

**Facilitating increases in long-term care funding  
– a discussion paper**

**December 2008**

## I - Summary

A new long-term care funding settlement is required for two reasons. First, the current system is unfair and inefficient. Variations in eligibility criteria across local authorities and the use of a means test that penalises those with relatively modest assets, even if they have low incomes, means that significant numbers of people are unable to access appropriate formal care services. Secondly, demographic changes are expected to increase demand for long-term care over the next few decades, with an increasing number of people living longer but with more complex conditions such as dementia.

This report examines funding from the perspective of low earners – people largely independent of state support but on below average incomes. It considers the appropriateness of a variety of options both for *accumulating* low earners – working-age adults seeking to spend some of their limited resources on purchasing assets and setting aside savings – and *decumulating* low earners – pre- and post-retirement adults drawing down their existing wealth and savings. The report is based on a literature review, discussions with funding experts and focus groups with low earners.

The key findings are:

- Extra resources for care will need to come directly from individuals' paying for their own care and indirectly from individuals as taxpayers or national/social insurance contributors – it is misleading to suggest it is the individual or 'government' who pays.
- A mixed market of state-sponsored and private funding mechanisms that co-exist and complement each other could best meet individuals' needs, resources, attitudes to risk and inclinations to plan.
- Equity release is particularly relevant for the current older generation, including decumulating low earners who are often asset-rich but income-poor:
  - existing equity release products are inappropriate for those who need to release relatively small amounts of equity to pay for domiciliary care or for preventative measures such as home modifications;
  - state support for equity release could help the private market to develop, in part by improving trust in the concept;
  - state intervention to fill remaining gaps in the market could be facilitated through a rejuvenated deferred payment scheme or through state-sponsored schemes;
  - state-sponsored equity release schemes could be run in tandem with current affordable housing schemes – joining-up decumulation of housing assets with accumulation policies.
- Pre-funded long-term care insurance (LTCI - insurance paid in advance of a care need) pools risks across society and therefore has associated welfare benefits:
  - existing LTCI products seem unaffordable for low adaptations;
  - state-support, provided in the form of a risk-sharing model between the private market and government, could make policies a little more affordable by reducing the costs faced by providers, but premiums will remain largely out of the reach of low earners;
  - direct state provision of care insurance such as the *National Care Fund* proposed by the International Longevity Centre, which is based on ability to pay rather than on risk and offers flexible payment options including the use

of equity release, may be necessary in order to extend LTCI to low earners

- Tax incentives and soft-compulsion could help encourage saving specifically for long-term care among younger generations including today's accumulating low earners.
- It is clear that different vehicles will be needed for different generations – a mix of products for the current, largely asset-rich, older population and products for younger cohorts, who have more time to plan but may not have the housing wealth of previous generations.
- Overall, a central problem in take-up of products is a lack of awareness of the need to plan or pay for care. Demand needs to be stimulated through awareness-raising and availability of guidance and advice.

The vision of a new funding settlement depends in large part on what the reformed care and support system looks like: that is, what people are paying for. We have explored this issue in our work on the architecture of a new long-term care system. Irrespective of the final vision settled on however, it appears inevitable that the long-term care bill will rise significantly and that individuals will therefore be required to foot the bill through both direct and indirect means. Therefore the debate should not be about who pays for care – the state or the individual – rather it should centre on what collective and direct mechanisms will best allow all individuals to meet the growing long-term care bill.

Projected falls in the size of the working-age population relative to the older population, the current economic downturn and the fiscal contraction due for 2011/12 onwards mean that existing collective funds are set to be in short supply. Demand for long-term care is not going to disappear, however, and society must face up to the challenge of directing appropriate funds to the sector. In addition to relying on general taxation and national insurance revenues, the Government could introduce and draw on a care-specific social insurance fund. However, such measures will inevitably supply a proportion of the increased funding at best.

Direct funding by individuals will therefore also need to increase. To facilitate this, a range of markets need to be developed that enable people to plan effectively for long-term care. Differing care needs, resources, attitudes to risk and inclinations to plan mean that a single funding mechanism that provides a 'best-fit' for all is likely to prove inadequate. Instead, development of a range of products that can exist alongside and complement each other will allow individuals to select the products most appropriate to their personal circumstances. We have identified three potentially mixed markets that could facilitate increased direct and indirect funding by individuals.

First, we have looked at equity release products. Although private market products are available, a number of market failures mean that take-up has been low and very few people have used equity release as a means of funding care. There is an apparent lack of trust in equity release among the public, amid concerns about value for money. Access is restricted for owners of lower value properties and benefit recipients face the prospect of losing their entitlements due to the relatively large minimum initial drawdown. In addition, there is reluctance among IFAs and brokers to sell equity release because of the complexity of offerings and the costs involved in acquiring the knowledge required to advise on the

product.

The equity release industry could act to correct some of the supply-side failings by developing more flexible products and providing more assistance to brokers. State support could remove further supply constraints by cutting the costs faced by providers and modifying the rules regarding benefit entitlement. Where supply-side failures mean that the private market will not function, the state can intervene by providing its own low-cost alternatives, accessible to people in lower value homes and to those who want a small initial drawdown. State approaches could vary from local authorities making increased use of deferred payments and other loans secured against clients' properties to a fully-functioning state-sponsored equity release scheme that focuses on asset decumulation. This approach could be designed to run in tandem with the Government's affordable and social housing programmes.

The second market we have considered is the one for pre-funded long-term care insurance (LTCI). The risk-pooled approach afforded by this product represents a more efficient means of guarding against long-term care costs for all potential care users. As with equity release, take-up has been low and a number of market failures are evident. Providers face difficult pricing decisions because of the uncertainty associated with longevity estimates. As a result, premiums have tended to err on the side of caution. Conversely, individuals tend to underestimate the risk of needing to fund care, meaning that premiums appear to offer poor value for money. For many, LTCI simply appears to be out of reach because of their inability to afford the premiums from their liquid assets.

Again, some of the supply-side issues could be corrected by players within the industry. For example, providers could introduce dual pricing to separate out the risks of needing domiciliary and residential care. Alternatively, they could seek to bundle LTCI with equity release so that individuals can obtain cover without facing any reduction in their day-to-day income. State support could further reduce costs to providers and therefore to consumers. Long-term care involves some measurable risks, but the uncertainty surrounding longevity cannot be modelled in the same way. By agreeing to take responsibility for longevity, either through limited-liability or co-payment models, the state could allow insurers to concentrate on producing efficient risk-based prices. More directly, the state could develop its own equity-related LTCI scheme. An income-based product such as the National Care Fund proposed by the International Longevity Centre (ILC) would provide a standard level of pre-funded cover for all who want it, which could include the option to purchase preventative services such as home adaptations and telecare, while those in the position to purchase a higher standard of cover could buy top-ups from private providers.

A third market exists for long-term savings products. Among the post-baby boomer generation, it is not clear what asset holding will look like in the coming decades. It is quite possible that higher levels of personal debt among younger cohorts and delayed access to the market among first time buyers will result in fewer households enjoying the significant housing wealth gains experienced by previous generations. Irrespective of these potential trends, a significant proportion of older households will continue to have either relatively small housing assets or none at all, while others will want to supplement the care payments they make from equity release or LTCI by drawing down their savings.

Awareness of privately-provided products such as retirement pensions and ISAs is

widespread, but many people enter retirement with inadequate savings. Some of this implied market failure is already being tackled through the Government's attempts to improve personal pension provision, including the introduction of auto-enrolment and personal accounts. Specific tax incentives at the point of saving and soft compulsion at the point of decumulation could help encourage saving specifically for long-term care among younger cohorts.

Concerted industry and state action could provide a comprehensive range of product options that co-exist and enable individuals with different care needs, resources, attitudes to risk and inclinations to plan to approach long-term care in a way that best suits them. However, our work with low earners suggests that the barriers to take-up of long-term care financing products are largely rooted in demand-side market failures. Individuals' ignorance or unwillingness to consider the need for long-term care financial planning will need correcting if products are to be taken up: improved demand would be likely to stimulate supply better than improved supply would encourage demand.

We held two low earner workshops in October 2008 to consider the merits of a number of the product options discussed in this paper. While there was a pragmatic acceptance among participants that long-term care funding needs to increase and that some of the available options represent sensible products, there was considerable resistance to the idea that individuals should be required to fund their own care.

In general, there was low awareness of the realities people will face when they come to needing long-term care and very few said they had made any plans. There was a belief that the current system penalises people for saving and rewards those who live in the here-and-now rather than building up savings and there was a preference for collective funding, with many participants feeling they should be entitled to be looked after in their old age having paid national insurance and tax all their lives. Other suggestions included introducing a new National Lottery game and holding a regular national fundraising event for older people much like Children in Need or Live Aid.

Generally, views among home-owning low earners about equity release were mixed. Some reacted positively to the concept, particularly those without dependents. However, the attraction was largely related to the opportunity to provide for a comfortable early retirement rather than funding long-term care. Other participants were nervous about the concept of equity release. In particular, they expressed concern about taking on further debt at an advanced stage of life. Most participants were sceptical about the value for money offered by the schemes and were much more amenable to the idea of a state-run equity release scheme because they felt the profit motive would be removed. It was also felt that a government scheme would be more trustworthy than a financial provider product.

