

## **Private funding mechanisms for long-term care**

**Sandy Johnstone**

This report investigates recent private funding mechanisms for long-term care.

The problems facing future generations over the cost of long-term care will undoubtedly increase, and unless a national compulsory scheme to fund it is introduced, many individuals will be facing massive personal costs. In addition to this, there is currently a lack of structure and education on how people could be making plans for such care.

This report includes a detailed examination of the various plans which have been available to the public since the start of the 1990. It analyses the barriers to success which the financial services industry encountered, and potential routes for the future. The prospect of a national compulsory scheme is also reviewed. The report concludes with key recommendations on how a coherent, robust funding system for the future might evolve.

The report offers some stimulating food for thought. It will be of particular interest to financial services industry, local authorities, care providers, charities which focus on elder care, and many government departments.



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# Executive summary

Long-term care provision in the United Kingdom has been the subject of much debate and analysis over the past decade and yet the issue of how to fund the cost of that care for future generations remains unresolved. Much of the debate has revolved around how the State should address the problem and the general public, as a consequence, are unsure as to where their responsibilities and liabilities lie. There is a perceived unfairness around the current system, which leaves significant financial responsibility resting with the individual above basic income and asset levels.

The purpose of this paper is to examine in detail the financial services options that have been available to individuals as routes to pay for their care over the last ten years.

## Summary findings

- Insurance plans designed to cater for the cost of care in later life have not been popular and, as a result, most insurers have now withdrawn from this market.
- Investment-based plans have failed to maintain protection levels and have now also been withdrawn from the market.
- Annuities that are specially designed to fund care fees and that recognise reduced life expectancy do provide a solution for some, but access to advice at a time of crisis may be difficult.
- Equity-release or lifetime mortgages are popular but are not being used as a funding mechanism to pay for care.
- The current pensions 'crisis' bears many of the same hallmarks as those relating to long-term care planning.
- As with the Pensions Commission report,<sup>1</sup> there does not appear to be a single solution to the problems surrounding long-term care. A combination of measures may be more likely to succeed.

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1 *Pensions: Challenges and Choices*, the first report of the Pensions Commission, October 2004.

## **Recommendations**

- 1 Income in retirement will be a prime issue as the United Kingdom faces up to the effects of demographic change. The work undertaken by the Pensions Commission must recognise the need for people not only to plan for a decent regular income in retirement but also to address the cost issues that arise from the potential need for long-term care. This might include the concept of accelerated pension benefits being paid on a tax free basis, when the need for long-term care arises.
- 2 Clear direction from Government should be delivered to highlight the need for people to plan for their future care needs in old age.
- 3 Urgent steps need to be taken to ensure that access to adequate support and guidance is available to care users and their families to help them navigate their way around a very challenging and complex system.
- 4 The insurance industry should be encouraged to reintroduce forms of long-term care insurance that provide consumer confidence. The regulation of such plans by the Financial Services Authority is welcomed, however the insurance industry needs to be reassured that their role is endorsed by the public sector, including Government.
- 5 The concept of a public–private partnership, where an initial period of disability might be covered by private insurance, with the State providing a safety net thereafter, needs to be carefully examined. The key issues would revolve around the need for a seamless link between both partners and sustainability over the long period in terms of public finance.
- 6 If public–private partnerships are to be developed for care planning, then agreement needs to be reached on what the gateway to benefit entitlement should be. Furthermore, if both public and private sectors are to work in tandem then the single assessment process needs to have a common assessment tool to ensure consistency of benefit entitlement.
- 7 Immediate-needs annuities and lifetime mortgages have a key role to play in helping individuals fund their care, therefore education and dissemination of information on such plans must not be hampered by the regulatory constraints that are coupled with the delivery of financial advice. The Financial Services Authority should be encouraged to identify simple methods by which this can be achieved.

- 8 Various tax disincentives and benefit entitlement issues need to be addressed to ensure that the public do not suffer financially as a result of accepting personal accountability for their care costs. This has particular relevance where lifetime mortgages are being deployed to generate care funding.
- 9 Serious consideration should be given by Government to the concept of introducing a form of compulsory provision, with the possibility that this be introduced in a phased manner, thus avoiding the prospect of some of the population having to pay for the current generation of people in care in addition to the future funding of care in later years.



