reluctance to insure, it may well be that the Government will have to work with the financial services industry to create a state-sponsored insurance scheme built around a public-private partnership, with a choice architecture that facilitates take-up close to population-level.

Perhaps most importantly, backing the approach of a state-sponsored insurance scheme would also enable

International case studies point to public-private partnerships in delivering a state-sponsored long-term care insurance scheme as being an effective future route for England and Wales...

policymakers to passport the UK to the abolition of means-testing in the social care system: one of the four pillars for pensioner means-testing in the UK and a major barrier to raising rates of pension saving.

Key points:

- The conclusion that pre-funded LTCI is never likely to prove an adequate response to the problems posed by the long-term care funding system is neither new nor controversial.
- Abroad, and within academia, the failure of pre-funded LTCI markets to achieve anything approaching adequate take-up has featured extensively in academic research; however, this evidence is rarely cited in the UK debate. Some commentators have appeared to lack the necessary analytical tools and framework to be able to understand why individuals do not purchase pre-funded LTCI, despite it superficially appearing that it would be in their interests to do so.
- The failure of the pre-funded LTCI market in the UK is not a failure of the financial services industry. The issues encountered owe far more to the characteristics and vagaries of human behaviour and cognition, than any industry shortcomings, and are common across LTCI markets abroad.
- There can be now no intellectual justification for suggesting that pre-funded LTCI can be an adequate policy response to the UK's long-term care funding challenge.
- It is actually far from clear that it is actually in the interests of the insurance industry for long-term care funding reform to focus on private insurance. Even under highly optimistic scenarios, the likely annual profit to be generated by pre-funded LTCI is likely to be so small as to be insignificant for many providers. Yet the implication of a policy framework built around private LTCI is that the means-tested safety-net of state support would have to persist: social care would continue to be a pillar of the UK's retirement means-testing regime that does so much to undermine pension saving.
- Nevertheless, there are multiple other roles that the financial services industry could take in long-term care funding reform, besides providing consumer insurance, which nevertheless facilitate the greater financial contributions and risk-pooling that the long-term care funding system so clearly needs. As such, the crucial distinction may not be between a public versus private solution to long-term care funding, so much as a market-based private solution versus a state-sponsored approach that relies on the financial services industry in a delivery role.
- The biggest commercial opportunities for the financial services industry may therefore be in delivering and servicing an innovative state-sponsored, public-private partnership, insurance scheme, rather than a reborn pre-funded LTCI market. Various real and theoretical case studies are available: Eldershield in Singapore; the scheme arising from the US Community Living and Assisted Support Services Act (CLASS); and, the proposal for a National Care Fund in the UK. Rather than a market of tens of thousands, such public-private partnerships would result in participation levels measurable in the tens of millions.
- Backing the approach of a state-sponsored insurance scheme would also enable policymakers to passport the UK to the abolition of means-testing in the social care system: one of the four pillars for pensioner means-testing in the UK and a major barrier to raising rates of pension saving.

Appendix 1: Pre-funded long-term care insurance for England and Wales - Thumbnail models of a potential market

This section provides a thumbnail model of the kinds of returns that might be achievable in a market for pre-funded LTCI.

The model assumes:

- Average value of premium is £20,000.
- All policies are bought at 65.
    - This is when liquid wealth is at its highest before start of decumulation process.
    - Purchase can be tied to process of retirement, choosing of annuity, visit to IFA, etc.
- 2012 prices
- Take-up rate: no higher than 15%, which would put the UK around the top of the international league table (current policies in force are 32,000, however no new policies are being written as all providers have left market).
- Year 2012: 716,800 people turn 65 (Source: ONS).