There was little appetite for LTCI. Premiums were considered too high, particularly as the potential reward of a place in a care home was not something that instinctively appealed. Reduced premiums would make LTCI more attractive, as would the option of using equity release to pay LTCI premiums. As with equity release, participants favoured the prospect of a state-run scheme. Again trust and cost issues were raised. In addition, people preferred a state-run scheme along the lines of the ILC's *National Care Fund* because people could be charged on the basis of ability to pay rather than risk.

It is therefore clear that it is necessary for industry and the state to work towards spreading the availability of a mix of long-term care financing products. It is not sufficient however: demand also needs stimulating and entrenched resistance to individual responsibility needs to be challenged. The state must take responsibility for ensuring that the reality of long-term care funding is communicated to the public with urgency and honesty. Working in tandem with financial service providers, who have an interest in increasing demands for their products, the state also has a duty to ensure that good quality, objective money guidance is provided that covers the full range of available products and allows individuals to select solutions most appropriate to their circumstances. Armed with this knowledge, individuals will then be better placed to take responsibility for their long-term care needs and plan appropriately. While these measures should help to stimulate demand, it is likely that resistance will remain and that the Government will also need to use soft-compulsion and behavioural methods to ensure that suitable options are taken up in significant numbers.

Progress can be made in the short-term. While a national funding settlement remains vital, corrective action does not have to wait until one has been reached. It is clear that any set of solutions will involve individuals accessing sources of private finance. Action designed to improve supply of, and demand for, appropriate products should therefore be entered into without delay.

## II - Introduction

Earlier in 2008 we published two reports, *Lost*<sup>1</sup> and *A to Z*<sup>2</sup>. The former looked at low earners' perceptions and experiences of long-term care, while the latter considered the functioning of the long-term care market. Taken together, the reports identified a number of market failures and specific concerns for low earners. We have subsequently looked at four areas in greater detail: navigating care; innovation and efficiency in care supply; local market shaping; and funding. This report considers a range of options for facilitating increases in long-term care funding from both collective and individual sources and considers their effectiveness and attractiveness from the perspective of low earners. It is designed to contribute to the consultation launched by the Government in May 2008 on reform of the design and funding of adult social care which will inform a Green Paper in 2009.<sup>3</sup>

We define long-term care as personal and nursing care and support delivered to those aged 65 and above, either in their own homes or residential settings. Currently, two-thirds of the value of long-term care is provided on an informal basis by family and friends and one-third is provided on a formal, paid-for, basis. Of this one-third, around 45 per cent is paid for directly by individuals and 55 per cent is paid for collectively by individuals via the state.<sup>4</sup> Of the 2.5 million older people in England currently in need of long-term care, around 280,000 are believed to receive neither formal nor informal support and a further 450,000 are thought to receive inadequate levels of care.<sup>5</sup>

We define low earners as those who earn below median incomes, but who are (more or less) independent of state support. This definition can cover both those in work and retired individuals with private income from a pension or other source. Long-term care directly impacts on the lives of low earners for two main reasons. First, relative to the wider population, low earners are twice as likely to be care users and 25 per cent more likely to be carers.<sup>6</sup> Secondly, low earners are on the "cusp" of means testing eligibility and therefore spend a larger proportion of their weekly budgets on care costs than both higher and lower income groups.

In relation to long-term care it is necessary to consider two separate low earning stages. Around 12 million younger low earners can be described as being in an accumulation stage: that is, they are seeking to spend some of their limited resources on purchasing assets and setting aside savings. By contrast, three million older low earners are in a decumulation phase: following retirement they are unlikely to acquire new assets and instead derive a pension income by drawing down their existing wealth and savings.

The two groups face different challenges in relation to long-term care. Low earning decumulators often find themselves in a difficult position when faced with the means testing

---

<sup>1</sup> Resolution Foundation, *Lost: low earners and the elderly care market*, February 2008

<sup>2</sup> Resolution Foundation, *A to Z: Mapping long-term care markets*, April 2008

<sup>3</sup> DH press release, "Government launches national debate on the future of care and support", 12 May 2008:

<http://nds.coi.gov.uk/environment/fullDetail.asp?ReleaseID=367176&NewsAreaID=2&NavigatedFromDepartment=False>

<sup>4</sup> Carers UK, *It could be you: a report on the chances of becoming a carer*, January 2001:

<http://www.carersuk.org/Policyandpractice/Research/Profileofcaring/1207223744>

<sup>5</sup> Analysis conducted by Deloitte on our behalf, reported in Resolution Foundation, *A to Z: Mapping long-term care markets*, April 2008, p2.

<sup>6</sup> This is likely to be because lower earners rely considerably on informal care, and their low earning families provide this; but may also be because carers tend to give up work or work part time to fulfil their caring duties - thereby pushing them into the "low earning" income bracket.

criteria of the current long-term care system. Almost two-thirds of low earners aged 67 and over are homeowners, with an average property value of around £150,000, and are therefore too wealthy to be eligible for state subsidised care. They have relatively little liquid wealth though: low earners hold disproportionately more of their wealth in housing assets than other income groups. These low-income, low-liquid wealth homeowners are therefore faced with a limited number of choices: sell their home and downsize, using the remaining capital to purchase domiciliary care; sell their home and move into residential care (perhaps prematurely); or resort to (rather than choose) informal care.

In theory, low earning accumulators should be able to factor long-term care concerns into their accumulation decisions. In practice, however, they are typically unable to set aside sufficient sums to provide an income in retirement that is adequate for normal living expenses, let alone additional care costs. In addition, today's accumulators are more highly indebted than today's decumulators were at the same stage of their lives, and it is not certain they will enjoy the same levels of return on property experienced by older generations. They therefore face the prospect of having even fewer choices in retirement than today's decumulators have.

Our wider work on the future architecture of long-term care considers ways of improving outcomes for all low earners. This report looks more specifically at options available to decumulating home-owning low earners and to accumulating low earners. In addition to reviewing a selection of reports on reform of long-term care funding, we have discussed funding mechanisms with a range of experts drawn from the financial services industry, research organisations, consumer bodies, care providers and local authorities. Expert groups held in July and October 2008 were supplemented with subsequent one-to-one interviews.

We also investigated attitudes among the British public. We polled 2,000 GB adults in December 2007 to explore perceptions of the affordability of long-term care and opinions of funding models, and we commissioned Deloitte to host focus groups and interviews with low earners early in 2008 to gain a more in-depth insight. Opinion Leader held low earner workshops in Bristol and London on our behalf on 1 and 2 October 2008 to look more specifically at reactions to some of the funding options set out in this paper.



### III – Need for funding reform

#### Current spending on long-term care

Long-term care is funded from a number of sources, including the NHS, local authorities, private payments including state benefits and a number of one-off grants. As such, it is difficult to determine the exact level of spending. In 2006/07, the Department of Health and local authorities together spent £9.0 billion on personal social services for older people in England, recouping £1.7 billion in user charges.<sup>7</sup> Care users are thought to have spent a further £0.6 billion on top-ups and, while there is no definitive data, other private expenditure was estimated to be in the region of £3.5 billion.<sup>8</sup> Taken together, these figures suggest that public expenditure amounted to around £7.3 billion and private expenditure to around £5.8 billion.

#### Existing funding failings

Funding reform is required for two reasons. First, the current funding system is both unfair and inefficient. Secondly, demographic changes are set to both increase demand for care and constrict supply of informal care.

#### Funding process

An older person who feels they need social care must request an assessment by their local authority. The subsequent Single Assessment Procedure (SAP) assesses all of the individual's needs (covering social care and healthcare) in one go. Once a SAP is carried out, a care plan is written, outlining the individual's assessed needs. There are three broad possible outcomes: the local authority thinks the person is not eligible for any social care; the local authority thinks the person needs social care at home (domiciliary) or in a care home; or the local authority thinks the person needs social *and* medical care (a "combined package of care" or "continuing health and social care") at home or in a care home.

The assessment is dependent on locally-set eligibility criteria. There are four bands of need set out in guidance: critical, substantial, moderate and low. Faced with finite resources, local authorities are increasingly tightening the eligibility criteria they use, thus reducing the numbers assessed as being eligible, particularly for domiciliary care.<sup>9</sup>

Where the local authority assesses the individual as being eligible for care, it can then use a means-test to determine who pays. This is done on a discretionary basis for home care and on a mandatory basis for residential care. The residential means test consists of a capital element and an income element. Individuals with qualifying capital above the upper threshold of £22,250 receive no financial support. Those with less than £13,500 capital are assessed on the basis of their income only. Those with capital valued between the two thresholds are assessed on the basis of their income and their "tariff income" which is valued at £1 for every £250 capital they have above the lower threshold. The current rate of the Personal Expenses Allowance (PEA) is £21.15 per week; any income, including tariff income, above the PEA goes towards the cost of the care home accommodation.

<sup>7</sup> NHS Information Centre, *Personal Social Services Expenditure and Unit Costs England, 2006-07*, February 2008, Table 2.1: [http://www.ic.nhs.uk/webfiles/publications/PSSEX10607/2006-07%20Expenditure\\_final%20v7.0.pdf](http://www.ic.nhs.uk/webfiles/publications/PSSEX10607/2006-07%20Expenditure_final%20v7.0.pdf)

<sup>8</sup> CSCI, *Self-funded social care for older people: an analysis of eligibility, variations and future projections*, 29 January 2008, Table 2: [http://www.csci.org.uk/pdf/20080128\\_Self-funded\\_social\\_care\\_for\\_older\\_people.pdf](http://www.csci.org.uk/pdf/20080128_Self-funded_social_care_for_older_people.pdf)

<sup>9</sup> Over two-thirds of local authorities responding to Counsel and Care's *National Survey of Local Authority Care Charging and Eligibility Criteria 2008* have eligibility set to critical or substantial.