# Background to long-term care insurance

The arrival of long-term care insurance (LTCI) in the UK coincided with the Community Care Act 1990,<sup>2</sup> which was preceded by the Griffiths Report.<sup>3</sup> Insurers realised that there was an opportunity to present an insurance solution to the problem of how to pay for care.

Over the past ten years, LTCI has been marketed and sold in the UK, however the levels of uptake have been relatively low compared with market expectations. Many reasons have been given for this lack of public acceptance. Commentators said that the insurance products were complex, expensive and represented poor value for money. Over and above this, until October 2004, the Financial Services Authority had not regulated the sale of these plans. The media, politicians and some of the main charities have always expressed the view that regulation was an imperative, bearing in mind the cost of the plans and the vulnerability of some of the potential purchasers. Consequently, some potential purchasers may have felt that buying such a product was unsafe. What may actually be the primary cause of the very low uptake on these plans was, and is, the uncertainty over what the State will provide.

Over the course of 2004, the main providers of LTCI withdrew most of their products from the market. It is, however, helpful to examine how these products worked, as we may see a return to the market in the future if the insurers were to consider this to be a viable proposition. An environment where such products might be reintroduced would have to include more intense education of the public on the need to plan for the cost of care in old age and government endorsement of the insurance plans that might assist in such planning. If a public–private partnership were to be considered, then this would certainly rekindle the appetite of the insurers to develop new products for such a scheme.

For those who wished to use private insurance products to enhance their care-planning provision, there were four main options as described below.

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2 The NHS and Community Care Act 1990.

3 *Caring for People*, Sir Roy Griffiths, 1989.

### **Section 1: existing products**

#### **Option 1: insurance plans**

The first option was an insurance plan, also known as a pre-funded plan, which paid a benefit when the customer could no longer perform a number of activities of daily living (ADLs). An annual benefit was selected at the inception of the plan and there was a facility to link the benefit to an index such as the retail price index (RPI). Premiums were payable on a regular or lump-sum basis and the insurer could review these premiums after an initial period of, say, five or ten years, or on the policyholder reaching a predetermined age. The reviewable nature of this contract was one of the principal downsides of this type of plan. 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. Some providers did guarantee rates but these were mainly available only for policyholders who had reached the age of 75. There is now only one company that provides this form of insurance in the UK.

#### **Option 2: investment-based plans**

The second form of LTCI was introduced on the back of an investment plan that was intended to provide a lump sum, or return of capital, over and above the protection element of the plan. These plans were popular at one stage, as they were seen as addressing one of the main criticisms of the pure insurance plan, which was that they did not return any premiums in the event of death. The investment market performance over the past few years has resulted in these investment-based plans failing to deliver the returns that were originally forecast. As a result, most of these policyholders have to face a choice of having to either invest more money to bolster their plans back up to their previously forecasted levels or accept a substantially reduced level of long-term care protection. Virtually all such plans are now unavailable, as all the insurers that offered them have now withdrawn them from the market.

#### **Option 3: conversion policies**

The third variant was a conversion option, which was tacked onto a mainstream protection policy such as a critical illness or a whole of life plan. It is difficult to determine how many of these plans might ultimately be converted into LTCI. There

were very few providers that offered the option and it is too early to be able to identify any trends in conversion ratios. It is significant to note that the vast majority of cases sold by one provider that did offer the LTCI conversion option related to male lives. As is mentioned elsewhere in this document, females are the most likely beneficiaries of LTCI protection. So, although sales of these protection plans were high, they are unlikely in the future to evolve into measurable sales of LTCI. As with the two types of LTCI mentioned above, these conversion options also became unavailable over the course of 2004.

All three of these options offered the client a choice at the time of a claim in terms of how their care needs might be delivered. This is extremely important, as it would be impossible for the client to anticipate what type of care they might need in the future. Typically, after the insurer had admitted the claim, a care consultant would meet with the client and their family to review what care options would be most suitable to the client's needs. This could either be on a residential or domiciliary basis, with provision for assistive devices such as grab rails, ramps or stair lifts. The cost of the care package could not exceed the policy benefit level but clearly some extra care could be funded by either the client or their family. In addition, as the client's care needs changed, the care plan could be revised accordingly.

There was also a fourth alternative, which is still available. This does not cater for those who are planning for a future need for care; it deals more with the actual funding of care that is required immediately, such as at the time of discharge from an NHS bed and a move to residential care.

