A *National Care Fund* for Long-Term Care

By James Lloyd

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About this Report

This report is a discussion paper. It seeks to provide fresh insight and analysis into the issue of the future funding of long-term care for older people. It is designed to provoke discussion, with the ultimate aim of contributing to the improvement and development of related public policy.

This report has also been published in short-form as a policy brief, which is available to download from the website of the ILC-UK: www.ilcuk.org.uk

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Preface

Tuesday February 26th 2013

Dear Mr Smith,

I am writing to inform you that having reached the age of 65, you have been enrolled into the National Care Fund, which will pay for the cost of standard-class care for you, if you are assessed as requiring long-term care at a later stage in your life.

The fee you have been assessed to pay for joining the National Care Fund is £9500. This fee does not have to be paid now. You can pay the fee at any time and in several different ways. If you prefer, you can do nothing and the fee will simply be charged as a levy on your estate after your death. It will however be necessary to charge a basic rate of interest on this fee, until it has been received by the National Care Fund.

Enrolment into the National Care Fund is not compulsory. If you wish, you can withdraw at any time during the next 12 months by filling in a form available from your GP surgery, Post Office or local council. If you do withdraw, you will not have to pay the joining fee of £9500. However, by withdrawing from the National Care Fund, you will then be liable for the full cost of any long-term care you need in future years, which for many people can amount to tens or even hundreds of thousands of pounds.

The National Care Fund will pay for a standard-class package of care, which comprises a basic level of care appropriate to your needs, and adjustable to your living situation and preferences. It is important that you understand what is included in this standard-class package of care. Further details are contained in the enclosed leaflet. Alternatively, for more information about the National Care Fund, what types of care it will pay for, and the different ways you can pay your joining fee, you can call the Freephone number: 0800 1234 5678.

You may wish to make provision for higher levels of care, on top of the standard-class package of care paid for by the National Care Fund. You can do this by purchasing one of the many long-term care insurance products available from approved insurance companies. To learn more about these, you can talk to an adviser from the National Financial Advice Service, an independent financial adviser, or visit the website of the National Care Fund: www.ncf.org.uk

Yours sincerely,

T. Daniels
Northwest Enrolment Manager
National Care Fund

Executive Summary

- **The future funding of long-term care for older people is a major challenge for public policy given demographic change, increasing longevity and the need to spend more on care to raise quality.**
- **Proposals for state-funded universal free care, including a possible co-payment element, have become increasingly problematic in light of the unprecedented transfers of wealth from younger to older cohorts that have occurred during a period of extended above-average inflation in property prices.**
- **A social insurance fund to pay for long-term care for older people – a *National Care Fund* – could be limited to those aged around 65 and over.**
- **Enrolment would involve a one-off contribution fee at a level determined by an assessment of means, resulting in entitlement to a standard package of care paid for by the Fund.**
- **Older people would be given maximum flexibility in when and how they paid their contribution, including the option to defer payment until after death in the form of a charge levied on their estate.**
- **'Auto-enrolment' – automatic enrolment with the retained right to withdraw – could be applied to ensure high levels of participation by older cohorts.**
- **The poorest older individuals would have their contributions to a *National Care Fund* paid for by the state. An upper-cap would ensure the wealthiest older households did not have to make excessive contributions.**
- **A fully-fledged market in complementary private sector long-term care insurance products would ensure that all are able to insure themselves up to a level they deem appropriate.**
- **A *National Care Fund* retains the best aspects of state-funded universal free care – universal entitlement and social minimums of provision – without imposing a new fiscal burden on younger cohorts.**
- **A *National Care Fund* enables older people to use their property wealth – without having to move house – to insure themselves for the risk of long-term care and applies the principle of social insurance to facilitate the necessary redistribution to those less well-off.**
- **Asking older people to fund their own long-term care insurance is not 'cold-hearted' or against the spirit of intergenerational solidarity. In fact, set against the fiscal pressures imposed by demographic change, it represents a concerted effort to preserve the intergenerational contract.**

The Challenge

The demand for long-term care will increase substantially in coming decades as a result of demographic change and rising life expectancy. This increased demand will impose a significant economic burden on society, on top of the widely recognised need for society to spend more on long-term care to raise quality.

Despite the risk of long-term care being both universal and 'catastrophic', UK citizens are largely uninsured against it. This contrasts sharply with the range of trivial and non-trivial risks, such as ill-health and mobile phone theft, which individuals are insured against through complex, overlapping and interacting private sector and state provision.

The private-sector market for long-term care insurance remains minimal because of a range of demand-side and supply-side limiting factors. The role of the state in insuring citizens against the risk of long-term care is also limited, despite variations in the use of means-testing in Scotland compared to the rest of the UK.

Debate on this topic has usually focused on some form of universal free care for older people that would be funded by the state from general taxation, with a possible 'co-payment' element. This sort of model is usually seen as the fairest solution to the challenge of funding long-term care for older people.

State-funded services are paid for by taxpayers. The bulk of general taxation is derived from the working-age population through employment-based taxes, such as income tax. Universal free care would therefore represent a new kind of transfer from younger cohorts to older cohorts. This transfer can be seen as an extension of similar transfers, such as the state pension and the NHS, which are the embodiment of the 'intergenerational contract'.

The addition of new welfare functions to the intergenerational contract would create two 'transition cohorts': the first (older) cohort to receive free care and the first (younger) cohort to pay for it.

However, trends in assets and debt have seen current older cohorts becoming the wealthiest in history, resulting from rising property wealth and reflected in increasing mortgage debt among the young who have commensurately become the most indebted cohort in modern times. This represents an unprecedented transfer of wealth from young to old that has occurred through the property market during an extended period of above-average price inflataion.

The Problem

These trends create serious problems for the equity and fairness of models of taxation-funded universal free care for older people. The implementation of this model of long-term care funding would see by far the richest cohort in history becoming the first to receive universal free care. This would be paid for, to a significant extent, by the most-indebted cohort in modern times, who had in fact already transferred much of their current and future income and wealth to these older cohorts through the property market.

Such tensions within the model of universal state-funded free care for older people provide several insights that can be used to inform a revised model. In particular, it is clear that when property wealth is taken account of, the majority of older people have sufficient wealth to insure themselves against the cost of long-term care. Funding models that enable older people to use their property wealth are superior to solutions built around retirement income or liquid assets. The pooling of the risk for long-term care through a 'cohort-specific' mechanism, rather than across the whole population, could prevent a new fiscal burden falling on younger cohorts.

It is also important to recognise that there will always be some older people with negligible means who are unable to insure themselves. Any settlement related to long-term care will therefore inevitably have a redistributive element.

A New Approach

The outline of a new model for funding long-term care for older people is therefore clear: older people able to use their property wealth to insure themselves through a cohort-specific risk-pool, with a necessary redistributive element.

A social insurance fund for long-term care would fit such parameters and could be called the *National Care Fund*. This would provide 'pre-funded' insurance for long-term care with enrolment linked to a one-off contribution, which would be proportionally determined by an overall measurement of assets and income. Entitlements would be the same for all those enrolled and fixed at a level that would, at the very least, provide the minimum level of care that society deems morally acceptable.

A critical aspect of the success of a *National Care Fund* would be high rates of participation by older people. Two basic approaches to achieving enrolment would be voluntarism and compulsory contributions. However, voluntarism would risk low-levels of enrolment due to the behavioural barriers to participation, such as psychological barriers to considering end-of-life issues. Compulsory contributions would risk being viewed as equivalent to a new kind of taxation, and could generate widespread opposition to the Fund.

A 'middle-way' is possible. The principle of 'auto-enrolment' is already at the centre of the UK Government's reform of the pension system: employees will be automatically enrolled into a personal pension scheme but will retain the right to withdraw. This principle of auto-enrolment could be applied to the creation of a *National Care Fund* and would overcome the difficulties posed by voluntary and compulsory participation.

Applying auto-enrolment to a *National Care Fund* would likely result in high rates of participation among all those above the lower age-limit because de-enrolment would require individuals to deliberately choose – and take action – to become uninsured, with the acceptance of associated risks. Individuals who did de-enrol would be subject to the current means-test on their assets for state-funded care. The Government could help to frame the choice to remain enrolled by communicating to individuals the risks and costs of being uninsured in relation to long-term care. Auto-enrolment overcomes – in one stroke – many of the barriers that inhibit the purchase of long-term care insurance products.

Individuals who choose to de-enrol from a *National Care Fund* could be allowed to re-enrol, but charged a higher joining fee. Individuals who identified themselves as uninsured by de-enroling could also be gently encouraged to re-enrol or to make alternative private sector arrangements. Those who sought to re-enrol at a much later stage, for example, when they were close to requiring expensive long-term care, could be allowed to re-enrol but for a significantly higher level of contribution, so that insurance offered by a *National Care Fund* was, in effect, an 'immediate needs annuity' rather than 'pre-funded insurance'.

Individuals already in need and receipt of care at the age threshold for a *National Care Fund* would be assessed and enrolled like all others. However, for every such individual, it is proposed the Government would contribute an extra amount to the *National Care Fund,* equivalent to the difference in cost of an 'immediate needs annuity' to fund the standard benchmark level of care for this person.

The Mechanics

The lower-age band for a *National Care Fund* could be fixed either at the State Pension Age or some lower age. A flexible lower age-limit may be the best approach. The full range of an individual's income, liquid and illiquid (property) assets would be subject to assessment. The assessment of means could take place through various mechanisms and could build on the current infrastructure for assessing older people's means, such as the Pension Service.

Individuals would be given the maximum possible choice and flexibility in how and when they paid their contribution into a *National Care Fund* including the options to pay in full on

enrolment, to pay regular instalments from pension and other income, or to defer payment until after death so that an appropriate charge is levied on their estate. The option to defer payment would encourage continued participation in a *National Care Fund* since individuals usually 'discount' future losses.

Deferring payment would require interest to be accumulated and paid but this could be at a low level, equivalent to current loans to citizens underwritten by the state, such as loans to cover student tuition fees. These interest rates are actually below long-term rates of growth in the value of assets such as property.

An average contribution fee for joining a *National Care Fund* could be around £10,000. The upper level of contribution into a *National Care Fund* would have to be set at a level, such that the insurance provided would be competitive with equivalent products that could be provided by the private sector. In fact, large swathes of the older population would be subject to the upper default contribution fee.

Contribution fees would be lower for poorer households. For individuals with less than the current means-tested capital limit of £21,500, there would be an incentive to withdraw from the *National Care Fund*. The Government could lower this limit but, preferably, could undertake to pay the contribution for joining a *National Care Fund* on behalf of the poorest older individuals. This new 'benefit' would help to normalise and universalise enrolment and, more importantly, would transfer risk from the state to the *National Care Fund*. Such a measure would also give the state scope to supplement from the taxpayer the redistribution that would take place anyway within a *National Care Fund*.

The Insurance Provided by a National Care Fund

It is proposed that nursing care for all should continue to be funded by the state. Personal care and 'hotel costs' could be funded by a *National Care Fund*, as well as 'non-essential components' of long-term care that may have important preventative benefits.

It is important that the defined benchmark package of care funded by a *National Care Fund* be neutral in relation to type and severity of condition, setting (domiciliary vs. residential) and form of funding delivery (direct payment, Individual Budgets, etc.).

A Complementary Private Market

The success of a social insurance fund for long-term care would be dependent on the existence of a fully-fledged market in complementary pre-funded long-term care insurance products. This is necessary to ensure that even wealthier older individuals are not subject to the unfairness of being forced to run-down their assets in order to pay for a level of care which they deem sufficient and acceptable; a pre-requisite for consensus and support for a *National Care Fund*.

'Pre-funded' long-term care insurance products from the private sector should be explicitly complementary and interlocking with the 'insurance' provided by a *National Care Fund*. In effect, such products should 'start' where the cover from a *National Care Fund* 'ends'.

The Government would need to work with the private sector to overcome the barriers to private sector long-term care insurance, including financial capability and the difficulties that individuals have in predicting care needs, framing what would be an acceptable level of care and predicting the cost of care.

The Government should enable the introduction of a new typology and schema of care services that is not 'producer-defined' but which is intuitive and understandable to someone who has had negligible contact with the care industry. Only when the Government, insurance industry and care sector successfully collaborate on a standardised classification and

typology of care services will the demand for long-term care insurance truly be unlocked and a fully-fledged market in long-term care insurance ensue.

Running a National Care Fund

A *National Care Fund* would require the creation of an independent regulatory authority to oversee it and ensure the fair balancing of interests and risks between individuals enrolled in the Fund, particularly in relation to individuals currently needing care and those likely to need care at a considerably later stage.

Many of the administrative functions of a *National Care Fund* could be undertaken by the private sector. In fact, it is proposed that a *National Care Fund* be split into four sub-funds which could be awarded to private sector companies to operate and manage on the basis of a competitive tender. This would reduce the scope for catastrophic error resulting from only one organisation trying to manage the Fund and enhance the ability of the companies involved to provide complementary pre-funded long-term care insurance products.

Promoting a National Care Fund

Promoting a *National Care Fund* to the public would involve several steps, including raising awareness of the universal risk of needing long-term care and the need to be insured in relation to it. The cohort-specific nature of a *National Care Fund* would allow the Government to tap into notions of cohort solidarity. The Government could emphasise the *enablement* provided by a *National Care Fund*, in that individuals would be enabled to use their assets to insure themselves. The Government could also emphasise that remaining enrolled in a *National Care Fund* would 'protect the inheritance'.

Some particular benefits of a *National Care Fund* include: universal provision; social minimums of provision; removal of the agency problem around care and assets; the scope for social solidarity to reduce avoidance of contribution fees; the scope for the Government to encourage those who have de-enrolled to become insured; choice, and adaptability to future changes in demography and wealth. By enabling older people to use their housing wealth to fund basic long-term insurance, a *National Care Fund* would also effectively free up income and liquid assets for other purchases including complementary private-sector long-term care insurance.

Conclusion

Despite its radical features, a *National Care Fund* is feasible. In contrast to state-funded models, which are widely acknowledged to be unaffordable, the model of a *National Care Fund* recognises that for most older people, all the wealth that could ever be needed to insure them against the cost of long-term care is available in their property. It is easier to build a solution to long-term care funding around money that is there, than money that is not. The *National Care Fund* would give older people the opportunity to make the social insurance contributions going forward that they were not required to make during their working-life.

Simultaneous to current public policy debate on long-term care funding is an active debate around how to support unpaid carers. The argument for using tax revenue to support carers is far more compelling than providing free long-term care for individuals who have more than enough wealth to contribute to an insurance scheme.

The strain on public finances imposed by demographic change in the coming decades will amplify threats to the intergenerational contract. By seeking to extend the intergenerational contract through state-funded universal free care, supporters of this model risk stretching it to destruction. Asking older people to fund their own long-term care insurance is not 'cold-hearted' or against the spirit of intergenerational solidarity. In fact, it represents a concerted effort to preserve the intergenerational contract.

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Part 1

Chapter 1: The Challenge – Funding Long-Term Care for Older People

1.1 What is Long-term Care?

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 can be both 'formal' and 'unpaid'/'informal'. Unpaid care is the care provided by family and friends. 'Formal' care is care provided by paid carers and can include nursing care and personal care, provided in a care home or domiciliary setting.

Although long-term care can be required by individuals of any age, the majority of care is provided to older people among whom there is the greatest prevalence of long-term conditions and disabilities.

Despite the amount of discussion it currently generates in public policy debate, long-term care can be difficult to define. Indeed, how long-term care is defined can itself be a critical point of contention and controversy at a local level when the care that individuals receive after medical treatment overlaps with the care that individuals need as a result of longstanding disabling conditions. The picture is further complicated by factors such as advances in telecare, assistive technology and trends in care provision, for example, a growing emphasis on home care.

For this reason, no rigid definition of long-term care is provided here for the purposes of this discussion paper. As will emerge, the task of defining long-term care is itself part of the challenge confronting policymakers.

1.2 What is Projected to Happen to Demand for Long-term Care?

The UK Government is fortunate for the fact that several high-quality studies modelling future demand for long-term care have now been undertaken. For example, a 2006 study from City University predicts that increases in the volume of care provided in all care settings will be around 30-50% by 2050.[1] As a result of such studies, a widespread consensus now exists that the demand for long-term care will increase substantially in the coming decades. This is primarily the result of two important long-term trends:

- Demographic change – the transition of the 'baby-boomer' generation into retirement, and the growing number of retired people as a proportion of society.
- Increasing human longevity and the fact that increasing life expectancy is not necessarily matched by increasing *healthy* life expectancy.

Most care is provided 'informally' as unpaid care and it is expected that this will continue to be the case. As a result, the effect of care provision on an individual's life, such as labour market activity, pension accumulation and quality of life are all important questions for the development of public policy. However, in relation to formally provided long-term care, the critical concern for policymakers is the future cost of formal long-term care to society.

1.3 What is Projected to Happen to the Costs of Long-term Care on Society?

Future projections of the cost of long-term care are extremely sensitive to numerous factors. For example, assumptions about future numbers of older people, the prevalence of different

[1] See Karlsson M et al. (2006).

types of conditions and dependencies, patterns and prevalence of informal care provision, and the unit costs of different types of formal care.

Going as far as possible to take account of such factors, one study found that under a 'base-case' scenario, assuming no change in the percentage of older people receiving formal and informal care, between 2000 and 2050 the percentage increase in long-term care expenditure as a proportion of GDP would be 102%.[2] A different study projected total expenditure on formal long-term care to increase from £11 billion per year to approximately £15 billion per year by 2040 (in 2001 prices).[3] A further study used its own baseline scenario to project total costs of £10.1 billion in 2002 rising by 139% between 2002 and 2026 to £24.0 billion. This would represent an increase from 1.1% of GDP to 1.5%.

In the coming decades, all these figures will be updated in light of new data on mortality and healthy life expectancy, as well as trends in household composition and unpaid care provision. The key point, on which there is general consensus, is that even if the prevalence of unpaid care provision stayed the same, the increase in demand for formal care resulting from demographic change would of itself require an increase in financial resources so large as to be measurable as a percentage of national GDP. However, where this new money to fund long-term care will come from is only part of the challenge currently facing policymakers.

1.4 What is Wrong with the Current System of Long-term Care?

Further widespread consensus exists that the current system of long-term care in England and Wales is failing, quite besides the extra economic burden that will result from demographic change and increasing longevity. Similarly, criticism is also made of Scotland's long-term care system, despite its policy of 'free personal care'.

What are the problems? Several key issues should be highlighted:

- Funding – a general consensus exists that overall spending on care is insufficient resulting in unacceptably poor quality care provision and related outcomes in many instances. This issue of 'under-funding' clearly risks being compounded by the rising demand for long-term care in future decades.
- Fairness – whether or not an individual requires formal long-term care is fundamentally the result of bad luck (putting aside other factors such as the availability of family members to provide unpaid care). As a result, the cost burden of paying for long-term care falls entirely arbitrarily on individuals and their families. Individuals with income and wealth above the means-tested threshold face large parts of their accumulated capital being spent on funding long-term care. This is something that can be particularly disastrous for low-to-median income households.
- System design – even though individuals typically prefer to remain in their own home, rather than provide expensive packages of care to achieve this, the current system gives local authorities an incentive to put people in a care home in order to recover more of the costs through charges on people's assets once those homes have been sold.
- Complexity – the UK system of long-term care is poorly understood by many professionals and service users.
- Variations in entitlements – geographical variations in entitlements have lead to accusations of a 'postcode-lottery'.
- Diagnostic inequities - older people with serious and unstable physical health problems may qualify for NHS funded continuing or nursing care. Those whose needs are seen as non-clinical, e.g. because of a stable longstanding condition, are likely to be excluded from this support.

A further important issue is the significant role of means-testing in the current system, which is widely perceived to penalise savers. However, this specific issue is more complex than it

[2] See Comas-Herrera A et al. (2006).
[3] See Karlsson M et al. (2006).

appears. Although retirement income from private pensions does result from saving, the value of the largest asset that most individuals possess in retirement – their home – results not from saving but from asset price inflation, and is therefore unearned and unrelated to saving.

1.5 What is the Challenge?

There is widespread consensus that the current system of long-term care in the UK requires reform, and that this reform is urgent, given the coming increase in demand for long-term care resulting from demographic change.

Such is the complexity of the problems with the long-term care system that there is not one challenge for policymakers, but several. These multiple linked challenges involve both the funding and the design of an improved long-term care system. These include:

- Where will the money come from to increase spending on long-term care in the UK?
- How will care paid for by the taxpayer be rationed?
- Given that individuals spend their working lives saving for a desired level of comfort and quality of life in retirement, how can a system respond appropriately and fairly to inequality in means, expectations and outcomes in long-term care?
- What is the correct role for risk-pooling in relation to long-term care and how should it be organised?

Although such questions cannot be considered entirely in isolation from each other, this report is primarily concerned with the challenge of the future funding of long-term care for older people. This challenge results from under-funding of current provision and from the increasing financial cost of long-term care provision that will be associated with demographic change in the coming decades.

Following the introduction of free personal care for older people in Scotland in 2002, the UK now has two divergent systems. The exact nature of 'free personal care' care in Scotland is elaborated in more detail below.

1.6 The Scope of the Challenge of Long-term Care Funding

As described, a unique constellation of factors have combined to make the challenge of funding long-term care for older people one of the most important policy issues confronting society. What is the scope of the challenge of long-term care funding? It is important to frame this challenge in terms of its historical specificity.

Such are the problems in the design of the current long-term care system and the magnitude of the funding problem ahead, the task for policymakers is characterised in many quarters as a need to implement a 'once-and-for-all' solution. On this view, a new system of long-term care funding is required that will survive in perpetuity, applying to both today's older generation and to every succeeding cohort.

For a single system of long-term care funding to be appropriate for every successive cohort of older people, each cohort would need to be substantially similar in crucial respects, such as their demographic profile. However, this is clearly not the case:

- The 'baby-boomer' generation, whose passage into retirement is prompting the 'crisis' of long-term care, are unique in their demographic profile.
- The baby-boomer generation are unique in their 'wealth profile'. As is described in more detail below, the baby-boomer generation are, on some measures, the wealthiest cohort in history.

In this context, there is no reason to expect that an appropriate solution required now to the problem of funding long-term care for the baby-boomer generation would be equally appropriate for every further generation. Indeed, given advances in assisted living, telecare

as well as medicine and healthcare generally, the demand for long-term care by older cohorts decades from now may be very different to today.