The types of income which are taken fully into account include: occupational pensions; most benefits (including the retirement pension); annuity income (with some exceptions); income from certain disregarded capital; income from an insurance policy (except mortgage protection insurance where the income from the policy is being used to meet the repayments on the loan); and income from certain sub-lets. A partial disregard of income is applied in the case when a resident of a care home receives an occupational pension, personal pension or payment from a retirement annuity contract *and* has a spouse who is not living in the same care home. In this case, half of these stated pension types should be disregarded, so long as the disregarded amount is passed in its entirety to the spouse. Annuity income from a home income plan may be fully disregarded, as is annuity income from a gallantry award, namely the Victoria Cross Annuity or the George Cross Annuity. Other types of income are fully disregarded, including: the guardian's allowance; Christmas bonus; council tax benefit; Disability Living Allowance (mobility component) and mobility supplement; income in kind; social fund payments (including winter fuel payments); war widows and widowers special payments; and certain charitable and voluntary payments.

Where a combined package of care or continuing health and social care is suggested, all medical elements of the care, whether provided in a care home or at the individual's home, are provided without charge by the NHS. The individual may still be liable for social care costs though.

A local authority sets how much it is prepared to pay for care home fees. Homes charging below or at that rate are then open to contracts with the authority. The amount set by an authority is discretionary, but guidelines state this amount can't be so low that there may only be one home in the area charging that amount – a person should have at least some choice of eligible homes. If a person prefers a more expensive home rather than one of the ones with a contract with their authority, then a relative or someone else can pay a third-party top-up to cover the difference. Those with assets above £13,500 can also opt to contribute more in order to go to a more expensive home.

### **Unfairness**

In 2007, we commissioned YouGov to poll over 2,000 British adults.<sup>10</sup> Results from the survey, which looked at attitudes to the quality and affordability of the long-term care system, were detailed in our publication *Lost*.<sup>11</sup> Overall, just 6 per cent of respondents agreed with the statement that the current long-term care system in Britain provides older people with care that is affordable and 64 per cent disagreed. When quizzed about the means-testing threshold of £21,500 which prevailed at the time, 74 per cent of respondents agreed with the statement that it was too low. Just 7 per cent felt that the threshold was set at about the right level and 4 per cent said that it was too high.

Deloitte subsequently undertook a series of focus groups with low earners on our behalf. Participants consistently expressed concern about the unfairness of the current funding system: in the low level of means testing benchmarks which excludes the majority of low earners from any state-funded care; in the inclusion of housing assets which penalises those who have saved; and in the way people have to “fight” or otherwise manipulate the system to receive their due.

---

<sup>10</sup> 2,006 British adults completed online questionnaires between 3 and 5 December 2007.

<sup>11</sup> Resolution Foundation, *Lost: Low earners and the elderly care market*, 19 February 2008: <http://www.resolutionfoundation.org/publications.php>

While the unfairness of the means test is largely perceptual, local variation in the application of eligibility criteria has been shown to be objectively unfair. According to CSCI, variation in rates of service recipients per capita across councils in England is significantly higher than would be expected given differences in need and wealth, indicating that councils have different policies regarding eligibility thresholds.<sup>12</sup> CSCI concluded that eligibility inconsistencies were in evidence not just across local authorities, but also within councils.<sup>13</sup>

### **Inefficiencies**

In addition to being unfair, Deloitte concluded that tightening of eligibility criteria across local authorities produces inefficiency in the market. Tightening has occurred in response to inadequate funding and has caused local authorities to target resources on intensive and remedial care at the expense of investing in preventative services.

Deloitte identified a second inefficiency resulting from local authorities' determination to reduce costs by negotiating lower fees with care suppliers for state-funded care users. Care providers react to this squeeze on their profits by increasing costs for self-funded care users. This cross-subsidisation can price self-funders out of the market or lead to the running down of resources faster than might otherwise be the case. By helping to use up private funding more quickly, local authorities are contributing to demand for state-funding later down the line.<sup>14</sup>

Deloitte also found that private funding is being channelled inefficiently. Low awareness of how long-term care operates and generally poor financial planning in the UK means that the financial services market is under-developed in this field, with equity release and long-term care insurance products suffering from low take-up. Access to financial products is constrained in part by supply-side issues related to the difficulties of providing commercially viable options for differing customer profiles and in part by low inherent demand. Low take-up in the equity release market creates the likelihood that fewer people are receiving care in their own homes than is appropriate, because of their inability to release illiquid wealth held in their homes other than by selling them. Similarly, the stalling of the long-term care insurance market means that instead of risk-pooling and thereby sharing exposure to potential care costs, all individuals face the prospect of bearing 100 per cent of the costs. By reducing the purchasing ability of people with care needs, these inefficiencies may have limited the supply of a wider range of non-residential care alternatives in the UK.

### **Future funding pressures**

Demographic changes are expected to increase demand for long-term care over the next few decades. An increasing number of people are living longer, but with more complex conditions such as dementia and chronic illness. The Government expects falling death and birth rates to mean that one-in-five of the English population will be over 65 by 2022, compared with fewer than one-in-six in 2006.<sup>15</sup> Alongside this increase in demand for care, informal supply is expected to contract due to the effects of increasing geographical mobility,

---

<sup>12</sup> CSCI, *Self-funded social care for older people: an analysis of eligibility, variations and future projections*, 29 January 2008, Chapter 6: [http://www.csci.org.uk/pdf/20080128\\_Self-funded\\_social\\_care\\_for\\_older\\_people.pdf](http://www.csci.org.uk/pdf/20080128_Self-funded_social_care_for_older_people.pdf)

<sup>13</sup> CSCI, *The state of social care in England 2006-07*, 29 January 2008, p35: [http://www.csci.org.uk/about\\_us/news/state\\_of\\_social\\_care\\_2007\\_ne-1.aspx](http://www.csci.org.uk/about_us/news/state_of_social_care_2007_ne-1.aspx)

<sup>14</sup> Resolution Foundation, *A to Z: Mapping long-term care markets*, February 2008, pp24-25

<sup>15</sup> HM Government, *Putting People First: A shared vision and commitment to the transformation of Adult Social Care*, 10 December 2007, p1:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_081118](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081118); ONS, *Population Trends 132 – Summer 2008*, Table 1.4: <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=6303>

the decline of the traditional family unit and the continued increasing involvement of women in the workforce. At the same time, unit costs for formal care are rising, driven primarily by wage pressures which reflect the recruitment difficulties face by care providers.

Based on a continuation of current patterns of care, the Government has acknowledged that an ageing population and rising unit costs of care will mean that state funding for formal adult social care (long-term care plus care and support for younger adults with physical sensory impairments or learning disabilities) in England will face a £6 billion shortfall by 2026.<sup>16</sup> In this scenario, further eligibility tightening by local authorities will mean that increasing numbers of self-funders will have relatively higher needs. These older people will, by definition, require more intensive and expensive care packages. Individuals will therefore have to meet higher care costs or increase their reliance on informal care with associated disadvantages in respect of health, income and employment opportunities for carers.<sup>17</sup>

---

<sup>16</sup> HM Government, *The case for change: Why England needs a new care and support system*, May 2008

<sup>17</sup> Carers UK estimate there will be 9 million carers by 2037 - see <http://www.carersuk.org/Newsandcampaigns/Mediacentre/Tenfactsaboutcaring>.

## IV – A new funding settlement

A new funding settlement is required, to both meet the expected rising demand and promote greater fairness and efficiency.

A number of potential funding settlements were discussed in a background paper to the Wanless Social Care Review in 2006, presenting an array of choices between individual and collective responsibility and between pre-funded risk-pooling and out-of-pocket payments. The options presented can be grouped under three broad headings: state-funded models; privately-funded models; and mixed models.

State-funded models included the provision of free personal care using funding from general taxation and the provision of explicit care entitlement for people contributing to a social insurance fund. Privately-funded models were divided between those based on pre-funding, such as long-term care insurance (LTCI) products, and those facilitating out-of-pocket payments, such as equity release products. A number of mixed models were also explored. Several rule changes to the existing means-testing arrangements were considered, including raising the higher and lower assets thresholds. A partnership model offering a universal minimum level of care alongside incentives for private top-ups through some form of match-funding was set out, as was a limited-liability model in which the state takes over responsibility for long-term care costs from individuals after a specified period or level of expenditure. The report also outlined savings-based models, which the state could incentivise via tax breaks or which could be linked to existing pension products.<sup>18</sup>

Based on its criteria of fairness, economic efficiency, user choice, physical resource development, clarity and sustainability/acceptability, the Wanless review ultimately recommended the introduction of a partnership model.<sup>19</sup> However, the Government chose not to adopt this model and the then Parliamentary Under Secretary of State for Care Services said earlier this year that:

*While I've always said that Wanless was a very important contribution to this debate, it's absolutely clear to me that Wanless did not actually come up with all of the solutions if we're talking about a fundamentally new care and support system, rather than how do we roll forward the existing social care system 20 years.<sup>20</sup>*

The vision of a new funding settlement depends in large part on what this “fundamentally new care and support system” looks like: that is, *what* people are paying for. Our work on the architecture of a new long-term care market sets out a number of options, each with different implications, and the Government may present more in its Green Paper. As a minimum, the eligibility test requires standardisation across local authorities to put an end to the postcode lottery, and the tendency towards tightening needs reversing to ensure that individuals with low care needs do not enter residential care prematurely. Similarly, the means test, which disadvantages those who own assets but have relatively low incomes, should be replaced with some form of universal entitlement. Some form of means test will still be required to

<sup>18</sup> Wanless Social Care Review Background Paper 12, *Funding Options for Older People's Social Care*, 2006:

[http://www.kingsfund.org.uk/publications/kings\\_fund\\_publications/appendices\\_to.html](http://www.kingsfund.org.uk/publications/kings_fund_publications/appendices_to.html)

<sup>19</sup> Wanless Social Care Review, *Securing Good Care for Older People: Taking a long-term view*, 2006, pp xxx-xxxi:

[http://www.kingsfund.org.uk/publications/kings\\_fund\\_publications/securing\\_good.html](http://www.kingsfund.org.uk/publications/kings_fund_publications/securing_good.html)

<sup>20</sup> *Community Care*, “Social care experiencing its ‘most important year’”, 31 July 2008, pp4-5:

<http://www.communitycare.co.uk/Articles/2008/08/01/108983/ivan-lewis-challenges-adult-care-sector-to-deliver.html>

provide further support for those unable to supplement their entitlement, but no one should be expected to meet the full cost of their care.

