Funding Long-term Care – The Building Blocks of Reform

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About this Report

There is widespread agreement that the UK long-term care funding system requires significant reform. This report sets out the core tasks required of that reform, and provides an accessible introduction and overview to the wide range of available funding options that could be applied to the long-term care system: the 'building blocks' of reform. The report is for both a specialist and general readership.

Chapter 1 (p.4) sets out the core tasks required of reform to the UK long-term care funding system, against which different long-term care funding models must be judged.

Chapter 2 (p.8) reviews the context for reform, identifying the key issues that must be considered when evaluating different models of long-term care funding.

Chapter 3 (p.15) identifies the different basic models of long-term care funding available, briefly summarising and evaluating each 'building block'.

Chapter 4 (p.26) explores how these different models of long-term care funding can be integrated and combined.

This report is concerned with the *funding* of long-term care. As such, it does not address other aspects of the long-term care system, such as provision, care markets, quality and dignity.

Acknowledgements

In order to be as accessible as possible, this report eschews the use of numbers, graphs and references. This means that the report draws on the work of various researchers and specialists in long-term care funding without providing full and detailed references and acknowledgements. Nevertheless, it is important to acknowledge that many authors have written about long-term care funding, contributing to the body of knowledge and ideas that this report seeks to summarise. This report represents a sincere and faithful attempt to capture the full breadth of these ideas and present them objectively in a single document.

Chapter 1: What is the Challenge?

Long-term care is distinct from healthcare and refers to a range of types of care provided to individuals experiencing long-term disabling conditions. Long-term care is often referred to as 'personal care' or 'social care', and excludes nursing care, i.e. care provided by health professionals. Long-term care can take place in the home (domiciliary care), or some form of residential environment (care home, sheltered housing).

The system of funding for long-term care in the UK requires reform. Many problems, inconsistences and inequalities are identified by critics of the system, such as variations in entitlements to state-funded care among different local authorities. Stakeholders in the social care and older people's sectors have argued for over a decade that deep and far-reaching reform is needed.

At the heart of this task of reform to the long-term care funding system are two fundamental challeges that must be addressed if a lasting and sustainable solution is to be achieved. These challenges provide the key tests against which the different options for long-term care funding summarised in this report are judged. This chapter outlines the nature of these challenges.

Increasing the amount of risk-pooling

Long-term care must become a commonly insured risk.

Individuals go through life insured against various risks, both trivial (mobile phone theft) and non-trival (ill-health, poverty, premature death). This insurance is organised both by the state and the private sector. For example, the NHS represents a giant state-organised health insurance scheme that individuals pay into via general taxation, with associated redistribution, resulting in a universal standardised entitlement to healthcare. The private sector organises insurance for many diverse smaller risks that fall beyond the scope of the state, such as travel insurance and car insurance. Some risks are pooled by both the private sector *and* the state, such as the risk of becoming homeless, which is insured universally by the state (housing benefit), and by the private sector among home-owners (house insurance).

However, the risk of needing long-term care is different. Unlike all other major risks that individuals confront, such as ill-health and unemployment, most individuals are not insured against the risk of needing long-term personal care and the costs of this care.

The state does not pool the risk of long-term care via general taxation and never has done, except for the very poorest households with total assets below a low threshold – currently £22,250 – who are entitled to free long-term care paid for by the state.

The extent of private sector risk-pooling in relation to long-term care is also minimal. Individuals can buy 'pre-funded' insurance policies, i.e. insurance bought before care is needed, which pays out when care needs develop. However, the total number of 'pre-funded' long-term care insurance policies sold by the private sector is estimated at around 40,000, compared to a potential market among the retired population of several million.

The risk of needing long-term care therefore appears different from every other major risk that individuals confront in their lives. Despite the risk of needing long-term care being universal, for the majority of individuals this risk is not 'pooled': individuals do not pay into an insurance against the risk of needing long-term care and are not insured against it.

The effect of this absence of risk-pooling in relation to long-term care funding is clear: individuals requiring long-term care, and their families, experience the current system as being fundamentally unfair.

Being uninsured, i.e. not in a risk-pool for long-term care, means that the misfortune of requiring care is compounded by the fact that individuals, or their families, must pay for care 'out-of-pocket' using their own means, or rely on unpaid care as a substitute.

Indeed, the accumulated total cost of long-term care required by individuals can be 'catastrophic' as individuals are forced to 'spend-down' their wealth to the tune of many tens or even hundreds of thousands of pounds, until they reach the means-tested threshold of £22,500. Often this involves forced liquidation of assets that can see individuals compelled to sell their homes. The unfairness of this 'cliff-edge' means-test is particularly sharp for those who have been low-earners and find themselves just above the capital threshold.

A key task for reform of the long-term care funding system therefore emerges: greater risk-pooling in relation to long-term care is required. Long-term care must become a 'commonly insured' risk. Individuals must pay into a risk-pool for long-term care so that when care is needed, they are entitled to a level of benefit, which could be cash or a fixed level of care, that significantly limits the need for them to pay for care themselves out-of-pocket, or rely on unpaid care. As the different funding options outlined in Chapter 3 show, this risk-pooling could be organised by the state, private sector or other risk-pooling mechanisms.

Only when the risk of needing long-term care is substantially pooled will the amount that individuals requiring care have to pay 'out-of-pocket' be minimised. Indeed, a far greater level of risk-pooling in relation to long-term care is needed if the UK long-term care funding system is to be regarded as "fair" and "working", finally ending the demands for reform that have been a feature of the system for many years. It must be emphasised that a politically sustainable long-term care funding system will require that a 'critical mass' of risk-pooling is achieved, so that a sufficient majority of individuals passing through the system view their outcomes as fair and acceptable. This will only occur when most individuals are insured against the risk of long-term care, up to a level of care provision that they deem adequate.

A key test of any proposed model of long-term care funding is therefore whether and to what extent a model increases the amount of risk-pooling in relation to long-term care.

Increasing the amount of national wealth spent on care provision

The UK must allocate a greater proportion of societal wealth to paying for long-term care.

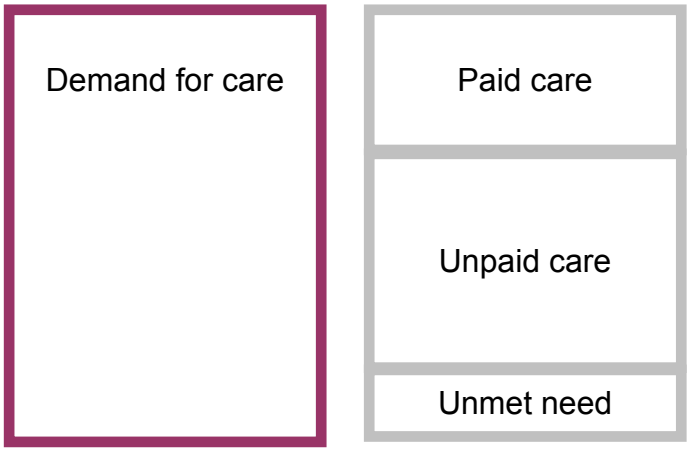
The poor outcomes that many people experience in relation to long-term care in the UK reflect the mismatch between the demand and supply of care across society. Within the UK population, there is a measurable volume of demand for long-term care, i.e. a measurable number of individuals who require some form and type of personal care for an extended period arising out of a range of physical and mental conditions.

At present, some demand for care is met through 'formal' care, which is provided by individuals who are employed to provide care. Formal care is paid for by the state (through local authorities) for the poorest households. For other individuals and their families, formal care must be purchased using their own means.

The total volume of formal care provision within society paid for by the state or private households is significantly less than the total demand for care. Rationing by local authorities is widespread. Similarly, many families paying for care themselves do not have sufficient available resources to purchase formal care, or to purchase *enough* formal care.

This difference between the volume of demand for care within society and the supply of formal care results in the provision of unpaid care by family and kin. It also – shockingly – results in a persistent volume of unmet need within the system.

In fact, the total supply of formal care across society is actually less than the volume of care provided by family, friends and kin. Such 'informal'/unpaid care amounts to the largest share of care provision within UK society.



In many situations, families and kin *want* to provide unpaid/'informal' care, and this form of care will always therefore be a significant feature of the long-term care system.