Viewed this way, the challenge is not to develop and implement a '*grand historic settlement*', but to implement a unique solution to a unique problem. Indeed, the development of one solution for today's older cohort does not preclude the development of other sustainable long-term care funding models for younger cohorts.[4]

Having set out the scope and nature of the challenge of funding long-term care for older people, the next chapter considers the risk of needing long-term care in the context of other 'life risks', and assesses the difficulties involved in insuring this risk by both the private sector and the state.

Key Points from Chapter 1:

- The demand for long-term care will increase substantially in coming decades as a result of demographic change and rising life expectancy. This increased demand will impose a significant economic burden on society, on top of existing needs to spend more to raise quality.
- The current challenge of long-term care funding for older people is a unique historical problem. Attempts to find a solution should not therefore be framed in terms of a 'once-and-for-all' solution. It would be illogical to expect one system to be appropriate for cohorts with entirely divergent demographic and wealth characteristics.

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[4] For example, some commentators have advocated the creation of long-term care insurance 'personal accounts' for younger cohorts, mirroring the National Pension Saving Scheme that is currently at the heart of UK pension reform.

Chapter 2: The Risk of Long-term Care and Insurance

This chapter explores private sector and state responses to the risk of needing long-term care. However, to place the risk of needing long-term care in context, the chapter first begins by reviewing this risk against other types of risk that individuals confront.

2.1 Life Risks and Insurance

During their lives, individuals confront various risks, which they are insured against. This insurance occurs through complex, interacting and overlapping provision by the private sector and the state, and is the result of action by both the individual and the state.

The provision of insurance by the private sector involves individuals either voluntarily choosing (e.g. travel insurance), or being required (e.g. motor insurance) to purchase insurance products from private sector providers.

Public models of insurance see the state organising insurance, whether through general taxation or, as is common in a number of Western European countries, state organised contributions to social insurance funds.

The provision and organisation of insurance through the 'welfare state' takes place because of several factors. Such factors include the need to redistribute wealth to insure the poorest members of society, the historical socially-embedded nature of certain forms of public provision, and situations of 'market failure', i.e. where the private sector does not provide insurance, for example, because of adverse selection. In addition, the provision of insurance through the state reflects an important and valuable moral belief in the minimum provision that should be made for all members of a civilized society, which is articulated in a consensus regarding citizenship-based entitlements.

There is not space here to review the huge academic literature that exists on private and public sector provision of insurance, models of the welfare state and social policy. Nevertheless, given the possibility of both private and state-based responses to the risk of long-term care, it is worthwhile briefly putting the risk of needing long-term care in the context of the various other risks that individuals face in their lives. These risks can be both trivial and non-trivial, such as mobile phone theft and debilitating ill-health.

Adopting a broad and simplistic characterisation, the risks that individuals are commonly insured against include:

- Death and the effect on family members - life insurance.
- Loss or damage to possession in the home - home contents insurance.
- Damage to property - buildings insurance.
- Loss or damage to car or motor vehicle - motor insurance.
- Loss or damage to mobile phone - mobile phone insurance.
- Cancellation, disruption and ill-health while abroad - travel insurance.
- Loss of income through unemployment and ill-health when repaying a mortgage - mortgage payments insurance.
- Accidental disability – insurance to ensure financial provision is guaranteed if loss of income results from an accident.
- Ill-health – the NHS and limited private health insurance.
    - o The NHS, funded through general taxation, works as a giant health insurance scheme, in which the risk of requiring healthcare and its associated cost is

insured via universal, progressive, means-tested taxation. This enables the state to:
    - Ensure the necessary wealth distribution required to make health insurance available to poorest members of society who would not otherwise be able to afford health insurance from the private sector.
    - Allow individuals to shift their contributions across the life course, i.e. ‘paying in’ via taxation when young, healthy and in the labour market, and ‘drawing down’ when retired and much more likely to require healthcare.
  - Private health insurance is purchased by a minority of the population.
- Poverty - benefit payments provided by the state insure against the risk of extreme poverty, which may result from unemployment or low income. Provided to the unemployed and those on low incomes, such benefit payments insure individuals from the risk of poverty (i.e. homelessness and hunger) that may result from unemployment or low income.

2.2 The Risk of Long-term Care in the Context of Other Life Risks

Where does the risk of needing long-term care fit on this list of commonly insured risks? The answer is complex, because of the different components of long-term care and different systems within the UK.

In relation to private sector insurance of the risk of long-term care, the market for products that insure against the cost of long-term care is extremely small. The risk of needing long-term care is not therefore a commonly insured risk by the private sector.

In relation to the state, some incomplete insurance of the risk of needing long-term care does exist. Following the recommendation in 1999 by the Royal Commission on Long-term Care that personal and nursing care be provided free to older people in the UK, all parts of the UK introduced free nursing care for older people in care homes. In this sense, nursing-care, as a component of long-term care, can be included on this list of commonly insured risks.

In 2002, Scotland became the only part of the UK to introduce free personal care for older people both in care homes and in domiciliary settings. In the rest of the UK, individuals must still pay their own personal care costs. If a person is assessed as needing care in a care home, they are expected to pay the full cost of care in a care home if they have more than £21,500 in capital, including property, savings and other investments. Aside from Scotland, personal care is not therefore on this list of commonly insured risks.

In contrast, although not specifically a cost of care, the ‘hotel costs’ associated with care in a care home clearly represents part of the risk of needing long-term care. Throughout the UK, including Scotland, older people are still required to pay the ‘hotel’ charges resulting from their care, provided they have the capital to do so.

In this way, only one part of long-term care – nursing care – is firmly on this list of commonly insured risks. However, it could be expected that the complete cost of long-term care would be one of the commonly insured against risks that individuals face in life, alongside the other risks listed above. Why?

First, the risk of needing long-term care applies to everyone regardless of gender, social group, wealth, ‘health-related behaviour’ (smoking, fitness etc.) and ethnicity. In this sense, the risk of needing long-term care is inescapable and universal.

Second, long-term care is a ‘catastrophic risk’ – the cost of care required by an individual may be unaffordable to most people. Indeed, even basic forms of care provided for long periods can effectively bankrupt individuals and families who are significantly high up the income and wealth scales.

On this view, arguably the most remarkable feature of the system of long-term care funding in England and Wales is that it almost entirely excludes any form of risk pooling and insurance. For reasons outlined in more detail below, the private sector is largely absent from long-term care. The insurance of the risk of long-term care through the state is limited to those with minimal assets that fall below a set means-tested level.[5]

It is this minimal insurance and risk-pooling that results in the arbitrary unfairness experienced by many individuals and families in the long-term care funding system. Despite being insured against many trivial and non-trivial risks throughout their lives, individuals find themselves almost entirely ‘exposed’ in relation to the risk of needing long-term care when they reach the final stages of life.

This review highlights a central aspect of the challenge of long-term care funding for older people: greater levels of insurance risk-pooling would not only be logical and consistent with the insurance-based response to other risks that individuals face during their lifetime, it is the only way to overcome the unfairness and arbitrary nature of the current system and the misfortune of requiring long-term care.

This raises the question: why do the private sector and the state do not do more to pool the risk of needing long-term care in England and Wales? This question will be explored by first looking at the private sector.

2.3 The Risk of Long-term Care and Private Sector Insurance

Three types of long-term care insurance product can be identified. These are:

- ‘Pre-Funded Insurance’ – insurance purchased by individuals when healthy prior to needing care, taking into account that they will need care and the probability of how long the care will be needed for.
- ‘Immediate Needs Annuity’ – an insurance product for individuals receiving or about to begin receiving care. The annuity covers the cost of the care for the life of the individual.
- ‘Deferred Care Annuity’ – an insurance against the cost of long-term care being beyond the means of an individual and their family, i.e. insurance against care lasting for so long that the cost would use up all of a person’s assets.

Clearly, pre-funded insurance represents the ‘ideal’ type of long-term care insurance, given that immediate needs and deferred care annuities effectively represent a response to failing to insure against the costs of care.

As outlined, given the nature of the risk of needing long-term care, it could be expected that there would be a fully-fledged market in private long-term care insurance.

However, this is clearly not the case in the UK, where the vast majority of insurance providers are absent from the market. An ongoing debate exists as to why this situation is the case and a long list of factors can be put forward as an explanation. Demand-side factors limiting the private long-term care insurance market include:

- Ignorance of the risk of needing long-term care.
- Mistaken belief that free long-term care will be provided by the state.
- Cost – long-term care insurance products are unaffordable to those with negligible assets and very low income, such as those in social-rented housing. Even those with low-to-median income and assets may struggle to afford some long-term care insurance products.
- Lack of qualified financial advice – even if greater demand for long-term care insurance products existed and more insurance companies were keen to enter the

[5] However, by definition, if such individuals are of low means and have contributed less to general taxation, their receipt of free care represents not so much insurance, as redistribution.

market, the number of financial advisers qualified to advise on long-term care insurance products is so low as to be a major impediment to the development of the market.
- Difficulty in predicting care needs and framing what would be an acceptable level of care.
- Difficulty in predicting the cost of an acceptable level of care up to three decades ahead of it being required, and therefore allocating capital on insuring against this cost.
- The bequest motive – individuals wish to maximise the assets available to transfer to younger family members in preference to insuring themselves against the cost of long-term care, even though their bequest may be used up if they have to pay for their care.
- Belief that family members will provide care and that formal care will therefore be unnecessary.
- 'Positivity effect' – a psychological aspect of ageing is the 'positivity effect' in which the brain subconsciously excludes 'negative information' in an attempt to regulate the emotions.[6] In the context of the difficult choices required from older people regarding the risk of dementia and disability and associated need of long-term care, this psychological aspect of ageing may make it hard for older people to properly address the issue of their long-term care provision.
- Financial capability - failure to understand (potentially complex) long-term care insurance products, which is compounded by declining cognitive capabilities among older cohorts (numeracy etc.).[7]
- Inertia – as with many types of financial behaviour, individuals display simple inertia in relation to the risk of needing long-term care, when confronted with multiple complex choices.
- Ongoing confusion as to what forms of long-term will and will not be provided by the state in the future.
- Precautionary saving – individuals know neither how long they will live nor what their end-of-life costs will be, so prefer to maximise their income and assets available to meet these unknown costs and risks rather than the specific risk of needing long-term care.
- Some long-term care insurance products in the past have been perceived to offer unattractive terms, and a legacy perception continues to exist.

Supply-side factors relate to the difficulty that insurers have had in developing products. These centre around uncertainties related to:

- Future demand, such as patterns of informal care provision.
- Future (healthy) life expectancy.
- Future unit costs of long-term care, i.e. what will happen to the cost of long-term care provision in the future.
- Future reform of the long-term care funding system, making it difficult to design products that complement future publicly organised provision.

In addition, insurance companies have struggled to develop the market to a size that makes products both attractive and profitable.

A further general limit to the growth of private sector long-term care insurance will always be individuals in retirement with negligible income and assets who will nevertheless require long-term care, but would always struggle to afford to purchase long-term care insurance products. As a result, some form of wealth redistribution in the form of free long-term care organised through the state is *inevitable*. In short, the role of the private sector will always be part of a mixed public and private system of insurance provision in relation to the risk of needing long-term care.

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[6] This field of research in the psychology of ageing represents a new and emerging speciality. For example, see Charles S et al. (2003).
[7] For example, see Banks J & Oldfield Z (2007).

Such is the number and complexity of these factors affecting demand and supply for long-term care insurance among older people, it is not clear that a functioning market in insurance products against the risk of needing long-term care would result if only several of these factors were addressed effectively. It is also clear that Government action would be required to address some of these factors, for example informing the public about the risk of needing long-term care and creating public confidence in the value and suitability of long-term care insurance products.

However, none of this discussion should be seen as evidence that private sector insurance products have no role to play in any long-term care funding system. Indeed many of the limits identified have been successfully overcome in relation to other types of insurance product. The issues highlighted above simply demonstrate the scope of the challenge for the private sector and Government to overcome in relation to the development of a market in long-term care insurance products.

2.4 The Risk of Long-term Care and the State

How has the UK state responded to the universal risk of long-term care that its older citizens confront? Following political devolution, two divergent systems exist: one in Scotland, and a second in the rest of the UK.

- *Scotland*

A new system of public funding for long-term care for older people was introduced in Scotland in 2002. Notionally 'free personal care', this system involves the restriction of the use of means-testing and a significant contribution by the state to the costs of personal care, regardless of an individual's income and assets.

In reality, free personal care is not as simple as it sounds, because individuals retain the right to use their own money to 'top-up' the amount spent on their care, and because of the different components of long-term care (e.g. 'hotel' costs versus personal care). As a result, means-testing can creep back in for the assessment of how much will be contributed to 'hotel costs'.

Such complexities mean that long-term care, as it is now provided in Scotland, is not actually the sole domain of the state, as might be expected by the notion of 'free personal care'. In 2004, the cost of an average care home place in Scotland was £427 per week (Bell & Dowes: 2006). Self-funders represented about 40%. After the £210 per week (maximum) contribution from the state, self-funders were still paying an average of £217 per week.

The extent of continued self-funding on this scale pinpoints the failure of free personal care in Scotland. Despite, and in addition to, the added fiscal burden to the state, some individuals in Scotland are still having to run-down their assets in order obtain a level of care they consider acceptable. This highlights the limits to universal state-funded free care as an insurance scheme in the context of wide variations in means. Free personal care in Scotland fails as an insurance scheme because individuals are still having to use up their assets to fund their care, which as an outcome, is entirely unnecessary and preventable, if a proper system of long-term care insurance were available.

A report by Audit Scotland (2008) found that the total costs of free and personal nursing care for the first four years following its introduction were £1.8 billion, although councils would have spent around £1.2 billion of this even if the policy had not been introduced. The report's authors estimated that the additional costs for the first four years of this policy were £600 million. This resulted in a shortfall in central funding of up to £63 million for 2005/06. This overspend highlights the difficulties in projecting forward the demand and costs of long-term care for older people.

- *The rest of the UK*

Among the remaining home-nations of the UK, free personal care provided free by the state is subject to means-testing, ensuring that only those with income and assets below a fixed level (£21,500) are entitled free long-term care. Free personal care has been rejected by the state as unaffordable and fiscally unsustainable.

State funding for long-term care occurs through three principal channels. Local authorities fund personal care for older people in residential and domiciliary settings. The NHS contributes some resources to long-term care. The Department for Work and Pensions provides some benefits to those requiring care. Attendance Allowance (AA) is a tax-free benefit for people aged 65 or over who need help with personal care because they are physically or mentally disabled.

2.5 Insurance and the Risk of Long-term Care in the UK

In this way, it is possible to see that long-term care remains remarkably uninsured compared to the other risks that individuals confront in their lives. This is despite the fact that long-term care is an insurable risk, as shown by social care systems in other countries. In the UK, the private sector is largely absent, and the state has also restricted its potential insurance and risk-pooling role.

Arguably, the introduction of 'free personal care' in Scotland represents risk-pooling. However, this is not strictly the case. Since older cohorts in Scotland are the first to be insured against the risk of needing long-term care without having contributed to the cost of a similar policy for any preceding cohort, the current older cohort has not participated in a risk-pool so much as it has been a lucky 'first' generation, entitled to a new welfare benefit.

It is against this backdrop that debate has taken place about the funding of long-term care for older people. As outlined, this challenge is to:

- Increase overall spending to enable improved care outcomes and in the context of growing demand driven by demographic change.
- To increase the scope of risk-sharing in relation to long-term care, such that it loses its anomalous status compared to other common risks, and reduces the scope for the cost of long-term care to fall arbitrarily on unlucky individuals and families. Indeed, the objective of Government should be to eliminate the risk of long-term as a threat to the wealth of individuals. The Government should seek to ensure that besides the regular income that older people have that can be used to pay for care, no part of their assets should be left exposed to the risk of long-term care. Only then will individuals feel that the system is fair.

For a variety of reasons, including many set out here relating to private sector insurance provision, debate on the funding of long-term care for older people has gravitated towards models in which the state pays for all or the largest share of an individual's long-term care costs. This approach to the challenge of long-term care funding is therefore reviewed in detail in the next chapter.

Key Points from Chapter 2:

- Despite the risk of long-term care being both universal and catastrophic, UK citizens are largely uninsured against it. This contrasts sharply with the range of trivial and non-trivial life risks which individuals are insured against through complex, overlapping and interacting private sector and state provision.
- The private-sector market for long-term care insurance remains minimal because of a range of demand-side and supply-side limiting factors.

- The role of the state in insuring citizens against the risk of long-term care is minimal, despite variations in the use of means-testing in Scotland compared to the rest of the UK.
- Given that long-term care is an insurable risk, the Government's obective should be to ensure that no individual confronts having to run down their assets to fund care which they deem acceptable. Only when this is achieved, including for wealthier older households, will older people and their families cease to feel that that the long-term care funding system is unfair.

Chapter 3: State-Funded Solutions to Long-Term Care Funding - A Generational Perspective

This chapter explores the main models of funding long-term care for older people that have been proposed in response to the challenge set out in the preceding chapters. The chapter then goes on to assess these models from the perspective of intergenerational equity.

3.1 State-funded Solutions to the Challenge of Long-term Care for Older People

During the years of debate on the funding of long-term care for older people, many stakeholders have repeatedly proposed a model incorporating universal free care funded by the state. In this model, the state pays for all, or the largest share of, an individual's long-term care, regardless of their income and assets. This would usually involve the benchmarking of some quality or unit cost of care, which the state would undertake to fund.

Universal free personal care was the substantive recommendation of the majority report of the Royal Commission on Long-term Care in 1999. More recently, stakeholders have begun to argue for payment by the state of a fixed percentage of all core costs associated with long-term care, with individual co-payments funding the rest. Such a 'partnership model' was the principal recommendation of the 2006 Wanless Social Care Review. This model would provide all older people with a free minimum guaranteed amount of care set, for example, at 66% of a total benchmark care package. Individuals could then make contributions matched by the state up to a certain limit. This would mean that for every £1 that individuals contribute to their care is matched by the same amount from the state until the benchmark care package is achieved. Those individuals on low incomes in retirement would be able to make additional contributions through the benefits system.

3.2 Why is the State Funding of Long-term Care for Older People Supported?

The model of universal free care has been repeatedly advocated by a range of stakeholders in the debate on the funding of long-term care for older people. What are the advantages of this model?

- Minimum guaranteed care – by guaranteeing a particular level of care to all regardless of means, the state fulfils society's responsibility to ensure a minimum level of care for all its citizens.
- Fairness – state funded models incorporating free personal care overcome the arbitrary nature of the risk of needing care, which at present contributes to many people's perceptions of unfairness when an individual's assets, accumulated over a lifetime, are used to pay for care.
- Size of risk-pool – the bigger the risk pool used to insure individuals reduces the marginal costs of running the risk pool, and potentially reduces the contributions required. Universal risk pooling across an entire population represents the largest risk pool possible.
- Redistributive element – as described above, the state would always have to take some role in organising an insurance response to the risk of long-term care in order to pay for those in retirement with negligible income and assets. State-funded provision of a guaranteed level of basic care to all enables this redistribution to take place.
- Agency among older people – as described, the problem of agency among older people has been a significant barrier to the development of the private sector long-

term care insurance market. Under universal free care, an older person displaying inertia who takes no action in regard of the risk of long-term care will nevertheless be guaranteed to receive a basic level of care.
- User feedback – universal free care is usually found to be popular with older people and their families, as has been found in studies in Scotland.

3.3 State-funding: Who Pays?

To consider who actually pays under state-funded models, it is necessary to analyse what is actually meant by 'the state'. Debate on reform to the funding of long-term care for older people in the UK usually invokes a simplistic notion of 'the state', i.e. the state is characterized as some external transcendent agency that is able to step-in and pay for the cost of care.

This approach overlooks the fact that 'the state' does not possess an independent revenue stream of its own, but draws the bulk of its income from general taxation on its resident population. Many different types of tax comprise the revenue generated through general taxation, including income tax, VAT, stamp duty, etc.

The largest single component of revenue drawn from general taxation is income tax, followed by social security contributions. Together these comprise around 45% of national revenue. Both taxes are levied in the main on individuals in employment, below the state pension age. Although pensioners do pay tax on income, including state and private pension income, the income allowance for income tax increases for people in retirement.[8] Furthermore, most individuals experience a drop in income on retirement and so pay less income tax. By retirement, most older people have finished paying their mortgage and have no child-rearing costs. As a result, both income needs and outgoings tend to be lower.

Since the state draws the bulk of its revenue from people of working age in employment, state-funded models of long-term care funding, which require more money from the state to pay for universal free care, would see the incidence of this new cost falling mainly on people of working-age, particularly younger cohorts who have many years of employment ahead of them.

The introduction of a state-funded, i.e. taxation-funded, model of free universal care would therefore involve a significant transfer of wealth from those of working-age to those in retirement. The existence of such a transfer would not be novel or new. The state regularly oversees the transfer of wealth from those of working-age to those in retirement, reflecting the 'intergenerational contract' embodied by key functions of the state.

3.4 Models of Universal Free Care in the Context of the Existing UK Intergenerational Contract

Various activities and services of the UK state reflect an implicit intergenerational contract. In particular, the state pension and the NHS both result from the continued existence, and support for, an intergenerational contract, i.e. a contract between young and old, based on a continued sense of intergenerational solidarity, and reliant in part on a perception of intergenerational equity:

- The state pension - when working-age individuals make state pension contributions through employment-based taxes, (i.e. notional social security contributions), their money does not in fact go into specific allocated pension accounts, but instead contributes to the cost of paying the state pension to the older cohort above the state pension age. The intergenerational contract is implicit in the functioning of the state pension. Each generation pays for the state pension of the previous generation

[8] For 2008-2009, the personal allowance for income tax is £5435. For those aged 65-74, the amount is £9030 and for those aged 75 and over, the amount is £9180.

through general taxation, on the expectation that subsequent generations will do the same for them.

- The National Health Service (NHS) is a textbook case of intergenerational solidarity and the intergenerational contract in practice. The NHS is funded in large part by taxes on the working age population. However, usage of healthcare is significantly associated with proximity to death, which for most people is in retirement.[9] Implicit in the continued existence of the NHS is, therefore, an intergenerational contract that sees younger healthier individuals contribute through general taxation to the costs of the NHS on the understanding that in old age, when retirement from the labour market reduces their contribution to general taxation, younger generations will fund the NHS and the costs of their healthcare in old-age.