Irrespective of the final vision settled on, it appears inevitable that the long-term care bill will rise significantly and that society will therefore need to meet the bill. The debate should not be about who pays for care – the state or the individual – rather it should centre on what collective and direct mechanisms will best allow all individuals to meet the growing long-term care bill.

### **Collective funding mechanisms**

Projected falls in the size of the working-age population relative to the older population, the current economic downturn and the fiscal tightening due from 2011/12 onwards mean that existing collective funds are set to be in short supply. Demand for long-term care is not going to disappear, however, and society must face up to the challenge of directing appropriate funds to the sector. The state-funded models set out in Wanless – taxation, national insurance and a hypothecated social insurance fund – remain relevant options.

Models in place in other countries provide explicit entitlements to support based on need and are funded via some form of income or wealth tax, or via an age-specific care contribution. Germany introduced social insurance in 1995 in the form of an income tax on all adults including pensioners. Levels of contributions and benefits are all fixed by Federal law and are paid in equal part by employers and employees. The initial rate of 1.7 per cent (0.85 per cent for employers and 0.85 per cent for employees) has since risen to 1.9 per cent. To compensate employers for the extra costs, two public holidays were scrapped when the charge was introduced. Access to care depends on a standard national assessment. Users can receive insurance benefits as either services or cash, or some combination of the two.

On the premise that at least some of the increased future cost of long-term care is likely to be paid for directly by individuals, our 2007 YouGov poll of British adults presented respondents with the choice of three specific options: 46 per cent favoured paying into a compulsory national savings scheme over the course of their lifetime; 17 per cent said that they would prefer to pay into private insurance schemes over the course of their lifetime; and 6 per cent selected the option of using their property or other assets. However, the uncertainty surrounding these choices was reflected by the fact that 31 per cent selected either “none of these” or “don’t know”.

In 2006, the JRF presented a range of funding options that it had developed in its earlier report *Facing the Cost of Long-Term Care*<sup>21</sup> to eight focus groups made up of 59 participants aged 26-90. The JRF reported that the groups viewed an increase in general progressive taxation to be fairer than the existing means-tested system, guaranteeing a certain level of support that individuals could supplement with their own resources. Particular interest was expressed in the possibility of a national fund or specific long-term care tax – in some groups the idea of a national ‘ring fenced’ care fund was suggested by people without being introduced by the researchers – provided safeguards were in place to prevent the funds being raided for other purposes.<sup>22</sup>

---

<sup>21</sup> JRF, *Facing the Cost of Long-term Care: Towards a Sustainable Funding System*, 2005: [www.jrf.org.uk/bookshop/eBooks/1859353894.pdf](http://www.jrf.org.uk/bookshop/eBooks/1859353894.pdf)

<sup>22</sup> JRF, *Testing consumer views on paying for long-term care*, 2006: <http://www.jrf.org.uk/bookshop/details.asp?pubid=780>

However, despite this apparent support among the public, it is likely that resistance would be met in practice.<sup>23</sup> Revenues would be vulnerable to the economic cycle. In Germany benefits have fallen behind inflation and 40 per cent of older people in care are supplementing their insurance with state assistance.<sup>24</sup> In addition, it would pose the problem of transition generations: cohorts that fund both current and future care. Given the unearned wealth accrued by many in older generations associated with housing inflation, and the relative indebtedness of many in younger generations, such a scheme could prove difficult to sell. This difficulty could be overcome by phasing in the scheme, but there is very little political appetite: the then care services minister Ivan Lewis, speaking at a *Community Care* stakeholder event in July 2008 said that taxpayers would be reluctant to pay more.<sup>25</sup>

It is clear, therefore, that collective funds will inevitably supply a proportion of the increased required long-term care funding at best: individuals will also be required to increase their direct funding of care.

### **Individual funding mechanisms**

Rather than attempting to design a single 'best-fit' funding solution that prescribes an appropriate balance between collective and individual sources, this report assumes that state funding will increase to meet some but not all of the future costs of long-term care. It sets out a range of methods for individuals to meet the remaining shortfall which can potentially co-exist and complement each other, allowing individuals to select the products most appropriate to their personal preferences and circumstances in the next 20 years and beyond.

The products can be grouped into three broad categories: out-of-pocket, pre-funded insurance and long-term savings. While we expect private markets to develop products that will meet the needs of a number of consumers, inherent market difficulties mean that the state will also need to play a role in developing suitable options.

Out-of-pocket payments are likely to be used most frequently by those currently within the older age group and baby-boomers who are either already facing long-term care costs or may do so in the relatively near future. They will, however, have continued relevance over time for members of younger cohorts who fail to appropriately plan for old age or choose not to insure themselves against long-term care needs. Primarily, out-of-pocket payment can be met by releasing equity in the home and potentially purchasing immediate needs annuities.

Pre-funded long-term care insurance is also likely to be of relevance to those currently in the older age group, although it is probable that baby boomers approaching retirement will be better placed to access reasonable premiums. Younger cohorts should also be able to gain from the welfare benefits associated with insuring against care needs, but it is possible that the ways in which they fund premiums will differ from those adopted by baby boomers. In the next 20 years, the funds used to pay premiums are likely to be tied in some way to home ownership. This may prove more difficult in the long-term, because access to the same gains in housing wealth enjoyed by baby boomers may be less widespread.

---

<sup>23</sup> Commission on Taxation and Citizenship, *Paying for Progress: A new politics of tax for public spending*, November 2000

<sup>24</sup> Jessica Asato Consulting, *The future of long-term care financing for older people – facing the reality*, March 2006

<sup>25</sup> *Community Care*, "Social care experiencing its 'most important year'", 31 July 2008, pp4-5:

<http://www.communitycare.co.uk/Articles/2008/08/01/108983/ivan-lewis-challenges-adult-care-sector-to-deliver.html>

Encouragement of long-term savings mechanisms which can then be used to purchase insurance or to fund out-of-pocket costs is therefore of importance to the post baby-boom generations. Such products are unlikely to be accessible for many in the older cohorts because existing levels of saving for retirement are known to be inadequate.

## **Out-of-pocket payments**

### **Typical costs of long-term care**

Saga has reported that the average annual cost of residential care in 2007 was around £28,000.<sup>26</sup> Given that the average completed length of stay in residential care is around three years, an individual requiring residential care might expect to face a total long-term care bill of around £84,000. There is, however, a long tail to the longevity of residential care clients, with a minority remaining in the home for a significant number of years and therefore potentially facing very high costs.

Counsel and Care's survey of 34 local authorities in England found that hourly rates charged by councils in 2008 varied from nothing to £18, with the average cost among those authorities that charged being £12.84.<sup>27</sup> The NHS Information Centre's survey of home care users aged 65 and over in 2005-06 found that around half of the households received five hours or less of care per week, just below one-quarter received between five and ten hours and just over one-quarter received more than ten hours of support per week.<sup>28</sup> An individual receiving ten hours' contact per week at the average rate quoted by Counsel and Care would face an annual bill of around £6,700.

### **Immediate needs annuities**

Individuals assessed as needing care who are unable to access state support must choose to either meet their care costs from their finances on an ongoing basis, knowing that they will qualify for public funds if they spend down their savings beyond a certain limit, or purchase an immediate needs annuity.

Immediate-needs annuities provide a guaranteed income for life in exchange for a lump-sum investment, thereby capping the cost of care for the individual and providing greater certainty over the residual size of their estate. The reduced life expectancy associated with people already requiring care means that they are paid benefits at enhanced rates, with the size of their initial investment based on a medical assessment. Some policies pay benefits direct to a care home or carer, others allow payment direct to the insured.

Around three-quarters of annuities are taken out by women, and the average age of customers is 87. Precise premium and benefit sizes vary depending on individual circumstances, but in broad terms premiums of around £80,000 return around £1,600 monthly benefit.<sup>29</sup>

---

<sup>26</sup> Saga press release, "Final cost of long-term care predicted to double in 20 years", 11 Feb 2008:

[http://www.saga.co.uk/corporate/press\\_releases/press\\_release.asp?id=1823&nextButton=40&dotyyyy=2008](http://www.saga.co.uk/corporate/press_releases/press_release.asp?id=1823&nextButton=40&dotyyyy=2008)

<sup>27</sup> Counsel + Care, *Care Contradictions: putting people first? The harsh reality for older people, their families and carers of increasing charges and tightening criteria* Counsel and Care's National Survey of Local Authority Care Charging and Eligibility Criteria 2008, September 2008:

[http://www.counselandcare.org.uk/assets/library/documents/Care\\_Contradictions\\_2008.pdf](http://www.counselandcare.org.uk/assets/library/documents/Care_Contradictions_2008.pdf)

<sup>28</sup> NHS Information Centre, *Personal Social Services Survey of Home Care Users in England aged 65 and over, 2005-06*, 15 December 2006: <http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/personal-social-services-survey-of-care-users-in-england-aged-65-or-over:-2005-06>

<sup>29</sup> Conversation with Brian Fisher, LTC Marketing Manager AXA Lifetime Care.