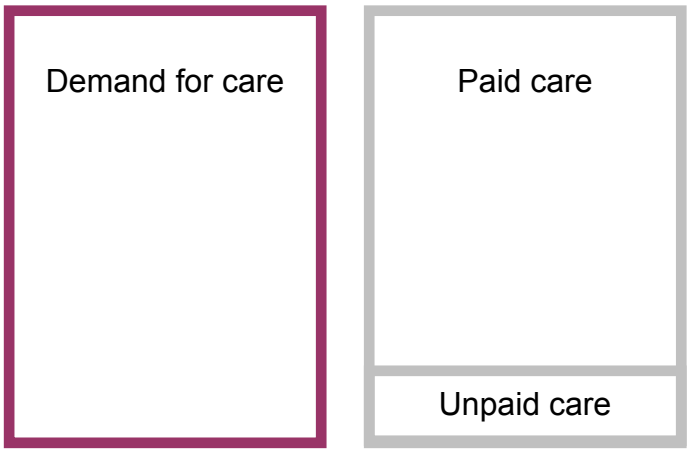
However, many informal care relationships are characterised by excessive volumes of care provision, far exceeding the burden of any paid carer in both the hours of care provided per week, and in many cases, the stress associated with care provision without organised support.

As a result, although unpaid, such informal care imposes direct and indirect costs on individual carers and the state. Many carers providing excessive volumes of care experience negative outcomes in relation to well-being and health, and also suffer opportunity-costs, for example, in relation to loss of earnings and accumulated pension contributions. Reducing the negative effects of unpaid care provision on carers is itself a key objective of Government policy.

Improving the outcomes experienced by both those requiring long-term care and those providing it will require the supply of care in society to increase, so that the supply of care more closely matches the total demand for care. This increase in the supply of care within society may occur as either formal care or unpaid care.

However, significantly increasing the supply of unpaid care is unfeasible given the limited availability of unpaid carers. It is also undesirable given the negative outomes that many carers experience arising from their provision of unpaid care. Indeed, there is an urgent need to actually reduce the burden of care on existing carers.

This means that the volume of *formal* care provision in society must rise dramatically. Formal care will never wholly replace unpaid care, particularly given that many families choose to provide unpaid care. Rather, the supply of formal care across society must be sufficient to eliminate unmet need from the system. It must also be sufficient so as to make unnecessary the excessive burden of unpaid care currently shouldered by many individuals and families, i.e. sufficient to create a more balanced 'co-production' of care in which care is provided by both paid carers and family members.



Increasing the supply of formal care within society will cost money. Academic research published by Carers UK, a charity representing carers, suggests that the equivalent cost of unpaid care provision in the UK was £57 billion in 2002 and £87 billion in 2007. Given the existence of unmet need in the current system, and the £19 billion of public spending on social care services for adults and children, this suggests that if the total demand for long-term care in society were to be *entirely* met by formal care, the cost would be many tens of billions of pounds.

Whatever balance of formal and unpaid care emerges following reform, a greater proportion of the country's wealth, both private household wealth and public spending, will have to be allocated to the task of paying for formal care.

The second key test of any model of long-term care funding is therefore whether it provides a mechanism for facilitating an increase in the amount of national wealth allocated to the task of formal care provision. The wealth of society takes many different forms, both liquid and illiquid, and as is found in Chapter 3, different models of funding long-term care provide different mechanisms for directing this wealth into the long-term care system.

Next steps

This chapter has set out two key tasks at the heart of any fundamental and sustainable reform of the long-term care funding system: ensuring greater risk-pooling in relation to long-term care, and providing a mechanism for increasing the volume of national wealth allocated to the task of formal care provision.

The next chapter outlines the issues and context for reform that be must considered when evaluating different long-term care funding models. The third chapter summarises these options in their most basic form as 'building blocks' and the fourth chapter explores how these options can be combined and integrated.

Chapter 2: The Context for Reform

The preceding chapter identified the two principal challenges that are core to the task of reforming the UK long-term care funding system: increasing the scope of risk-pooling in relation to long-term care; and, increasing the proportion of national wealth - both public and private - spent on formal care provision.

Numerous different models of long-term care funding are available that go some way to addressing one or both of these challenges. However, in evaluating such models, various complicating factors and constraints must also be considered that provide the context for reform. This chapter identifies some of the key issues that must inform choices about models of long-term care funding.

Perceptions of long-term care funding

Public knowledge of the funding of long-term care in the UK is low. Consultations repeatedly show a widespread belief that all long-term care is currently paid for by the state as part of the NHS. When individuals learn that the state does not pay for universal care free at the point of use, individuals often argue that this should in fact be the case. Among older cohorts in particular, there is often a belief that they are entitled to free care paid for by the state on the basis of their National Insurance contributions, despite the fact that such contributions have never been used to fund free care for all.

As a model of long-term care funding, universal free care funded by the state has both benefits and limitations, which are detailed in the next chapter. Problems associated with the funding of universal free care have prevented successive Governments from implementing this funding model, except in Scotland, which introduced a universal entitlement to a basic level of funding for personal care, albeit at a level which still requires large numbers of individuals to pay out-of-pocket and, at least for residential care, could more accurately be described as a universal ‘co-payment’.

A sharp divergence therefore exists between public perceptions of how long-term care is funded, should be funded, and the range of other possible funding models that exist. This divergence, and the significant political challenge it implies if other models are to be adopted, accounts in large part for the continued failure to introduce a new system for funding long-term care across the UK. Indeed, the state of current public perceptions regarding long-term care mean that changing these perceptions will be an integral part of any reform process.

Necessity of long-term consensus

Rather like reform to a pension system, major changes to long-term care funding require consensus to be formed and maintained over a period of many decades. Any reform will require public support and participation, and this will rely on the existence of trust among the public that as they pass through any new system, the ‘rules of the game’ will not change. This has two important implications for reform.

First, long-term care is an inherently non-partisan issue. The time horizon of long-term care reform extends far beyond any elected government. Reform will therefore only be possible following the emergence of widespread political and cross-party consensus, in order that participants in any new system can have confidence that the system will not change around them when a new government is elected. This means that, by definition, if a political party announces a policy for long-term care funding reform that is different from the policy of other parties, both policies are, in effect, redundant.

Second, in order for political consensus to be maintained, the system must work for everyone such that long-term care funding does not again become the subject of demands for reform. All social and age groups must be happy with the outcomes they experience following any reform. If this does not occur, political opposition will form against the system, consensus will break down, long-term care funding reform will again become a political issue and, anticipating major change, individuals may begin to withdraw from participating in the reformed system. For example, a new long-term care funding system that improved outcomes for low-to-median income households in retirement but not high-income households would ulimately generate discontent, and reform of the system would again become a topic of discussion.

Similarly, reform that relied on the use of private sector insurance products that only achieved 25% of their potential market would be unsustainable; ultimately, there would be enough individuals and families in the remaining 75% that would be unhappy with their outcomes for political opposition to the system to emerge, generating discussion of potential reform, thereby undermining the insurance market as individuals waited to see what emerged from the reform process.

These observations show that it is important for reform to the long-term care funding system to achieve consensus by improving outcomes for all social and economic groups, such that long-term political consensus is maintained.

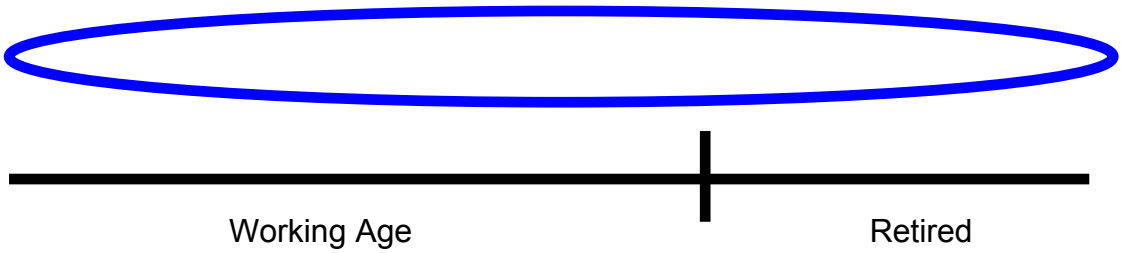
Demographic change: demand for care

Demand for long-term care in society is widely projected to increase substantially in coming decades, adding to the financial pressures on the current system that currently lead to rationing of public and private spending on care. These increases in demand will very largely be related to the ageing of the UK population. In future, there will be more individuals in late old-age, which is the peak-age for experiencing care needs. Advances in healthcare technology are also anticipated to increase the amount of time that individuals survive while experiencing substantial mental and physical disability that require care provision.