The assumptions for each scenario are as follows:

Optimistic Scenario	
Take-up rate	15%
Market share	25%
Profit	15%

Pessimistic Scenario	
Take-up rate	10%
Market share	15%
Profit	10%

Pessimistic Scenario	
Take-up rate	5%
Market share	10%
Profit	7.5%

Optimistic scenario

Take-up rate	15%
New policies	107,520
Total value of new premiums	£2,145,000,000
Market share	25%
Value of premiums by market share	£536,250,000
Profit on premiums	15%
Profit	£80,437,500

Medium Scenario

Take-up rate	10%
New policies	71,680
Total value of new premiums	£1,433,600,000
Market share	15%
Value of premiums by market share	£215,040,000
Profit on premiums	10%
Profit	£21,504,000

Pessimistic Scenario

Take-up rate	5%
New policies	35,840
Total value of new premiums	£716,800,000
Market share	10%
Value of premiums by market share	£71,680,00
Profit on premiums	7.5%
Profit	£5,376,000

Appendix 2: A framework for evaluating the role of financial services in funding long-term care

This Appendix explores how financial services, including products such as pre-funded long-term care insurance and immediate-needs annuities, should be evaluated as potential models of long-term care funding.

Previous policy analysis of the potential role of financial services has typically adopted only a narrow set of criteria for evaluation, for example, likely take-up and coverage. However, such limited analysis is inadequate and inappropriate for an area of policy as broad and complex as social care, in which multiple different types of policy-driven reform programmes are ongoing, and associated with considerable upfront investment by central government.

This chapter therefore sets out four broad sets of criteria for evaluating the role of financial services in funding long-term care:

- Performance against the usual rationale for market-based solutions to public policy objectives;
- Potential to achieve the objectives of long-term care funding reform, for example, around the elimination of 'catastrophic costs' among households;
- Coherence with the achievement of wider social care policy objectives, such as *integrated care* and *personalisation*;
- Effect on wider public policy objectives such as incentives to save for retirement.

Market-based outcomes	Market potential
	Efficiency
	Choice
	Innovation
	Effect on public spending
LTC funding policy objectives	Catastrophic costs
	Sufficient money in the system
	Fiscal pressure
	Means-testing
	Sustainability
	Transferring risk to the capital markets
Social care policy objectives	Integrated care
	Prevention
	Personalisation
	End to cost-shifting
	Carers' outcomes
	Distribution and efficiency
	User outcomes
Wider public policy objectives	Incentives to save for retirement
	Strategies to meet the cost of an ageing population
	Equity

Evaluating the role of financial services: outcomes of a market-based approach

Public policy choices around the involvement of the state in the economy and the production of goods and services by the state versus the market are the topic of an extensive literature in economics. However, in terms of practical policymaking, only a handful of criteria are used to judge when governments should "leave it to the market". These include:

- Market potential

Would relying on a private sector solution actually result in a market, and a market that is competitive, rather than tending toward monopoly?

- Efficiency

Would a competitive market lead to goods and services being produced efficiently and more cheaply than by the state?

- Choice

Would a reliance on market mechanisms give individuals greater choice – a choice which they value - over the characteristics of the goods and services they consume?

- Innovation

Would a competitive market lead to variation and experimentation in the design and delivery of goods and services, leading to positive outcomes for consumers?

- Effect on public spending

Does a policy of relying on market mechanisms result in higher or lower costs for public spending?

Evaluating the role of financial services: long-term care funding outcomes

The long-term care funding system in England and Wales, as described above, results in not one, but a number of problematic outcomes, that have caused stakeholders to repeatedly call for reform. What are these problems and what outcomes would represent a solution to them?

- Accumulated catastrophic costs

For those individuals who fall outside the scope of the safety-net of state support on account of being too wealthy to qualify, three outcomes are possible: receipt of care by family members, unmet need or the purchase of care services privately 'out-of-pocket'.

The purchase of care services privately out of pocket may comprise personal care in the home, telecare and housing adaptations, personal care in a residential care setting, and the accommodation costs associated with residential care.

An individual's ability to pay for care out-of-pocket will vary according their household income and wealth, the liquidity of their wealth, and the extent to which they can use it to generate an income.