AXA Lifetime Care's *Immediate Lifetime Care* product is available for people aged between 18 and 99 who are already suffering from mental or physical disability and either already receiving or about to receive formal care. Payments begin immediately and are paid direct to the care provider on a monthly basis. Benefit escalators and future top-ups can also be purchased. Partnership's *Immediate Care Plan* provides similar benefits but is only available to people aged 60 or over. It stipulates a minimum premium of £5,000 and offers the opportunity to capital-protect: guaranteeing a return on capital to the estate either within a fixed period or, for a higher fee, upon death.

Deferred care plans operate in a similar way to immediate-needs annuities, but benefits are paid out after a few months or years. It suits people who have funds to pay for care for an initial period, but want some protection if the care continues beyond that period. They therefore represent a privately-funded version of the limited-liability model set out in Wanless. The most common period of deferment among customers is five years.<sup>30</sup>

Immediate-needs annuities are usually purchased after the individual has sold their home and entered residential care. They are very rarely used to fund domiciliary care because of the high costs involved. Therefore, in order to fund domiciliary and lower-needs care, individuals need to have access to savings without selling their home. Failure to source liquid monies can cause some individuals to sell their home and enter residential care prematurely.

### **Equity release**

According to the Council of Mortgage Lenders (CML), the number of owner-occupiers aged 60 and over is set to increase by 2.8 million between 2006 and 2026, rising from 6.3 million to 9.1 million. This increase would mean that the value of un-mortgaged equity owned by older households would rise from £1,000 billion to £1,400 billion if house prices were to remain constant in real terms. If house prices were to increase broadly in line with earnings, then un-mortgaged equity among older households would increase to £2,300 billion.<sup>31</sup>

Equity release is not a solution available to all, but it could provide a means for many with low incomes to purchase immediate needs annuities or directly fund long-term care needs.

### ***Income-poor, asset-rich***

A sizeable number of older people are income-poor but asset-rich. The Actuarial Profession's 2005 equity release report estimated that 4.3 million people aged 65 and over are homeowners with inadequate retirement income.<sup>32</sup> IPPR analysis of the English Longitudinal Study of Ageing 2002-03 found that around one million older homeowners have un-mortgaged housing assets worth more than £100,000, but incomes so small that they qualify for means-tested benefits. The number of people falling into this income-poor, asset-rich category is expected to grow over the next 10-15 years: of those aged 50 or over who were yet to retire, 15.6 per cent were projected to have less than the amount required to

---

<sup>30</sup> Conversation with Philip Brown, Head of Retirement & Care Product Development, Partnership.

<sup>31</sup> CML, *Prospects for UK housing wealth and inheritance*, July 2008:

<http://www.cml.org.uk/cml/filegrab/ResearchReportProspectsforUKhousingwealthandinheritance.pdf?ref=5975>

<sup>32</sup> The Actuarial Profession, *Equity Release Report 2005*, 13 January 2005, p10:

[http://www.actuaries.org.uk/\\_data/assets/pdf\\_file/0006/19248/equityreleaserepian05V1.pdf](http://www.actuaries.org.uk/_data/assets/pdf_file/0006/19248/equityreleaserepian05V1.pdf)

secure Age Concern's *Modest but Adequate* retirement income and equivalised housing equity worth over £100,000.<sup>33</sup>

### **Equity release and low earners**

Based on our definition of low earners, around 53 per cent are homeowners, rising to 62 per cent among older low earners. Altogether, 28 per cent of low earners own their own home outright, a higher proportion than those in either lower or higher income brackets. Low earners hold disproportionately more of their wealth in housing assets than other income groups: the average value of the home is three times greater than their average liquid assets, compared with a factor of two among those in the higher income bracket. Taken together, these factors suggest that improving the ease of access to equity release products is likely to be of use to a large number of low earners.

The set up costs and fees associated with equity release products vary from customer to customer and from product to product. However, typical charges include: arrangement fees of between £300 and £500; valuation fees linked to the value of the property usually in the region of £300; legal costs of between £300 and £700; and buildings insurance of between £200 and £300. Customers borrowing more in subsequent years with drawdown products are sometimes charged further lending fees. In addition, early repayment charges are usually applied if a mortgage is repaid before the end of the contract. The various costs, along with generic expenses associated with visiting an IFA, may act as a disincentive to some low earners. However, most fees can usually be added to the loan, thus reducing the initial outlay, although these amounts are then subject to interest charges.<sup>34</sup>

### **Lifetime mortgages**

There are two main types of equity release product available in the UK: lifetime mortgages and home reversion plans. Lifetime mortgages have been regulated by the FSA since 2004 and home reversions since 2007.

Lifetime mortgages provide applicants with tax-free funds, either as a lump-sum or regular payments, which are repayable when they die or move into long-term care. If they move home, the loan can move with them. Drawdown loans, which allow customers to access an initial lump-sum and set a further amount which they can draw on as suits them over time, have become increasingly popular and now account for more than half of all lifetime mortgages. Most lifetime mortgages include a no negative equity guarantee, to ensure that the total amount owed is not greater than the sale price of the house. The maximum loan-to-value (LTV) available to a 70 year old ranges from 22.5 per cent to 35 per cent.<sup>35</sup> This rises to around 50 per cent for people at the top end of the age scale. The average age of clients is around 68.<sup>36</sup>

The majority of products compound interest at a fixed rate during the lifetime of the loan. Table 1 details the amounts due for repayment associated with three different initial advances and at three different rates of interest. Taking a lump-sum of £60,000 at a fixed

<sup>33</sup> IPPR, *Housing-Rich, Income-Poor: The potential of housing wealth in old age*, October 2005: <http://www.ippr.org.uk/publicationsandreports/publication.asp?id=331>

<sup>34</sup> FSA Factsheet, *Raising Money from your Home*, p19: [http://www.moneymadeclear.fsa.gov.uk/pdfs/equity\\_release\\_ink.pdf](http://www.moneymadeclear.fsa.gov.uk/pdfs/equity_release_ink.pdf)

<sup>35</sup> The Actuarial Profession, *Equity Release Report 2005*, 13 January 2005, p17:

[http://www.actuaries.org.uk/\\_data/assets/pdf\\_file/0006/19248/equityreleaserepian05V1.pdf](http://www.actuaries.org.uk/_data/assets/pdf_file/0006/19248/equityreleaserepian05V1.pdf)

<sup>36</sup> Conversation with Andrea Rozario, Director General SHIP: 10 September 2008.

rate of 7 per cent would require a repayment of £84,135 if the customer died or entered long-term care after five years, and a repayment of £325,646 if it became due after 25 years.

Several other options are available. Interest-only mortgages require customers to pay interest on the loan each month at a variable rate. The amount originally borrowed is then repaid when the home is sold. Fixed repayment mortgages charge no interest. Instead, a fixed repayment is agreed at the outset which the lender takes when the home is sold. Home Income Plans provide a lump-sum, from which an annuity is bought. This income is then used to pay the interest on the loan. Shared appreciation mortgages allow customers to face lower interest charges in return for agreeing to give the provider a share in any increase in the value of the home when it is sold.

**Table 1: Indicative debt levels associated with fixed rate lifetime mortgages**

Loan period (years)	Annual interest rates		
	5%	7%	9%
<b>£45,000 lump sum</b>			
5	£57,433	£63,115	£69,238
10	£73,300	£88,522	£106,531
15	£93,552	£124,156	£163,912
20	£119,398	£174,136	£252,198
25	£152,386	£244,234	£388,039
<b>£60,000 lump sum</b>			
5	£76,577	£84,153	£92,317
10	£97,734	£118,029	£142,042
15	£124,736	£165,542	£218,549
20	£159,198	£232,181	£336,265
25	£203,181	£325,646	£517,385
<b>£75,000 lump sum</b>			
5	£95,721	£105,191	£115,397
10	£122,167	£147,536	£177,552
15	£155,920	£206,927	£273,186
20	£198,997	£290,226	£420,331
25	£253,977	£407,057	£646,731

### **Home reversion plans**

Under home reversion plans, an individual sells up to a 100 per cent share of their home to a provider for a tax free lump-sum and continues to live there rent-free. The amount paid is based on a valuation below the market value of the property, typically between 35 per cent and 60 per cent.<sup>37</sup> On death, or a move into a care home, the property is sold and the provider receives the value of the share of the home they own. The individual therefore achieves more certainty about the size of their estate but, if house price inflation is high or if the duration of the plan is short, the income lost to the estate can be greater than the interest charges associated with lifetime mortgages. A minimum age is often stipulated which is higher than for lifetime mortgage products. Typically products are reserved for those aged 65 and over and a maximum LTV of around 60 per cent is available.<sup>38</sup> Under some schemes, customers pay a small amount of rent to the provider in return for receiving a larger initial price.