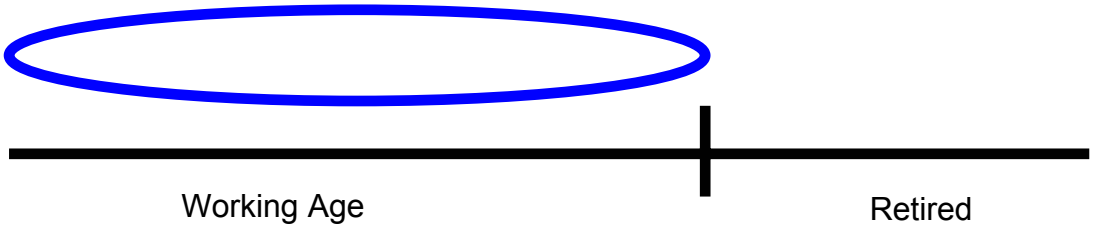
Scope of risk-pooling: universal; cohort; pre vs. post-care need

The previous chapter highlighted why greater risk-pooling in relation to long-term care is needed. However, a risk-pool for long-term care can be ‘drawn’ in many ways, i.e. the determination of which individuals are in a particular risk-pool and which are not.

Different funding models for long-term care propose different risk-pools, which vary by age-membership and whether or not individuals already require care. For example, universal free state-funded long-term care would pool the risk of long-term care across the entire population:

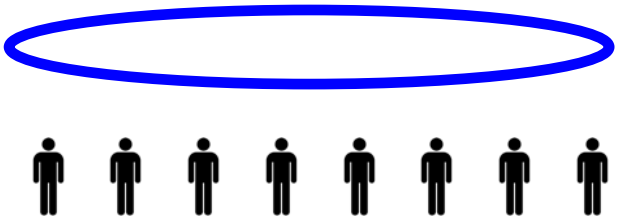


Other long-term care funding models propose pooling the risk of long-term across defined cohorts – ‘cohort insurance’ - for example, just individuals of working age:

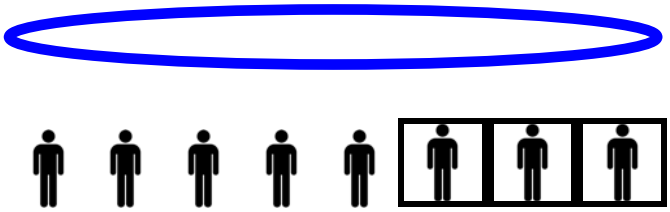


Alternatively, a risk-pool for long-term care could be pooled across just the retired cohort:

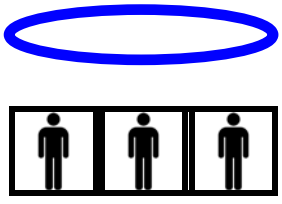
Different models for funding long-term care also pool risk in different ways in relation to the incidence of care needs. For example, some financial products pool the risk of paying for long-term care among everyone, i.e. before anyone needs care:



This is known as 'pre-funded insurance'. Subsequently, some individuals in the risk-pool will require care, and the risk is therefore pooled among those who are fortunate and those who are not.

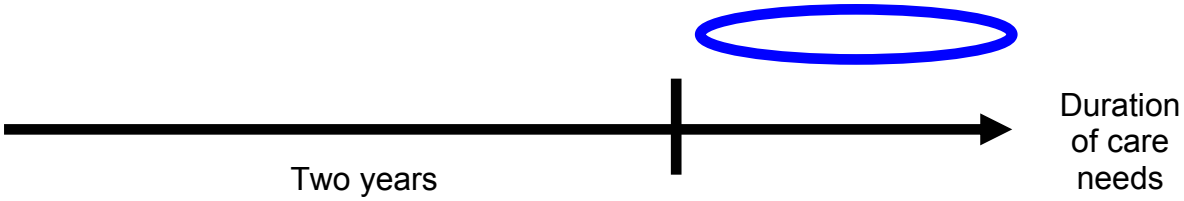


In contrast, some financial products for funding long-term care are purchased at the 'point-of-need', and pool the '*longevity risk*' associated with paying for care only among those individuals already requiring care:



In contrast to 'pre-funded insurance', these financial products are not concered with the overall risk of needing care and having to pay for it, but with the specific risk that care will be required for an extended period – 'longevity risk' – i.e. the uncertainty over the longevity of the

person needing care, the total care they will require and the cost of that care. Such products usually propose a cut-off, measured in duration of care needs or expenditure on care, after which, the cost of long-term care is borne by the risk-pool. For example, two years is often proposed as a reasonable such period.



Demographic change: fiscal sustainability

As demand for long-term care increases in line with the ageing of the UK population, the scope for the state to fund care will come under pressure from two factors.

First, the ageing of the UK population will increase demand for other types of public spending, in addition to long-term care. In particular, demand for healthcare provided by the NHS will increase, as will the number of individuals eligible for the State Pension.

Second, as the 'baby-boomers' enter old-age, the ratio of working-age individuals to people in retirement will decline. This means that there will be fewer people to pay income tax and other taxes to fund those aspects of public spending principally directed at older people, such as the NHS and the State Pension. Demand for these services will rise while the revenue available to the state to meet this demand will proportionally decrease.

The sustainability of public spending on the NHS and the State Pension will therefore be subject to intense fiscal pressure arising from demographic change, even before consideration has been given to whether more public spending could be used to fund long-term care, and the rising demand for care in society that will occur.

Indeed, it is worth reflecting on the fiscal pressure that currently exists in relation to the NHS and the State Pension, and the outcomes that result. Already the limited resources available to fund the State Pension have resulted in rationing; the existence of means-tested Pension Credit, a retirement income 'top-up', amounts to an implicit official recognition that the State Pension is insufficient to live on.

In relation to the NHS, demand for healthcare and limited health budgets are resulting in various forms of rationing, which are increasingly capturing public attention. In particular, some families are forced to pay for expensive life-extending drug treatments 'out-of-pocket', when such drugs will not be funded by the NHS. In this way, the NHS is already failing to meet the expectations and aspirations of individuals, and forcing families to make impossible choices between selling their home and purchasing drugs privately.

The issue of how to pay for long-term care cannot therefore be meaningfully separated from the wider debate as to how the UK pays for its ageing population. Even before long-term care is considered, the fiscal sustainability of the the NHS and the State Pension are under pressure from the ageing of the population. How the state meets its existing pension and healthcare obligations will also determine how UK society funds long-term care. The UK cannot design and adopt a new long-term care funding system against a neutral context, but rather, must recognise the constraints of fiscal sustainability arising from demographic change.

Necessity of means-testing

There will always be individuals who require care but have no means to pay for it. At present, the UK long-term care funding system includes a central role for means-testing. Individuals

with more than £22,250 of assets must pay for their care themselves. Only one model of long-term care – universal state-funded free care – would not involve means-testing. However, all other models imply the application of means-testing.

This creates several difficulties. First, means-testing is sometimes resisted by individuals and can therefore be difficult to implement. In relation to long-term, the deliberate movement and transfer of assets in order to 'game' a means-test is known as 'deliberate deprivation'. Second, using means-testing to allocate public spending, particularly among pensioners, is perceived to penalise those who have been responsible and saved their retirement, i.e. means-testing in retirement disincentivises retirement saving among those of working age.

Finally, given that most models of long-term care funding imply means-testing of individuals in retirement, if reform of the long-term care funding system is to occur, it is likely to require explicit public re-articulation of the role of means-testing in long-term care funding, which many members of the public are not aware of. This fact underscores the political challenge inherent in reform.

Necessity of redistribution

Just as there will always be individuals requiring care but lacking any means to pay for it, there will always be individuals with extremely limited available means to contribute to a risk-pool to insure themselves against long-term care, whether as retirees or working-age individuals. This suggests the need for redistribution within risk-pooling mechanisms, i.e. variations in contributions, to prevent individuals from being excluded from insurance.

Long-term care as a 'decumulation phase' event

Economists distinguish between two phases in the life course: the accumulation phase, when assets and wealth are built up; and, the decumulation phase, usually beginning around 65, when the process of 'spending down' wealth and assets occurs.

The risk of needing long-term care is largely focused on the end of life, which for most people occurs after retirement in the decumulation phase. However, financial behaviour, planning activities, priorities and attitudes to various risks are different between the accumulation phase and decumulation phase. Many individuals in the 'accumulation phase', particularly younger people, therefore fail to comprehend or attach significance to the risk of long-term care, nor undertake voluntary preparations for it. This has several important implications for models of long-term care funding requiring actions by individuals in the accumulation phase.

First, younger working-age cohorts are likely to resist or ignore any voluntary opportunity to make *specific* financial preparation for requiring long-term care – such as paying into long-term care insurance – when they are in 'accumulation phase', as distinct from general asset accumulation activities, such as pension saving and investments in property. Indeed, it should be noted that undersaving into voluntary pension schemes is widespread among younger cohorts in relation to an event – retirement income needs – that has a far greater probability of occurring than the risk of requiring long-term care.