### **Option 4: immediate-needs annuities plan**

The last type of plan, and the only one where sales growth is evident, is described as a point-of-need annuity. These are annuities that offer enhanced rates because the purchaser will most likely have a lower life expectancy than the norm. An annuity is purchased normally after the family home has been sold and the income from the annuity is paid gross, if it is paid directly to a service provider, which in most cases will be the care home. At present, it is extremely uncommon for such a plan to be used to fund domiciliary care, as it is normally the proceeds of the sale of the home that are used to buy the annuity. In some circumstances, a residue of funds will be capable of being retained after the purchase of the annuity has been made. This results in some of the proceeds from the sale of the family home being able to produce extra income while the annuitant is alive and an inheritance for the family on death.

At the end of 2003, the Association of British Insurers reported that the total number of all LTCI policies in force was approximately 46,000. There were 29,500 pre-funded plans, 12,800 investment-based plans and just over 3,600 point-of-need plans. There are no data available on the conversion option category.

The number of policies bought in 2003 was 2,500 pre-funded plans (10 per cent down on previous year), 250 investment-based plans (60 per cent down on previous year) and 1,500 point-of-need plans (previous year on a par with 2003).

### Examples of cost

To illustrate typical costs of the first type of LTCI (option 1) described above, i.e. the pre-funded plans, examples using Scottish Widows premiums are set out in the box below.

The basis of any claim being paid on the policy would be that three ADLs had been failed or that the policyholder was suffering from cognitive impairment. Plans were available that paid benefits on the failure of two ADLs. Benefits were payable for life providing the ADLs continued to be failed.

#### **Typical costs of option 1 for a male aged 67, £10,000 annual benefit, 13-week deferment period**

##### *Single premium (lump sum)*

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

##### *Monthly premiums*

- £89.41 – with benefit *and* premium linked to RPI.
- £62.53 – with level benefit.

#### **Comparative figures for a female**

##### *Single premium (lump sum)*

- £19,335.30.
- £10,178.00.

##### *Monthly premiums*

- £111.19.
- £76.30.

Despite the higher premiums for females, women bought 60 per cent of all policies. The reasons for this are partly to do with the fact that many informed purchasers will have seen that the majority of people who face significant care costs are in fact women. In addition, from a psychological perspective, partners tend to believe that they will be able to provide mutual, informal care when they need it. However, when one of the partners dies, more often than not the man, the surviving female has to review her future care needs and associated costs, at which point insurance becomes a more prominent proposition, providing the financial means were there to pay for it. The proportion of widows/single women who bought long-term care insurance was quite significant. It should be explained that a benefit level of £10,000 per annum was not untypical, as it was anticipated that other income sources would also be available for care fee payments, thus the insurance benefit acted as a top-up facility. These costs were therefore what a typical LTCI purchaser would be considering. The most common age at which these plans were bought was 67, although some people bought in their mid 50s and others were as old as 90.

From these premium indications, it is clear that the right level of cover could be expensive. The alternative, which many customers may have considered, offered a major opportunity for procrastination. This is an immediate-needs annuity (option 4). Sales of these plans are very low, however the 1,500 policies sold in 2003 produced a total premium paid of almost £95 million, resulting in an average purchase price of around £64,000. The difference between the point-of-need annuity and a pre-funded plan is that, for the former, the customer, or the relatives, know without any doubt that care is charged for and what their financial liabilities are. With the latter plan, there was always the hope that (a) it wouldn't happen to me or (b) things would get better in terms of state provision. It remains unclear why sales of immediate-needs plans have remained low, bearing in mind some of the figures<sup>4</sup> that have been put forward regarding the number of people who are forced to sell their homes every year to pay for their care. It has been suggested that the children of the person considering such a plan may influence the decision, as they may feel that the price of the plan is too much to risk, with future inheritances in prospect.

Apart from point-of-need plans, the sales data and the price of LTCI leave little doubt that this type of funding solution was unpopular with the public and, as a consequence of this low public interest, virtually all the main insurers have withdrawn from the pre-funded market.

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4 'Over 40,000 elderly people each year are being forced to sell their homes to pay for the cost of care' – *The Care Crisis*, Conservative Policy Unit report, 2002.

It is therefore concluded that pre-funded LTCI in its present form is not likely to help form a platform for self-provision for care of older people in the UK.

## Section 2: alternative products to pay for care

There are some alternative designs that could provide acceptable alternatives to the standard insurance plans that have been described above. These would require some form of public–private partnership to ensure that full protection for the individual could be achieved.