However, 'catastrophic costs' refers not to the affordability of one week or month's worth of care for an individual: it refers to the total costs that accumulate when care of different levels of cost is required and purchased over an extended period. Even low-level affordable care, e.g. £40 per week, when required for an extended period, such as 10 years, may result in a total lifetime care bill that is very large (£20,800). At the other end of the scale, requiring residential care for 10 years would cost someone around £260,000 in today's prices. How 'catastrophic' such costs are to an individual is relative, and will reflect their initial income and wealth before they began paying for care themselves.

It is a matter of some debate among commentators and policy analysts whether catastrophic costs resulting from low-level care over an extended period should be a concern for policy: on the one hand, spread over a long period, an individual may feel that such costs are affordable and not problematic. Conversely, such costs are predictable, insurable and therefore spend-down of wealth associated with paying for this care is unnecessary and represents a policy failing, as well – as discussed below – as a disincentive to save for retirement.

In some instances, individuals with housing wealth who are not entitled to public support, but do ultimately accrue significant care-related bills, particularly associated with residential care, may be compelled to sell their homes in order to pay for this care. It is this aspect of the incidence of catastrophic costs among the population that has in the UK frequently led to newspaper headlines describing individuals "forced to sell their home to pay for care".

In relation to evaluating the role of financial services in long-term care funding, the crucial question for policymakers is therefore: to what extent can financial services eliminate the incidence of 'catastrophic costs' from the long-term care funding system?

- Sufficient money in the system

Total demand for care in the UK is rising commensurate with the ageing of the population, and increasing longevity, including those individuals born with disabilities who, owing to medical advances, are surviving for longer that was previously the case.

The outcomes of individuals in need of care and support will depend on the provision and receipt of informal care, measurable at a household and population level, and the volume of expenditure on formal care, also measurable at an individual and population level.

A distinctive feature of the current system highlighted by stakeholders right across the full spectrum of the social care system is under-funding,

This shortage of funding results in rationing by local authorities, and by individuals in relation to the care they purchase out-of-pocket. This has an impact on the *outcomes* of individuals receiving care and the *quality* of the care they receive. Various indicators speak to the under-funding of the current system, for example, the fact that much of the social care workforce is paid at or around the National Minimum Wage.

As such, it is widely agreed that more needs to spent on social care in the UK. At a societal level, this means allocating a greater proportion of gross domestic product (GDP) on the production of formal care.

Evaluating the potential role of financial services in terms of the objectives of long-term care funding therefore means asking: how effective will financial services be at getting more money into the social care system? How will money this be risk-pooled across different groups within the population?

- Fiscal pressures on public funding of care and support

As described above, public funding of care and support is allocated by local authorities and rationed on the basis of an assessment of needs and means.

However, despite the operation of a complex rationing system, which varies by every local authority in England and Wales, there exists considerable fiscal pressure on public spending on care and support.

In large part, this reflects longstanding trends associated with rising demand resulting from demographic change: individuals are living longer, including when in need of care. As the baby-boomer cohort moves into retirement and late old-age, the number of individuals requiring care is also increasing commensurately. However, crucially, younger cohorts are less numerous, and the ratio between the retired population and the working-age population – the so-called 'elderly support ratio' - is declining. It is this combination of rising demand and a proportionally shrinking working-age population that is imposing acute fiscal pressure on the system of public funding of care and support in the UK, including Scotland.

For example, local authorities report an increase in their spending on adult social care service from £15.3 billion in 2007-08 to £16.1 billion in 2008-09, representing around 5% in cash terms and 3% in real terms. Over a longer term, there has been a real term increase of 13% since 2003-04 and 54% over the 10 years from 1998-99.[66]

The result of both trends has been a consistent tightening of the criteria used to ration public support.