Second, given that younger cohorts attach such low significance to the risk of requiring end-of-life care, they may oppose compulsory increases in income tax to fund increases in public spending on long-term care, particularly given competing household budget priorities for individuals in the accumulation phase, such as getting on the 'property-ladder', feeding and clothing children, etc.

These observations highlight the disconnection between long-term care as a mostly decumulation phase event, and the accumulation phase, which is the the period during the life course when individuals are usually most able to afford to pay contributions towards insuring themselves for long-term care. This divergence is also found in relation to healthcare: individuals use most of the health resources they will consume during their life in their final

years, which for most people occurs in the decumulation phase. For this reason, many systems of healthcare funding operate on the basis of a compulsory pay-as-you-go 'intergenerational contract', which enables individuals to 'pay-in' during the accumulation phase and 'draw-down' when in the decumulation phase. Small payments during the accumulation phase, such as notional National Insurance contributions, are effective in enabling individuals to insure themselves against risks which are primarily end-of-life decumulation phase events, such as ill-health, since payments are both spread over a long time-period, and are made when individuals can most afford them. For this reason, models of long-term care funding that similarly enable individuals to spread contributions to a risk-pool for long-term care across the accumulation and decumulation phases of the life course are viewed as optimal by many stakeholders.

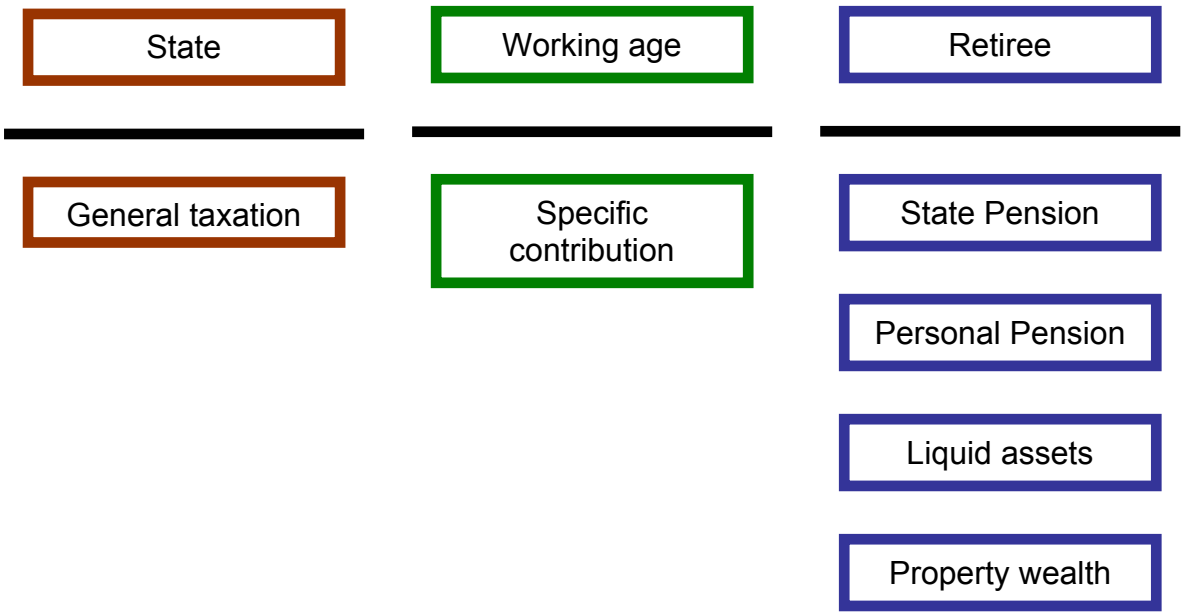
Nevertheless, despite the low profile of long-term care among individuals in the accumulation phase, long-term care is not an exclusively decumulation phase event. Individuals of all ages may require long-term care. This means that the question of funding long-term care also applies to individuals in the accumulation phase, even though it is older people's long-term care that is the most significant concern for policymakers given the effect that demographic change will have on demand for care.

Funding sources for long-term care

The previous chapter highlighted the need for a greater proportion of national wealth to be spent on care provision. Considered in terms of the total wealth within society, there are a limited number of potential sources of new wealth that can be brought into the long-term care funding system. These are associated with:

- Public (state) spending (general taxation).
- Specific new earmarked contributions and provision by working-age individuals in the accumulation phase that are distinct from taxation, for example, contributions to a private sector insurance product or a contribution to a new social insurance fund.
- The various types of income and assets available to individual older people in the decumulation phase.

If a greater proportion of the wealth of UK society is to be spent on long-term care provision, this wealth will have to be derived from one or more of these sources. All of these possible sources of new wealth that can be transferred into the UK long-term care funding system are represented here:



However, these potential sources of new wealth are not only limited in number, but are also unstable, and subject to fluctuations associated with the economic cycle. For example:

- The potential role of general taxation in funding long-term care is subject to variations in economic growth and the economic cycle, with associated implications for public spending.
- The State Pension is funded directly out of general taxation and therefore also subject to the pressures on public spending that occur at different stages of the economic cycle.
- The total property wealth of older cohorts is variable, reflecting the tendency for long booms and sudden busts to characterise the property market.
- The scope for specific contributions into the long-term care funding system by working-age individuals is subject to competing consumption needs of households in the accumulation phase, such as buying a home, 'food & fuel', and child-rearing, as well instability associated with unemployment.

Multiple long-term care funding models may be appropriate

Debate on long-term care funding reform consistently assumes that a single 'optimal' model exists that could be appropriately applied across the entire population. However, there is no logical or practical necessity for this to be the case. Multiple long-term care funding models may be appropriate for applying to:

- Different cohorts; e.g. working-age and retired.
- Different income and wealth groups.

Major reform of the long-term care funding system may also require the application of 'permanent' models, which are anticipated to persist and be sustained in the long-term, and 'transitional' or 'bridging' models for certain groups, that combine with permanent options in the gradual move to a single long-term system, but which are ulimately phased-out as the transition to a new system is completed.

Next steps

This chapter has briefly reviewed the context for reform and some of the key issues that must be considered when evaluating different options for long-term care funding. Although the issues briefly outlined here are complex, for the sake of brevity other issues have actually been overlooked, such as the geographical variations in unit care costs that affect any long-term care funding system.

In the next chapter, basic 'stripped-down' versions of the different options for long-term care funding are summarised and evaluated. The final chapter explores some of the interesting ways in which these different 'building blocks' can be overlayed and combined.

Chapter 3: The Building Blocks of Reform

This chapter summarises the range of different possible funding models for long-term care in the UK, listing the 'pros' and 'cons' of each. The models outlined here are presented in isolation in their most simplified form as potential 'building blocks'. Each model varies by the *level of compulsion*, *funding source*, the *point and scope of risk-pooling* (pre-care, point-of-need) and whether the model is principally directed at the *accumulation phase or decumulation phase*. The primary sources of *new* wealth that each model would direct into the long-term care funding system are highlighted.

It is assumed throughout that nursing care paid for by the state will continue to be a universal entitlement. As described in the previous chapter, there will always be individuals without any resources who require care, so all of the models here assume that the state will continue to pay for the care of the poorest households, with the necessary application of means-testing. This also implies that the scope for 'deliberate deprivation' of assets – the 'gaming' of means-tests to avoid payment – will also likely be a feature of many models presented here, although to varying degrees.

Current system

Summary:

All individuals over-65 entitled to Attendance Allowance, a tax-free benefit for people who need help with personal care because they are physically or mentally disabled; currently £67.00 (higher rate) or £44.85 (lower rate) per week. However, beyond these benefits, entitlement to state funding of long-term care is limited to individuals with total assets below £22,250. Local authorities are responsible for allocating and rationing this funding. Individuals who are council funded in care homes must normally contribute all their income less £21.15 per week retained for personal expenses. People receiving state-funded care in their own homes must contribute from their income after retaining the equivalent of Pension Credit plus a 25% buffer.

Pros:

+ The limited public money that is spent on long-term care is targeted at the poorest households.

Cons:

- Minimal risk-sharing; households with wealth above low threshold are forced to pay for care out-of-pocket.
- Limited state-funding of care, and the limited private resources of individuals results in insufficient formal care provision, and an excessive reliance on unpaid care provision in the system.
- Penalises individuals who have saved for retirement but who have misfortune of requiring care, and lack an accessible opportunity to insure themselves against the risk of requiring care.

Universal state-funded free care

General taxation

Summary:

State funds benchmark level of care or cash equivalent to at least minimum socially-acceptable level of care, free for all regardless of wealth and risk-profile. Extra public

spending required would be funded by increases in taxation or cuts in other forms of public spending.