### Insurance for the later years of dependency

The standard insurance contracts described earlier would exclude the first 13 weeks of disability. The first option would be to design a plan that had a significantly longer deferment period such as 104 weeks. This concept might prove to be attractive to the public if there were some form of state protection at the early stages of disability. Such a plan was available from Scottish Widows and the comparative figures are shown in Table 1.

The fact that benefits are payable for an undetermined period has a significant effect on the pricing of these products. Insurers and reinsurers are concerned with the extra risk that this represents and therefore build this risk factor into their rates. As can be seen, extending the deferment period does reduce the insurance cost considerably.

**Table 1 Comparative figures (Scottish Widows) for a standard insurance contract and a plan with a longer deferment period**

	Male		Female	
	13-week deferment	104-week deferment	13-week deferment	104-week deferment
Single premium with RPI (£)	14,726.33	7,504.51	19,335.30	10,960.88
Single premium level (£)	7,618.70	5,000.00*	10,178.00	6,743.91
Monthly premium with RPI (£)	89.41	46.22	111.19	63.15
Monthly premium level (£)	62.53	40.09	76.30	51.38

\* Minimum single premium of £5,000 applies, therefore benefit in this example would be increased above the £10,000 to reflect this.

The concept of sharing the risk between the State and the individual has been discussed within the insurance industry for some time. One concept was to offer enhanced asset protection to those who purchased LTCI, a model that has operated in some states in the USA for some time. Basically the scheme works on the following lines. A person purchases £30,000 of LTCI, calculated on the basis of an annual benefit of £10,000 per annum payable over three years. This increases his asset-protection level by one-and-a-half times or twice this amount. If such a scheme were to apply in the UK, then the asset-protection level would increase from £20,000 to £65,000 or £80,000, depending on the factor used. It is difficult to imagine this sort of incentive being sufficient to persuade the UK population to buy into the whole concept of self-provision for LTC, bearing in mind the average value of a family home in the UK.

However, the development of insurance plans that provide protection against a personal risk when the balance of the risk is underwritten by the State could potentially have much stronger consumer appeal. A first option of public-private partnership might be for the State to deal with early disability up to 104 weeks. This could dovetail with the insurance plan described above. There are alternative risk splits that could be considered. For example, there is the option of reversing the deferment period.

### **Insurance for a limited period of disability**

This would result in the insurer dealing with, say, the first 104 weeks of disability leaving the State to deal with the costs thereafter. It might be assumed that the cost of the insurance element would be the difference between the standard rates shown above and the rates for 104-week deferment. This is not quite the case, as mortality is a factor that influences the pricing structures. In other words, some policyholders are likely to die shortly after disability strikes, for example as a result of a stroke. Such a plan was available from another LTCI provider, namely BUPA.

Table 2 illustrates the costs of this type of policy.

This model is the least expensive from a consumer perspective, but it should be borne in mind that this may not represent a perfect solution, as the number of ADLs that need to be failed is three, which represents a rather high level of disability.

**Table 2 Benefit of £10,000 per annum with 13-week deferment and benefit paying period of 104 weeks – three ADL failures or cognitive impairment would trigger a claim**

	Male	Female
Single premium with RPI (£)	4,200.00*	6,758.96
Single premium level (£)	2,900.00*	4,500.00*
Monthly premium with RPI (£)	34.92	49.21
Monthly premium level (£)	29.70	40.41

\* BUPA<sup>5</sup> applied a minimum premium of £5,000 but these are the approximate risk premiums that would have been relevant if no such minimum were applied.

These are only two models of risk sharing and insurers could no doubt produce illustrations on variations to these themes.

For example, an alternative form of risk sharing could be based on care cost limits, where the individual agrees to foot the bill for the first £25,000 of care with the State stepping in thereafter. Again, insurers could develop such plans but at present there is none available in the UK.

There are some fundamental stumbling blocks that would have to be overcome if the private sector insurance plans were to perfectly complement the state provision. For example, insurers use ADLs as the gateway to benefit entitlement whereas the State relies on a single assessment process (SAP), which is interpreted or applied with some local variations around the UK. In addition, insurers restrict cover in relation to cognitive impairment to that which has an organic basis. Insurers retained a right to review premiums in the light of claims experience and investment conditions. This might not be acceptable in a public–private partnership that is designed to provide complete protection for the future.