  In this way, individuals are able to insure themselves in relation to ill-health, when they are young, fit and have a higher income, safe in the knowledge that in old age, when they can no longer contribute the same relative amounts to this health-insurance pool but are far more likely to need to use health services, they will nevertheless remain insured in relation to health. This contrasts, for example, with the US private health insurance system in which much private health insurance is employer-linked; when individuals enter retirement and become far more likely to need healthcare, many are therefore left uninsured.

The state pension and the NHS are organised around the intergenerational contract that underpins the welfare state. Set against these services, it is possible to see the introduction of universal free care for older people, state-organised and taxation-funded, as simply an extension to the domain of the intergenerational contract. This is why many proponents of universal free care for older people identify this model closely with the welfare state and its embodiment of fairness.

However, to properly assess how appropriate it would be to introduce taxation-funded universal free care for older people, it is necessary to recognise two things.

First, the operation of the intergenerational contract relies on a sense of intergenerational solidarity, which in turn is dependent upon a perception of intergenerational equity. This perception of intergenerational equity is itself dependent on there actually being some reasonable degree of equality between different generations, albeit recognising that individuals will always have different levels of assets at different stages of the life-cycle. As will be set out below, the last decade has arguably seen intergenerational equity decline.

Second, the extension of the model of the intergenerational contract and the introduction of new domains of wealth transfer from the young to those in retirement will effectively create two transition cohorts, i.e. the first older cohort entitled to receive this free benefit and the first working-age cohort that will have to pay for it. Properly assessing the model of universal free care for older people clearly requires an assessment of these two transition cohorts. Interestingly, a consistent feature of the debate around long-term care funding for older people is the absence of any such assessment. For this reason, a preliminary attempt at this assessment is made below.

3.5 Transition Cohorts for the Introduction of Universal Free Care in the UK

As outlined, the introduction of a taxation-based system of long-term care funding to provide free universal care would create two ‘transition cohorts’:

- The first (older) cohort to receive free long-term care despite not having paid for the free long-term care of any preceding generations.
- The first cohort of working-age that has to pay for the free long-term care of the older generation through general taxation.

[9] See Seshamani and Gray (2004).

At this point, it is worthwhile sketching what the ideal characteristics of these two transition cohorts might be, so as to provide a rough benchmark against which to assess the two potential transition cohorts that actually exist currently in the UK.

Ideally, the first older cohort to receive free long-term care:

- Would not on average have sufficient resources to insure themselves against the cost of long-term care, i.e. to buy into long-term care insurance, either individually or through some state or private sector organised insurance scheme.
- Would comprise a declining or at least static percentage of the overall population.[10]

Ideally, the first cohort of working age to pay for the free long-term care of the older generation:

- Would comprise a static or growing percentage of the population.
- Would not be under significant financial strain, with low average levels of debt.
- Would be making adequate provision for their own retirement, i.e. supporting today's older cohorts would not be in any sense at the expense of making adequate provision for their own old-age.

Some of these dynamics are captured in the idea of the 'elderly support ratio'. This is the population of working age divided by the population of pensionable age. In the UK, the elderly support ratio is declining and is projected to fall from 3.35 in 2002 to 2.53 in 2031.[11] This means that in the future, the number of people of working age, who contribute the bulk of general taxation revenues, is declining, relative to the number of people aged over the state pension age.

The declining elderly support ratio has long caused policymakers to worry as to the fiscal sustainability of existing activities and functions of the state based on the intergenerational contract, such as the state pension and the NHS. Indeed, the most persistent criticism made against the model of universal state-funded free long-term care for older people has long been that such a funding model would simply be unaffordable and unsustainable in light of the declining elderly support ratio.

With this thumbnail-sketch in mind, it is now necessary to review in detail the assets, wealth and income of those cohorts in the UK who would be the 'transition cohorts' for the introduction of universal free care paid for by the state through general taxation.

3.6 Asset Accumulation Across the Generations in the UK

This section draws on research published by the ILC-UK in September 2007 called *Asset Accumulation across the Life Course*.[12] The research analysed changes in all non-pension household assets and debt across all age groups for the years 1995-2005. The research used data from the 1995, 2000 and 2005 waves of the British Household Panel Survey, which is a nationally representative panel survey undertaken annually since 1991. The principal findings of this research, with associated graphs, are contained in Appendix 1.

Asset Accumulation across the Life Course was a cohort-based analysis of changing patterns of wealth in the UK. A number of findings relevant to the current discussion can be highlighted.

- Between 1995-2005, all cohorts experienced increases in net illiquid wealth. Younger cohorts experienced the biggest proportional increases. It is reasonable to presume

[10] For example, the creation of the NHS was followed by a dramatic increase in the birth-rate, represented by the 'baby-boom' generation, underpinning the fiscal sustainability of the NHS for decades to come.
[11] See Government Actuaries Department (2003).
[12] See Boreham R and Lloyd J (2007).

that this was driven by both property price inflation and the increasing use of family wealth to fund large deposits for property purchases.[13] However, by volume, it is older cohorts that experienced the largest net increases in illiquid wealth. For example:

- An average 70-year old in 2005 saw their household net illiquid assets increase to around £215,000 from £88,000 a decade before.
- An average 75-year old in 2005 saw their household net illiquid assets increase to around £205,000 from £87,000 a decade before.

Such increases in wealth occurred even though these older cohorts were in retirement, and entirely contradicts the 'life-cycle hypothesis of consumption' which posits that individuals will decumulate, i.e. run-down, their assets in retirement.

- Alongside increases in illiquid wealth, younger cohorts saw significant increases in average household mortgage debt. For example, an average 40-year old had £60,000 of mortgage debt in 2005, up from £30,000 in 1995. Differences between cohorts were also striking: in 2005 an average 35-year old had household mortgage debt of £64,000; in 1995, an average 35-year old had household mortgage debt of £35,000. Real increases in average mortgage debate such as these far exceeded growth in real incomes among younger cohorts.

- The research found declining rates of personal private pension contribution across all cohorts.

- In relation to household income, the research found rising real incomes among younger and middle-aged cohorts and static real incomes among older cohorts. Given economic growth results in rising earned real incomes, this finding was to be expected. However, flat real incomes for older cohorts identifies the fact that most older individuals do not decumulate their assets in retirement in order to increase their income.

Overall, the research showed that among all cohorts, property-owning households had experienced significant increases in net wealth. The largest increases in net wealth by value was among older cohorts. For younger cohorts, increasing net property wealth was accompanied by much larger volumes of mortgage debt. Non-property owners, among younger and older cohorts, are obviously largely excluded from these changes, pointing to potentially growing inequality across cohorts.

What do these changes mean? Older cohorts have become by far the wealthiest in history, while the youngest cohorts have become one of the most indebted cohorts in modern history. These trends pinpoint the transfer of wealth from younger cohorts to older cohorts that has occurred through the operation of the housing market during an extended period of consistently high levels of house price inflation.

Given the relevance of this upward wealth transfer to proposals for universal free care for older people, and the two transition cohorts this would create, the process involved requires careful explanation.

3.7 Generational Wealth Transfers in the UK Through the Housing Market

The above analysis shows that older cohorts have experienced dramatic increases in their net wealth driven by rising property prices, and associated with dramatic increases in average mortgage debt among younger cohorts.

[13] See Appendix 1 for discussion.

This trend has been characterised by commentators as a transfer of wealth from 'young to old'.[14] Why? In the normal functioning of the property market when house prices rise in line with inflation and rising incomes, a moderate and predictable level of wealth redistribution occurs from those at the bottom of the property ladder (the young) to those at the top (older cohorts). In an extended period of above-trend house price inflation, this effect becomes so amplified that it represents a distinct transfer of wealth from young to old, over and above what would be expected to result from normal economic growth.

What is the mechanism involved? When an individual purchases a property with a mortgage, they borrow on their future income, and in so doing, transfer a portion of their current and future income and wealth to the seller of the property.

When younger cohorts take out increasingly large mortgages, this means that they are transferring an increasing proportion of their current and future income and wealth to the seller of the property. When this process is multiplied thousands of times through the complex chains of the housing market, the amplified effect is to transfer wealth from younger cohorts to those members of society with the most property wealth, which is generally older people. In a period of dramatic house price inflation, this process departs from what could be considered a normal circulation of wealth that would be associated with house prices rising in line with economic growth.

Although it can be argued that an older person does not actually 'realise' their property wealth until the moment it is sold, this misses the point. Property is a store of money and wealth like any other, and the rising values of property owned by older cohorts represent rising wealth, even when it has not been converted into some other store of wealth, is nevertheless real. In this way, even though someone may have lived in the same property for many years, they possess a certain level of wealth stored in the form of property, and the level of this wealth is entirely determined by the willingness of people in the property market to transfer large sums of their current and future income and wealth into the property market.

Clearly, this process of wealth transferral via the property market is complex, involves transfers of wealth upwards to cohorts who would not qualify as 'old' and is determined, in addition, by socio-economic factors: possession of significant property wealth is a function of income and existing wealth, not just age.

It would also be wrong to assume that all those in retirement live in highly valuable properties and, in fact, rates of property ownership decline among older cohorts and significant numbers of older people have not benefited from rising property wealth. Nevertheless, by volume, older cohorts pre and post-state pension age have on average benefited significantly from inflation in the value of their property assets, and this has been matched by growth in the value of mortgage debt held by younger cohorts.

Although exceptions will always be available, it is clear that when looking at the average across different cohorts, there has indeed been a transfer of wealth from younger working-age cohorts to older cohorts.

3.8 Taxation-based Solutions to Long-Term Care Funding: A UK Generational Equity Perspective

This lengthy and detailed review of the two 'transition cohorts' that would be created by the introduction of universal free care for older people, i.e. those in retirement and those of working-age now, enables a rounded assessment of universal free care, as an extension to the activities of the state based on the intergenerational contract.

Indeed, this analysis shows that if a taxation-funded system of universal free long-term care for older people were introduced, this would see by far the richest cohort in history becoming the first to receive universal free care, which would be paid for to a significant extent by the

[14] For example, see Weale M (2007).

most-indebted cohort in history, who had in fact already transferred an unprecedented volume of their current and future income and wealth to these older cohorts.

By assessing the 'intergenerational equity' dimension of taxation-based models for universal free long-term care in this way, it is clear that these models actually undermine intergenerational equity. Despite such models generally being heralded by proponents as the fairest model of long-term care funding available, on closer examination, such state-funded models appear manifestly unfair.

Indeed, such models risk compounding the deterioration in intergenerational equity that has occurred through high levels of property inflation. This is on top of the criticism usually levelled at models of state-funded universal free care: that such models are fiscally unsustainable.

The claim of fairness attached to taxation-based models of universal free care for older people, and the activities of the state generally, rely on the progressive nature of income tax. The strong progressive element of UK general taxation effectively redistributes wealth from wealthier to poorer. The unfairness of the model of taxation-funded universal free care for older people derives in particular from the fact that this progressive function of income tax and the state is reversed: this model would see the state redistribute wealth from those heavily in debt to those with high levels of accumulated wealth, much of which is unearned and untaxed.

Two counter-arguments can be put forward to argue that this wealth transfer from young to old through the functioning of the property market should be disregarded in discussion of models of long-term care funding. The first argument points to wealth transfers from old to young through the family. The second argues that since property prices can go down, especially after periods of marked price inflation, wealth transfers from young to old through house price inflation should be ignored. These arguments are profoundly flawed and a full critique for both is contained in Appendix 2.

Key Points from Chapter 3:

- Proposals for universal free care for older people would be funded by the state from generational taxation.
- The bulk of general taxation is derived from the working-age population through labour-based taxes. Universal free care would therefore represent a new kind of transfer from younger cohorts to older cohorts.
- This transfer can be seen as an extension of similar transfers, such as the state pension and the NHS, embodied by the 'intergenerational contract'.
- The addition of new welfare functions to the intergenerational contract would create two 'transition cohorts'; the first (older) cohort to receive free care and the first (younger) cohort to pay for it.
- Detailed analysis of assets and wealth among different cohorts shows that older cohorts are the wealthiest in history, resulting from rising property wealth and reflected in increasing mortgage debt among the young, who have consequently become the most indebted in history. This points to a transfer of wealth from young to old through the property market.
- These trends have important negative implications for the equity and fairness of models of taxation-funded universal free care for older people.
- The introduction of a taxation-funded system of universal free long-term care for older people would see by far the richest cohort in history becoming the first to receive universal free care, which would be paid for to a significant extent by the most-indebted cohort in modern times, who had in fact already transferred much of their current and future income and wealth to these older cohorts.

Chapter 4: Principles for a Fair Solution to Funding Long-term Care

The preceding chapter examined proposals for universal free care funded by the state as a response to the challenge of funding long-term care for older people.

Proponents of this model generally argue it is the fairest possible solution to the challenge of long-term care. However, by subjecting this model to a basic cohort analysis of trends in assets and debt, the model emerges with characteristics that appear to contradict basic notions of fairness. The introduction of universal free care is shown to result in the wealthiest older cohort in history becoming the first to receive universal free care, paid for to a large extent by the most indebted cohort in history, who have in fact already transferred significant amounts of their current and future income and wealth to older cohorts.

The fact that a model of universal free care for older people would incorporate individuals with significant means has long been recognised, and is generally disregarded as an inevitable outcome, given the absence of a fully-functioning market in long-term care insurance products. However, this contradiction implicit in the model of universal free care has become quantifiably more severe in light of changes to the property market, particularly when set against the pressures on the household budgets of younger cohorts and their under-saving for their own retirements – itself a cause of major public policy reform in the UK. Despite these trends being well-known, there has been little attempt to consider them as key concerns in revised models of universal state-funded free care.[15]

However, this critique does not negate the very real and imminent challenges described at the beginning of this report related to funding older people's long-term care. Despite the characteristics of the model of state-funded universal free care highlighted above, this model may yet be the 'least-bad' option. Before such judgements can be made, it is necessary to take the insights and limitations of this model and use them to explore what alternative models can be developed.

4.1 Principles for a Fair Solution to Funding Long-term Care

Given that the model of state-funded universal free long-term care for older people is shown to be critically unfair in key respects, what principles can be learnt from this analysis for developing an improved solution to the challenge of long-term care funding? This chapter derives some basic principles.

1) *Older people's assets must be used in an insurance risk-pool related to long-term care*

Supporters of universal free personal care funded by the state apparently support a risk-sharing insurance-based model of funding for long-term care, organised by the state. Yet once the argument is accepted that the future funding of long-term care for older people must involve a risk-sharing insurance based solution, the next question is: do older cohorts on average have sufficient wealth to obtain their place in such a risk-pool, whether organised through the state or the private sector? In short, do older people typically have the means to insure themselves in relation to long-term care? Given the patterns in wealth accumulation among older cohorts that have occurred in the last decade, the only reasonable answer to

[15] For example, 'generational equity' was not one of the 28 tests used to evaluate different models of long-term care funding in the Wanless Social Care Review.

this question is an emphatic: yes. Clearly therefore, older people's assets must have a role in enabling older individuals to buy into a risk-pool for long-term care.

2) Property is the key

As referred to above, older people's household incomes tend to be static in real terms and low overall compared to younger cohorts (although typically older people's income needs are lower, with negligible child-rearing and housing costs). In fact many older people's incomes are highly constrained, making income-based proposals for long-term care, such as pension draw-down models, limited in their suitability. Similarly, the liquid assets of older cohorts have been shown to be unremarkable, at least compared to the dramatic increase in illiquid (property) wealth among older cohorts.

This suggests that any attempt to develop a solution to the challenge of long-term care funding for older people must begin with, and remain focused on, their property wealth. A model based on older people's illiquid wealth appears preferable to both income and liquid investment-based solutions. Indeed, commentators have long asked where the money to fund long-term care for older people will be found. The analysis above suggests it can be found in the illiquid wealth held by older cohorts.

3) Necessity of redistribution

When individuals pool-risks through the state, this does not just represent a pooling of risk. This mechanism also enables the state to carry out necessary redistribution. Given that contributions into a state-organised risk-pool are means-assessed, i.e. based on progressive taxation, there is an explicit redistribution from wealthier to poorer. This redistribution is necessary because there will always be individuals who do not have sufficient means to insure themselves against key risks, such as ill-health. In this way, the state is able to guarantee social minimums of provision and insurance which society deems morally necessary. This necessity of redistribution also applies to the risk of needing long-term care. Since the private sector is unable to implement such redistribution on the scale required, it is clear that the state must necessarily have a role in pooling the risk of requiring long-term care.

4) Cohort-specific risk pooling

When individuals are insured through the state and general taxation in relation to the various risks that the state insures against, the risk is pooled across all age-groups. However, in light of wealth transfers from young to old, it seems reasonable to limit the amount that working-age cohorts contribute to funding the long-term care of older people, if indeed they should have to contribute anything at all. Changes to assets and debt among different cohorts and the unique demographic specificity of the long-term care funding challenge suggest that the scope of risk-pooling for long-term care be restricted to a specific age-group or cohort. In this way, a new financial burden imposed on younger cohorts would be prevented.

Implicit in the idea of cohort-based risk pooling is a conception of vertical and horizontal inequality, i.e. inequality between cohorts and inequality across cohorts. In response to an increase in inequality between cohorts, models of funding long-term care for older people arguably need to implement risk-pools across cohorts, which use horizontal inequality as a guiding factor for the redistribution from wealthier to poorer.

Why? The necessary redistribution to poorer members of older cohorts can come from wealthier individuals in any age-group, including younger cohorts. However, wealth transfers from younger to older cohorts have bestowed large numbers of older people with unprecedented levels of wealth. A compelling argument therefore exists that it is wealthier older cohorts who must shoulder the burden of funding the redistribution necessary to ensure that all older individuals are guaranteed minimum levels of income and welfare.

4.2 An Outline of a Fair Solution

Already the outline of an alternative model of funding for older people's long-term care has emerged: older people able to use their property wealth to insure themselves through a cohort-specific risk-pool, with a necessary redistributive element.

In Part 2 of this report, this thumbnail outline is expanded into a detailed model.

Key Points from Chapter 4:

- The majority of older people have sufficient wealth to insure themselves against the cost of long-term care.
- Funding models that enable older people to use their property wealth are superior to solutions built around retirement income or liquid assets.
- The pooling of the risk of long-term care should be cohort-based rather than across the whole population.
- There will always be some older people with negligible means who are unable to insure themselves. Any settlement related to long-term care will therefore inevitably have a social insurance, redistributive element.
- The outline of a fair solution to funding long-term care for older people is therefore clear: older people able to use their property wealth to insure themselves through a cohort-specific risk-pool, with a necessary redistributive element.

Part 2

Chapter 5: A National Care Fund

Part 1 of this report has set out the challenge of funding long-term care for older people. The reasons for the lack of a developed private sector insurance market have been outlined, including the inevitable need for some public involvement to enable redistribution to older people with few assets who must nevertheless be guaranteed a minimum, socially acceptable, level of care.

State-organised, taxation funded models for universal free care have been examined and found to contain important redistributive elements from young to old which are potentially unfair and threaten intergenerational equity. Such problems merely compound the long-observed problems inherent in such models around their low-levels of fiscal sustainability.

From the preceding analysis, a few basic principles for an alternative model of long-term care funding were derived. These suggest that older people should be able to use their property wealth to insure themselves through a cohort-specific risk-pool. The necessity of redistribution highlights the requirement of a role for the state. However, the inequalities in means, and therefore expectations, across older cohorts also suggest a role for the private sector.

Various models could be developed to fit around these principles. For example, a hypothecated tax on capital gains on primary homes for individuals over 65 would match some of the outcomes required. However, such a model would be deeply unpopular, and policymakers have long avoided hypothecated taxes (specific taxes tied to specific services or outcomes) for fear of 'opening the barn door' to a stampede of demands for hypothecated taxes, breaking down the legitimacy and credibility of general taxation. A negative public response would almost certainly characterise another possible model: legislation making the purchase of long-term care insurance from the private sector compulsory for older cohorts.

What sort of model is needed? A system is needed which makes comprehensive provision for the basic welfare needs of citizens, incorporating high-levels of risk-sharing with a redistributive element from wealthier to poorer, organised by the state but not funded through general taxation. Policymakers in many countries have found themselves attempting to devise such a system in relation to dilemmas around welfare-state risk-sharing. Time and again, they have adopted a specific model from the 'policymakers toolbox'. This is the 'social insurance fund'.

5.1 Social Insurance Funds

The UK has never had a social insurance fund, despite them being common in many western European countries. As a result, many people are unfamiliar with the concept. What is a social insurance fund? No two social insurance funds are exactly the same, but they generally have the following characteristics:

- A large insurance scheme that insures citizens in relation to a specific set of risks.
- An explicit recognition of social solidarity usually coupled with a redistributive element in relation to needs and income.
- The benefits, eligibility requirements and other aspects of the Fund are clearly defined, generally by the state.
- Funded by taxes or specific premiums paid by (or on behalf of) participants but without necessarily excluding other sources of funding, such as ongoing state contributions or other 'top-ups'.
- Explicit provision is made to account for variations in income and wealth.
- Contributions to the Fund are progressive, and adjusted to individuals' means or income.
- The fund relates to a clearly defined section of the population.

- Participation in the Fund is either compulsory, or made sufficiently attractive through subsidy or other means, such that high rates of participation result.
- Levels of contributions will often have an upper-limit in order that those at the top of the income or wealth scale do not have to make levels of contributions that would be considered excessive or make the entitlement benefits poor value to what could be provided by an equivalent private sector insurance product.

The best way to understand how social insurance funds operate is to consider an actual existing fund in operation. A case study of Ireland's national Social Insurance Fund is therefore provided.[16]

Case Study: Ireland's Social Insurance Fund

Most employers and employees (over 16 years of age) in Ireland pay social insurance contributions into Ireland's national Social Insurance Fund to be entitled to a range of benefits. In general, the payment of social insurance is compulsory. Health is dealt with separately (individuals are expected to pay a 'Health Contribution' charged at 2% on all income, and not paid into the Social Insurance Fund, but to the Department of Health and Children to fund health services in Ireland).

If someone is in employment, the amount of social insurance they pay depends on their earnings and the type of work they do. For people in employment in Ireland, social insurance contributions are divided into different categories, known as classes or rates of contribution. The type of class and rate of contribution paid is determined by the nature of employment. For example, a person employed in a supermarket earning less then €38 per week will be insured under Class J. If that person earned over €38, they would probably be insured under Class A. In fact, most employees in Ireland pay Class A PRSI. This class of contribution will usually entitle someone to the full range of social insurance payments that are available from the Department of Social and Family Affairs, assuming someone meets the qualifying criteria.