In particular, the use of needs-assessments by local authorities has seen a growing number ration entitlement to those with worse needs. The 'Fair Access to Care' (FAC) criteria used by local authorities are set at Low, Moderate, Substantial and Critical. In 2008-09, around three-quarters of local authorities set access to care at the substantial threshold, compared with 63% in 2006-07.[67]

In the wake of the wider crisis that has afflicted public spending in the wake of the post-2007 global financial crisis, the demographic factors imposing fiscal pressures on social care spending have been joined by an unprecedented fiscal crisis afflicting all public spending.

In terms of evaluating the role of financial services in long-term care funding, the critical question is therefore: to what extent can financial services relieve fiscal pressures on the Exchequer associated with the meeting of public obligations to fund care and support.

- Means-testing

As described above, a key component of the rationing mechanisms used by local authorities to distribute public funding on care is means-testing. However, various stakeholders in the long-term care funding debate have argued for an elimination, or reduction, in the incidence of means-testing in the social care system. There are several arguments for this proposition.

First, there is some evidence that the prospect of being means-tested causes individuals to disengage with publicly funded available support, including both potential entitlement to care funding, as well as advice, holistic support for carers and various other local authority services.

Second, means-testing is liable to 'gaming', which in the social care system is known as 'deliberate deprivation' of assets. Individuals and their families transfer assets around in order to increase a person's entitlement to means-tested public support. As such, means-testing is limited in its effectiveness as a mechanism to ration public support.

Third, means-testing disincentivizes individuals from accumulating savings and wealth: a consistent policy objective of all governments. In particular, the risk of being means-tested in retirement when in need of care and support disincentivises retirement saving (see below).

Finally, it is worth noting that public consultations repeatedly reveal a dislike of the concept of means-testing among the public. A report on consultations undertaken by the Department of Health about social care reform quotes one local organization: "Means testing… means that they lose dignity, something that people have held onto, and goes hand in hand with respect and independence."[68]

In terms of evaluating the role of financial services in long-term care funding, the key questions are therefore: to what extent can financial services enable the removal of means-testing from the social care system? If means-testing must be preserved, what will be its shape and form?

- Long-term sustainability

The outcomes for the long-term care funding system described above could be subject to different policy 'fixes'. However, a key objective for reform would be for a new funding solution that 'fixed' the system to be sustainable over the long-term. Policymakers would not want to pursue sizable reform, imposing significant transition costs, only for further reform to be required because outcomes in the system proved no longer financially tenable or politically acceptable. Evaluating the role of financial services in funding long-term care therefore requires asking whether

outcomes achieved would be sustainable over the long-term, both financially and politically.

- Transferring longevity-risk and morbidity-risk to the capital markets

Longevity-risk refers to the uncertainty regarding how long individuals will live for, and morbidity-risk refers to uncertainty regarding the proportion of individuals across the population who will experience care needs, whether they are met by informal care or paid care.

HM Treasury is already heavily exposed to longevity-risk via public spending on entitlements and services to the oldest age-groups, notably the State Pension, public sector pensions, as well as the NHS and social care expenditure. In practical terms, this creates considerable uncertainty regarding likely future public expenditure projections, ultimately influencing policy choices in the present.

In relation to public and private expenditure on long-term care, longevity-risk and morbidity-risk could be pooled via insurance, and transferred via the reinsurance industry to the capital markets. This insurance could be organized by the financial services industry using consumer financial products, or through a state-sponsored insurance fund, before the longevity-risk and morbidity-risk are transferred reinsurers.

From the point of view of HM Treasury, reducing exposure to longevity and morbidity-risk in the context of LTC funding reform is a desirable outcome. A useful criterion for evaluating the role of financial services in funding long-term care is therefore the extent to which it enables the transfer of risk to capital markets.

Evaluating the role of financial services: social care policy objectives

Despite the considerable volume of material produced by various organizations on the topic of financial services and long-term care funding, there has been little effort to situate potential financial services solutions in the context of wider social care policy objectives, such as *prevention* and *integrated care*.