A more thorny issue relates to underwriting. Insurers underwrite each case on an individual basis and, as a result, those who do not represent a normal risk will either be charged higher premiums or in some cases be declined. Unless such insurance were compulsory, it is unlikely that insurers would be prepared to accept all cases at a standard premium level.

Assessment of benefit entitlement when a claim is made is a critical factor in any partnership model. The development of a standardised assessment tool would offer more potential for mutual acceptance of the independence and accuracy of the assessment. Agreement would have to be reached on whether the private insurance deal simply paid for the cost of care, or whether the benefit amount would be paid in full on admission of the claim.

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5 BUPA FutureCare with Choice, provided by BUPA Health Assurance Ltd.



In principle, any form of risk sharing can be developed, however the key to acceptance has to be that the two elements complement each other, thus providing total protection for the individual. Financial advisers and insurers would find it impossible to mass market any of these plans unless there was a complementary safety net provided by the State. At present only clients with considerable personal income and/or assets could seriously consider them.

### *Conclusion*

In its current state, it is difficult to conceive of a national public–private partnership insurance deal evolving from such a small market. Initial discussion with some representatives from local authorities has suggested that extensive consultation and planning would be needed before a seamless structure could be evolved. Local authorities are concerned about the financial risks of underwriting ‘free’ care, even if part of the cost is borne by private insurance. Past history has also shown that the public does not perceive LTCI as an acceptable solution in any event, so any form of voluntary scheme is unlikely to succeed.

The same cannot, however, be said for point-of-need annuities where, although sales are relatively low, they are nevertheless providing a reasonable funding solution for care home fees. Discussions with local authorities reveal that there are regular occurrences of self-funders who find that their funds have run out and who then turn to the local authorities for financial assistance. The degree to which this occurs is unquantified but there is the distinct possibility that this finance from local authorities could be saved if the residents of care homes were alerted to the benefits of professional financial advice at the time of entering a home. From a local authority perspective, the problem is that they will never see the residents at the point of entry to the home; they meet up with the resident only when funds have been exhausted. Care home operators do not envisage their role to be the educator, nor do local authorities. The sale of such plans is already regulated by the FSA; therefore there should be no need for inherent distrust of the plans.

A system of intervention needs to be devised to ensure that residents and their families have the opportunity to make ‘informed choices’ over the funding of care home fees. The entire care market would stand to benefit, as state funding would be conserved, local authorities would avoid the difficult issue of dealing with top-ups and all that this entails, and the family and resident would in some cases have conserved part of the estate for future generations.

### Lifetime mortgages

The property-owning public has enjoyed spectacular growth in housing value and, as a consequence, many older people now feel that, by using housing equity, they can improve their way of life in retirement. In 2003, over 25,000 lifetime mortgages were arranged, compared with 16,300 in the previous year. The average loan taken out in the second half of 2003 was £44,000 and the total borrowing for 2003 exceeded £1 billion.

The Financial Services Authority has introduced regulation of the sale of lifetime mortgages from October 2004 and this regulation will cover reversion schemes, which are a variant of lifetime mortgages, hopefully in 2005.

At present, there is very little evidence of people using lifetime mortgages to pay for care or for that matter LTCI. The uses of the funds are much more of an aspirational nature although some are used to fund home repairs or improvements.

In most cases, a cash release is taken and the interest on the loan is left to roll up over the ensuing years. There is an income option available for those who wish to generate more regular income as distinct from a lump sum. Interest rates vary but not dramatically so. Currently they are in the region of 7 per cent. The prospect of continuing rises in property values offsets the concerns that some might have about the mounting debt that will accumulate as a result of the interest rolling up. Virtually all providers do however provide a 'no negative equity' promise.

Nevertheless, the effect of this roll-up can be significant.

A loan of £30,000 with an annually compounded interest rate of 6.75 per cent will have grown to:

- £41,587 after five years
- £57,850 after ten years
- £79,917 after 15 years.

A more extreme example, using an interest rate of 7.5 per cent and a loan period of 25 years, would produce a repayment cost of £182,950.

The average age of a lifetime mortgage buyer is 72.