A wide range of benefits are available to people who have paid social insurance. Entitlement to these benefits is dependent on a number of conditions other than the social insurance contribution requirement. The social insurance qualifying criteria vary depending on what payment a person is applying for. In general, the following will be examined:

- What class/classes of social insurance a person has paid;
- The age when a person started making social insurance contributions;
- How many paid and/or credited contributions a person has made since entering insurable employment.

The social insurance payments (i.e. benefits) that are available include: jobseeker's benefit; illness benefit; maternity benefit; adoptive benefit; health and safety benefit; invalidity pension; widow's/widower's contributory pension; guardian's payment, and carer's benefit.

[16] The details of this case study have been adapted from Ireland's "Citizen Information" website. See: http://www.citizensinformation.ie

5.2 A UK Social Insurance Fund for Older People's Long-term Care

The framework of a social insurance fund can be applied to the principles derived above for a fair solution to funding long-term care for older people in the UK.

This suggests the creation of a social insurance fund in the UK, limited to older cohorts as a defined population, in which older people would be able to participate using their accumulated property wealth, and which would pay for a defined socially acceptable level of long-term care for everyone in the Fund. In effect, the social insurance fund would be a provider of a 'pre-funded' insurance product for long-term care, in that individuals would ideally be enrolled before they require care.

As a *social* insurance fund, contribution levels would be determined by overall measurement of assets and income. However, benefit entitlements would be universal and fixed at a level which would provide at least the minimum level of benefit that society would deem morally acceptable, if not a level of care above this socially acceptable minimum.

Social insurance funds are usually given grand and solemn names to underline their importance to social welfare and social justice, and to enhance their credibility. A UK social insurance fund for long-term care could be called the *National Care Fund*, with its implicit echo of the *National Health Service*, which is universally known and has been the core of the UK welfare state for 60 years. This name will therefore be used from now on.

With the outline of a basic model, there are many questions around how a *National Care Fund* (NCF) would operate. These questions include:

- What entitlements would an NCF provide?
- How much and when would individuals contribute to an NCF?
- How would an NCF be operated?
- How would an NCF be promoted to the public?

The following chapters will address these and related questions in detail, beginning with the fundamental question of how sufficiently high-rates of participation in an NCF could be achieved.

Key Points from Chapter 5:

- The model of a social insurance fund is suitable to enabling older people to use their (property) wealth to insure themselves through a cohort-specific risk-pool.
- A UK social insurance fund for older people's long-term care funding could be called the *National Care Fund* (NCF).
- An NCF would provide 'pre-funded' insurance for long-term care, with contribution levels being determined by overall measurement of assets and income. Entitlements would be universal and fixed at a level that would, at the very least, provide the minimum level of care that society would deem morally acceptable.

Chapter 6: Enrolment into a National Care Fund

The longstanding debate around the funding of long-term care for older people is, in a crucial sense, a problem of *agency*. It has long been recognised that large swathes of the older generation have sufficient income and wealth to buy their way into a long-term care insurance risk-pool, whether publicly or privately organised, but there are significant constraints and limits to this taking place.

This chapter therefore considers the two principal mechanisms for achieving participation in a *National Care Fund* (NCF), and their associated problems. The chapter then considers a third potential method for achieving enrolment.

6.1 Compulsory or Voluntary Participation in an NCF?

Participation by older cohorts in an NCF could be achieved through legislation to make participation compulsory, or by making participation entirely voluntary, and therefore discretional. Both approaches are problematic.

- *Compulsory participation in an NCF*

Government legislation would be required to make participation by older people in an NCF compulsory. Proposals for such legislation could be challenged from several quarters.

At a *societal* level, proposals for compulsory participation in an NCF by older people could be deeply unpopular and would risk being perceived as equivalent to a new form of taxation, and an attempt by the state to ‘grab the assets’ of older people.

At the level of the *media*, newspapers may recognise the potential for *compulsory* social insurance contributions by older people to stoke outrage among their readers. Active media opposition to compulsory enrolment into an NCF would therefore be highly likely.

At a *political* level, consensus for compulsory participation in an NCF would have to be achieved and maintained over a long period, i.e. the lifetime of several Parliaments and governments. However, older people’s assets are a much debated and politically sensitive topic, as is shown by the highly-charged debate around inheritance tax. As a result, if political consensus were achieved for compulsory contributions to an NCF, there would always be a significant level of risk that Opposition political parties would fall back on the issue of ‘protecting’ older people’s assets from the state in order to achieve political gain. The political consensus required to implement compulsory participation in an NCF would always be at risk of falling apart.

More generally, considerable courage from a Government with high levels of political capital would be required to introduce a new compulsory levy on older people’s assets. This factor on its own would act as a major barrier to the introduction of compulsory participation in an NCF.

Collectively, these risks suggest that compulsory participation in an NCF would be politically unfeasible, and therefore unlikely to be used by a Government seeking to create an NCF. As a mechanism to ensure enrolment into an NCF, it must be discounted.

- *Voluntary participation in an NCF*

Given the clear problems associated with compulsory participation in an NCF, the simple alternative is to make participation in an NCF voluntary, i.e. at the discretion of older people

and their families. As a nationally organised scheme, which would necessarily have an upper cap on contributions, it would be entirely feasible for the 'insurance product' provided by an NCF to be better value than any equivalent 'product' from the private sector, so there would be considerable incentive to join the scheme. However, despite this, would older people voluntarily choose to participate?

The limits to voluntary participation are very similar to the demand-side limits to the private sector long-term care insurance market. Such is their importance it is worthwhile detailing these factors again:

- Ignorance of the risk of needing long-term care.
- Mistaken belief that free long-term care will be provided by the state.
- The bequest motive – individuals wish to maximise the assets available to transfer to younger family members.
- Belief that family members will provide care, and that formal care will therefore be unnecessary.
- 'Positivity effect'.
- Financial capability – if marketed poorly, and in the absence of previous UK examples of a social insurance fund, older individuals may fail to understand why they should participate in an NCF.
- Inertia – as with many types of financial behaviour, individuals display simple inertia in relation to the risk of needing long-term care.
- Ongoing confusion as to what forms of long-term care will and will not be provided by the state in the future.
- Precautionary saving – individuals know neither how long they will live nor what their end-of-life costs will be, so prefer to maximise their income and assets available to meet these unknown costs.
- Adverse selection – the classic insurance problem of adverse selection may result from voluntary participation. Although, as described, everyone is at risk of needing long-term care regardless of their health profile, some individuals may correctly evaluate their risk of requiring long-term care and choose to participate accordingly, resulting in an NCF comprising mainly high-risk participants.

Even if the benefits of an NCF were marketed highly effectively to older people and their families, significant questions and risks would remain about rates of participation. Creating an NCF reliant on voluntary participation would therefore be highly problematic for any government following this course.

6.2 The Third Way to Achieve Enrolment

It therefore appears that enrolment into an NCF could be highly problematic. Neither compulsory nor voluntary participation mechanisms provide a convincing model of how sufficiently high rates of participation could be achieved through a model that could realistically be implemented. Compulsory participation would be too politically unpopular, and the constraining factors to voluntary participation would likely result in inertia on the part of many potential participants.

This suggests a major challenge to the successful functioning of an NCF. However, a third 'middle-way' model of participation could be achieved which would side-step all of the issues listed above. This approach has not received proper discussion previously in the context of the long-term care funding debate even though it is at the core of a major batch of reforms currently being implemented by the UK Government. This approach is 'auto-enrolment'.

Under the principle of automatic enrolment, individuals are automatically enrolled in a collective scheme, but retain the option to withdraw, i.e. de-enrol. The principle of auto-enrolment is currently a central feature of the Government's reform to the UK pension system. It is worthwhile fully considering why auto-enrolment is being used in these reforms.

Personal Accounts and the UK Government's Pension Reform

At the beginning of the 21st Century, there was widespread recognition that the UK pension system was failing and needed reform. Several complex, overlapping problems were involved. The key challenge was under-saving, i.e. individuals failing to save enough for retirement in personal pensions. Numerous reasons were identified for the prevalence of under-saving:

- Widespread ignorance of the need to save for retirement, particularly among younger cohorts.
- Mistaken belief that the state pension would be enough to meet expected income needs in retirement.
- Financial capability – low levels of 'financial capability' have been found to be widespread in the UK population, and this is identified as a cause of under-saving, and of poor usage of various retirement saving vehicles, including personal pensions.
- Inertia – as with many types of financial behaviour, individuals display simple inertia in the face of complex choices and decisions regarding how much to save for retirement.

The Pension Commission, led by Lord Adair Turner, was asked by the Government to formulate recommendations for addressing the various problems with the UK pension system, including addressing how rates of saving could be increased.

The Commission identified low rates of contribution and participation in private pension schemes, as well as barriers to saving such as inertia. In its Second Report, the Pension Commission therefore reached the conclusion that voluntarism was not sufficient, but that it would not be appropriate to introduce a system of fully compulsory private saving. In particular, the Commission recognized that schemes that relied on voluntarism did not deliver despite expensive Government initiatives to increase take-up, such as the introduction of Stakeholder Pensions.

Instead, the Pension Commission argued for the application of automatic enrolment at a national level to overcome the behavioral constraints to long-term saving, while nevertheless leaving individuals free to make their own decisions. The recommendations of the Pensions Commission have been substantively adopted by the Government. Auto-enrolment is to be applied to so-called 'personal accounts' as part of the National Pension Savings Scheme.

The Pension Commission did not in fact devise the principle of auto-enrolment. Rather, the principle has been applied for many years by some employer pension schemes and, in fact, the government of New Zealand that was the first to implement its usage at a national level.

The model for an NCF outlined here is different to the National Pension Savings Scheme in key respects. However, the principle of auto-enrolment is highly relevant to the problem of long-term care funding in which, as with the problem of insufficient pension contributions, the Government needs individuals to deploy their income and assets in a particular way, but cannot resort to compulsory mechanisms.

The principle of 'auto-enrolment' could be successfully applied to a social insurance fund, such as the model of a *National Care Fund* being proposed here. All individuals above a certain lower age-limit would be automatically enrolled into an NCF but would retain the right to withdraw.

Importantly, it is only the state that has the legitimacy to introduce the mechanism of auto-enrolment and in relation to schemes that are, at least superficially, state-organised. This is especially the case if, as proposed here, the principle of auto-enrolment applies to an

individual's property wealth. The Government could not justify the introduction of auto-enrolment into specific private sector long-term care insurance products.

There are compelling reasons to believe that auto-enrolment would result in high rates of participation in an NCF. Non-participation would require individuals to consciously take the decision to de-enrol, and follow through with action. This would see individuals deliberately choosing to be uninsured, and knowingly accepting this risk. If the Government simultaneously communicated the risks of being uninsured, coupled with the possibility to defer paying a contribution (and therefore to discount the value of this loss), which is described more in the next Chapter, there is a very strong case to believe that the majority of individuals would remain enrolled in an NCF.

It is also worth noting that auto-enrolment overcomes, in a stroke, many of the behavioural and other barriers to the purchase of long-term care insurance. These include: difficulty in predicting care needs and framing an acceptable level of care; difficulty in predicting the cost of care; the psychological barriers to purchasing long-term care insurance; low levels of financial capability and declining cognitive capacity, and inertia.

Having set out the contributory basis for an NCF, the next chapter addresses in detail the mechanics of participation and how this principle could be applied in practice.

Key Points from Chapter 6:

- A critical aspect of the success of an NCF is high rates of participation by older people.
- Two basic approaches to achieving enrolment would be voluntarism and compulsory contributions. However, voluntarism would risk low-levels of enrolment due to the behavioural barriers to participation. Compulsory contributions would risk being viewed as equivalent to a new kind of taxation, and could generate widespread opposition to the scheme.
- The principle of 'auto-enrolment' is already at the centre of the UK Government's reform of the pension system, being applied to the creation of 'personal accounts' into which individuals will save for retirement.
- The principle of auto-enrolment could be applied to the creation of an NCF and would overcome the difficulties posed by voluntary and compulsory participation. On this approach, all individuals above a certain specified age would be automatically enrolled into an NCF but would retain the right to withdraw.
- Applying auto-enrolment to an NCF would likely result in high rates of participation, because de-enrolment requires individuals to actively choose to be uninsured, with the acceptance of associated risks. The Government could help to frame this choice by communicating to individuals the risks and costs of being uninsured in relation to long-term care.
- Auto-enrolment neatly overcomes many of the barriers that inhibit the purchase of long-term care insurance products.

Chapter 7: The Mechanics of Participating in a National Care Fund

The preceding chapter set out the principle that would be used to ensure participation in an NCF: auto-enrolment. This chapter addresses the various issues and mechanics of participation in an NCF from assessment of means through to payment. This is a highly complex topic that cannot be fully addressed in one discussion paper. As a result, recommendations and guiding principles are offered instead of precise prescriptions.

The chapter seeks to address the issues sequentially: when would someone enter the defined age-population for an NCF; when would someone be assessed; how would someone be assessed; when would someone pay, etc.

7.1 When Would People Enter the Defined Population For an NCF?

Having specified that an NCF would be cohort-specific, i.e. participation would be determined by age, it is necessary to identify what the age-limits of the population in a risk-pool for an NCF would be. Clearly there would be no upper age-limit; individuals would remain in the NCF until death.

The lower age-limit is the critical issue. This would be the age at which individuals would be auto-enrolled into an NCF, and liable to make some means-related contribution.

The setting of the lower-age needs to reflect two dynamic processes:

- At a certain age and life-stage individuals do become more aware of the risk of needing long-term care and begin to contemplate how they would come to receive the long-term care that they might require. These changes are associated with passing into a new life-stage.
- The lower age-limit would ideally be below the age at which most people require long-term care. However, health inequalities mean that there is wide variation across older cohorts, particularly among different socioeconomic groups, in when individuals leave the labour market and, more importantly, when individuals begin to need some form of long-term care. Some individuals may require low-levels of social care when still considered to be 'young-old'.[17]

With these processes in mind, several lower-age limits are worth considering:

- The state pension age (SPA) is currently 65, but will rise to 68 by 2050. The SPA is an important 'psychological marker' in the life course, and is the age at which the vast majority of individuals have retired from the labour market. The SPA, in theory, also represents the 'peak' of life course asset accumulation, after which individuals begin to draw down their assets. However, this point is analysed in more detail below.
- The age of 60. Entering the sixth decade is an important psychological marker for many individuals. It is also the age at which many individuals begin implementing plans to retire and convert their assets, i.e. downsize.
- A flexible lower-age limit, tied to when individuals begin drawing down their state pension or claiming pension credit.

Several alternative lower-age limits can therefore be proposed. The guiding principle should be flexibility.

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[17] Given that lower healthy life expectancy and an earlier need for long-term care is associated with poorer socio-economic groups, such individuals would likely make a negligible assessed contribution.

7.2 When Would Individuals Be Assessed For a National Care Fund?

The preceding section addressed when individuals would be auto-enrolled into an NCF. Parallel to this issue is the question of when individuals would be assessed to determine their appropriate contribution to an NCF. As a social insurance fund, a *National Care Fund* would necessarily require contributions to be progressive and proportional to an individual's income and wealth, i.e. contributions are determined by an individual's means.

It would make intuitive sense for someone to be assessed to determine their contribution to an NCF as soon as they reach the lower age limit for an NCF. However, this issue is more complicated than it appears, and requires further discussion because a person's means can vary significantly pre- and post-retirement.

Across the life course, an individual's total income and wealth will vary by life-stage; most people accumulate wealth through pension and other savings during their working life. In addition, an individual's relative income and wealth will vary relative to other members of their cohort.

In theory, the moment that individuals retire, which is usually the SPA, represents the 'peak' of their asset accumulation during their life. However, as was shown by the research summarised in Part 1, significant asset accumulation may continue throughout retirement, as a result of asset price inflation.

This demonstrates the key point: retirement is a dynamic life-stage of both accumulation and decumulation. When individuals enter retirement, their overall levels of assets can increase and decrease during the period of their retirement. Decumulation may follow a period of continued accumulation. Accumulation might occur after a period of post-retirement decumulation. What can drive these processes? Several common effects may be involved:

- Asset accumulation in retirement can be driven by:
    - House-price inflation that causes the total wealth of property-owners in retirement to increase.
    - Inheritance or gift-bequests.

- Asset decumulation in retirement can be driven by:
    - The conversion of assets into income. For example, individuals may downsize their property to release equity, which is then used to purchase an annuity that will increase their retirement income.
    - The bequest motive – individuals may transfer wealth to younger family members. This may occur in order to escape inheritance tax, or be on the basis that these relatives have greater need for the money.
    - High levels of spending or large charitable gifts.

These dynamic phases of accumulation and decumulation, and the variation among individuals, complicates the issue of when someone should be assessed for their contribution to an NCF. Whereas currently, individuals are assessed by local authorities when they reach the point of requiring care, the essence of a social insurance fund is that individuals pay a means-adjusted contribution long before they may need to draw on the fund.

However, if significant accumulation can occur in retirement, when is the appropriate moment to assess an individual's means to determine their level of contribution into a social insurance fund? An assessment of income and assets that took place at the start of retirement may become inappropriate, particularly if an individual was to receive a large inheritance in retirement, or experienced a large increase in the value of their property wealth, over and above inflation in property prices nationally.

This is a difficult question; however, it is not an overwhelming problem. Indeed, to some extent, the questions may be immaterial. Why? Given stratified patterns of wealth holdings

across UK society, it is reasonable to hypothesise that individuals who would be likely to receive large amounts of wealth in retirement would already have significant levels of wealth, and as such that they would anyway be subject to the necessary upper-limit charge for participation in an NCF (the rationale behind an upper limit is explained below). The receipt of a large amount of inheritance capital would not therefore actually affect their level of contribution.

The conclusion of this long discussion is therefore that although retirement is a dynamic period of life course asset accumulation and decumulation, on balance, the assessment of an individual's assets and wealth probably should be at the entry-age into an NCF.

7.3 What Would Be Assessed?

In order to determine an appropriate level of contribution to an NCF, taking account of the social insurance element and the necessary variations in contribution depending on means, an assessment of an individual's wealth and assets would be required. The full range of income and assets that individuals possess in retirement include:

- Income from the state pension, personal pensions and other investments.
- The full range of liquid assets and investments, such as ISAs, shares and savings bonds.
- Illiquid assets, i.e. property, including primary and secondary homes.

Means-testing is criticised by some as a mechanism that penalises savers. However, by incorporating property in the range of assets that will be assessed to determine levels of contribution to an NCF, such assessments of means could not be described as penalising saving. This is because the value of illiquid assets individuals possess in retirement (their total property wealth) typically comprises a larger part of their total wealth portfolio, and usually dwarfs volumes of savings and liquid assets. The value of such illiquid assets is determined largely by inflation in house-prices. Incorporating an evaluation of wealth and means that incorporates property wealth has limited scope to deter saving.

7.4 How Would an Evaluation of an Individual's Means and Assets Be Undertaken?

The operation of an NCF would require an assessment of an individual's means and assets to be undertaken. Such a detailed aspect of implementation cannot be fully addressed here, and precise recommendations are not therefore offered.

Nevertheless, some comments on feasibility can be undertaken by reviewing the landscape of organisations and mechanisms in place that already involve assessments of means.

In this regard, it is worthwhile highlighting the Pension Service, which is part of the Department for Work and Pensions, and already regularly assesses the assets and incomes of older people in relation to Pension Credit, Housing Benefit and Council Tax Benefit. Such information could already by used to assess the contributions individuals would have to make to participate in an NCF.

It must be acknowledged that such means-testing is subject to criticism and, indeed, means-testing is a blunt policy tool. The Government itself estimates that around £2 billion in Pension Credit goes unclaimed each year.[18] However, the Government is fully aware of such problems, and the creation of the Pension Service is itself, in part, a response, focusing as it does on positive entitlements in order to remove the perceived 'shame' of being means-tested.[19]

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[18] See DWP (2006).

[19] Any means-assessment creates incentives for individuals to engage in 'deliberate deprivation' of assets. At present, it is recognised that individuals who are subject to a means-test to evaluate their contribution to the costs of long-term care may engage in transferral of their wealth in order to protect

Beyond the current infrastructure, such as the Pension Service, it would be necessary to develop further mechanisms for assessing individuals' means. This implementation challenge would be significant. However, it is worth noting two points:

- Although this assessment may be invasionary, it would be undertaken in the context of an organisation – a social insurance fund - that was arms-length from the Government and the state.
- The charging structure for an NCF would include an upper limit that around one third of the older population would automatically qualify for by, for example, owning a house worth over £400,000. The poorest segments of the older population are already means-assessed by the Pension Service. In this context, only around one third to one quarter of the older population would truly be subject to a new form of means-assessment through the implementation of an NCF.

7.5 When and How Would Individuals Pay to Participate in an NCF?

As indicated by the previous discussion, the full-range of assets and income that individuals possess in retirement would have to be taken account of in evaluating the charge that would be levied for participation in an NCF.

The key guiding principles that would determine when and how individuals pay their contribution to an NCF would be choice and flexibility, to take account of the full variation in individual circumstances, but also to allow as much choice as possible so that individuals can exercise their preferences.

It is often observed by commentators that the 'baby-boomer' generation *expect* choice and prize it as a good in itself. However, it is important to recognise that individuals may actually need choice and flexibility in when and how they contribute to an NCF.

If older cohorts are to be enabled to use their *illiquid* property wealth to insure themselves in relation to long-term care, this suggests a scope for individuals to defer their contribution to an NCF. It would not be desirable for individuals to be forced to sell their properties in order access this wealth. The option to defer payment, potentially for several decades, would therefore be needed.

The critical consideration here is the wide variation among how individuals allocate their wealth in retirement. For example, some individuals may downsize from a large house to a small house in order to release capital, which can be converted to retirement income. This shows a preference for using retirement wealth on general consumption, rather than housing. Some individuals may settle for a relatively low income in retirement in order to have their wealth in their property, because they prefer to live in a large home, or an expensive area, rather than have a higher income.

Over the course of a person's retirement, these preferences may well change. In effect, the choice of when to pay into an NCF would represent just one more allocation choice that individuals would confront in retirement. Crucially, some people may prefer to defer payment during their lifetime, and instead have the contribution levied as a charge on their estate after death, and the model of an NCF proposed here would allow individuals to do this.