This omission is important. Simultaneous to the evolution of the long-term care funding debate over the last decade, dramatic, innovative changes in policy direction have occurred in social care which, taken together, arguably represent the frontier of reform to public sector services in the UK.

The implementation of these 'supply-side' changes is imposing considerable policy change and transition costs on the social care system, associated with major change management programmes – notably *Putting People First* – that are frequently 'co-produced' by Whitehall policymakers, local government and social care providers. More than anything else, these reforms are focused on improving the outcomes of users of social care services.

Any proper evaluation of the role of financial services in funding long-term care must therefore take full and wide-ranging account of how a potential role for financial services will interact and cohere with the achievement of these social care policy objectives. These objectives include:

- Integrated care

Policymakers in health care and local government have sought to increase the integration of health and social care for several decades.

From a *user* perspective, the objective of integrated care is a consistent, low-burden care pathway

characterized, for example, by single information and access points, and a single assessment process, rather than repeated assessments by different organizations across health and social care.

From a *provider* perspective, integrated care is characterised by data-sharing, joint-working, and joint-commissioning of services, with the aim of reducing waste and overlap, increasing efficiency and undertaking the organizational and 'back-office' changes that enable an improved 'user experience'. Arguably, the most extreme form of provider-led integrated care is pooled-budgets in which different organizations from across the spectrum of local government and health care pool resources in order to achieve shared objectives, such as a lower incidence of falls in the population.

- Prevention

Particularly during the last decade, social care policymakers have become increasingly interested in the potential of preventative interventions that reduce the incidence – and therefore the cost – of social care needs across the population. Prevention can be characterized as the prevention of need, and the prevention of increased need following the onset of disability.

This has led to extensive experimentation at a local and national level in exploring the effectiveness of different types of preventative intervention, most notably, the £60 million Partnerships for Older People Projects (POPP) programme, funded by the Department of Health. The key emerging insights of the prevention agenda are the frequently holistic nature of effective interventions. An evaluation of POPP found that a wide range of projects resulted in improved quality of life for participants and considerable savings, with activities ranging from low-level services, such as lunch-clubs, to more formal preventive initiatives, such as hospital discharge and rapid response services.[69]

A key policy challenge that has emerged is how to encourage organizations, particularly in local government, to invest in prevention, particularly given that the financial benefits of prevention associated with lower-need may not actually accrue to the organization expected to make the investment in prevention.

Nevertheless, the importance of the prevention agenda, and the evolving frontier in knowledge and research around it, should not be underestimated. The ultimate cost of social care to the population in the context of an ageing population will be determined by the effectiveness of preventative interventions and the success of policymakers in ensuring their implementation at a local level. Failure in this regard will increase the cost of social care to society in future decades.

Evaluating the role of financial services in funding long-term care therefore requires exploring how private finance funding solutions would or would not help the advancement of the prevention agenda.

- Personalisation

Arguably the largest supply-side change in the social care system over the last decade has been personalization, driven by the *Putting People First* agenda.

The key objectives of personalization are to give users of formal care services choice and control over the care they receive, and care that is personalized to their individual needs, preferences and circumstances.

The key policy devices used to achieve personalization among publicly funded social care users are Personal Budgets and Direct Payments. A Personal Budget is the sum of money that a council decides is necessary

to spend in order to meet an individual's needs following an assessment. The budget can be allocated as a Direct Payment or the council can retain direct control of the budget. An increasing number of councils are putting mechanisms in place that offer older people greater choice over the range of options open to them for managing the money in their personal budget, including the ability to mix and match between different options.[70] The government has set the target of 2013 for giving all eligible individuals personal budgets if they wish for them.

The personalization agenda that is unfolding in UK social care arguably represents the cutting-edge of public service reform not just in the UK, but internationally. Although some aspects of the personalization agenda are deliberately experimental in nature, and the full implications of personalization are still being identified and understood, there can be no doubt that the personalization revolution in social care is a 'one-way street': choice and control cannot be put 'back in the box' now they comprise common entitlements and expectations.