The challenge of persuading homeowners to use home equity to help pay for care is considerable. In the first instance, most lifetime mortgages carry a condition that effectively requires the loan to be repaid if the homeowner has to leave to go into a care home. This requirement does not come into play if the partner remains in the home, however. Domiciliary care could be funded through a lifetime mortgage, but the prospect of residential care being needed at a later stage may deter individuals from going down that path. If there were some form of guarantee that delivered sufficient residual equity to purchase an immediate-needs annuity to fund subsequent residential care then the route to using lifetime mortgages to fund domiciliary care might be considerably smoother. A further consideration relates to state benefit entitlement, as the implementation of a lifetime mortgage to stimulate income or capital to pay for domiciliary care could result in benefits being curtailed. If an individual were to enter into such a scheme to enhance their care package then this should *not* result in benefit loss.

With the disappearance of pre-funded LTCI from the market, the opportunity to link lifetime mortgages with pre-funded LTCI is no longer possible, however there remains the possibility of linking lifetime mortgages with point-of-need plans.

There is the potential for this to provide a funding device, especially for domiciliary care and for the installation of assistive devices such as ramps, grab rails and stair lifts. The level of enhancement of the annuity is theoretically linked to financial considerations that relate to the terms of the mortgage, as shortened life expectancy directly affects the price of both products. The current form of income-generating lifetime mortgages is based on the principle that the lump sum acquired from the equity release is converted into an annuity but reduced life expectancy is not factored in.

To put this into perspective, a standard annuity that did not factor reduced life expectancy that produced an income of £1,000 per month to pay for a domiciliary care package for an 82-year-old woman would cost £140,452.65. Under current tax law, assuming the standard rate of tax would apply, tax of £11.71 would be deducted from the monthly payment of £1,000. In addition, this income would probably deny the woman any entitlement to means-tested benefits. An alternative option would be to secure an equity-release plan that specifically produced a similar income. To secure this, the property would have to have a minimum value of £215,000 with a release of £96,000. Again, tax and benefit entitlement would be an issue. Removal of these double disincentives would potentially popularise such a scheme.

It is understood that one product provider is developing a product that combines a lifetime mortgage and a point-of-need care plan, and that takes reduced life expectancy into account. This is likely to be launched soon. Others may well follow.

### *Conclusion*

As with pre-funded LTCI, the deployment of lifetime mortgages to directly fund care costs has not been prevalent. The issue goes back to the belief that 'it won't happen to me' or the State will enhance provision in the future. However, for those who are facing an immediate need for the funding of care costs, there could be a much stronger role for lifetime mortgages. Re-examination of benefit entitlements would greatly assist in this area, as much of the target market will be in the asset-rich, cash-poor sector of society. A culture of delivering incentives to provide funding for care, such as maintaining benefits that would otherwise have been payable, would be hugely welcome.

### **Pension products**

One of the first ventures into long-term planning by a financial services provider involved the use of a pension pot not only to buy a pension annuity at the start of retirement, but also to provide an accelerated income in the event of ADLs being failed. To have access to the accelerated benefit at a later stage in life, the pensioner would in exchange have to take a reduced pension at the start of retirement. The plan was launched but subsequently the Revenue withdrew authorisation and it was shelved. The Revenue has recently reversed their decision, but so far this has not been developed as a potential long-term care-planning tool. LTCI benefits on a pre-funded plan are tax free and one of the elements that might need to be addressed would be whether the accelerated benefit paid when disability kicks in should be taxed.

Some might argue that it is difficult enough to persuade the UK working population to make adequate provision for a decent income in healthy retirement, far less providing for the extra costs of care. For example, among the 'take-home messages' that resulted from a meeting of the International Longevity Centre-UK in London at the beginning of 2003, the following points were made.<sup>6</sup>

- In 2001, the average private pension fund was worth £24,000, which will generate an income of only about £2,500 per year.
- According to the Financial Services Authority (FSA): 'Most consumers buy non-inflation proof and often single life annuities. Lots of men buy single annuities. I'm not sure if their wives know.'

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6 'Funding the New Longevity', International Longevity Centre-UK and Faculty of Actuaries, January 2003.

The concept of pensions converting into long-term care benefits is fine in theory, but the reality is that, for most people, such an option would be very low on their priorities, especially if the basic pension were modest. However, for those who are fortunate enough or prudent enough to have secured a relatively 'good' pension, a facility for accelerated benefits in the event of long-term care being needed could be of benefit, especially if the accelerated element could be paid gross.

Another tax issue associated with pensions relates to the tax-free lump sum that is available at retirement. In exchange for a reduced pension, current regulations permit a tax-free lump sum to be taken without there being any stipulations as to how the lump sum is used. Some have suggested that there might be some conditions applied to the tax-free status, such as a requirement that a percentage of the lump sum had to be used for LTCI.