<sup>37</sup> FSA Factsheet, *Raising Money from your Home*, p7: [http://www.moneymadeclear.fsa.gov.uk/pdfs/equity\\_release\\_ink.pdf](http://www.moneymadeclear.fsa.gov.uk/pdfs/equity_release_ink.pdf)

<sup>38</sup> Conversation with Andrea Rozario, Director General SHIP: 10 September 2008.

In 2006, 94 per cent of an estimated £1,154 million equity release lending was in the form of lifetime mortgages and 6 per cent was in the form of home reversion.<sup>39</sup> Lifetime mortgages have tended to dominate the market for two reasons. First, the majority of new entrants to the market have been mortgage lenders who are naturally inclined to sell mortgages rather than reversions. Secondly, the mortgage product is a less complex sale for the broker or IFA. There is some evidence to suggest that consumers prefer the certainty of reversions to the longevity risk associated with lifetime mortgages, suggesting that demand for reversions could increase in the future, particularly as reversions tend to offer better value if house prices fall.<sup>40</sup>

### **Uses of equity release**

There is no definitive data detailing the uses of equity release proceeds and the typical customer profile in the UK. In general, equity release is believed to be accessed for aspirational purposes, with home improvement being the primary use. There is no indication of what proportion of this is spent on modifications to the home related to ageing, nor on what proportion of customers use equity release to fund healthcare needs.<sup>41</sup>

More detailed statistics are available in Australia, many of which echo the perceptions of the UK market set out above. A SEQUAL/Trowbridge Deloitte report found that in the six months to December 2007, the 'reverse mortgage' (lifetime mortgage) market grew by 11.8 per cent: an annualised rate of 25 per cent. Couples accounted for 44 per cent of outstanding lifetime mortgages, single women accounted for a further 40 per cent and single men made up 16 per cent of the market.

The average age of existing borrowers was 74 and the 70-79 age group accounted for 60 per cent of loans. A further 21 per cent of borrowers were aged 80 and above. Maximum loan-to-value rates were found to vary from 15 per cent for those aged under 65, to 40 per cent for those aged over 80. Within these maximum limits, actual LTV amounts received varied from 12 per cent among the under-65s, to 22 per cent among the over-80s. Use of equity release appears to be growing among younger age groups. Under-70s comprised 40 per cent of all new loans in 2007, compared to 29 per cent of outstanding loans. The average age of new borrowers was 72.

Indicative data on the use of proceeds in Australia suggests that home improvement was the most common purpose. Other specified uses included income, debt repayment, travel, car purchase, reinvestment and gifts. Aged care was thought to be the primary purpose in around 4 per cent of cases.<sup>42</sup>

### **Equity release market failings**

Despite the apparently large number of income-poor, asset-rich individuals living in the UK who would appear likely to benefit from equity release, the market remains relatively small. In 2006, a total of 135,000 products were live, representing 5.4 per cent of the 65+ age group with current care needs and 1.5 per cent of the total 65+ group.<sup>43</sup> These figures are

---

<sup>39</sup> CML, *Please release me! A review of the equity release market in the UK, its potential and consumer expectations*, March 2008, p9: <http://www.cml.org.uk/cml/media/press/1551>

<sup>40</sup> The Actuarial Profession, *Equity Release Report 2005*, 13 January 2005, p13  
[http://www.actuaries.org.uk/\\_data/assets/pdf\\_file/0006/19248/equityreleaserepian05V1.pdf](http://www.actuaries.org.uk/_data/assets/pdf_file/0006/19248/equityreleaserepian05V1.pdf)

<sup>41</sup> Conversation with Andrea Rozario, Director General SHIP: 10 September 2008.

<sup>42</sup> Senior Australians Equity Release Association of Lenders (SEQUAL)/Trowbridge Deloitte, *Reverse Mortgage Market Study*, December 2007: [http://www.sequal.com.au/images/stories/sequal\\_trowbridge\\_deloitte\\_reverse\\_mortgage\\_study\\_2007.pdf](http://www.sequal.com.au/images/stories/sequal_trowbridge_deloitte_reverse_mortgage_study_2007.pdf)

<sup>43</sup> Laing & Buisson, *Care of Elderly People Market Survey 2007*, p23

reduced to a fraction of 1 per cent if the Australian experience of care needs being the primary reason for accessing equity among just 4 per cent of customers is reflected in the UK. A number of market failings have served to restrict demand and supply.

First, the public does not appear to trust the equity release products provided by private financial organisations. The CML's 2008 review of equity release in the UK concluded that consumers' wariness is borne partly of concerns about losing their homes and leaving debts to their children, and partly of fear of compounded interest and poor value for money. These worries are reinforced by negative coverage in the media, with better than expected longevity meaning that equity release clients often face very large final repayments. The perceived reluctance of well-known high street providers to enter the market due to reputational issues further undermines confidence in the product, although the CML argued that many larger providers *are* involved as funders of some of the firms offering products and that this needs to be communicated to the public. The report highlighted the findings from a 2005 survey which found strong support for more guidance and advice on equity release, particularly in relation to the potential risks.<sup>44</sup> A 2005 JRF study into attitudes to inheritance found that scepticism towards equity release was virtually removed following the suggestion that products could be run on a not-for-profit basis by a respected and trusted organisation.<sup>45</sup>

Secondly, access among homeowners is restricted, with individuals owning low value properties often being unable to secure equity because providers view the set-up costs as being too high relative to expected returns, especially in areas where housing is not expected to increase significantly in value.<sup>46</sup>

Thirdly, the relatively large sizes of minimum initial drawdown, typically between £10,000 and £15,000, mean that many on low incomes are discouraged from accessing equity release because of the impact it could have on their eligibility for benefits.<sup>47</sup>

Fourthly, the complexity of some equity release products and the preference for face-to-face advice rather than over the telephone mean that the IFA and broker community has been reluctant to sell them. Instead, the equity release broker market is made up of a small number of specialist intermediaries. In part this reflects differences in profile between typical IFA customers and typical equity release candidates. It has also occurred because advisers are required by the FSA to develop skills and processes that are relevant to equity release but not to other financial products. Intermediaries must therefore invest a significant amount of time reaching the standard required to sell equity release products. In the absence of a visible pool of prospective customers, an intermediary could view this effort as being uneconomic. Bias towards lifetime mortgages among brokers may also have resulted in potential demand for home reversions remaining undiscovered.<sup>48</sup>

These failings do not appear to be intractable, with some evidence of a softening in attitudes towards drawing down housing wealth later in life. The JRF has found that although existing equity release products are perceived as difficult to understand, risky and poor value for

---

<sup>44</sup> CML, *Please release me! A review of the equity release market in the UK, its potential and consumer expectations*, March 2008: <http://www.cml.org.uk/cml/media/press/1551>

<sup>45</sup> JRF, *Attitudes to inheritance in Britain*, July 2005, p65: <http://www.irf.org.uk/bookshop/eBooks/1861347707.pdf>

<sup>46</sup> CML, *Please release me! A review of the equity release market in the UK, its potential and consumer expectations*, March 2008: <http://www.cml.org.uk/cml/media/press/1551>

<sup>47</sup> JRF Product Working Group, *Equity release: paying for additional help at home*, 3 June 2008

<sup>48</sup> The Actuarial Profession, *Equity Release Report 2005*, 13 January 2005:

[http://www.actuaries.org.uk/\\_data/assets/pdf\\_file/0006/19248/equityreleaserepian05V1.pdf](http://www.actuaries.org.uk/_data/assets/pdf_file/0006/19248/equityreleaserepian05V1.pdf)

money by the British public, people are reasonably positive about the theory of equity release. Looking more specifically at the use of equity release to fund long-term care, the study found that 16 per cent of British adults would consider selling or borrowing against their home in later years to pay for care.<sup>49</sup> Subsequent JRF focus groups highlighted considerable resistance to the idea that older people should have to forfeit or borrow against their homes to pay for care. However, some participants did question the 'natural right' of people to pass on assets, with younger and BME participants arguing that parents have no obligation to leave assets to children who are unprepared to look after them.<sup>50</sup>

Similar evidence is provided from elsewhere in the world. A 2005 survey of 7,000 Australians aged 50 and over by the Australian Housing and Urban Research Institute (AHURI) identified "a significant shift in the values and priorities of older Australians ... transforming the patterns of future housing tenure, lifestyle and family relationships". Respondents were divided into three age cohorts: the baby boomer cohort aged 50-59; the young-old cohort aged 60-74; and the older-old aged over 75. A shift towards more active use of housing equity and a decline in the bequest motive was apparent, with 20 per cent of respondents saying they expected to use up all of their assets before they died; rising to 25 per cent among the baby boomers cohort.<sup>51</sup>

### **Scope for equity release market innovation**

The success of drawdown equity release products highlights the appetite for more flexible products. In relation to long-term care, providers could potentially do more. For example, lower initial advances would make the product more appealing to long-term care users in receipt of benefits. Capital-protection products and the development of hybrid mortgage and reversion products would also be likely to encourage individuals concerned about the prospect of spending their children's inheritance. Products which offer a maintenance service might be attractive to people with long-term care needs, particularly as they are less likely to be able to maintain their properties themselves. At the same time, such a service would help preserve the value of the property for the equity release provider.

The market also needs to tackle the lack of appetite for sales among intermediaries. To this end, the industry should consider providing easy access to comprehensive training and support and issuing brokers with simple guides that help explain benefit rules for example.