Evaluating the role of financial services in funding long-term care therefore means assessing how a funding system built around financial services would or would not help with the achievement of personalization in the social care system.

- End to cost-shifting

'Cost-shifting' (or 'cost-shunting') in social care refers to the practice of attempting to transfer the cost of a person's social care to another individual or organization. Although it is an under-researched topic in the social care system, cost-shifting occurs in every direction.

Families attempt to shift the cost of care to local authorities by gaming local authority means-tests ('deliberate deprivation'). Local authorities may shift costs to the NHS through delays in the community care assessment of older people. This phenomenon, known as 'bed-blocking', forces increased costs on to NHS budgets.

NHS organizations attempt to shift costs to local authorities by arguing that a person's care needs are non-medical, and therefore, must be met through local authority social care budgets. Alternatively, the NHS may attempt to keep a person with medical needs in a nursing home, with many of the ancillary costs falling on the local authority, rather than admitting them to secondary (hospital) care.

Local authorities – and by extension, the Exchequer – attempt to shift the cost of social care on to families by restricting entitlements and funding for care, and in some instances, through improper practices in community care assessments.[71] Local authorities also arguably shift some of the cost of publicly-funded residential care on to wealthier households by negotiating below-market rates which are only feasible for providers because of a cross-subsidy from wealthier, private-purchasing, households.

Cost-shifting is a regrettable but widespread feature of the UK social care system, reflecting the design of the system that has evolved incrementally over time, and its dysfunctional operation in practice.

Assessing the role of financial services in the long-term care system therefore requires examining whether a greater role for financial services would result in more or less cost-shifting within the system.

- Improving the outcomes of carers

As described above, the majority of care provision across the population is informal care provided by family and kin. Various studies have identified negative outcomes for carers associated with informal care

provision relating to financial, social, physical and psychological outcomes.

The last decade has witnessed dramatic advancements in policy toward informal care, including successive carer's strategies, which attempt to coordinate different areas of policy (benefits, employment, respite care, etc.) relevant to the outcomes of informal carers. Examples of policy outcomes include the right of carers to request local authority assessments of their needs, and innovation in the design of services to support carers. Nevertheless, most stakeholders recognize that the UK has a considerable distance to travel in embedding a coordinated and effective policy agenda toward informal carers, particularly those combining informal care with paid work in the labour market.

Evaluating the role of financial services in funding long-term care therefore means also being attuned to the implications for informal carers and policy to support them.

- Distribution and efficiency

Policymakers are concerned with ensuring the appropriate distribution of resources in the social care system and the efficient consumption of formal care. As such, various potential tools, which may or may not be deployed as part of a new funding settlement on long-term care, continue to be examined by policymakers. These seek to ensure that potential users ration demand, and that consumption of social care resources is not wasteful and represents value-for-money. For example, 'matching contributions' could be applied in the long-term care funding system to ensure that households ration their demand for formal care funded by the state, particularly with reference to the willingness and ability of families to provide informal care.[72]

Examining the role of financial services in funding long-term care therefore means assessing whether different private finance solutions will aid or frustrate the attempts of policymakers to ensure appropriate distribution and efficiency of consumption within the social care system.

- User outcomes

Finally, the most important aspect of social care policy is user outcomes, whether measured through basic satisfaction surveys, or scientifically developed new survey tools such as Social Care Related Quality of Life (SCRQOL) measure.[73]

Evaluating the role of financial services in funding long-term care must involve consideration of the ultimate effect on the outcomes of recipients of social care.

Evaluating the role of financial services: coherence with wider public policy objectives

As well examining how a greater role for financial services coheres with long-term care funding policy objectives and wider social care policy, it is crucial to identify and evaluate financial services funding options against wider public policy objectives. Three critical objectives can be identified:

- Incentives to save for retirement

The UK has a deep and long-standing problem with under-saving for retirement. This has resulted in a long arc of policy development and reform, notably the Pension Commission, led by Lord Turner, and the creation of the National Employment Savings Trust (NEST), and the imminent introduction of universal 'auto-enrolment' into workplace pension schemes.