### *Conclusion*

Income in retirement is a critical issue in the UK and the recent report produced by the Pensions Commission points to the fact that there will not be one single solution to the problem. It is much more likely that a combination of propositions will be introduced to solve the pension problem. The general malaise that relates to pensions planning bears huge similarities to planning for future care needs. The general public as a whole do not seem to be prepared to face up to the reality that they are individually accountable for their own futures. Care income and normal living income in old age remain detached in public policy terms, yet there is no real logic in this.

The public's track record in voluntary planning for future care costs is, on the face of it, very poor. Insurance products have not been purchased to any degree at all. Equity-release products are becoming more popular but not in the context of paying for care, and the pensions culture appears to be live for today and to hell with tomorrow. With the massive proportionate increase in the retired population over the next four decades, something over and above the status quo has to be achieved. Might it be compulsion?

### **Compulsion**

This alternative approach, which has been proposed by various bodies, including the Joseph Rowntree Foundation in its 1996 report *Meeting the Costs of Continuing Care*, has been considered but not adopted by Government.

It has been suggested that any form of compulsion, whether it be through direct taxation, hypothecated tax or a national care insurance scheme, would be regarded as another form of stealth tax. Currently, those who have assets and/or income above a certain level are subjected to a much more pernicious form of stealth tax, as this is levied only on those who are unfortunate enough to suffer from disability in old age. There is no equity whatsoever in these circumstances. Insurance companies charge all their customers a premium and the pool of people know that they will not all claim but, if they do, they will be protected. The current system of having to pay for care removes the concept of risk pooling, leaving only the unfortunate to pay for their own care. Whether we describe the individual contribution to the risk pool as a premium or a tax is really academic. The current system does not call on those with modest means to pay for their care, nor would a compulsory system. The distinction is that if and when an individual has the means to make some individual contribution to the cost of society's future care needs then it is only reasonable that they should do so.

The JRF inquiry in 1996<sup>7</sup> proposed that a form of national care insurance be created with contributions being made by all working people up to the age of 65. In this context, it is debatable as to whether the age limit of 65 makes sense, especially as this retirement age threshold is very likely to be raised.

A prime concern expressed was that a national care insurance plan would require a double contribution from younger people, as they would be funding not only future care but also current care. The possibility of phasing in the scheme does not appear to have been reviewed. If such phasing could be achieved whereby current and imminent care costs could be funded as it is now, with future care being addressed by the new model, then success might just be a real prospect.

### **Third-party observations/other schemes**

#### *Conservative Party scheme*

The Conservative Party has recently proposed an insurance plan<sup>8</sup> to address the issue of funding long-term care in the United Kingdom. When last in power, the Conservative Party floated a version of the asset-protection concept currently deployed in the USA in the lead up to general election that was lost to New Labour, who sidestepped the issue by travelling down the Royal Commission<sup>9</sup> route.

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7 *Meeting the Costs of Continuing Care*, report and recommendations from the Joseph Rowntree Foundation, 1996.

8 Rt Hon. Michael Howard QC, MP, speech at the Conservative Party's 'Older People's Summit', 14 September 2004.

9 *With Respect to Old Age*, a report from the Royal Commission on Long-term Care, 1999.

*The Care Crisis*,<sup>10</sup> published in 2002, examined the problems of supply in terms of care homes in the UK. It did not examine individual funding issues but indicated that further work in this area would be undertaken.

In the second half of 2004, the Conservatives put forward their funding proposals and these are based on a pre-funded LTCI concept similar to some of the concepts outlined earlier in this paper. The core of the model involves a three-year benefit-paying policy that would deal with initial disability care costs, the deal being that, if such insurance were arranged and the three-year claim period had run its course, then all subsequent care would be funded by the State. Full details on how such a scheme would be administered and what it would cost have yet to be revealed.

### *Liberal Democrats Party scheme*

The Liberal Democrats have announced that their approach to how we fund long-term care would be to raise the tax rate on all incomes over £100,000 per annum from 40 to 50 per cent to fund a 'fairer' means of delivering care for older people. Again full details on administration and application have yet to be revealed.

Apart from proposals from the various Opposition parties, the thoughts and observations of experienced practitioners in the delivery of care to older people have also been taken into account. These are as follows.