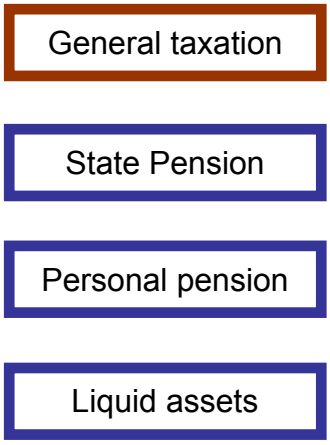
Pros:

+ Maximises size of possible risk-pool in relation to long-term care, i.e. across whole population.
+ Reliance on existing tax and benefit system means minimal new administration costs, nor transition costs to new system.
+ Coherent with public perceptions of health and social care system.

Cons:

- Fiscal sustainability; would require significant increase in rate of general taxation or substantial reallocation of public spending away from other areas, such as the NHS. This unsustainability would be exacerbated in coming decades by demographic change and the declining 'elderly support ratio'.
- Pernicious redistribution; income-based taxes falling on those of working-age form the bulk of revenue for general taxation. Imposition of universal free care would therefore create two 'transition cohorts' associated with first (retired) cohort to become entitled to universal free care and first (working-age) cohort that would have to shoulder extra fiscal burden. However, this would create significant scope for pernicious redistribution, for example, poor low-income young households would begin having to pay for care of wealthier older households who have sufficient funds to insure themselves, and who were not themselves required to shoulder equivalent burden for preceding cohort when they were of working-age.
- Ties long-term care directly to public spending so that funding streams would be under continual pressure from competing policy objectives (e.g. healthcare, education) and subject to cuts or rationing during periods of intense fiscal strain, e.g. during economic recession.

Co-payment (care funding)



Summary:

A variant of universal free care in which the state funds a universal capped standard proportion or fixed cash amount toward care costs, requiring individuals to make a co-payment 'out-of-pocket' or through payments from an insurance scheme. The level of co-payment required from individuals can be fixed at a low level (e.g. 10%), which at least ensures that individuals ration their demand for care because they attach financial value to it. Alternatively, co-payments required from individuals can be fixed at a high level (e.g. 90%), so that the state makes only a token contribution. The current universal benefit, Attendance Allowance, is effectively an example of co-payment. Finally, co-payments could be proportional to individual means, although such a benefit would impose prohibitive administrative costs and heavily incentivise deliberate deprivation.

Pros:

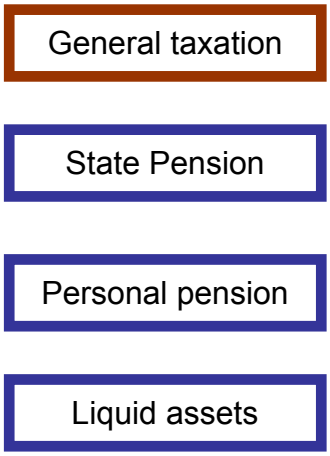
+ A higher universal contribution to the costs of care is likely to be politically popular, and potentially a useful political 'sweetener' in any reform of long-term care system which didn't feature universal free care, i.e. co-payment means that 'everyone gets something'.

Cons:

- Assuming low co-payments from individuals are required, fiscal unsustainability and pernicious redistribution akin to that associated with the imposition of universal free care. -

- Assuming high co-payments, limited risk-pooling; depending on what level of co-payment is required, individuals are still forced to pay for majority of care costs out-of-pocket.
- Does not provide mechanism for significant increase in proportion of national wealth spent on care provision, besides increasing pressure on taxation and public finances.

'Partnership model'



Summary:

A variant of universal co-payments; everyone requiring care is entitled to a basic level of free care or cash paid for by the state. Above this low benchmark, the state would make matching proportional contributions to the amounts spent by individuals on care using out-of-pocket payments or insurance. However, there would be a second higher benchmark level of care beyond which matching contributions by the state would stop or be phased out.

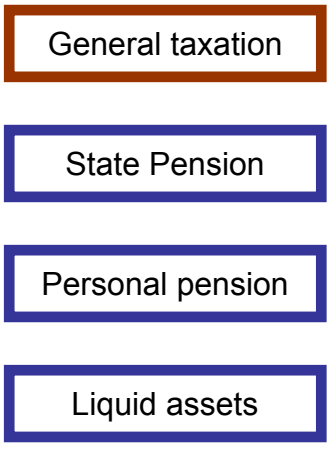
Pros:

+ Pools the risk of long-term care to the extent that all individuals receive something.
+ Rewards those who have saved for retirement by potentially enabling them to access higher level of care than those who did not, i.e. reduces the disincentive effect of means-testing.

Cons:

- Limited risk-pooling; as with co-payments, individuals may be required to pay for majority of care costs out-of-pocket, depending on how benchmarks are set.
- Does not provide mechanism for substantial increase in proportion of national wealth spent on care provision.
- Scope for pernicious redistribution as individuals able to insure themselves for care become entitled to a (low) level of state-funded free care.
- Effectively incorporates inequality in provision into the heart of the system as individuals with more wealth to spend on care provision are rewarded with extra support from the state.
- Variations in retirement income and wealth are not just due to saving, but to the incidence of adversity such as longstanding ill-health or caring responsibilities. As such, some individuals who were unable to save significantly for retirement and therefore to purchase care out-of-pocket would be excluded from higher levels of state support, effectively penalising individuals for experiencing adversity.
- Fiscal unsustainability with significant universal entitlement to state funding of care.

Limited liability model



Summary:

A variant of universal state funded free care in which the state shoulders the 'longevity risk' of all requiring care by undertaking to pay for care beyond a fixed benchmark, measured in total accumulated duration of care needs, or total private expenditure on care. Effectively 'caps' the liability that individuals confront in paying for care costs, whether individuals are paying 'out-of-pocket' or have participated in an insurance scheme. A period of two or three years is commonly proposed as the period for which individuals would have to pay for care themselves before state support begins.

Pros:

+ Protects all individuals from risk of 'catastrophic' care costs.

Cons:

- Limited risk-pooling; most individuals and families would continue to have to pay for care out-of-pocket until reaching the threshold of state support.
- Significant administrative difficulties associated with measuring when care needs and care provision begins, particularly given individuals may experience successive but distinct periods of care need, characterised by different levels of care need. The model requires measurement of care-needs (duration and level of care-need) or care-expenditure (accumulated receipts for expenditure on care services, cross-checked to avoid wasteful expenditure against record of care-needs and type of services purchased). These tasks are made particularly difficult given the prevalence of unpaid care provision and the fact that many individuals need and receive care without any contact with the formal care system.
- If individuals have to be in receipt of formal care for a fixed period before becoming entitled to state-funded free care, this may incentivise the withdrawal of unpaid care provision by families.
- Does not provide mechanism for significant increase in proportion of national wealth spent on care provision.

Private sector insurance: pre-funded

Liquid assets

Personal pension

Summary:

Some private sector insurance companies offer 'pre-funded' insurance for long-term care, i.e. an insurance policy purchased prior to incidence of care that will pay-out if and when care is required, proportional to care needs.

Pros:

+ Pre-funded insurance pools both the risk of needing long-term care and the associated longevity-risk.
+ As a purely private transaction, no new costs for the state involved.
+ Competitive market in pre-funded long-term care insurance products may result in innovation and cost-effective products.

Cons:

- Cost; pre-funded long-term care insurance is too expensive for some individuals given limited income and liquid wealth.
- Supply-side barriers exist for providers of pre-funded LTC insurance products. However, these are generally regarded as surpassable.
- Significant demand-side barriers exist to development of market, including: declining 'financial capability' of target market; low knowledge of risk of care; pyschological barriers to considering end-of-life issues; competing financial priorities in retirement such as immediate consumption and 'bequest motive'; requirement to visit a financial adviser. Demand and supply-side barriers have seen the number of pre-funded long-term care insurance policies sold remain around 40,000 despite potential market of several million people among retired population, raising questions about whether such products alone could achieve the volume and scope of risk-pooling required for a politically sustainable long-term care funding system.
- Problem of low take-up means limited scope for significant increase in proportion of national wealth spent on care provision.

Private sector insurance: immediate needs annuities

Liquid assets

Personal pension

Summary:

Some private sector insurance companies offer annuities for purchase by individuals (or their families) requiring care, i.e. at the 'point-of-need', that provide an income until death whenever it occurs. Such products pool the 'longevity risk' of care costs among those individuals requiring care, i.e. that care will be required for an extended period resulting in 'catastrophic' care costs. Requires risk-assessment of person requiring care.

Pros:

+ Purely private market transaction that does not require state involvement.
+ Enables individuals requiring care to pool their longevity risk and protect themselves from the risk that their care provision will use up all their capital; a segment of their capital is protected.