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this wealth, and to reduce their relative contribution to the costs of their care. The Department of Health's Charging for Residential Accommodation Guide (CRAG) advises local authorities that avoiding accommodation charges does not have to be the only motive behind a transfer of capital in order for it to be treated as deliberate deprivation but it must be a significant one. Under section 21 of the *Health and Social Services and Social Security Adjudications 1983*, if a resident has 'deliberately deprived' themselves of an asset, the local authority can seek to recover any sums which it consequently has to pay towards the resident's care costs from the person whom the asset was transferred to. This power can only be used if the deliberate deprivation occurred within six months of the resident approaching the local authority for funding.

Having set out these dynamic considerations, it is possible to hypothesise some scenarios:

- Some individuals will prefer to pay the full assessed amount in full as soon as they reach the defined assessment-age, using their liquid assets or income.
- Some individuals will prefer to pay their assessed amount in stages, e.g. on a monthly or yearly basis, drawing on their retirement income from investments and pensions, or through the liquidisation of their assets.
- Some individuals, for example, with low income and liquid assets, may prefer to use their property wealth to cover the charge for participation in an NCF. In effect, they will defer payment until whenever that property wealth is released, i.e. when the property is sold, either on death or when an individual moves into a care home.

Enabling individuals to pay into an NCF at some unspecified time in the future, including after death, should increase participation rates because individuals will 'discount' the future loss of wealth, compared to that loss taking place in the near-term.[20]

The organisational and governance mechanics of how individuals would pay into an NCF represent an implementation challenge, and precise answers will not be attempted here. However, again the starting point would be the current landscape of institutional arrangements that oversee the payment by older individuals of contributions to their long-term care.

7.6 How Much Would Individuals Have to Pay?

The above sections have outlined when and how individuals would be assessed for their contribution to an NCF, and the maximum flexibility and choice that would be provided to individuals in when and how they pay. This section addresses the crucial question of how much individuals would have to pay to join an NCF.

Defining the scale of enrolment fees for joining an NCF would require extensive consultation with older people and their families, as well as research and forecasting into long-term trends for unpaid care provision, demand for formal long-term care, and likely trends and innovations in the form and delivery of formal long-term care provision, etc.

As a *social* insurance fund, enrolment into an NCF would necessarily involve variation in participatory contributions according to wealth and means.

It is clear that there would have to be an upper-limit on contribution levels. This is because otherwise, those individuals further up the income and wealth scale would find their contributions poor value compared to equivalent insurance products offered by the private sector, and would therefore be heavily incentivised to withdraw from the Fund, undermining its sustainability and scope for redistribution. In this sense, there would be an upper *default* value, which a large swathe of the older population would be charged for.

More generally, the insurance entitlements provided by enrolment into an NCF would need to represent good value for all individuals across the full spectrum of income and wealth, in order to achieve widespread support and participation. Nevertheless, because of the economies of scale associated with an NCF, it is entirely feasible that individuals with income and assets above the average could be required to pay above-average contributions without such contributions representing poor-value compared to private sector alternatives.

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[20] This insight is gained from behavioural economics, which suggests that individuals engage in 'hyperbolic discounting', i.e., individuals value outcomes in the near term more than in the long-term. The second insight from this field is loss aversion, which is the empirically demonstrated tendency for people to weigh losses significantly more heavily than gains. Considered together, this suggests that individuals may be more accepting of a loss of income and wealth the further into the future this loss occurs. For an example of how this has been incorporated into a model of a pension saving program, see Thaler R and Benartzi S (2004).

The amounts that individuals contributed for participation in an NCF would therefore vary across the older cohorts. However, for the sake of the argument being developed here, it is proposed that the *average* charge be £10,000. This is a large amount. However, it is worth putting it in some context.

In 2005, an average 65-year old had net non-pension household assets of £209,000. This amount represented an increase of around £122,000 from 1995, or an average increase of £12,000 per year over ten years. If the minority of non-property owners were excluded from this calculation, these figures would be higher. Clearly, an older person's household will on average include a spouse who will have a claim on half the household's assets. However, it is clear that the proposed average charge would be far from unaffordable for an average 65-year old.

If the average charge for participation in an NCF was to be £10,000, this would involve those individuals with above-average income and assets contributing more, e.g. £12,000. Within an NCF, there would then be a subsidy, i.e. a redistribution from wealthier to poorer individuals. In this way, the 'social' element of the social insurance fund model is explicit. If the effective cross-subsidy from wealthier to poorer was insufficient, the state could then 'top-up' the notional contributions from the poorest individuals.

At the bottom of the contribution scale would be individuals with the lowest income and means. These may be individuals with no personal pension, living in socially or privately rented accommodation (i.e. without any illiquid wealth), with no liquid assets, and in receipt of pension credit and other associated retirement income benefits.

How would the lower level of contribution be set? For anyone with capital below the current capital limit of £21,500, there would be an incentive to withdraw from an NCF. This is because such individuals would be entitled to free state-funded long-term care regardless of whether they were enrolled in an NCF. There are several possible responses to this issue, which would determine the lower level of contribution to an NCF:

1) The capital limit of £21,500 could be lowered, so that the amount of people in this category was reduced to a negligible number. However, it has to be recognised that even if the lower capital limit was £1, there are still individuals with effectively no assets.
2) The Government could pay the contribution of someone with less than £21,500 of assets. In effect, the Government would be creating a new benefit for older people; a contribution to an NCF. By doing this in a visible way, the Government would enhance the perception that all individuals were paying into the fund; the Government would 'normalise' contributions. More importantly, by paying a contribution fee for enrolment into an NCF on behalf of the poorest older individuals, the Government would transfer the risk of paying for their care to an NCF; more individuals would be placed in the cohort-based risk-pool.
3) The Government could undertake a combination of 1 and 2.

There are also questions around those with assets just above £21,500. For example, individuals with £30,000 might be incentivised to leave an NCF if they only had £8500 of wealth at risk, and were asked to pay a substantial contribution. This demonstrates that the contribution amounts for less wealthy households would have to be set very carefully. For example, someone with £30,000 of assets might only have to pay £200 (possibly with a top-up from the state). In effect, such individuals would be getting insurance cover worth £8500 for the cost of £200. More than that, many people would also value the opportunity to 'pay their due'.

By enabling such a supplementary payment by the state into an NCF, this would give scope for the state to increase the value of its contributions, i.e. to act as a top-up to an NCF, if it became clear that the scale of contributions was not enough to fund the defined benefits it was obligated to provide. It would also allow the Government to reduce the amount of effective redistribution that would have to occur from wealthier to poorer older individuals within an NCF.

7.7 Payment, Deferral and Interest

An important consideration regarding when individuals would pay into an NCF is the issue of interest. As has been described, it would be important for an NCF not to penalise individuals whose wealth was tied up in property and who therefore wished to defer their payment contribution to an NCF, potentially until after their death. Indeed, enabling older people to use their property wealth in this way is one of the basic principles behind the model of an NCF, as proposed here.

However, if individuals do choose to remain enrolled into an NCF but defer payment, then in effect this 'debt' to an NCF would have to accumulate interest. As a social insurance fund with the backing of the state, an NCF would be able to charge very low, non-commercial levels of interest if this mechanism was required. An equivalent model here is the current UK system of student loans for higher education. Such loans are underwritten by the state and are therefore subject to a very low rate of interest, which is below commercial rates. For 2007/8, the interest on such loans was 4.8%. By ensuring that an NCF charged a similarly low level of interest, the state would not penalise individuals who wished or had to defer their payment and therefore accrue interest. It is worth noting that over the long-term, the interest charged on loans underwritten by the state are usually below average growth in the value of assets, such as property.

7.8 Auto-enrolment and the Default Payment Mechanism

The principle of auto-enrolment in the context of a social insurance fund implies that following assessment, the method and timing that individuals would pay into the fund would be subject to a default position. If individuals do nothing, do not specify when or how they wish to pay into an NCF, there must be a default mechanism through which payment will occur. What should the default be?

Again, the fact that so much of older people's wealth available to contribute to an NCF is tied-up in property indicates that the default mechanism for auto-enrolment should focus on their property wealth. Since it would be unfeasible and undesirable to require individuals to move home during their lifetime, this suggests that the default payment mechanism should actually occur after a person has died. In effect, therefore, the default position for an NCF becomes a charge, with an associated accrual of interest, levied on an individual's estate after their death.[21]

7.9 Auto-enrolment, Exit and Re-enrolment

For a social insurance scheme to work, as for any kind of insurance to be effective, there must be clear risks and costs associated with non-participation, i.e. for individuals to be un-insured. This incentive mechanism is required, otherwise no individual would choose to be insured.

The implementation of this 'penalty mechanism' which penalises the non-insured is arguably the hardest part of a social insurance fund to implement. In this sense, the strength of the UK Government's position in this regard is that the penalty mechanism already exists and is embedded: it is the current long-term care system, which penalises individuals who have not insured themselves against the risk of needing long-term care. This means that the current charging structure for long-term care with a capital threshold of around £21,500 would remain or, as outlined above, may be lowered.

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[21] In this way, an NCF would function as an optional and progressive inheritance tax to pay to cover the cost of contributing to a social insurance fund.

As described, the principle of auto-enrolment would see people automatically enrolled into an NCF. What would happen if individuals did choose to de-enrol, exit the risk-pool of the NCF and lose entitlements to the benefits of participation?

As is set out in more detail below, de-enrolment would give the state the opportunity to contact individuals to remind them of the risk of requiring long-term care, and the financial costs associated with it. Individuals could be encouraged to purchase long-term care insurance from the private sector, or to re-enrol into the NCF.

Should individuals be allowed to re-enrol into the Fund? There are arguments for and against this. For example, by not allowing re-enrolment, the Government would maximise the incentive for individuals to remain in an NCF. On the other hand, since the Government needs as many individuals as possible insured against the risk of long-term care, it could make sense to allow individuals to re-enrol, albeit under certain penalty conditions. Following a cooling-off period, the Government could increase the charge associated with re-enrolment into an NCF, with this amount increasing the longer that someone is de-enrolled.

However, for the NCF to operate as a social insurance fund, there must clearly be the potential for individuals who do withdraw to ultimately be ‘penalised’. If individuals de-enrol from an NCF and do not make alternative provision through purchasing private sector long-term care insurance, these individuals must be subject to the full-means test and charging scheme that currently exists, with the scope for the vast majority of their assets to be used to fund their care.

The greatest risk to an NCF in this regard would be that individuals would choose to de-enrol and subsequently wish to re-enrol when they evaluated the risk of needing long-term care as being higher, i.e. adverse selection. At the extreme, individuals may attempt to re-enrol shortly before they enter long-term care having realised the risks involved.

This suggests that individuals would have to be risk-assessed before being allowed to re-enrol, and that those with higher risks would have to pay a higher charge, or simply be refused.

In one scenario, following a cooling-off period, individuals could be given a time limit, such as one year, after which they will lose the right to re-enrol and will merely be advised by public agencies on private sector insurance products. Alternatively, individuals seeking to re-enrol after this period when they are on the verge of needing care could be allowed to re-enrol but at a much higher charge. In effect, the NCF would then provide an ‘immediate needs annuity’ rather than pre-funded insurance.

7.10 How Would Individuals De-enrol From an NCF?

A variety of mechanisms could be implemented to allow individuals to de-enrol from an NCF. Forms to do this could be provided at GP surgeries, Post Offices and local councils. By filling in and returning such forms, individuals would therefore identify themselves as uninsured, creating potential for the Government to target them with gentle encouragement to become insured, to highlight the risks of needing long-term care and to inform them of long-term care insurance products available from the private sector.

7.11 Funding Care for Those at the Threshold of a National Care Fund

The model for a *National Care Fund* set out in this paper would involve individuals being automatically enrolled upon reaching a certain age threshold, assessed for their level of contribution to the Fund, and becoming entitled to receive a standard level package of care funded by the Fund. A clear question for this model is: what would happen to individuals already in need of care who reach this age threshold?

Clearly such individuals must continue to receive the care which they need. However, several questions are raised: should such individuals be enrolled into an NCF? Should care subsequently be funded by the state or by an NCF? If individuals already in need of care are enrolled into an NCF would this amount to adverse selection?

One option would be for individuals in receipt of care at the age threshold for an NCF to not be enrolled and to have their care funded by the state. This would improve the risk profile of individuals being enrolled into an NCF. However, it would effectively create two classes of people in old age. It would be preferable for all individuals to be notionally treated the same

Would enrolment amount to adverse selection? To the extent that adverse selection amounts to a *deliberate* attempt to game an insurance pool, it would not and, for this reason, there would be no point in considering the imposition of a 'penalty fee', that might be considered for those seeking to *re-enrol* into an NCF. This approach is also coherent with the underlying principle of an NCF, i.e. cohort-based risk pooling.

It is therefore proposed here that upon reaching the age threshold of an NCF, individuals already requiring care should be auto-enrolled and assessed for their means like other individuals and, subsequently to have an appropriate level of care funded by an NCF.[22] However, to take account of the fact that such individuals already require care, it is proposed that the Government would contribute an amount to an NCF for each such individual equivalent to the cost of an immediate needs annuity to fund the standard benchmark package of care.

7.12 Funding Long-term Care for Younger Groups

Since there is no reason to expect demand for long-term care among such age-groups to increase in coming decades, the funding of care for these groups poses a less of a challenge for policymakers. Although such groups are not the principal focus of this paper, the success of the long-term care funding arrangements for older people proposed in this paper would require coherence with the funding of long-term care for other groups.

Children requiring care are entitled to disability living allowance (DLA), which is a tax-free benefit for children and adults who need help with personal care or have walking difficulties because they are physically or mentally disabled. This financial support from the state is coherent with the proposals in this paper for a *National Care Fund* to fund long-term care for older people.

Adults requiring help with personal care or who have walking difficulties because they are physically or mentally disabled are entitled to DLA. Again, this financial support from the state for working-age adults requiring care is coherent with the proposals in this paper.

Key Points from Chapter 7:

- A lower-age band for an NCF would have to be fixed, either at the SPA or some lower age. A flexible lower age-limit may be the best approach.

[22] Would it be appropriate to assess the means of someone already requiring care for their contribution to an NCF? The important factor here is that contributions are appropriate to a level of means. If an individual had spent many years unable to work and therefore had negligible assets, their contribution to an NCF would be commensurately negligible. If somone was in possession of significant wealth despite being disabled, for example, through the receipt of a large inheritance, it would be fair to expect a contribution to an NCF. This would ensure that all are treated equally, and recognise that even those with disabilities are able to make a contribution to social insurance. This is especially true for those individuals who require care but are nevertheless able to work, and wish to make a contribution to society and social insurance like everyone else.

- On balance, it is probably most appropriate for individuals to be assessed for their level of contribution for joining an NCF at the same time that they automatically enrolled into the Fund.
- The full range of income, liquid and illiquid assets would be subject to assessment.
- The assessment of means could take place through various mechanisms, and could build on the current architecture for assessing older people's means, particularly the Pension Service.
- Individuals would be given the maximum choice and flexibility in how and when they paid their contribution into an NCF, including the options to pay in full on enrolment, to pay regular instalments from pension income, or to defer payment until after death, so that an appropriate charge is levied on their estate.
- The upper level of contribution into an NCF would depend on a number of factors, not least the benefits that would be payable, i.e. the socially acceptable minimum level of care. For the sake of argument, £14,000 is proposed as an upper-limit, with £10,000 being the average contribution fee.
- In relation to a lower-level of contribution for those with negligible income or assets in receipt of the full range of retirement benefits, there would be an incentive for individuals with less than the current capital limit of £21,500 to withdraw from an NCF. The Government could lower this limit but, preferably, could undertake to pay the contribution to join an NCF on behalf of the poorest older individuals. This new 'benefit' would help to normalise universal enrolment but, more importantly, would transfer risk from the state to an NCF. Such a measure would also give the state scope to supplement the redistribution that would take place anyway within an NCF.
- Deferring payment would require interest to be paid but this could be at a low level, equivalent to current loans to citizens underwritten by the state, such as loans to cover student tuition fees. These interest rates are actually below long-term rates of growth in the value of assets, such as property.
- Given the use of auto-enrolment, an NCF would require a default payment mechanism to operate, i.e. if individuals do nothing. On balance, it would make sense for this default payment mechanism to be a charge on a person's estate following their death.
- The current UK charging structures for long-term care currently penalise individuals who are not insured in relation to long-term care. In order to incentivise insurance, this system could be mostly retained.
- Individuals who choose to de-enrol from an NCF could be allowed to re-enrol but charged a higher joining fee, as well as being encouraged to purchase private sector long-term care insurance products. Those who sought to re-enrol at a much later stage, for example, when they were close to requiring expensive long-term care, could be allowed to re-enrol but for a significantly higher joining fee, so that insurance offered by an NCF was in effect an 'immediate needs annuity' rather than 'pre-funded insurance'. Alternatively, the Government could maximise the incentives to remain in an NCF by not allowing re-enrolment under any circumstances.
- De-enrolment could occur through individuals completing and returning a form available from suitable agencies, such as the local council and GP's office. In this way, individuals would usefully identify themselves as uninsured in relation to long-term care.
- Individuals already in need and in receipt of care at the age threshold for an NCF would be assessed and enrolled like all others. However, for each such individual, it is proposed the Government would contribute an extra amount to the NCF equivalent to the difference in cost of an immediate needs annuity to fund the standard benchmark level of care for this person.

Chapter 8: What Would a National Care Fund Pay For?

The previous chapters have explored how enrolment into a *National Care Fund* would be achieved, and some of the mechanics for operating an NCF.

This chapter addresses what an NCF would pay for, i.e. having been enrolled into an NCF and assessed for a defined level of contribution, exactly what benefits would be provided by an NCF?

A simple answer to this question is available: as a social insurance fund, an NCF would pay for – at the very least – the minimum socially acceptable level of long-term care, following an assessment of need.

However, although the benefits of an NCF would be universal – the same for everyone enrolled – defining this standard level of long-term care that would be funded by an NCF needs to take account of multiple complex factors. In addition to the scale of enrolment fees for an NCF that could be feasibly implemented, these factors include:

- The multiple components of long-term care, including those non-essential components, which nevertheless have important preventative or health-determining aspects.
- Variations in preferences, setting and funding delivery.

These different factors are reviewed in more detail below. However, this is a highly complex issue that cannot be adequately addressed in the context of a single discussion paper. Instead, some guiding principles are suggested.

8.1 The Multiple Components of Long-term Care

The difficulties in defining long-term care were identified at the very start of this paper. Perceptions of what constitutes long-term care can be subjective. When 'long-term care needs' overlap with 'health-related care needs', it can be extremely difficult to classify long-term care, and therefore how care should be paid for. Such a difficulty is inevitable in any funding model that distinguishes between long-term care and health care, but this difficulty is not insurmountable.

Detailed below are some of the different components of long-term care that could be funded by an NCF as part of the 'standard-level package of care' that it would provide to those assessed as needing care. These components are described, along with consideration regarding whether they should be paid for by an NCF.

- *Nursing care*

At present, everyone in need, regardless of setting and means, is eligible for NHS-paid care from a registered nurse. It could be argued that following the creation of a social insurance fund for long-term care, such a fund should provide entitlement to nursing care so that existing state-spending on nursing care for older groups should cease or be channeled through the social insurance fund.

However, if an NCF, as proposed, was optional and based on auto-enrolment, it would be unfeasible to make entitlement to free nursing care dependent on participation in an NCF. For

this reason, it is proposed that entitlement to nursing care should continue to be funded by the state on a universal and free basis.

- *Personal care*

Personal care is usually viewed as including help with personal hygiene, continence management, food and diet, mobility problems, and the administering of simple medical treatments. Personal care can be provided in a residential setting, i.e. a care home, or in a domiciliary setting, i.e. in someone's own home or that of their family.

Personal care is free in Scotland up to a defined level of contribution. In the rest of the UK, personal care is paid for entirely out-of-pocket, until capital has been depleted down to the level of £21,500.

Since the current cost of personal care places such a burden on families, and this element of long-term care is likely to increase as a financial burden on society, it is proposed that personal care be included in the benefits funded by an NCF up to a certain defined level. Indeed, as a fundamental component of long-term care, an entitlement to a defined level of personal care would clearly need to be a principal benefit of participation in an NCF.

- *Hotel costs*

Hotel costs refer to the non-nursing and non-personal care costs associated with residential care in a care home. Rather like actual hotels, variations in hotel costs depend on the associated level of quality of accommodation they provide. Dignity in care is felt to require a 'hotel' in which most people of any age would not actually object to living in. 'Hotel costs' significantly determine quality of life for individuals receiving care.

The introduction of an NCF, and the sharing of the risk of needing care is therefore an opportunity to increase the amount available to spend on hotel costs. This will directly lead to improved quality of life for care home residents and greater dignity. However, since some individuals choose to receive care in a domiciliary setting, and do not therefore incur hotel costs, this suggests some form of payment similarly directed at improving a person's accommodation be available for those receiving care in the domiciliary setting, albeit without being financially equivalent to hotel costs.

- *Non-essential components*

Beyond the main recognisable components of long-term care, it is possible to identify services, particularly for those with low-levels of need which might be seen as 'non-essential', but which are important because they improve quality of life and are preventative, i.e. their provision helps to prevent or delay higher and more expensive levels of need. Prevention is cheaper than treatment, and it would be cheaper overall for an NCF to fund some non-essential preventative components of long-term care to reduce the subsequent demand and cost of higher levels of care. This suggests that such components of long-term care, such as appropriate adaptations in the home, should indeed be among the basic package of benefits funded by an NCF.

8.2 Principles for Responding to Variations in Preferences, Setting and Funding Delivery

In addition to the different core components of long-term care, further complexities result from variations in preferences, setting and funding delivery. A guiding principle for defining the standard package of care funded by an NCF would be neutrality in relation to these variations. For example, an NCF should not privilege one care setting over another. Some individuals may choose to remain in a domiciliary setting. This removes some of the hotel

care costs associated with residence in a care home but may incur higher costs in other forms, for example, the unit costs of personal care.

A further guiding principle for defining the benefits payable by an NCF would be to avoid penalising individuals for variations in preferences.

In terms of funding delivery, some cover provided by an NCF would be provided directly to the providers of care, for example, a nursing home. However, there has been an increasing trend in recent years toward autonomy, control and personalisation in care funding for those in a domiciliary setting. This trend has culminated in recent Government policy for 'Individual Budgets'.