However, the means-testing of state-funded entitlements to pensioners disincentivises retirement

saving: individuals effectively disqualify themselves from welfare entitlements in retirement if they make their own provision, for example, through saving into a personal pension. As noted above, means-testing is also widely resented by older people, and causes some to disengage entirely from potential entitlements.

The UK currently has four pillars to retirement means-testing regime. These include: income (Pension Credit), Council Tax (Council Tax Benefit) and the costs of renting for pensioners (Housing Benefit). The fourth principal type of means-testing in retirement is social care.

Considered on its own, the operation of the means-test in the social care system and England and Wales effectively means that individuals have to accumulate at least £23,500 before it "pays to save". When housing wealth qualifies as assessable capital in a local authority means-test because no one else occupies the property, the value of housing wealth takes individuals past this threshold. However, in many other instances when a person's home does not qualify as assessable capital, the possession of more than £23,500 of savings and investments will ensure that a person in need of care will receive no financial support from their local authority.

More generally, whatever the current specification of means-testing rules in different local authorities, which many people do not understand in detail, the broad presence of means-testing in the social care system effectively sends a signal to working-age individuals that they will be penalized for saving for retirement. As such, the social care system in England and Wales discourages individuals from saving for retirement.

This fact is particularly important in the context of current interest among policymakers in potential mechanisms to raise the value of the State Pension, effectively enabling the abolition of Pension Credit. Achieving such a change represents a momentous fiscal and policy challenge, but it is widely perceived to be necessary if the UK is ever to reach adequate levels of retirement; indeed, it would represent a very large boost to pensions policy. However, the effect of this potential policy change on retirement saving would be undermined if means-testing is retained in the social care system.

Policymakers therefore confront a choice as to whether means-testing in the social care system should comprise a permanent feature of the UK 'retirement saving proposition'. Eliminating means-testing for Pension Credit, while retaining means-testing in the social care system, would arguably represent a failure in joined-up policy implementation.

Evaluating the role of financial services in funding long-term care therefore means exploring its potential effect on removing means-testing from the social care system, in order to 'fix' retirement savings incentives.

- Strategies to meet the cost of an ageing population

Like many countries, the UK population is ageing and is now characterized by a declining elderly support ratio. The growth in the number of older people will impose widely-documented fiscal pressures on those items of public spending principally directed at the older population, notably the State Pension, the NHS, as well as universal entitlements such as the Winter Fuel Allowance and subsidized public transport.

Meeting this challenge is likely to provoke heated, complex policy debates across these different domains as policymakers balance competing objectives around universality, welfare, fiscal sustainability, means-testing and rationing.

Critically, how UK policy evolves in response to one area of age-related public spending will also affect how it is able to respond to pressure on other areas. A joined-up approach to meeting the cost of an ageing

population across different areas of public spending is clearly preferable.

A key consideration for evaluating the role of financial services in funding long-term care is examining how different approaches would form part of wider strategies to meet the cost of an ageing population. The wealth of the older population must be deployed strategically by policymakers, to the extent that it can be incorporated into how society meets the cost increasing longevity.

- Equity

Most areas of public policy are evaluated for equity of outcomes. In relation to long-term care funding, this might be relevant to: equity of outcomes for carers and recipients of care; and, equity of distribution of public support.

Another key outcome for social care funding would be equity of protection from catastrophic costs. This is a particularly interesting point because to be meaningful, 'equity of protection' needs to be proportional to the income and wealth of different households. As has often been observed of proposal to cap the liability of household to pay for care, for example at £80,000, this provides little or no protection to less wealthy households.

Considerations of equity are particularly important for a policy domain such as social care given the highly personal, and politicized nature of much policy debate on long-term care funding.

The role of financial services in funding long-term care therefore needs to be evaluated in terms of equity.

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