Cons:

- Low-level of risk-pooling, i.e. only among those individuals requiring care, effectively compounding the misfortune of requiring care.
- Cost; since individuals are already in receipt of care, the cost of immediate needs annuities can be prohibitively expensive for many. In particular, the more impaired the life the lower the cost of the product, meaning that such products can be prohibitively expensive for those with just low or moderate care needs.
- Does not provide mechanism for significant increase in proportion of national wealth spent on care provision.

Private sector insurance: deferred needs annuities

Liquid assets

Personal pension

Summary:

Effectively a private sector insurance version of the limited liability model. Individuals purchase an annuity which only begins to pay for care after a fixed volume of care needs, e.g. two years, and subsequently pays an income until death. Like immediate needs annuities, individuals pool the 'longevity-risk' associated with long-term care, but are choosing to pay for first period of care out-of-pocket. Products can be purchased prior to incidence of care-need or at point-of-need.

Pros:

+ Pools longevity-risk among all individuals that purchase product, protecting them from risk of 'catastrophic' care costs.

Cons:

- Limited risk-pooling; only pools part of longevity risk, i.e. for risk of needing care beyond a fixed benchmark of care, e.g. two years.
- Cost; deferred needs annuities are typically unaffordable for many households.
- Does not provide mechanism for significant increase in proportion of national wealth spent on care provision.

Co-payment (insurance premium)

General taxation

Summary:

The state funds a fixed co-payment toward the cost of pre-funded long-term care insurance, regardless of wealth profile. Equivalent to a 'voucher' that individuals could use to 'top up' their contribution to insurance scheme as part of either private sector insurance, or potentially, a state-organised insurance scheme.

Pros:

+ A universal contribution to the costs of insurance may incentivise individuals to insure themselves and soften the 'shock' that many individuals experience when considering the cost of insuring themselves.
+ If vouchers for long-term care were universally distributed, this may kick-start the market in long-term care insurance.

Cons:

- A co-payment towards the cost of a pre-funded insurance premium may be insuffcient to significantly enlarge the market for such products, resulting in limited risk-pooling.
- Pernicious redistribution; state-funded co-payments for premiums would be made available to some who are able to independently afford the cost of pre-funded insurance.
- Although clearly incentivising individuals to insure themselves, does not on its own provide mechanism for significant increase in national wealth spent on care provision, but rather, acts as incentive for households to deploy private wealth in this way.

Disability-linked annuities

Personal pension

Summary:

Annuities are retirement income products that individuals purchase with their pension saving, and which pay out a guaranteed income until a person's death, whenever that occurs. Some insurance companies offer 'disability-linked annuities', which pay a higher level of income when the purchaser experiences care needs; the income paid out by the annuity varies according to the care needs of the purchaser. However, to fund this higher income when care needs arise, the immediate pre-care income is lower than that of an equivalent non-disability linked annuity.

Pros:

+ Potentially brings new money into long-term care system, in that by deferring part of their income, individuals requiring care will have a higher income than would otherwise have been the case, which can be used to pay for costs of long-term care.
+ Pools risk among all individuals purchasing such an annuity, i.e. those requiring care and those not.

Cons:

- Shortfalls in individual pension saving and entitlements are widespread meaning that such products are far from a universal solution and for many individuals, may yield income insufficient to pay for basic level of care. Importantly, there is generally a negative correlation between accumulated pension saving and risk of requiring long-term care.
- Although effectively a form of cohort-insurance, i.e. limited to individuals above the average age of purchasing annuities (typically 65), the risk is pooled only among those able to purchase annuities.
- Demand-side barriers exist because disability-linked annuities provide a lower immediate (pre-disability) income than other types of annuity. Most individuals choosing an annuity seek

to maximise immediate income, demonstrated by relatively small number of 'earnings-linked' and 'dual-life' annuities, suggesting limited take-up and market for disability-linked annuities.
- Given limited income of retired cohorts, policymakers actually have an interest in maximising the immediate income/consumption of individuals, effectively as a form of prevention, i.e. higher income enables better nutrition, mobility, leisure, etc., all of which reduce risk of requiring long-term care.

State-pension deferral

State Pension

Summary:

Individuals retiring with sufficient National Insurance contributions entitled to the State Pension are given the choice to defer receipt, or reduce immediate income, in order to be entitled to a higher State Pension income if and when they require long-term care. In effect, individuals are enabled to treat the State Pension as a disability-linked annuity.

Pros:

+ Brings new money into the long-term care funding system through the transfer of future State Pension liabilities to the long-term care system.

Cons:

- Limited number of individuals have sufficient personal pension income and other assets so as to be able to forgo all or part of their State Pension income.
- As with disability-linked annuities for personal pension savings, individuals are likely to prioritise short-term immediate income above insuring against cost of long-term care, i.e. demand-side barriers exist.
- Potential administrative and other difficulities if individuals choose to defer their State Pension, but subsequently find that their income drops to the level of the Minimum Income Guarantee, resulting in entitlement to Pension Credit.

Equity release

Property wealth

Summary:

Both the private sector and the state (via local authorities) are providers of equity release products, which see retired homeowners in the decumulation phase realising part of the value of their home as an income, cash lump-sum, or both. 'Home-revision schemes' and 'life-time mortgages' are the two principal products. Equity release products can be used to fund care costs, effectively as an out-of-pocket payment that draws on housing equity rather than income or savings.

Pros:

+ By enabling individuals and their families to more easily access housing wealth, i.e. making it more 'liquid', equity release products may bring new wealth into long-term care funding system that would otherwise have been unavailable.

Cons:

- Currently, equity release can only be used to fund home care as such plans automatically require repayment on admission to a care home. However, this could be potentially revised through regulatory changes.
- Absence of risk pooling; individuals requiring care are effectively paying out-of-pocket for care, except using non-traditional source of income, i.e. the equity in their property. The misfortune of requiring care is still compounded by the need for individuals to pay for care.

- Underscoring the absence of risk-pooling, and given care costs can be 'catastrophic', individuals may run out of equity in their home to pay for care, possibly resulting in individuals having to reduce the package of care they receive.
- Existing equity release products are unpopular suggesting significant demand-side barriers.
- Administration costs of products may make it uneconomic for use in releasing small amounts of equity/income; however, with improved regulation/design, these difficulties could be overcome.

Long-term care savings accounts

Specific contribution

Summary:

Individuals save into specific savings accounts allocated to future long-term care costs. Saving could be incentivised through tax-relief. Principally suited to working-age individuals in the accumulation phase, although retired individuals could also save in this way. Adopting model of 'Personal Accounts' from pensions policy, employees could be auto-enrolled into savings account to overcome behaviourial barriers.

Pros:

+ Contribution toward long-term care costs are spread across working-life thereby making contributions easier to afford.
+ Provides mechanisms (increase in savings rate) for bringing new wealth into long-term care funding system.

Cons:

- Chronic pension undersaving already exists for an event that most individuals can confidently expect: retirement. As a result, interest in saving for long-term care specifically is likely to be even lower, particularly given the probability of requiring long-term care is lower than the probability of needing an income in retirement.
- Unsuited to those who may struggle to save through adversity, for example, ill-health or caring responsibilities.
- Absence of risk-pooling; this could be overcome if individuals subsequently use accumulated savings to purchase disability linked annuity, pre-funded long-term care insurance or immediate needs annuity. However, many individuals may struggle to save sufficient amounts to meet average cost of care or care insurance product, on top of undertaking adequate retirement saving.
- Does not provide effective solution for today's older cohort.

Social insurance fund (no generational transfer)

Specific contribution

Summary:

In the 'accumulation phase', i.e. pre-retirement, individuals make earmarked contributions to a social insurance fund in relation to long-term care. Contributions tied to employment and taken directly from pay-cheque. Contributions could be compulsory to achieve maximimum participation, voluntary, or apply a form of soft-compulsion, e.g. 'auto-enrolment'. Entitlement to benchmark level of care/funding paid for by the social insurance fund be could be regardless of total contribution, dependent on reaching a certain threshold of contributions, or deferred until certain age, e.g. State Pension age. However, entitlement would not be extended to those in decumulation phase (retirees), i.e. there would be no upwards generational transfer. Contributions can be variable and progressive. Individuals with few years of working-life remaining could be invited to make cash lump-sum top-up payments.

Pros:

+ Risk of long-term care is pooled among all individuals of working-age cohort, albeit not with retired cohort.
+ Lack of upwards generational transfer would mean that required contributions from working-age individuals could be relatively cheaper.
+ By spreading contributions across the entire accumulation phase, individuals are able to make the small incremental contributions that are more affordable in terms of household budget across the life course than any other funding model.
+ Low administration costs associated with collecting contributions through employers.
+ Brings new wealth into future long-term care funding system when individuals who have built up entitlements ultimately claim on insurance fund.
+ If contributions are proportional to income, contributions can be progressive and redistributive.
+ After several decades, the long-term funding system would have become completely fully-funded and sustainable, in that every cohort in retirement will have accumulated several decades of contributions, sufficient to fund an acceptable long-term care funding system, allowing for the phasing out of funding models directed at individuals currently in the decumulation phase.