'Individual Budgets' is a scheme for individuals in the community, designed to put the person who is supported, or given services, in control of deciding what support or services they get. Individual budgets let people use the money in a way that best suits their own needs and situation. Individual budgets are flexible enough to allow people who are satisfied with existing services to keep these, and also give people a range of options for building up more individually tailored support, using Direct Payments and other routes.

A further guiding principle for defining the benefits of an NCF would therefore be neutrality in the mechanism of 'funding delivery', so that individuals are able to use schemes such as Individual Budgets to create their own packages of care, funded by an NCF.

The creation of a social insurance fund and a risk-pool relating to long-term care implies pooling different kinds and severity of risk. An important principle of setting the benefits payable by an NCF would therefore be that it would not privilege particular kinds of conditions over others, and would treat different levels of conditions equally.

Finally, it would be important to design the benefits of an NCF to be coherent and fair in relation to different types of housing with care schemes, such as 'extra care'.

Key Points from Chapter 8:

- Although an NCF would provide a defined universal set level of entitlements, these will be entitlements to different types of long-term care in different settings.
- It is proposed that nursing care should continue to be funded by the state, and would not fall within the benefits of an NCF.
- Personal care and 'hotel costs' should be funded by an NCF, as well as 'non-essential components' of long-term care which may have important preventative impact.
- It is important that the defined benchmark package of care funded by an NCF be neutral in relation to type and severity of condition, setting (domiciliary vs. residential), and form of funding delivery (direct payment, individual budget, etc.).

Chapter 9: Achieving Comprehensive Insurance - A Complementary Market in Private Sector Insurance

The preceding chapter proposed some principles for defining the standard benchmark package of care that would be funded by a *National Care Fund* (NCF). At the very least, this would be the minimum socially acceptable level of long-term care, following an assessment of need. This chapter explores the necessity of a complementary market in private long-term care insurance products, their interaction with an NCF and how some of the barriers to this market could be overcome in the context of an NCF.

9.1 The Necessity of a Complementary Market in Private-Sector Long-term Care Insurance

A full solution to the challege of funding long-term care for older people must involve recognising wide variations in means among older cohorts, as well as variations in expectations of levels of care, and in what indvididuals deem sufficient. Given variations in wealth, there will always be some among older cohorts who will choose to spend their wealth on achieving a level of care above what can be provided through any publicly organised scheme, whether funded by the state or a social insurance fund. The continued high-levels of self-funding in Scotland by those notionally entitled to 'free personal care' demonstrates this inevitability. In this sense, maximising equality in care provision is unfeasible, not least because how much capital individuals wish to allocate to different types of care costs is dependent on their preferences.

However, when individuals 'top-up' their care through self-funded out-of-pocket payments on top of a benchmark level of care funded by the state (or a social insurance fund), this represents a failure of policy. Long-term care is an insurable risk, and it is unnecessary, preventable and, in fact, pointless for individuals to have to run-down their assets to provide a level of care which they deem desirable, or to pay out-of-pocket. An effective insurance solution should always be cheaper.

This suggests that a complete solution to the challenge of long-term care funding requires every individual to be insured up to the level of provision which they deem acceptable, in the context of their preferences and means. Since the proposal for an NCF set out in this paper would provide a basic package of care that was - at least - the minimum socially acceptable level of care, this means further insurance in relation to long-term is required. The most logical provider of this insurance would be the private sector. For this reason, policymakers concerned with a full response to the problem of funding long-term care for older people must also be concerned with developing a fully-functioning market in pre-funded long-term care insurance products.

It is important to understand that this task for policymakers is not merely *additional* to achieving the universal coverage and social insurance in relation to long-term care which, as is proposed in this paper, could be achieved through a *National Care Fund*. In fact, the success of an NCF would depend on the existence of a fully functioning complementary private sector market for long-term care insurance markets, and vice versa: one cannot succeed without the other.

Why is this the case? In order to succeed, an NCF would require widespread consensus, support and participation across all income and wealth groups, and an acceptance among those with higher income and wealth of the progressive nature of the contributions to an NCF, i.e. that poorer individuals would pay less.

In addition, the unfairness of having to run-down assets in order to fund an acceptable level of care is keenly felt by individuals high up the income and wealth scales. Their support for any new system will be dependent on them not continuing to be struck by this unfairness.

In order to maintain support and consensus for a social insurance mechanism, policymakers therefore need to ensure that wealthier individuals are able to insure themselves to the level of care which they deem acceptable. As outlined in Part 1, the objective of Government policy should be for every individual to be fully insured in relation to long-term care up to a level that is consummate with their needs, wealth and expectations. If the Government does not do this, it could expect widespread disengagement and low support for an NCF, and for the entire social insurance mechanism to potentially collapse.

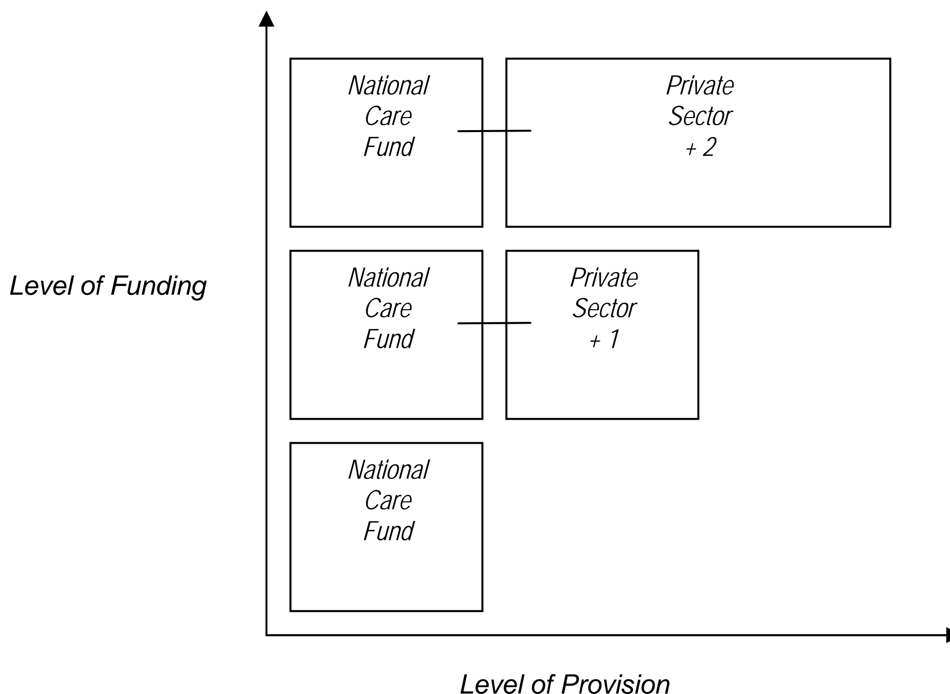
9.2 Scoping Complementary and Interlocking Private Sector Insurance Products

The operation of a fully-fledged market in long-term care insurance products would clearly interact, and be dependent upon, the scope and design of an NCF. In effect, with a guaranteed minimum level of provision for all ensured through the existence of an NCF, the private sector could then step in to insure for levels of provision over and above the guaranteed minimum level of an NCF.

This would enable the private sector to do what it can do more easily than public agencies: innovate, provide flexibility, and provide products suited for a wide variation in means and preferences. The private sector can accommodate the inevitable demand from individuals who wish to be insured up to a level beyond the guaranteed basic provision of an NCF, and have the money and desire to purchase such products.

In order for an NCF and private sector insurance products to interact optimally, they would not operate side-by-side, but would actually be complementary and interlocking. This would mean the provision of long-term care insurance products from the private sector would explicitly seek to lock-in on top of the basic insurance provided by an NCF. In this way, a ‘standard’ entitlement to care from an NCF could interlock with long-term care insurance products from the private sector, whether they are ‘premium’, ‘first-class’ or ‘deluxe’.

This dynamic can be represented graphically below:



9.3 Barriers to the Development of a Long-term Care Insurance Market

Part 1 of this paper provided a detailed list of demand-side and supply-side limits to the development of a market in long-term care insurance products.

The proposal for a social insurance fund for long-term care would overcome many of the problems that were identified, such as uncertainty over what care will be funded by the state. In fact, the creation of an NCF would provide the Government with multiple opportunities to address other limits to the development of the market for long-term care insurance markets, such as educating the public about the risk of long-term care, conveying the scope for insurance to 'protect the inheritance', and promoting the value of long-term care insurance products to overcome the legacy perception among consumers that they are to be avoided. The Government could also address the chronically low levels of advice available from qualified financial advisers.

More importantly, the Government would need to review some of the other behaviourial and decision-making barriers, including financial capability, and the difficulties that individuals have in predicting care needs, framing what would be an acceptable level of care, and predicting the cost of care. Such is the importance and complexity of these issues, they merit detailed exploration.

9.4 The Challenge to Long-term Care Insurance Products

As previously identified, the 'ideal-type' of long-term care insurance product is 'pre-funded insurance' which is purchased long before someone requires care or has contact with the long-term care system. The following scenario can be imagined and illustrates some of the challenges to this form of long-term care insurance:

> A man aged 65 is aware of the risk of requiring long-term in his final years and would like to insure himself against the cost of this care. He has the means and willingness to purchase a long-term care insurance product from the private sector, and is fortunate in being able to access one of the few advisers qualified to advise on such products. However, in choosing a product, the man needs to know what level of care he would want in decades to come, and how much this care will cost. After spending a considerable amount of time researching care homes in his local area, the man is able to ascertain roughly how much such a level of care would cost now. However, he does not know how much an equivalent standard of care in his area will cost 10-20 years from now, which is when he anticipates needing care, given the experience of his parents. Unable to be sure what level of financial provision from a long-term care insurance product will be sufficient, the man decides against purchasing an insurance product, preferring instead to invest his money in order to maximise the funds he has available to subsequently pay for care, if needed, through out-of-pocket payments.

This imaginary case-study illustrates several issues:

- The necessity for, and limited supply of, qualified financial advice for current long-term care insurance products.
- The difficulty individuals have in predicting their care needs and framing what would be an acceptable level of care.
- The difficulty that individuals have in predicting the cost of an acceptable level of care up to three decades ahead of it being required, and therefore allocating capital to insuring against this cost.

Indeed, even if individuals have the means and desire to purchase a long-term care insurance product, unless they can understand and conceptualise the care they will then receive, they will be reluctant to purchase an insurance product.

This clarifies a key dilemma for insurance companies in the development of pre-funded long-term care insurance products: the fundamental interest of consumers is not the financial cover that the insurance product provides, but the type and standard of care which the financial cover can purchase. The primary 'good' – *the care* – that drives demand for long-term care insurance products actually falls outside the scope and control of insurance companies.

An individual's demand and interest in a long-term care insurance product will be determined directly by how confident an individual is that an insurance product will fund the care they want. Since the individual cannot confidently anticipate the cost of particular standards of care several decades ahead, the individual cannot be confident about a particular long-term care insurance product.[23]

Given that, as described, the Government's objective must be for every individual to be fully insured up to the level of provision they deem appropriate, a major challenge for the Government, insurance industry and long-term care sector is therefore to overcome the issues identified above. For an NCF and complementary market in private sector long-term care insurance products to operate would require a transformation in the presentation, communication and 'packaging' of care insurance *and* care services. A first step is to recognise the limitations of 'price' in the care market, and the challenges in 'framing' care services.

9.5 Problems in 'Framing' Care Services

Why does price serve as a poor indicator of the quality and nature of care products, particularly care home fees? Whereas many products can be easily compared by potential consumers – tins of baked beans, DVD players, cars – it is much more difficult to compare the quality and value of care services.

In the case of care homes, properly assessing a care home requires a guided tour, which is a significant investment of time. However, many characteristics of care services are difficult to judge even through guided tours. Making judgements about care also requires a leap of imagination; individuals have to imagine their particular needs and preferences at a stage when they might require care. The conceptual and emotional barriers to doing this are so immense that many individuals do not engage in this.

In the case of care homes, there is at least a physical entity which individuals are able to view and evaluate. However, for other types of care services, for example, certain types of domiciliary care, many individuals struggle to imagine what the different types of care service may entail, let alone to make judgements about their preferred level of service.

Compounding all these difficulties is the time lag between when an individual would ideally insure themselves against the costs of long-term care, and when they might receive it. This time interval may stretch to several decades. In the intervening period, any number of factors may affect the price and supply of long-term care, such as changes to the labour market, and the ownership of companies providing long-term care services.

9.6 The Need for a New Schema and Typology of Care

All of the above issues highlight the need for an alternative schema to price for guiding individuals in their choices around long-term care, and related insurance products. Individuals

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[23] It is worth noting that, to a great extent, a social insurance fund, such as the model proposed in this paper, is able to overcome this problem. Inherent in the model of a social insurance fund is a 'statement' that the Fund will pay for a basic level of provision that is, at the very least, the socially acceptable minimum. The articulation of such social minimums is explicit in the foundation of a social insurance fund so individuals are often happy to participate because they are able to intuitively understand the level of care that participation will entitle them to.

cannot be expected to predict their demand, or the cost of care they would consider adequate, 30 years into the future.

Indeed, the above analysis suggests that a standardised classification of care services, which people can understand and which is 'communicable' across decades, would better serve the needs of the long-term care insurance market.

Such kinds of schema are clearly able to operate in other sectors. For example, the rating of hotels by apportioning 'stars' communicates important characteristics about a hotel, and is able to remain constant across long periods of time. Individuals are able to book a 5-star hotel several years ahead precisely because the star-rating conveys enough information for them to make their decision. Individuals are able to understand the basic information required for the decision – the star rating – and subsequently look at the individual features and services of a hotel to guide their choice.

Clearly, the complex multiple components of long-term care are extremely different to the hotel sector. However, if variations in long-term care services could be articulated and communicated in a form approaching the level of simplicity of hotel star-ratings, this would facilitate enormously the marketing of pre-funded long-term care insurance products and help to overcome the barriers to individuals making the decision to purchase such products. This applies not just to residential care homes, but personal care in domiciliary settings.

9.7 A New Schema for Care Services

The insurance industry will only be able to sell long-term care insurance products if it can clearly communicate to consumers what the benefits of the product are, i.e. the care itself. At present, insurance companies cannot do this because of the way that the care industry is organised.

Only when the Government, insurance industry and care sector are able to collaborate on a standardised classification and typology of care services which is understandable to individuals who have had no contact with the long-term care system will the demand for long-term care insurance products truly be unlocked, and a fully-fledged market in long-term care insurance ensue. Clearly, this would be challenging. Much of the care sector is 'producer-defined' in the way that services are described, conceptualised, presented and communicated. Instead, care services need to be framed in a way that requires negligible knowledge of the supply of care services. If this was achieved, key barriers to demand for long-term care insurance products would fall away, and the insurance industry could create matching and appropriate products. A new schema for care services would need to be standardised across the care services and insurance industry.

Implicit in this proposal are changes to the organisation and operation of the care industry. Indeed, the care industry would have to work with the Government to agree to a schema for services, and to provide care accordingly. However, there would also be benefits for the care industry in this approach. By agreeing to the development and implementation of a new schema and typology of care services, the care industry would enable the development of a full market in long-term care insurance products, and would be able to learn, from insurance industry bodies years in advance how many people were insured up to different levels of care. This would help significantly with the long-term planning and supply of care services, potentially enabling providers of care services to reduce costs.

Key Points from Chapter 9:

- The success of a social insurance fund for long-term care would be dependent on the existence of a fully-fledged market in pre-funded long-term care insurance products. This is necessary to ensure consensus and support for such a system across the board, and to ensure that even wealthier older individuals are not subject to the

unfairness of being forced to run-down their assets in order to pay for a level of care which they deem sufficient and acceptable.

- 'Pre-funded' long-term care insurance products should be explicitly complementary and interlocking with the 'insurance' provided by an NCF. In short, such products should 'start' where the cover from an NCF 'ends'.
- An NCF would overcome many of the barriers to the development of a long-term care insurance market, such as what care would be funded by the state. Nevertheless, several barriers would remain, including financial capability, and the difficulties that individuals have in predicting care needs, framing what would be an acceptable level of care, and predicting the cost of care.
- The Government should enable the introduction of a new typology and schema of care services which is not 'producer-defined', but which is intuitive and understandable to someone who has had negligible contact with the care industry.
- Only when the Government, insurance industry and care sector successfully collaborate on a standardised classification and typology of care services will the demand for long-term care insurance truly be unlocked, and a fully-fledged market in long-term care insurance ensue.

Chapter 10: Who Would Run a National Care Fund?

Having set out the mechanisms and benefits involved in an NCF and the need for a complementary market in private sector long-term care insurance products, this chapter addresses who would run an NCF. The chapter begins by reviewing some of the tasks involved.

10.1 What Tasks Are Involved in Running an NCF?

In designing an institutional framework to implement and run an NCF, it is first necessary to list the different tasks that would need to be undertaken. These include:

- Deciding, on an ongoing basis, what the benefit entitlements of an NCF would be, pooling risk and contributions between those in an NCF.
- For a fixed level of benefit, assessing what funds will be needed for an NCF to fulfil its obligations in light of:
    - Actuarial and other data on (healthy) life expectancy.
    - The provision of unpaid care.
- On this basis, assessing levels of contribution required from participants with different levels of income and wealth, including contributions that could be deferred over several decades.
- Managing the fund.
- Administration of an NCF, in terms of collection and distribution of payments, etc.

10.2 What Characteristics Does an NCF Need?

As a social insurance fund, an NCF would need to be clearly and visibly separate and independent from the state. This is because the credibility of an NCF would depend on older people seeing it as separate from the Government, the state and the tax system. In addition, if the fund of an NCF was held by the Government, there would be a risk that in the future a Government might use the money for purposes it was not intended for. The credibility of an NCF would rely on participants being wholly confident that this could never happen.

10.3 A National Care Fund Regulatory Authority

On the basis of the above comment, it is clear that some form of independent regulatory authority would be required for an NCF to operate. This body would be separate from an NCF, but would oversee its governance and determine its operating criteria.

In particular, a regulatory authority would be required to oversee the sharing of risks among individuals enrolled in an NCF. This task is especially important because of the long-term nature of the risk-pool involved. The task involves balancing the risks and benefits:

- Between those with different types and forms of care need.
- Between those with different levels of income and wealth.
- Between different age-groups, i.e. older participants who will require care in the near future, and young-old participants for whom the receipt of long-term care may be several decades away. This point would be particularly important if a regulatory authority anticipated changes to the average unit cost of different types of long-term care if, for example, technological change had a major impact on the future delivery and provision of long-term care.

By balancing these different risks, means and needs, a regulatory authority would ensure fairness among different participants of the Fund over several decades. This would require regular consultation with older people and their families.

10.4 Administering and Managing a National Care Fund

The tasks involved in administering an NCF are similar to many of the existing tasks involved in running private sector insurance companies. In fact, many of the tasks of running an insurance company can now be outsourced; some companies specialise in providing the administration for an 'out-of-the-box' insurance company.

This demonstrates that many of the tasks involved in the administration of an NCF could be outsourced to the private sector. These relate to:

- Assessing for a defined level of benefit what funds will be needed for an NCF to fulfil its obligations, in light of:
  - Actuarial and other data on (healthy) life expectancy.
  - The provision of unpaid care.
- On this basis, assessing levels of contribution required from participants by applying a charging structure laid down by an independent regulatory authority.
- Managing the Fund.

In fact, it is proposed here that a *National Care Fund* be split into around four 'sub-funds', each of which would be managed by private sector insurance companies. Why is this recommended?

- As an insurance fund that would potentially include almost all individuals over a certain age, the value of the Fund of an NCF would be worth hundreds of billions of pounds. Such is the size of the fund that if one organisation made errors in its management or related actuarial calculation, the consequences of these errors would be enormous, and would potentially undermine the credibility of an NCF. A preferable situation would be to have several independent organisations undertaking separate calculations. The levels of contributions that would subsequently be recommended could then be fed to an NCF regulatory authority which would then determine a final charging structure.
- Splitting an NCF into several sub-funds would enable the Fund to benefit from the best actuarial and fund management capability in the private sector.
- As has been described in the previous chapter, the success of an NCF would depend on a complementary market in private sector long-term care insurance. By enabling carefully selected companies to manage a segment of an NCF, these companies would be able to enhance their institutional expertise in relation to long-term care insurance and, therefore, provide improved long-term care insurance products to complement an NCF.

Licenses to manage the sub-funds of an NCF could be awarded to private sector companies on the basis of a competitive tender, related to cost (efficiency), relevant actuarial institutional expertise, and capacity. A condition of operating a sub-fund could be that companies would have to offer a full suite of complementary pre-funded long-term care insurance products. Despite the role of the private sector, the public face of a *National Care Fund* would continue to be that of a national social insurance fund.

10.5 Assessing Individuals Under an NCF

The final important task in administering an NCF would be assessing individuals who may be entitled to care. This could be undertaken by any number of different agencies, so no prescriptive recommendation is made here, except that a single standardised assessment process would be preferable. In this way, one assessment would entitle an individual to

support from an NCF, as well as any private sector long-term care insurance products that they had purchased. A single assessment may also create scope for the state to share the cost of such as assessment with the private sector.

Key Points from Chapter 10:

- An NCF would require the creation of an independent regulatory authority to oversee it and ensure the fair balancing of interests and risks between individuals enrolled in the Fund, particularly in relation to individuals needing care currently, and those likely to need care during a considerably later period of time.
- Many of the administrative functions of an NCF could be undertaken by the private sector.
- It is proposed that the fund of an NCF be split into four sub-funds which could be awarded to private sector companies to operate on the basis of a competitive tender. This would reduce the scope for catastrophic error resulting from only one organisation trying to manage the fund, and enhance the ability of the companies involved to provide complementary pre-funded long-term care insurance products.

Chapter 11: How Would a National Care Fund Achieve Public Support?

This chapter addresses how the Government could achieve public support for an NCF. The chapter approaches the issue in stages, beginning with how the Government can raise general awareness of the need for long-term care, exploring how the Government could promote the concept of an age-specific social insurance fund addressing long-term care, and finally addressing how the Government could sell the particular 'insurance-product' of an NCF.

Much of this content is determined by the particular nature of the social insurance fund proposed here, i.e. cohort-specific and built around the principle of auto-enrolment. This model would require the Government to inform individuals that they have been automatically enrolled in an NCF, and then encourage individuals to remain enrolled. The Department for Work and Pensions is already addressing precisely these sorts of issues as it seeks to promote 'personal accounts' for pension saving, which are also based on the principle of auto-enrolment.