Innovation could help stimulate the market. However, the measures set out above will have only limited impact on prices and perceived value for money: providers are ultimately commercial enterprises and therefore cannot reduce their charges below a profitable level. In relation to long-term care there may therefore be scope for some support for the market from the state in order to further reduce costs and so boost demand.

### **Scope for state support for equity release**

Faced with a failing market, but one for which latent demand may be growing, the state has a dual role to play: facilitation of improvements within the private market and direct provision of products for those unable or unwilling to access privately-provided options.

---

<sup>49</sup> JRF, *Attitudes to inheritance in Britain*, July 2005, p57-65: <http://www.jrf.org.uk/bookshop/eBooks/1861347707.pdf>

<sup>50</sup> JRF, *Testing consumer views on paying for long-term care*, 2006, pp9-10:

<http://www.jrf.org.uk/bookshop/details.asp?pubid=780>

<sup>51</sup> Australian Housing and Urban Research Institute (AHURI) Research Report No. 088, *Ageing in place: intergenerational and intrafamilial housing transfers and shifts in later life*, October 2005, pp86-87,98: <http://www.ahuri.edu.au/publications/p70223>

### **State intervention**

The state should be able to improve conditions in the private market relatively quickly. Review of the benefits rules for those who use equity release to fund care services could widen access. The JRF has proposed for example that the Government should allow people to access and use up to £3,000 of equity from their property each year, to enable them to make a wide range of home improvements, without losing their entitlement to means-tested benefits.<sup>52</sup> An alternative would be to increase the capital limits for all disability-related benefits.

The Government could also review the current level of regulation in the market. While visible regulation is beneficial for the reputation of equity release it imposes extra administrative costs for providers which are passed onto consumers, thereby making products less attractive. The more active Australian market is currently considered too vulnerable to undergo regulation, and providers are able to price their products more competitively. While removal of regulation in the UK would be likely to have a detrimental effect on demand, some relaxation might be possible without undermining the safety of consumers, particularly as the trade body SHIP already ensures stringent safeguards among its members' products. Regulation is tight in part because equity release is often seen as a 'product of last resort' and is therefore purchased by clients in distress. Stimulation of the market and improved trust among potential clients could help to remove this label and so further reduce the need for such high levels of regulation.

In addition to reducing administrative costs, the state could consider making funding available to equity release providers on favourable terms or making equity release funds accessed to pay for long-term care and preventative measures such as home adaptations and installation of telecare equipment subject to favourable taxation treatment. For example, the interest arising on equity release loans could be exempted from income assessment. Both approaches would allow equity release providers to reduce the rates of interest charged and so make the products more affordable. The effect of such cost cutting would be to shift typical costs of a lifetime mortgage from column three in Table 1 to column two. Any moves in this direction could be tied to conditions that providers work towards making smaller amounts available for initial drawdown and towards extending products and advice to owners of lower value properties.

A model in which the state provides financial support for, and implied endorsement of, the equity release market is already in place in the US.

#### State support for equity release in the US

Home Equity Conversion Mortgages (HECMs), introduced in 1989, allow home-owners aged 62 and above to access a line of credit through their homes with the Government guaranteeing lenders against loss. Under the scheme, private lenders provide the finance and the Department of Housing and Urban Development's (HUD) Federal Housing Administration (FHA) provides insurance.

As with standard lifetime mortgages, lenders recover their principal plus interest when the home is sold. However, in this instance, if the sales proceeds are insufficient to pay the amount owed, HUD will pay the lender the amount of the shortfall. The FHA collects an

---

<sup>52</sup> JRF, *Foundations: Paying for long-term care*, April 2006, p11:  
<http://www.jrf.org.uk/knowledge/findings/foundations/pdf/0186.pdf>

insurance premium from all borrowers to provide this coverage: an upfront premium which is 2 per cent of the maximum claim amount that may be borrowed plus a 0.5 per cent annual premium.<sup>53</sup> These costs, along with transaction costs represent a sizeable sum. Writing in 2000, Caplin calculated that the average cost of taking a reverse mortgage amounted to \$6,500, or almost 14 per cent of the initial loan.<sup>54</sup> There is some evidence that these charges have been set at too high a level, with HECM having consistently maintained a negative subsidy rate, meaning that the programme revenues have always exceeded costs each year.<sup>55</sup> By paying for this insurance, however, consumers have access to better terms and greater certainty. They are protected against the possibility that their lender goes bankrupt or is otherwise unable to make its regular payment for instance.

In order to access the funds, borrowers must complete a HECM counselling programme. HECM counsellors discuss program eligibility requirements, financial implications and alternatives to obtaining a HECM and provisions for the mortgage becoming due and payable. Upon the completion of HECM counselling, the homeowner should be able to make an independent, informed decision of whether the product will meet their needs.

There are no asset or income limitations on borrowers receiving HUD's reverse mortgages. There are also no limits on the value of homes qualifying for a HUD reverse mortgage, although there is a capped loan limit. Homeowners can select from five payment plans: a lump-sum received at the time the loan is made; monthly payments for as long as the borrower resides in the property (tenure); higher monthly payments for a fixed period of time after which borrowers may continue to live in the property and defer payment (term); a line of credit with which borrowers may control the amounts and timing of cash advances up to a maximum credit line (similar to drawdown products in the UK and chosen by around 75 per cent of borrowers); or some combination of these options.

HUD is able to offer borrowers flexibility in cash advance options because it controls its risk of loss by limiting the net present value (NPV) of all cash advances to an amount called the 'principal limit', which is uniquely calculated for each loan when it is underwritten. As long as the NPV of current and future cash advances does not exceed the principal limit, HUD is indifferent to the pattern of cash advances that borrowers take. Principal limit factors vary by age of the borrower and interest rate. For example, based on a loan with an interest rate of approximately 9 per cent, and a home qualifying for \$100,000, a 65-year-old could borrow up to 22 per cent of the home's value; a 75-year-old could borrow up to 41 per cent of the home's value; and an 85-year-old could borrow up to 58 per cent of the home's value.

The FHA applies a maximum loan limit in each county, which varies between \$200,160 in lower cost markets to \$362,790 in higher cost areas. Properties valued above the FHA loan limit remain eligible for HECM, but, because the principal limit is capped, homeowners with higher valued homes often choose conventional reverse mortgages, which are not constrained by the FHA limit. In 2007/08, 30 per cent of cases insured had property values above the FHA loan limit.<sup>56</sup>

---

<sup>53</sup> US Department of Housing and Rural Development website: <http://www.hud.gov/offices/hsg/sfh/hecm/hecmhome.cfm>

<sup>54</sup> Andrew Caplin, *The Reverse Mortgage Market: Problems and Prospects*, 1 June 2000: <http://cess.nyu.edu/caplin/reverse.pdf>

<sup>55</sup> US Department of Housing and Urban Development, *US Housing Market Conditions 1<sup>st</sup> Quarter 2008*, pp9-10: <http://www.huduser.org/periodicals/ushmc/spring08/ch1.pdf>

<sup>56</sup> US Department of Housing and Urban Development, *US Housing Market Conditions 1<sup>st</sup> Quarter 2008*, Exhibit 3: <http://www.huduser.org/periodicals/ushmc/spring08/ch1.pdf>



HUD has presented five reports to the US Congress about the progress of HECMs since their introduction. The latest, in 2003, was mandated by lawmakers to examine the potential impacts of three policy proposals.<sup>57</sup> First, a reduced mortgage insurance premium for HECM borrowers who refinance their loans; secondly, a national loan limit for HECM to replace the county-by-county FHA loan limits; thirdly, a reduced premium for borrowers who use the HECM loan to purchase long-term healthcare insurance. The first of these proposals was subsequently implemented in 2004, and the second is expected to become law in the near future. The third proposal is still under review.<sup>58</sup>

HECMs now make up between 85 and 95 per cent of the reverse mortgage market. In 2007/08, a total of 107,367 HECM loans were made in the US, up from 76,282 in 2006/07, 6,637 in 2000/01 and just 157 in 1990/91. The extent of acceleration in the market is illustrated by the fact that, of the 390,000 HECM loans advanced in total, more than 50 per cent occurred in the 24 months preceding March 2008. The average borrower's age has fallen fairly consistently over the lifetime of HECMs, from 76.7 years in 1990/91 to 76.0 years in 2000/01 and 73.5 years in 2007/08. Couples account for around 37 per cent of loans, single females for 45 per cent and single males for 18 per cent.<sup>59</sup>

HUD suggests that demand for HECMs has risen so dramatically due to a decade-long rise in home prices and the persistence of relatively low interest rates since 2000. Despite housing sales now facing a downturn in the US however, HECMs are believed to be financially sustainable, partly because the original pricing model assumes modest rates of property value growth with varying distribution and partly because borrowers are not facing negative equity and are therefore expected to retain their loans and ride out the storm.<sup>60</sup>

HUD also argues that increased interest among lenders since 2006 has stimulated the market. HECMs have been underpinned by the secondary mortgage market because originating lenders generally prefer not to hold HECM loans on their balance sheets. Until 2006, nearly all HECM loans were sold by originating lenders to a single investor: Fannie Mae, a government-sponsored enterprise that provides liquidity to the U.S. housing market. More recently, other investors have begun to compete with Fannie Mae in the secondary market for HECM loans. The first private-label (non-agency-backed) HECM security was issued during 2006. During 2007, Ginnie Mae, an agency within HUD that provides liquidity for government-backed housing loans, launched its HECM mortgage-backed securities program, bringing HECM into the agency market. A policy change in 2007, allowing adjustable-rate HECMs to be indexed to the London Interbank Offered Rate (LIBOR), is expected to support even higher levels of investor interest in HECM-backed securities.