Cons:

- As a form of 'cohort insurance' for working-age individuals, does not address problem of how to fund long-term care for current older generation.
- Current National Insurance contributions are effectively a 'branded' segment of income tax and fund current public spending, rather than a delineated insurance fund. As a result, a similar 'pay-roll contribution' may be widely regarded as equivalent to a tax, even if contributions were in fact allocated to a statutorily independent insurance fund at arms-length from Government.
- Would require difficult political choices regarding those who make limited contributions, e.g. as a result of ill-health, unemployment and caring responsibilities.

Social insurance fund (with generational transfer)

Specific contribution

Summary:

As above, individuals in the accumulation phase make earmarked contributions to a social insurance fund in relation to long-term care. However, contributions are used to fund universal free care for today's older cohort, i.e. entitlement is universal.

Pros:

+ As above, a social insurance fund built around payroll contributions could have relatively low administration costs, and would create a large risk-pool for long-term care among those who do and do not require care.
+ Would bring substantial volume of new wealth into long-term care funding system.

Cons:

- As with universal free care, a pernicious redistribution would occur from poor, low-income working-age households to wealthier older households with sufficient wealth to insure themselves in relation to long-term care.
- In the context of a declining elderly support ratio, contributions would have to be relatively high and increase over time, in order for the proportionally declining working-age population to fund care for an increasing number of individuals at the peak age for requiring long-term care. In effect, the problems of fiscal sustainability and the declining elderly support affecting the model of universal state-funded free care apply equally to a social insurance fund with a universal entitlement.

National Care Fund

Property wealth

Liquid assets

Personal pension

Summary:

A social insurance fund for the 'decumulation phase', i.e. post-retirement. Individuals with income and wealth above certain threshold, e.g. property owners with income above Pension Credit income threshold, are given option to pay a premium to insure themselves for a benchmark level of care or cash. Premiums can be fixed at a single level, or made progressive, through deployment of additional means-testing. Premium can be paid as lump-sum, regular instalments, or after death through the use of tied, highly-regulated equity release product. Although premiums could be compulsory, the state would be able to apply a variety of semi-voluntary enrolment mechanisms unavailable to private sector to ensure high rates of participation and overcome behavioural barriers, such as soft-compulsion/'auto-enrolment' with individuals retaining the right to withdraw for limited period. Delivery model could be entirely public, or in fact rely on private sector insurance companies to operate core functions under *National Care Fund* brand.

Pros:

+ Provides mechasism for major transfer of new capital into long-term care funding system, in particular, property wealth of older cohort.
+ Maximises scope for pre-funded risk-pooling in relation to long-term care among older-cohort.
+ Makes insuring against risk of long-term care as easy as possible for older individuals, for example, removing the need to visit a financial adviser. Individuals have maximum flexibility in when and how to pay including the option to prioritise immediate consumption by deferring charge for premium until after death.

Cons:

- Uncertainty over participation rates.
- As a form of 'cohort insurance' for older cohort, does not address LTC costs of working-age individuals.
- Some aspects of model, such as 'auto-enrolment', may be difficult for many individuals to understand and difficult to administer.
- Despite flexibility in options for when and how to pay, including after death, individuals may react badly to value of premium required in retirement, i.e. 65. Enabling early 'pre-payment' may be required.
- As a pure decumulation phase model, on its own it could have a disincentive effect on retirement saving. However, the incorporation of property wealth in the associated means-test would be likely to negate this disincentive effect given widespread preferences for property ownership.

Hypothecated inheritance tax/'Care Duty' + family wealth transfer tax

Property wealth

Liquid assets

Summary:

A flat-rate or progressive compulsory universal tax imposed on all estates, branded as a 'CareDuty', i.e. an hypothecated inheritance tax to fund long-term care. In addition, a corresponding 'Care Duty' is imposed on all family wealth transfers/gifts among family members who are still alive ('inter-vivo' transfers). The revenue stream is used to fund universal state-funded free care, or near equivalent, such as generous universal co-payment.

Pros:

+ Creates universal risk-pool for long-term care across entire population.
+ Brings significant volume of new wealth into long-term care funding system.
+ Incidence of tax will principally fall on estates of current older cohorts, reducing burden on today's younger cohorts and preventing the need for pernicious redistribution in the implementation of universal state-funded free care.
+ The rate of 'Care Duty' would not need to be significant and can be varied on demand.
+ Mechanisms already exist for its collection.
+ Putting a charge on lifetime transfers of property potentially curtails the serious problem of deliberate deprivation of assets to avoid care charges.

Cons:

- Inheritance tax remains extremely unpopular, and a compulsory hypothecated inheritance tax branded as a 'Care Duty' may nevertheless create widespread opposition.
- Families whose relative did not require care (around ¾ of estates) may question why their estates should be subject to a compulsory 'Care Duty', and in fact, seek to resist payment of duty. In particular, those families that provided unpaid care to a relative (effectively internalising the cost of care) may object in very strong terms to the requirement of paying a Care Duty.
- A universal hypothecated inheritance tax incentivises family wealth transfers pre-death; however, 'inter-vivo' transfers are extremely difficult adminstratively to tax compared to simple estate charges/inheritance tax.
- Hypothecated taxes are inconsistent with the prerogative of democratically-elected governments to decide how tax revenues are spent, and as such, are typically resisted by policymakers.
- A hypothecated inheritance tax for long-term care may be opposed by campaigners in other sectors who have called for a hypothecated inheritance tax to address other issues, notably child poverty and the environment.

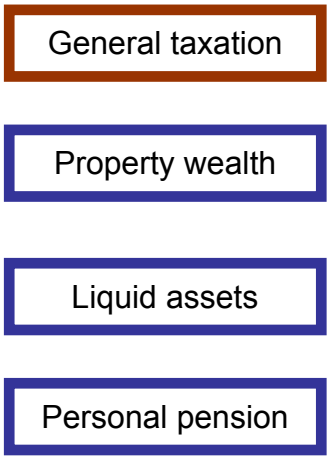
Next Steps

This chapter has set out the 'building blocks' of long-term care funding reform. However, as has been described above, these different funding models are not mutually exclusive nor incoherent. For example, reform of the long-term care funding system might seek to combine a standardised benchmark entitlement funded by a social insurance fund with widely available complementary pre-funded insurance products that allow individuals to increase their insurance up to a higher level of provision. Indeed, different models can be combined in multiple ways, and in fact, can be applied to different sections of the population. The final chapter therefore looks at some of the most interesting models that emerge when these different building blocks are integrated.

Chapter 4: The Hybrid Options

The previous chapter set out the basic 'building-blocks' of different long-term care funding models, which can be combined and integrated in many ways. This chapter summarises and evaluates several 'hybrid' models that are particularly noteworthy.

Co-payment (premiums) + *National Care Fund*



Summary:

The state offers co-payments/vouchers to all individuals in retirement for the cost of insuring against risk of long-term care through a *National Care Fund*.

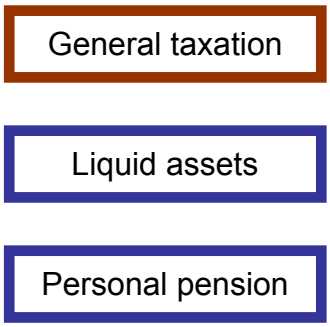
Pros:

+ Prospect of a co-payment/voucher toward cost of insurance may provide extra incentive for individuals to participate in *National Care Fund* and reduce shock associated with responsibility for meeting cost of premium.

Cons:

- Pernicious redistribution; state-funded co-payments for premiums would be made available to some who are able to independently afford the cost of *National Care Fund* premium.

Private sector insurance: pre-funded + limited liability model



Summary:

Individuals purchase private-sector pre-funded long-term care insurance which will fund care for a certain duration or total-cost, eg. two years. Beyond this benchmark, the state funds care directly regardless of individual means.

Pros:

+ By shouldering the population's 'longevity-risk' for long-term care, the state reduces the burden of longevity risk for private sector pre-funded insurance products, which would be able to charge lower premiums to consumers, potentially increasing the size of the market.

Cons:

- As with the limited liability model, there may be administrative difficulties associated with defining when care-needs begin, etc.
- Demand-side barriers to the purchase of long-term care insurance may remain, despite lower cost.