11.1 Raising Public Awareness About Long-term Care

At present, many people do not know about the risks of needing long-term care and the potential 'catastrophic' costs that long-term care can create, given the absence of fully-funded state support in relation to long-term care. A first step for the Government in any reform scenario will be to educate the public about the universal risk of long-term care, and the necessity for major public policy reform.

11.2 Introducing the Concept of a Social Insurance Fund for Long-term Care

Having raised awareness about the risk and costs of long-term care, the Government could introduce into public debate the issue of funding, and the need for all individuals to be insured against the costs of long-term care.

The Government could subsequently introduce the idea of an insurance fund for older people organised by the state. This could be framed by an appeal to social solidarity, encouraging all older people to recognise the shared risk of needing long-term care.

Indeed, it is worth highlighting that social insurance funds are ultimately built on social solidarity; it is this that allows rich and poor to pool their risks, and the former to redistribute wealth to the latter. Even though the UK welfare state, incorporating the NHS, is built on social solidarity, public and political discourse rarely discusses them in these terms. Various reasons could be proposed for this, such as the unpopularity of income tax. An NCF therefore presents a new opportunity for politicians to argue for the necessity and benefits of social solidarity, and in a new form: cohort solidarity.

11.3 Promoting the Insurance Product of an NCF

Once the Government has raised awareness of the risk of needing long-term care, and introduced the idea of a state-organised social insurance fund for older people, the Government can introduce the particular 'insurance product' of an NCF, i.e. the means-tested charge, and the associated benefits. The Government can frame this in several ways.

First, a key lesson relevant here from the private sector, whether coffee or cable TV, is that products are best framed as being medium, large and larger options. This categorisation prevents consumers who want the 'smallest' option being put off by a product that sounds insufficient or inferior.

Applying such an approach to the entitlements from a NCF suggests such entitlements should simply be a 'standard' package of funding, rather than a 'minimum' or 'basic'. Framing the package of NCF care funding as 'standard' will be important in enabling an NCF to act as a complementary product provider to the private sector, which can develop insurance products that interlock with that of an NCF. An NCF and the private sector would have to work closely together to ensure that individuals were presented with a menu of insurance options that was *simple*.

Second, the Government can relate an NCF to the desire of many older people to be independent and self-sufficient. The Government can present an NCF as an opportunity for older people to use their assets to insure themselves against the costs of long-term care.

Indeed, it is not difficult to find anecdotal evidence of older people who are keenly aware of the windfall of unexpected, unearned property wealth they have accumulated, who are frustrated at the lack of meaningful opportunities to insure themselves in relation to the risk of long-term care, and who abhor the idea that they would be dependent on younger people to pay for their care.

A key theme the Government could deploy in promoting an NCF to the public would therefore be *enablement*. This approach would emphasise that individuals have the means to insure themselves in relation to long-term care, and given the flexibility provided by an NCF, emphasise how such a scheme *enables* individuals to make provision for themselves.

Third, the Government could use the powerful drive behind the bequest motive felt by many individuals in retirement, i.e. a desire to maximise the volume of assets that they can pass on to their children in inheritance. The Government could highlight the risk to an individual's assets if they are uninsured in relation to long-term care, and encourage individuals to remain enrolled in an NCF in perhaps just five words: "protect the inheritance: stay in".

Many of these points could be addressed in the letter that would have to be sent to individuals when they were enrolled into an NCF. To illustrate this point, a sample letter for this purpose has been included as the Preface to this report.

Key Points from Chapter 11:

- Promoting an NCF to the public would involve several steps, including raising awareness of the universal risk of needing long-term care, and the need to be insured in relation to it.
- The cohort-specific nature of an NCF would allow the Government to tap into notions of cohort solidarity.
- Promoting the particular 'insurance product' of an NCF would require the Government to present it as a 'positive' product suitable to all, rather than as a 'basic' or 'minimum'.
- The Government could emphasise the *enablement* provided by an NCF, in that individuals would be enabled to use their assets to insure themselves. The Government could also emphasise that remaining enrolled in an NCF would 'protect the inheritance'.

Chapter 12: Further Benefits of a National Care Fund

The preceding chapters have addressed enrolment, the mechanics and promotion of a *National Care Fund*. This chapter sets out some important benefits of an NCF that have not thus far been highlighted.

12.1 Universal Provision

In Part 1 of this discussion paper, it was shown that one of the key benefits of models of universal free long-term care funded by the state was universal provision.

A key benefit of an NCF is also universal provision. Under an auto-enrolment system, everyone is automatically enrolled at, for example, the SPA. If individuals choose to de-enrol, i.e. they choose to actively de-insure themselves and do not subsequently purchase private sector insurance, then the state has limited responsibility for them.

12.2 Solves Agency Problem

As described earlier, a key benefit of models of universal free long-term care is that they address the lack of agency among many older people regarding long-term care. Under such a model, if an older person takes no action in response to the risk of long-term care, they are nevertheless insured by the state and entitled to a minimum level of provision.

Similarly, an NCF applying the principle of auto-enrolment also solves the agency problem: if an older person takes no action in response to the risk of long-term care, they are nevertheless insured and entitled to a minimum level of provision. At some point, a means-tested charge on their assets would be levied to pay for this insurance.

12.3 Social Minimums of Provision

It is generally agreed that an important aspect of a decent society is the articulation and implementation of social minimums: the state will ensure everyone is above a certain level of poverty and their care needs provided for.

Both universal free care and the model of an NCF would articulate and provide for social minimums. In this way, despite not being reliant on general taxation and the classic UK welfare state model, an NCF gives voice to the important political and social belief that all individuals in society be accorded a minimum level of welfare and care.

12.4 De-enrolment and the Availability of Private Sector Long-term Care Insurance

No matter how well the Government sought to promote an NCF to the public, some individuals would always reject such a ‘socialist’ system, taking the first opportunity to de-enrol from the Fund, and promptly purchase long-term care insurance from the private sector, even though a private sector standard-class package of care would inevitably cost more.

However, if indivuals are prompted to withdraw from an NCF and purchase an alternative private sector product, this still represents a positive outcome for the model: an older person using their own wealth to participate in a risk-pool for the risk of long-term care.

12.5 Social Solidarity and Evasion

Many people regard tax avoidance as legitimate. For some taxes, such as inheritance tax, avoidance is seen as something to be celebrated. Such tax avoidance behaviour relies on individuals not attributing any negative moral attributes to the act of avoidance, which is often seen as justified, given a perception in some quarters of public sector 'waste' and 'inefficiency'.

An NCF would not be subject to such avoidance behaviour to the same extent. Why? Based on a specific expression of social solidarity across a cohort, there would be much greater negative moral connotations to avoidance of paying the appropriate charge for participation in an NCF. In effect, avoiding or evading paying an appropriate fee would mean directly exploiting one's peers.

12.6 Opportunities for Maximising Rates of Insurance Among Older Cohorts

Some individuals would inevitably choose to de-enrol from an NCF. This would involve filling in a form and returning it to an administrative authority.

Once in possession of this information, and in cooperation with private sector insurance providers, the Government would possess the name and address of every older person who was not insured for long-term care. A public agency, such as the Pension Service, would then be able to contact such individuals on a regular basis, gently reminding them that they are uninsured, highlighting the potential 'catastrophic costs' associated with long-term care (including the effect on their children's inheritance), and suggesting that they obtain insurance by either rejoining an NCF or by purchasing an approved private sector provider of long-term care insurance products, a list of which could be helpfully provided.

12.7 Opportunities for Maximising Levels of Insurance Among Older Cohorts

By enabling older cohorts to insure themselves for a standard package of care through the deferred use of their housing wealth, an NCF would free up more of older people's income and liquid assets to purchase complementary higher levels of long-term care insurance from the private sector, as well as other goods older people wish to purchase.

12.8 Choice

The model of an NCF is premised on choice: individuals retain the choice to de-enrol. Individuals therefore retain choice and control. This feature also gives individuals and their families the choice to make arrangements that are best for them. If families are confident that they will provide care for older relatives at the end of life, then an older person can choose to de-enrol.

Under an NCF, individuals are also given the choice of how and when to use their assets, including the choice to remain in their home.

12.9 Adaptability

As set out, the model of an NCF could be modified and adapted to take account of various other policy drivers. Several examples are worth considering:

First, previous models of long-term care funding have suggested a 'co-payment' element that would both ration costs (through preventing excessive or unnecessary use of resources) and to unlock the private wealth of older people to co-pay. In principle, there is no reason that such a modification could not be drafted on to an NCF model of benefit entitlement, with the

Fund co-paying extra contributions from individuals needing care. However, a fully insured provision of funding on the basis of clear entitlements is arguably preferable.

Second, the scope of entitlement from an NCF could be extended to support services for an older person's unpaid carer. However, this might risk creating two classes of unpaid carers, and goes against the 'rights-based' approach to extending support to unpaid carers.

Third, once an NCF was socially embedded, enrolment into an NCF could be made compulsory.

Fourth, when the financial situation of younger cohorts improves, individuals could start saving into the equivalent of a personal account to fund the cost of contributing to an NCF at the point of retirement.

12.10 The Funding of Long-term Care would be Ring-fenced

During the next 20-30 years, it is likely that the UK will suffer a recession. At such times, the provision and funding of public services becomes squeezed and can even be subject to widespread cuts. If long-term for older people were funded by the state, this service would also be at risk of cuts and slashed funding, with the associated effect on older people's well-being and quality of life.

In contrast, under an NCF, the funding for older people's long-term care would effectively be ring-fenced and safe during a recession.

Key Points from Chapter 12:

- Some particular benefits of the model of an NCF include: universal provision; removal of the agency problem around care and assets; social minimums of provision; the scope for prompting individuals to be insured whether through an NCF or privately; the scope for social solidarity to reduce avoidance of contribution fees; the scope for the Government to target those who have de-enrolled with encouragement to become insured; the scope for maximising the amount of insurance older people possess through enabling them to use their housing wealth to fund basic insurance; choice; adaptability, and the scope to ring-fence the funding of older people's long-term care.

Part 3

Chapter 13: What Are the Next Steps?

If a *National Care Fund* were to be developed and implemented, what would be the next steps? This chapter identifies some key tasks in relation to refining the model, researching its likely impact, and exploring how it could best be implemented.

13.1 An NCF and the Benefits System

For the sake of simplicity, this discussion paper has shelved any consideration of how an NCF would interact with or affect related benefits, such as Attendance Allowance (AA) (an absence of good research on the use of AA is a further hindrance to discussion). Exploring how an NCF would optimally interact with such benefits, including possible reform of such benefits, is a key task.

13.2 Consulting with Older People

A number of research questions relating to older people flow from the model of an NCF proposed here. These include:

- How would older people feel about auto-enrolment?
- How much would older people feel to be an appropriate contribution to a social insurance fund?
- What level and volume of care do older people think should be included in an entitlement to a standard package of care?
- How do older people feel about the use of housing wealth to obtain insurance in relation to long-term care?

13.2 Consulting with the Private Sector

The model of an NCF would see almost the entire 'long-term care risk' of society sitting in the domain of the private sector, both in management of an NCF and in the development of a fully-fledged market in long-term care insurance products. Key tasks and research questions that flow from this include:

- How would insurance companies approach the task of managing an NCF?
- What kinds of complementary insurance products would the private sector wish to provide?

13.3 An NCF and Unpaid Care Provision

Ahead of the introduction of free personal care in Scotland, it was anticipated that unpaid care provision would decline, with a commensurate increase in demand for state-funded care. In fact, research has found that informal caring has not reduced.[24]

Nevertheless, a key research task would be to explore how an NCF might affect unpaid care provision. Even though financial concerns are not always a prime driver to providing unpaid care, auto-enrolment into an NCF might make individuals feel more entitled to paid care, and therefore more likely to consume it. Research and consultation with older people and their families would enable some projects on the likely effect on patterns of unpaid care.

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[24] See Bowes & Bell (2007).

13.4 Maximising Enrolment Through Promotion

The success of an NCF would rely on large numbers of indivduals remaining enrolled in the Fund. Given that the value of the insurance provided by an NCF would be superior to anything that could be offered by the private sector, it would make rational economic sense for individuals to remain enrolled. However, important psychological factors might incentivise individuals to de-enrol.

A key task would therefore be to explore how the Government could optimally frame the benefits of enrolment into an NCF, as well as communicating the risks and costs of long-term care.

13.5 Determining Benefits Paid By an NCF

Chapter 8 provided some initial commentary on how the package of care funded by an NCF should be comprised. This is a complex task, and key to the development of the model.

13.6 A New Scheme and Typology for Long-term Care Services

Chapter 9 argued that a fully-fledged market in long-term care insurance products would not result unless a new typology and schema for presenting and communicating care services was developed, which would be understandable to individuals who had had no contact with the care system. Addressing this issue would be an important task for the Government, insurance and care services industries.

13.7 Mechanisms for Means-Assessment

An NCF would require some form of basic means assessment for all older people, and a more detailed assessment for a substantial segment of the older population. Several key research tasks would therefore be:

- How appropriate would the data held by the Pension Service be for use by an NCF?
- What mechanisms would identify the large swathes of older people whose illiquid wealth would automatically qualify them for the default upper-tier contribution to an NCF?
- For those between these two groups, what mechanism for assessment of means would be most effective and accepted?

Chapter 14: Conclusion

Since the Royal Commission on Long-term Care concluded its work in 1999, the debate on long-term care funding has, despite appearances, advanced enormously. The evidence-base available for policymakers in relation to the future demand for care has improved dramatically, as has the evidence on older people's assets. A much greater and more nuanced understanding of the issues involved is now observable across a wide range of stakeholders. Most importantly, there is general consensus, including across all political parties, that change is needed.

Nevertheless, it is not difficult to pick out flaws in the debate. Many stakeholders have simply ignored the dramatic increase in older people's net assets, even while this has taken place simultaneous to the ongoing debate. Repeatedly, commentators fall back on characterising the discussion as being about the "individual versus the state". Such a simple notion of the 'state' is insufficient for this debate as it fails to capture the fact that it refers to tax-revenues derived from individuals of working age. More importantly, it effectively creates a false choice between no-risk sharing (the individual) versus risk-sharing (the state). The state is presented as the only mechanism available for risk-sharing when it is not: social insurance funds and private insurance are just two other mechanisms to achieve risk-sharing, even including a redistributive element. This approach also belies the fact that since it is illogical for people *not* to insure themselves against the risk of needing long-term care, any real debate on a solution to long-term care funding will always be about one form of risk-pooling against another form of risk-pooling. The 'individual' and his out-of-pocket payments should only ever have a minor role in any real solution.

The model of state-funded universal free care for older people has long been critiqued as financially unsustainable, particularly when health spending as a percentage of GDP is already projected to increase as the population ages. The argument deployed in this paper shows that in the UK this model would also be strikingly unfair. However, the best parts of this model, such as universal and minimum provision can still be retained through alternatives, such as the *National Care Fund* proposed.

The National Care Fund

There is no doubt that the model for a *National Care Fund* set out in this report is radically different from previous welfare models in the UK, not least because the UK has traditionally never had a social insurance fund. But the radical nature of proposals and the need to persuade the public are not of themselves reasons to disregard any model. Whenever major new innovations in public policy are proposed, sceptics counter that significant reform will never win public support. Many commentators argued that the UK state pension age of 65 was so entrenched it would be impossible for the Government to raise it to reflect increasing longevity. However, by carefully laying the evidence in front of the public and promoting debate, the Government has been able to build consensus and acceptance of the fact that the state pension age will increase to 68 by 2050. Although most individuals do not like these changes, they accept that they are necessary and that they will happen. Now is the time to do the same for policy on the funding of older people's long-term care.

However, despite its radical features, a *National Care Fund* is feasible. It is far easier to build a solution around money that is there, than money that is not. Campaigners have spent years calling for more spending on older people's long-term care, trying to extract money from limited state budgets. The ultimate fiscal unsustainability of this approach has stalled and dogged reform for years. Despite its radical nature, a *National Care Fund* is actually more feasible: it is built around money that is already there. All the money that could ever be needed to insure older cohorts against the cost of long-term care is available in their property.

Supporting Carers

Enabling older people to use their wealth to insure themselves will also free up public money for the other major challenge in social care policy: supporting carers. As demand for long-term care rises, most care will continue to be provided as unpaid care. There is a growing awareness of the burden that unpaid social care provision can have on carers, such as their resulting under-contributions to personal pensions. Various measures can be put forward which would improve conditions for carers, but most will require extra spending by the state.

In this context, taxation, including any scope to increase taxes, could be used to provide more universal funding of free care for older people, or for providing more support for carers. The argument for using tax revenue to support carers is far more compelling than providing free long-term care for individuals who have more than enough wealth to contribute to an insurance scheme. Although many people feel that after a lifetime of paying taxes, they should be entitled to free care, there is no good reason why this cohort should be the first to receive this entitlement: older people have not paid the taxes to fund the universal free care of any previous cohort. The *National Care Fund* would give older people the opportunity to make the social insurance contributions going forward that they were not required to make during their working-life.

Protecting Intergenerational Solidarity

Asking older people to fund their own long-term care insurance is not ‘cold-hearted’ or against the spirit of intergenerational solidarity. In fact, it represents a concerted effort to preserve intergenerational solidarity.

The growing imbalance of wealth between the generations, coupled with the declining elderly support ratio has already generated discussion among public commentators. Trenchant longstanding critics of the provision of public services and the welfare state have already locked on to growing intergenerational inequality as a new lever with which to attack the existence of publicly funded services. Such an approach, which is the opposite of this author’s position, shows how major the threat now is to the intergenerational contract embodied in the welfare state and services such as the NHS.

This requires supporters of the intergenerational contract to carefully monitor its legitimacy, and the extent of intergenerational solidarity. To this end, it is important to prevent an excessive burden on intergenerational solidarity, which would threaten the continuation of the intergenerational contract. By seeking to extend the intergenerational contract through state-funded universal free care, campaigners for this model risk stretching it to destruction.

The Welfare State in New Forms

Debate on long-term care funding often reflects on the need to revisit the founding principles of the welfare state. It is certainly true that when it was founded, nobody could have expected or predicted what has happened to life expectancy and healthy life expectancy in subsequent decades, the decline of traditional family structures and the emergence of demand for a distinct type of care separate to health care. As a result, long-term care was never written into the 'intergenerational contract' underpinning the welfare state and proper financial provision was never included: no generation has ever paid taxes to fund free long-term care for all.

However, this does not mean that the right course of action now is to reach back and pretend that the welfare state had been founded on an expectation for having to fund long-term care, with the associated higher taxes that would have been paid by citizens over the intervening 60 years. In fact, trends in assets have been highly fortuitous. Although at the inception of the welfare state, nobody predicted the demand for long-term care that now exists, nobody could have predicted a generation of older people that has accumulated far greater levels of wealth

than anyone expected, thereby giving them sufficient means to insure themselves in relation to long-term care. In this sense, society has been lucky.

It is therefore appropriate to develop and implement a particular solution to the distinct challenge that the UK now confronts. When William Beveridge recommended the creation of the welfare state in his 1942 report *Social Insurance and Allied Services*, it is unlikely he had in mind individuals who have accumulated wealth measurable in hundreds of thousands of pounds, unearned and untaxed. Were he alive today, it is almost inconceivable that he would be recommending universal state-funded free care for all. More likely, he would have sought to take the principles underlying the welfare state – fairness, risk-sharing, social insurance and minimum levels of provision – and found new ways to apply them, suitable to the situation at hand. That has been the aim of this discussion paper.

Appendices

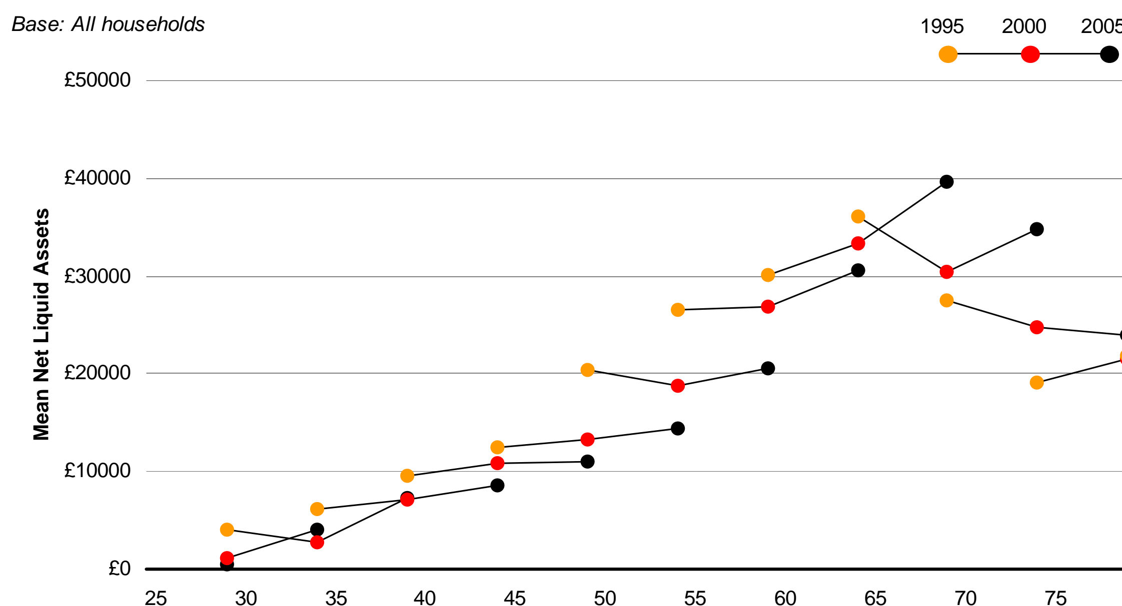
Appendix 1: Patterns of Asset Accumulation in the UK

This section draws on research analysing changing patterns of household assets and debt across the life course by age of 'household representative person', between 1995-2005. *Asset Accumulation across the Life Course* was published by the ILC-UK in September 2007. The research analysed data from the British Household Panel Survey. The findings of the research are presented by the 'age of household representative person'.

Net Liquid Assets

Liquid assets comprise savings, cash and investments[25]. Liquid debt can be a loan, a credit card or some other form of personal debt. Adding together liquid assets and liquid debt gives a picture of the net liquid assets of households at different stages of the life course. The picture that emerges is complex.