### *Experienced practitioners' commentary*

- The role of self-assessment was discussed, with conflicting views being expressed on the merits of such a process. On the one hand, individual choice and empowerment were regarded as valuable and of merit; conversely, the professionalism of a trained assessor of need was also considered to be invaluable. Some means of combining the two principles would be welcome.
- The means-testing process and the issue of entitlement were discussed with a strong case being made for more equity being needed between the under 65s and over 65s in terms of benefit entitlements.
- A predominant theme related to the quality and quantity of sheltered housing stock. If the solution to increasing numbers of care candidates and reduced residential places is the delivery of extra care and/or sheltered housing then a thorough examination of the comparative costs of the care packages needs to be undertaken. Home care is potentially more labour intensive than residential care

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10 *The Care Crisis*, a report from the Conservative Policy Unit, 2002.

and this must have a cost implication. In other words, residential care may be the pragmatic choice based on the pure finance.

- Extra-care communities would potentially compress the labour costs. If such a route is being considered as major part of future care policy, then the detail of such plans need to be carefully examined.
- It was recognised that community-based structures have a better chance of success but the risk of gated, exclusively aged communities could generate problems too. Many older people would not necessarily choose to live within an exclusively aged group, preferring a lifestyle that offers day-to-day living within a mixed-age community.
- Free personal care and the comparisons between Scotland were debated and there was recognition that a flexible approach was evolving in terms of what constituted free care south of the border.
- There needs to be recognition that property ownership and property values have a huge influence in the public's attitude to current practice in delivering and paying for care as it applies to them individually.
- In some areas of the country, e.g. the North East of England where the majority of care costs are state-funded, there is no rising tide of resentment over care costs and charging structures; whereas, in others, particularly the South of England, the protests are more noticeable. Part of the cause for this has also to be linked with the age profile of the areas, as distinct from property ownership *per se*.
- There is a genuine feeling however that, whatever regional differences there may be, any schemes designed to address these issues need to apply nationally rather than regionally.
- Certain care deliveries are definitely not considered to be part of a local authority's function. Gardening, dog walking and home cleaning, such as window washing, are nevertheless important in the mind of many homeowners and, if disability prevents the individual undertaking these tasks, loss of personal esteem and self-assurance can develop.



### *Conclusion*

From an Opposition perspective, the Conservatives and the Liberal Democrats are adopting two extremes, one relying on a voluntary insurance scheme with incentives and the other using direct taxation, which is a form of compulsion.

Experienced practitioners consider that future care will revolve much more around domiciliary packages, which in turn may involve equity release at the time when care is needed, rather than a solution that calls on individuals to plan for a future and uncertain need.

Consensus is difficult to find.

### **A final consumer perspective**

Prior to 2004, when there were LTCI products to consider, consumers were faced with a series of dilemmas. First, the plans were unregulated and, second, some said they were poor value for money. So consumers had to make decisions about which plans, if any, to buy. Most consumers opted to 'wait and see'.

The dilemma now being faced is more fundamental. If care is needed in the future how will it be paid for? A number of routes can be considered but, in the main, it is highly likely that most people will again adopt a 'wait and see' approach.

The dilemma that the consumer therefore faces is that, as there is no advice or direction available either from the State or from the financial services industry on how to plan for future care costs, they must make 'uninformed' decisions. These will almost certainly be to wait and see and to hope for the best. This is hardly a basis on which the United Kingdom should be facing up to the challenges that the cost of care will bring to us all in the future. It is time to grab the bull by the horns.

As has been suggested already, there is no single solution to private care funding. Similarly, it is unlikely that any one organisation is likely to be able to develop an all-embracing solution. There will be a need for the care industry, the financial services industry and government departments to work together. This paper is intended to provide a platform from which some coherent, robust solutions might develop.

### **Ways forward for the financial services industry**

There are some avenues that the financial services industry could pursue. The Immediate Needs Annuity market has a future but this could be expanded if such plans, in conjunction with Equity Release mechanisms, were to help fund the costs of domiciliary care. However, if we are to see a rebirth of real planning for future needs, the industry has to engage with government in the construction of public/private partnership schemes. Insurance for a specified period of disability (as previously described) with government providing a safety net for extended disability, is the only route by which the public would buy in to the concept of planning for the future through insurance. The hurdles that might be encountered have been identified in this paper, but with persistence and commitment they could be overcome. Such a scheme would truly benefit a public which at present has scant opportunity to deal with the threat of considerable costs in older age.