Equity release + private sector insurance: pre-funded

Property wealth

Summary:

Individuals in the decumulation phase purchase an equity release product 'back-to-back' with pre-funded long-term care insurance. For example, a home reversion scheme under which individuals are insured for the risk of long-term care in exchange for signing over part-ownership of property to private provider.

Pros:

+ Pools both the risk of needing care and associated longevity-risk.
+ Potentially drives an increase in the extent of risk-pooling using private sector insurance by enabling individuals to draw on their property wealth to fund their membership of a risk-pool for long-term care.
+ Provides mechanism for bringing new wealth into long-term care funding system, i.e. older people's property wealth.

Cons:

- Combination of two unpopular financial products likely to result in low voluntary take-up.

Equity release + private sector insurance: immediate needs

Property wealth

Personal pension

Liquid assets

Summary:

Individuals already requiring care purchase an equity release product 'back-to-back' to with an immediate needs annuity. By transferring part of the value of their home to a provider, individuals effectively protect the remaining value.

Pros:

+ Protects individuals requiring care against care costs being 'catastrophic', i.e. longevity risk.

Cons:

- Risk-pooling limited to those in need of care, compounding the misfortune of requiring care.
- Immediate needs annuities are based on risk-assessment and can be expensive, thereby limiting suitability for such a product to those with significant property wealth.

Private sector insurance + 'Partnership model'

Liquid assets

Personal pension

Summary:

An 'insurance escalator' approach - the state makes available a universal co-payment/voucher toward the cost of a pre-funded private sector long-term care insurance. In addition to this universal fixed co-payment toward cost of premiums, the state also funds further matching proportional contributions toward premiums up to a second benchmark level. In effect, the more that individuals contribute to insuring themselves for long-term care, the more the state contributes to this insurance. If directed at individuals in retirement, and assuming the existence of means-tested state-funded care, the reward for individuals saving for retirement and insuring themselves reduces the disincentive effect on retirement saving implied by the existence of means-testing.

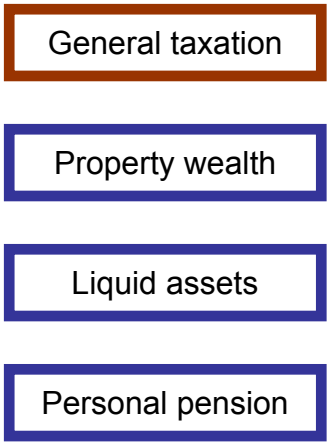
Pros:

+ Universal and matching co-payments toward insurance premiums may make market in long-term care insurance products more feasible.
+ Rewards those who have saved for retirement.

Cons:

- Pernicious redistribution associated with state co-payments directed at individuals who otherwise have sufficient funds to insure themselves outright. In addition, inequality is also implicit in system as individuals who have more money are given extra public contributions toward insurance enabling them to ultimately spend more on care than poorer households.
- Significant demand side barriers to purchase of private sector long-term care insurance would remain.

National Care Fund **+ co-payment (care funding)**



Summary:

The state funds a universal fixed proportion or cash contribution toward care costs of retired individuals who have chosen to insure themselve through a *National Care Fund*, and are therefore entitled to have the bulk of their care costs paid by the *Fund*. Although likely to be controversial, the co-payments toward care funding could be restricted to those who insured themselves in this way to provide an extra incentive to participate.

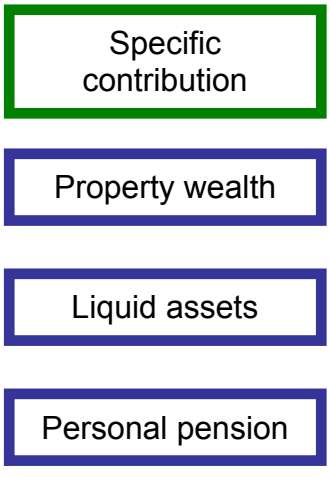
Pros:

+ If the politically feasible level for premiums that could be charged by a *National Care Fund* are insufficient to fund full cost of basic level of care, e.g. sufficient only to fund 50% of basic care costs, a state-funded co-payment toward care costs, e.g. of 10%, would reduce the disincentive effect on participation in the *National Care Fund* arising from the funding shortfall.

Cons:

- Some pernicious redistribution as the state makes payments to those who have sufficient wealth to insure against entire cost of care.

Social insurance fund (no generational transfer) + *National Care Fund*



Summary:

Working-age (accumulation phase) individuals pay into a social insurance fund for long-term care, progressively building up an entitlement to insurance against costs of long-term care. Contributions could be voluntary, compulsory or subject to auto-enrolment. Individuals in or near retirement are given opportunity to buy their way in to the fund via mechanisms provided by *National Care Fund*, i.e. for a fixed premium that can be paid as a lump-sum, through monthly instalments or deferred until after death. Combines a 'permanent model' and a 'bridging model', in that over the

course of several decades, all individuals in retirement would have made a full contribution to the social insurance fund during working-life.

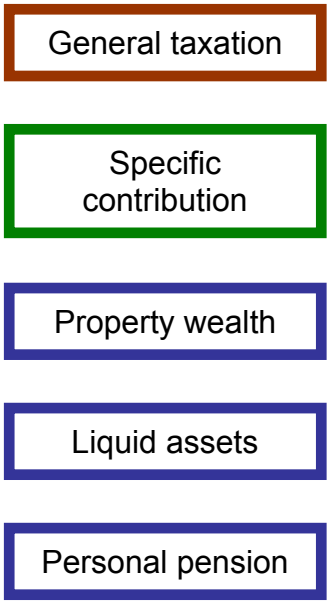
Pros:

+ Maximises scope of risk-pooling.
+ Addresses long-term care risk of both working age and retired cohort, but without pernicious redistribution.
+ Provides mechanisms for significant transfer of wealth into long-term care system.
+ Older cohorts may be more accepting of need to make significant contribution to insure themselves against risk of long-term care if younger cohorts were explicitly having to do the same, i.e. an expectation to rely on younger cohorts would in this scenario visibly represent 'free-riding'. Indeed, the common assumption among older cohorts that long-term care funding is the responsibility of the state would be challenged by the fact that younger cohorts were being required to make new and extra provision into a clearly delineated insurance fund.

Cons:

- Significant political challenge associated with making contributions acceptable to both retired and working-age cohorts.

Social insurance fund (no generational transfer) + *National Care Fund* + co-payment (premium) + co-payment (care funding) + limited liability model + private sector insurance: pre-funded



Summary:

As above, working age individuals pay a (compulsory) regular contribution into a social insurance fund for long-term care. Individuals in or near retirement are given a 'voucher' to insure themselves for long-term care, with the opportunity to buy their way in to the social insurance fund via the payment options of the *National Care Fund* model. In addition, state makes a flat-rate universal contribution, e.g. 10%, toward care costs of all those requiring care. Furthermore, the state undertakes to fund all care costs for retirees beyond a certain benchmark of care measured in total duration or expenditure on care, thereby transferring longevity risk of current retirees to state, reducing significantly the premiums required from retirees, and increasing the acceptability of such premiums. The private sector offers complementary pre-funded insurance products to the social insurance fund, so that individuals who wish to insure themselves up to a higher level of provision are able to so.

Pros:

+ Maximises scope of risk-pooling.
+ Addresses long-term care risk of both working age and retired cohort, but without pernicious redistribution.
+ Provides mechanisms for significant transfer of wealth into long-term care system.
+ Increases incentives to insure against risk of long-term care among older cohorts through co-payment toward insurance premiums.
+ Co-payments toward care funding ensure that all receive something.
+ Retired individuals are both incentivised to insure themselves by offer of co-payment premium, and more likely to accept need to pay for cost of insurance when confronted with working-age individuals being visibly forced to make new and specific provision.

+ By limiting the liability of a *National Care Fund* for the 'longevity risk' of today's older cohort the premiums for a *National Care Fund* could be made more affordable for retirees.

Cons:

- Significant political challenge associated with making contributions acceptable to both retired and working-age cohorts, despite incentive device of co-payment toward premiums for retirees.

Final remarks

This chapter has shown how different models of long-term care funding can be combined and integrated. Each model implies a different level of compulsion for individuals, a different level of risk-pooling (pre-funded through to no risk-pooling), action by individuals pre or post-retirement, and directs different sources of new wealth into the long-term care system from general taxation through to personal pension income.

Various other 'hybrid' approaches can be conceived. Indeed, as identified in Chapter 2, different models of long-term care funding may be apropriate for different income and age-groups, particularly during an extended transition to a new sustainable system.

Reform of the UK long-term care funding system is needed and will become politically unavoidable as the UK population continues to age. Whatever consensus emerges, the building blocks identified in this paper are likely to form the heart of this reform.

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