Trend in Mean Net Household Liquid Assets, by Age of HRP



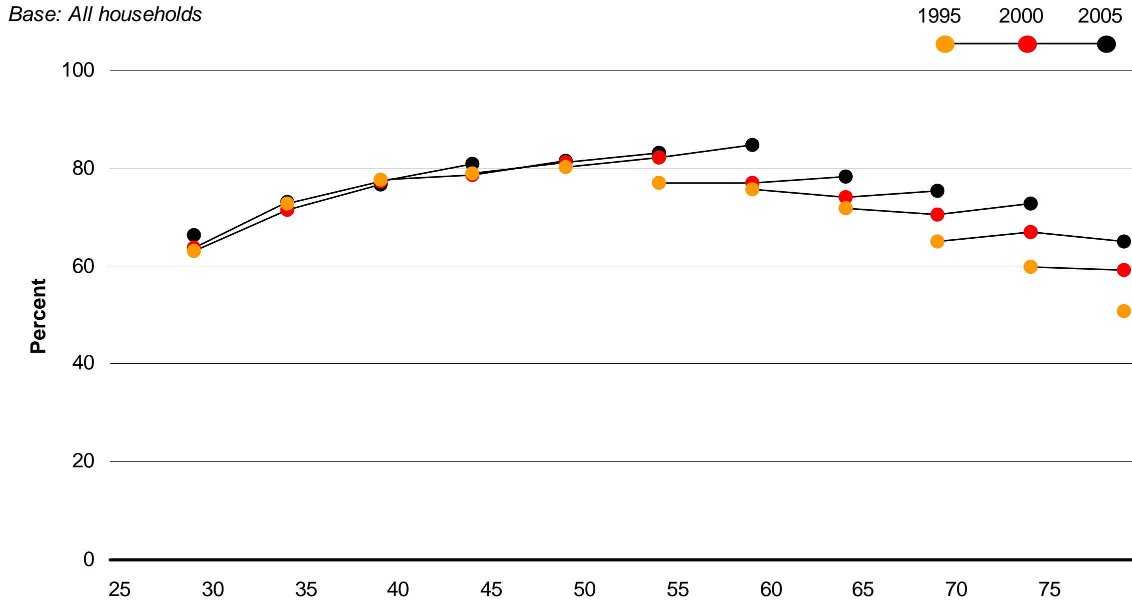
Among younger age groups, net liquid assets are low. The picture among older cohorts is complex. Those aged 65-70 years have seen larger increases in their net liquid wealth over the period. Individuals in the oldest age groups have seen their household liquid wealth both increase and decrease over the period, although the overall change for any of these cohorts is not more than £10,000.

[25] Liquid Assets included in the BHPS are savings accounts, ISAs, National Savings Certificates, Premium Bonds, Unit Trusts, PEPs, Shares, National Savings Bonds and other investments.

Illiquid Assets: Property Ownership

The proportion of households in different age groups owning a property has remained largely the same during the period 1995-2005. It is around 70% in the 30-39 age group, and remains at a plateau of around 80% from ages 40-65[26]. Among older cohorts, the proportion of households owning property within each cohort is less than 80%, and declines with each successive cohort to around 60% among those over-75.

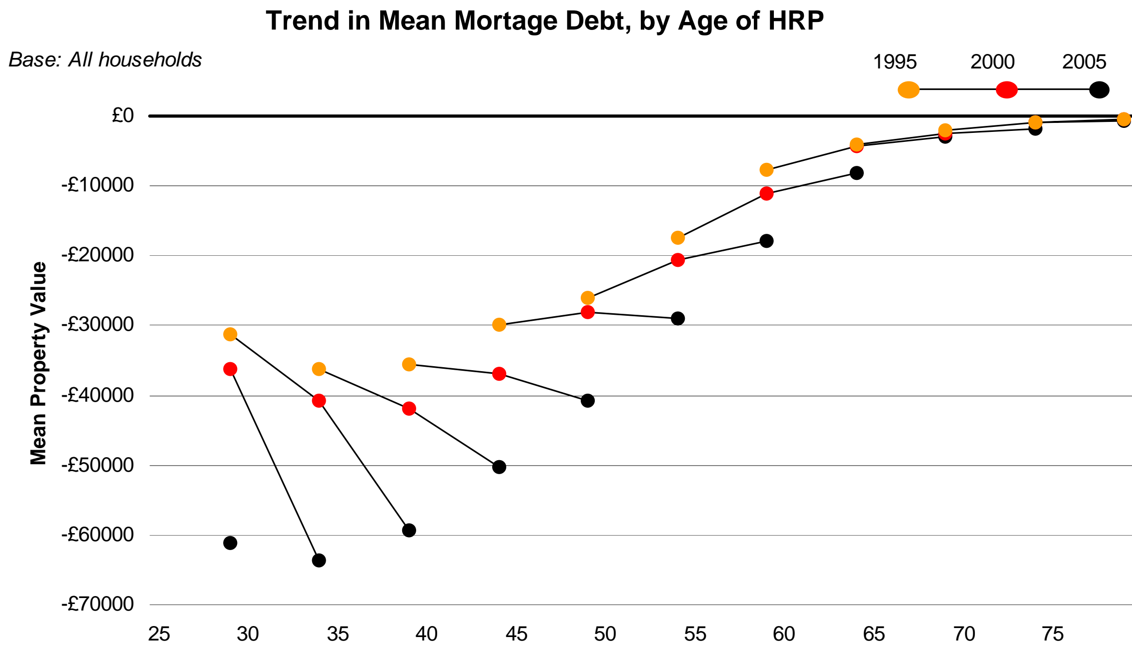
Trend in Owning Property, By Age of HRP



The number of households owning a second property has also seen little change over the period 1995-2005. The peak age-group for owning a second property was consistently 50-59, at a rate of 15% of all households in 2005.

[26] The wide-age bands used in this analysis may mask small marginal increases in the average age of a first-time buyer. Detailed information on this for the period 1995-2005 can be obtained from the website of the Council of Mortgage Lenders: www.cml.org.uk

Illiquid Debt: Mortgages



This graph shows the average mortgage debt of households, by age of household representative person. This graph shows increasing average mortgage debt among younger cohorts. However, the graph shows an average of households including those who do not own a property, and therefore would not have a mortgage. If non-property owning households are stripped out of the analysis, the increases in mortgage debt are more pronounced:

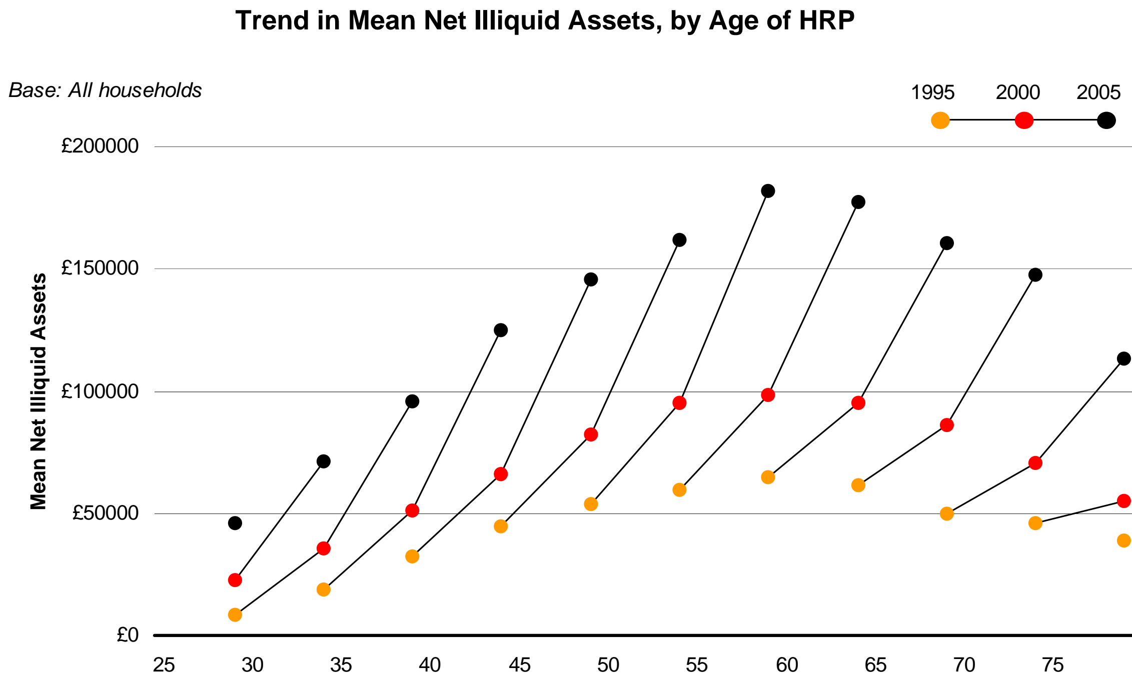
- An average 35-year old in 2005 had household mortgage debt of £88,000. In 1995, the average household mortgage debt of this cohort was £46,000.
- An average 40-year old in 2005 had household mortgage debt of £78,000. In 1995, the average household mortgage debt of this cohort was £50,000.
- An average 45-year old in 2005 had household mortgage debt of £62,000. In 1995, the average household mortgage debt of this cohort was £50,000.

This shows how younger cohorts have taken on more mortgage debt during 1995-2005. However, of greater interest is comparison between cohorts. For example, in 1995 a typical 30 year old property owner had household mortgage debt of around £50,000; the equivalent amount for a typical 30 year old in 2005 was £94,000. Among property owners in the 20-29 age range in 2005, the average household mortgage debt was £97,000. The equivalent figure for this age-range in 1995 was £46,000.

Net Illiquid Assets

Adding together total illiquid property assets and debt, i.e. total property wealth plus total mortgage debt, shows for all age-groups a strong upward trend for net illiquid assets.

Trend in Mean Net Illiquid Assets, by Age of HRP



The above chart shows changes in household illiquid wealth for all individuals. These findings are particularly noteworthy for the fact that although older cohorts have seen the greatest net increase in their household illiquid assets by amount, as a ratio to their equivalent assets in 1995, it is in fact younger cohorts that have seen the biggest increase proportionally. Again, if this analysis was limited to property-owning households only, these trends would be more pronounced.

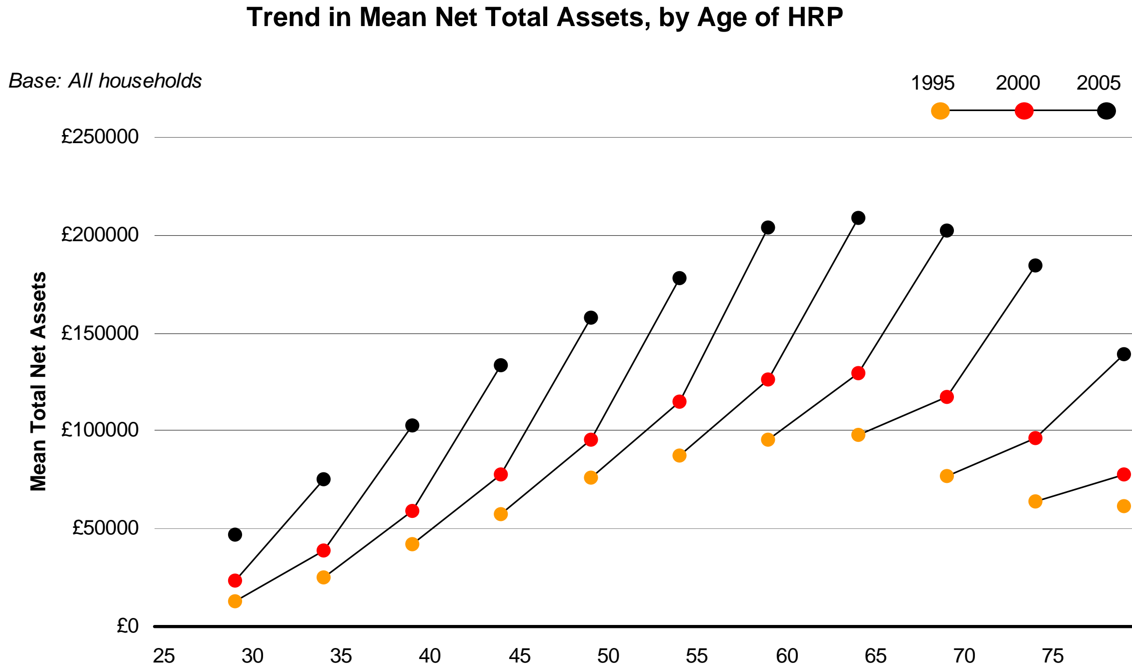
Much of these increases in illiquid wealth can be accounted for by increases in property prices. However, for younger age groups, it is likely to be a combination of both house-price inflation and the receipt of capital from parents or other family members to use as a deposit on property purchases. For example, among the declining proportion of those in the 20-29 age range that own property, those in this category in 2005 had on average around £50,000 of illiquid wealth. However, existing evidence that the median age of a first-time buyer in 2005 was 30 (Source: Council of Mortgage Lenders) suggests that illiquid wealth in this age group is not solely the result of asset price inflation, but may also result from parental gifts[27].

27 Indeed recent evidence indicates that in London, an assisted young first-time buyer had an average deposit of £57,000 compared to £12,500 for unassisted young first-time buyers. See Council of Mortgage Lenders (2007).

Liquid and Illiquid Assets: The Net Position

This graph shows total mean assets by age of household representative person.

Trend in Mean Net Total Assets, by Age of HRP

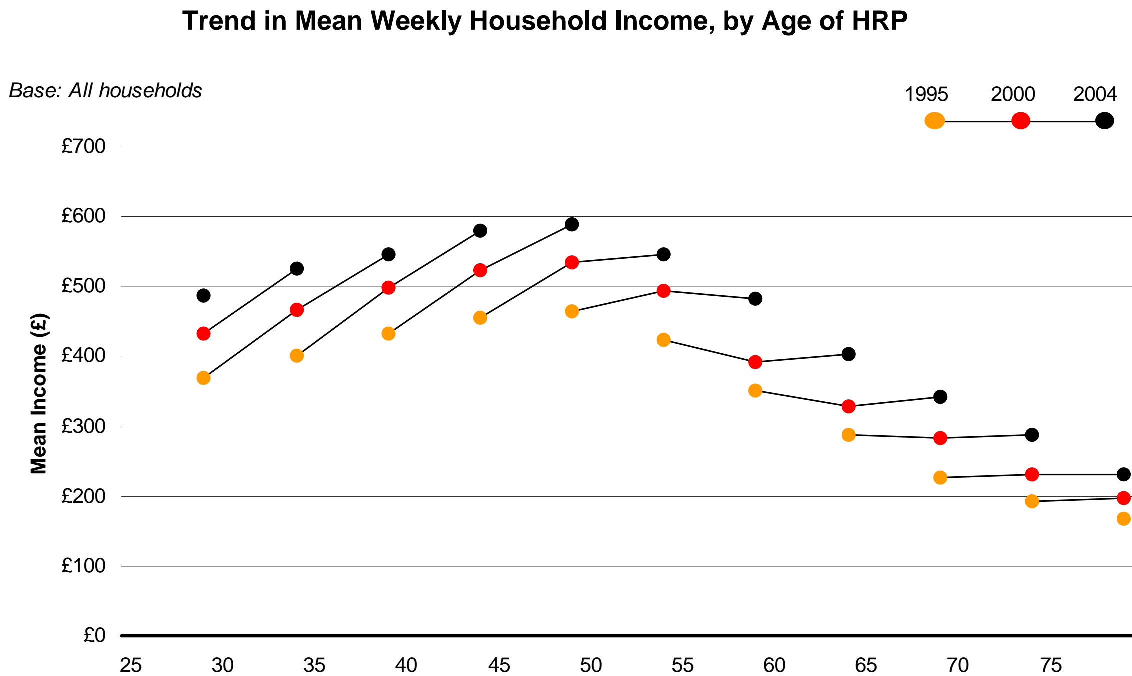


As would be expected, the chart closely resembles the chart for trend in total net assets.

Income

In addition to changes in household assets and debt, *Asset Accumulation across the Life Course* analysed changes to weekly household income.

Trend in Mean Weekly Household Income, by Age of HRP



Among those of working-age, weekly household income typically increased. Everyone aged 60 and below in 2005 saw their weekly household income increase over the period 1995-2005, by around £200-£250.

In contrast, individuals aged over 60 in 2005 saw either no change or slight reductions in their weekly household income over the period. Nevertheless, each older cohort saw higher incomes than those preceding it experienced at a similar age.

Appendix 2: Family Wealth Transfers and House Price Fluctuations

This appendice addresses two principal counter-arguments to the assertion that wealth transfers from younger to older cohorts through the housing market should be taken account of, in the formation of social policy, including the funding of long-term care for older people.

Appendix 2.1 Family Wealth Transfers as a Transmission Mechanism in Social Policy

A principal counter-argument to the assertion that the redistribution of wealth from young to old via the property market during a period of extended high house price inflation affects intergenerational equity is to argue that this upwards transfer of wealth is matched by a downwards transfer through families. In the view of this 'circle of wealth hypothesis', significant wealth transfers from young to old through the property market need not be of concern because, ultimately, the bulk of older people's wealth is transferred down to the young via the family.

Family wealth transfers can take two forms: inheritance on death, and 'inter-vivo' transfers while the giver is still alive. The extent, prevalence and volume of family wealth transfers in the UK is a hugely under-researched area. Indeed, anyone expounding the 'downwards wealth transfer' argument simply does not have the evidence to underpin such an argument, even though it is reasonable to expect and anecdotal evidence does suggest that families are transferring wealth downwards in increasingly large amounts.

Nevertheless, quite besides the issue of evidence, several other issues undermine the validity of this counter-argument in the context of social policy.

Wealth Inequality Among the Old as a Multiplier of Wealth Inequality Among the Young

As was shown above, rates of property ownership vary by cohort. However, within any cohort rates of property ownership rarely exceed 80%. As a result, a significant minority of the working-age population cannot expect to receive large transfers of wealth via their family, derived from rising property prices. However, this minority will nevertheless have to pay tax, including transfers to older cohorts. For this section of the population, any social policy that relies on family wealth transfers from old to young would clearly be unfair.

More generally, the progress of different households up the housing ladder is varied and uneven, and is regularly impaired by family breakdown or the presence of a longstanding disabling illness which reduces household income and its potential for accumulating property wealth. Such lower levels of accumulated property wealth clearly translate into smaller bequests of wealth on death, or availability for inter-vivo transfer.

In this way, variations in wealth among older cohorts can clearly facilitate inequality in younger cohorts, when that wealth is considered as a source of inheritance and bequests. For this reason, social policy cannot rely on family wealth transfers to achieve fairness between cohorts.

Family Discretion as a Tool of Social Policy

Although it is reasonable to assume that the majority of older people do seek to transfer some or all of their wealth down to younger family members, this is not a reliable outcome that can

be expected in anything approaching all cases. The bequest motive is extremely powerful; however, it is not universal. Families may choose to allocate inherited wealth in any number of incoherent and perverse ways. Indeed, the news media regularly enjoys reporting on incidences of older people transferring their wealth on death to unexpected recipients, for example, the owners of a local Chinese restaurant.[28] Although entertaining, such examples show the unpredictability of outcomes dependent on the discretion of individuals as they transfer their wealth.

It can be observed that the state regularly relies on unpredictable actions of individuals in their delivery of social policy, for example, when parents use their child benefit to buy alcohol. However, such circumstances are unavoidable when an adult has authority and responsibility for a child. Nevertheless, as a basis for maintaining intergenerational equity, it is wholly undesirable for social policy to rely on such discretion.

Life Course Timing

The 'circle of wealth' hypothesis implies that as individuals transfer wealth upwards to older cohorts via the property market, they simultaneously receive back compensatory wealth through their family. However, the reality is likely to be more complex.

As shown, the bulk of older people's transferable wealth is not in liquid form, but is illiquid property wealth. Any transferral of this illiquid property wealth downwards to children and other family members will be necessarily delayed until an older person releases it, whether on death or through moving into a nursing home.

With increasing longevity and growing 'intergenerational spacing' – the age difference between generations in a family – the age at which individuals will receive the bulk of their likely inherited family wealth will reach later and later in the life course, up to and actually passing the point of retirement. Put simplistically, and in the absence of reliable research, it could be expected that individuals transfer wealth upwards when they are young and take out large mortgages, and receive a transfer of wealth back at around the age of 60.

This delay matters enormously. The difference that a sum of money, for example £10,000, makes to an individual's life will vary significantly depending on what life-stage someone is at. In particular, most evidence shows that the life-stage associated with the most strain on household finances is in the years immediately following family formation, when parental income is still relatively lower than the peak of a person's career, but the household nevertheless has the heavy financial burden of child-rearing: food, clothing, toys, books, etc. As is now widely accepted, a family's level of financial security can impact on outcomes for the children right across the life course. During this crucial life-stage, individuals transfer wealth to older cohorts through both general taxation and the property market. Wealth received from family members in subsequent decades does not have the value in terms of life-course timing.

Appendix 2.2 Fluctuations in House Prices

When commentators observe the significant transfer of wealth from young to old through the property market, it is sometimes argued that this should be disregarded for social policy as house prices can fluctuate and gains in wealth be wiped out. However, in relation to the argument put forward in this discussion paper, such a counter-argument is extremely weak.

The significant transfer of wealth from younger to older cohorts in the UK resulting from an extended period of high house price has been illustrated in this discussion paper by the evidence of this transfer for the years 1995-2005.

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[28] See http://news.bbc.co.uk/1/hi/england/essex/7133165.stm

If house prices were to drop 20%-30% following the publication of this report, this would take average house prices back to their levels in 2005. In short, such a crash in house prices would not actually substantially affect the argument relating to wealth transfers from young to old.

Much of the argument that has unfolded in preceding sections has related to rising property prices. It is only therefore reasonable to ask: what would happen if property prices were to fall or crash?

If property prices were to fall by an unprecedented amount, e.g. 40%-50%, then it would be necessary to once again compare the assets of older and working-age cohorts and consider the implications for intergenerational equity posed by taxation-based models of long-term care funding for older people.

Under such a doomsday scenario, which would likely engender economic collapse, older cohorts would still possess significant property wealth compared to younger cohorts, many of whom would be in negative equity.

Thus, the central argument about the imbalance in wealth between the generations still holds. More generally, in relation to the topic of this report, public finances under such a doomsday scenario would struggle to meet existing obligations, such as the NHS, quite besides extending state-funded free care for older people.

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