---

<sup>57</sup> U.S. Department of Housing and Urban Development Office of Policy Development And Research, *Refinancing Premium, National Loan Limit, and Long-Term Care Premium Waiver for FHA's HECM Program*, May 2003:

[http://www.huduser.org/Publications/pdf/Actuarial\\_Final\\_5-13-03.pdf](http://www.huduser.org/Publications/pdf/Actuarial_Final_5-13-03.pdf)

<sup>58</sup> US Department of Housing and Urban Development, *US Housing Market Conditions 1<sup>st</sup> Quarter 2008*, p8:

<http://www.huduser.org/periodicals/ushmc/spring08/ch1.pdf>

<sup>59</sup> US Department of Housing and Urban Development, *US Housing Market Conditions 1<sup>st</sup> Quarter 2008*, Exhibits 1 & 3:

<http://www.huduser.org/periodicals/ushmc/spring08/ch1.pdf>

<sup>60</sup> US Department of Housing and Urban Development, *US Housing Market Conditions 1<sup>st</sup> Quarter 2008*, p10:

<http://www.huduser.org/periodicals/ushmc/spring08/ch1.pdf>

HUD believes that increased liquidity from an efficient secondary market will broaden lender distribution channels for reverse mortgages and expand the investor base. This trend should lead to lower borrowing costs for borrowers and product innovations.<sup>61</sup>

### **Direct state provision**

Experience in the US suggests that state-sponsorship can successfully stimulate the equity release market. The insurance provided by HUD has echoes of the no negative equity guarantee provided by UK equity release firms. In both countries, customers must pay a premium to secure this certainty: the difference is that in the US the charge is levied by the state while in the UK the cost is internalised by the provider. The US market does therefore not seem to have been stimulated by a state subsidy. Instead, the market is likely to have benefited from higher levels of confidence among US consumers stemming from the implied endorsement of the state.

Some form of state endorsement in the UK would be likely to have similar beneficial effects for the market. However, in order to correct the other market failures of lack of access to equity release for some individuals because of high set-up costs and the reluctance of providers to accept some property, more direct state-sponsorship might also be appropriate.

Asset accumulation and home-ownership are high on the Government's agenda with access to affordable home-ownership being provided via schemes such as Right-to-Buy, HomeBuy and Right-to-Acquire.<sup>62</sup> Against a backdrop of a faltering housing market, the Government has recently launched a new 'HomeBuy Direct' shared-equity scheme alongside a 12-month removal of stamp duty on properties under £175,000. In addition, a mortgage-rescue package announced by the Government includes scope for homeowners to sell up to 100 per cent housing equity to registered social landlords while remaining in their property.<sup>63</sup>

This final measure acknowledges the role the state can play in asset decumulation, which until now has received little attention. The establishment of a public equity release product could form part of a wider Government vision of home-ownership, which seeks to link equity release by those in retirement with shared-ownership for first-time buyers. One of the few asset decumulation programmes run by the state is the system of deferred payments introduced for care home residents.

### **Deferred payments**

The Government acknowledged that lack of confidence in equity release products constituted market failure and introduced a limited public sector product in October 2001.<sup>64</sup> Under section 55 of the Health and Social Care Act 2001, councils were given powers to take a legal charge on a care home resident's main or only home instead of seeking contributions from the individual. The accrued debt could then be recouped when the house was sold. Unlike commercial schemes, no interest would be charged on the debt until 56 days after the person's death, at which point a "reasonable" rate of interest could be introduced.

---

<sup>61</sup> US Department of Housing and Urban Development, *US Housing Market Conditions 1<sup>st</sup> Quarter 2008*, p10: <http://www.huduser.org/periodicals/ushmc/spring08/ch1.pdf>

<sup>62</sup> More details available on the Communities and Local Government website: <http://www.communities.gov.uk/housing/housingsupply/affordablehousing/homeownershipschemes>

<sup>63</sup> *The Guardian*, "Aid for first time buyers and repossessions rescue", 3 September 2008: <http://www.guardian.co.uk/money/2008/sep/03/houseprices.stampduty3>

<sup>64</sup> PIU, *Lending Support: Modernising the Government's Use of Loans*, March 2002: [http://www.cabinetoffice.gov.uk/strategy/work\\_areas/-/media/assets/www.cabinetoffice.gov.uk/strategy/piu%20loans%20pdf.ashx](http://www.cabinetoffice.gov.uk/strategy/work_areas/-/media/assets/www.cabinetoffice.gov.uk/strategy/piu%20loans%20pdf.ashx)

These 'deferred payments' are available to people in residential or nursing homes who have capital (apart from the value of their home) under the local authority limit, cannot meet the full fees of the home from their income and do not wish to sell their home or are unable to sell their home quickly enough to pay for their fees. While in residential care, the individual can let the home, let a person live there who does not make the home a disregarded asset or leave it empty. Residents must make a weekly contribution made up of their after-tax income minus their Personal Expense Allowance. People not claiming income support who set up deferred payments are classed as 'retrospective self-funders' and are therefore entitled to keep their Attendance Allowance. The individual can ask the council to pay fees in excess of its baseline level in order to achieve a higher level of care, but the local authority will only agree if it is certain of obtaining the difference in top-ups during the lifetime of the person from either the person himself or from a third party.

Local authorities were provided with ring-fenced grants for the first three years of the scheme. After that point, it was expected that a revenue stream associated with the first wave of applicants would provide funding for continuation of the scheme. However, there is little official data available, although take-up appears to have been low.<sup>65</sup> The largest barrier appears to be reluctance on the part of local authorities. The work involved for councils in drafting the legal agreements underpinning deferred payment arrangements acts as a disincentive, and many councils continue to use powers under section 22 of the Health and Social Services and Social Security Adjudications Act (HASSASSA) 1983, which allow local authorities to take a legal charge where a debt is outstanding, instead.<sup>66</sup>

Similar deferred payment arrangements were introduced to Scotland in July 2002 under the Community Care and Health (Scotland) Act 2002. A 2008 Scottish Government review of low take-up identified four main factors: mixed implementation by local authorities; information and communication failings; up-front costs; and the deferred payment process. Some local authorities were found to be not offering residents any vehicle by which to defer care home fee payments, while others preferred to continue to use the charging orders debt recovery process provided for under HASSASSA. The review found written information provided to prospective care home residents by councils was at best limited and at worst non-existent. In addition, care home residents were found to be deterred from entering a deferred payment arrangement by the up-front costs, including lawyers' fees and local authority charges. Similarly, applying for a deferred payment arrangement was said to be time-consuming and complex. Frequently, when presented with the alternative of selling the home and accepting a charging order with no up-front cost and no delay, residents and their families chose to go down this route.<sup>67</sup>

Again, relatively rapid corrective action can be taken. Many of these problems could potentially be overcome by more active promotion of the option by local authorities. The JRF has suggested that the inexperience of local authorities in providing equity release means that greater private sector involvement could improve the situation. It also felt that the scheme could be significantly expanded and made more flexible to allow individuals to use

---

<sup>65</sup> See for example, Ivan Lewis MP, HC Deb 5 Jun 2008 c964:

<http://www.publications.parliament.uk/pa/cm200708/cmhansrd/cm080605/debtext/80605-0011.htm#08060598000826>.

<sup>66</sup> Elderly Client Adviser website, *Deferred payments*, 21 Nov 2002: <http://www.ecadviser.com/xq/asp/sid.0/articleid.43FA7BB5-5093-4088-AD50-A12950E8C3D8/qx/display.htm>

<sup>67</sup> Scottish Government, *Evaluation and Assessment of Deferred Payment Agreements*, January 2008, Ch7: <http://www.scotland.gov.uk/Publications/2008/01/18105523/0>

their assets to fund domiciliary care.<sup>68</sup> This would be a welcome development as it could help delay entry into residential care until the most appropriate time for those individuals with low levels of liquid wealth.

#### State-sponsored equity release

The JRF has explored a number of models for state provision of equity release for low income individuals. Most simply, councils could identify one or more products and providers that they choose to direct their residents to if they require cash to access additional care at home. Alternatively, local authorities could offer equity release deals through a not-for-profit funding company sponsored by local government, with financing provided by the private sector. This finance could be provided at commercially viable rates or at rates subsidised by the local authorities. Delivery would be primarily local, but some services could be provided remotely over the telephone. National or regional organisations could manage the services, in order to ensure economies of scale.<sup>69</sup>

The JRF has established a working group tasked with designing a state-sponsored product that would allow low-income individuals in need of additional help at home to access small amounts of equity. No model has yet been finalised, but a number of local authorities are considering pilot schemes. Such pilots could be introduced relatively quickly and could be based on existing powers such as deferred payments, charging orders or the Regulatory Reform (Housing Assistance) Order 2002 which gives local authorities powers to develop equity release loan vehicles to provide assistance for homeowners to fund repairs or improvements in their homes. Similarly, partnership between the public and private sectors could centre on existing organisations such as Community Development Finance Institutions and the Home Improvement Trust. Although technically representing a form of equity release, these pilots could be marketed simply as loans secured against property.

As well as coordinating and potentially subsidising such schemes, local authorities would have a key role to play in identifying and approaching those residents who might benefit from low cost equity release in order to fund low level care or preventative measures such as home adaptations or telecare installation.

Building on the work of the JRF, an expanded state-sponsorship scheme designed to cover a wider range of potential clients could also be developed. A straightforward, capped product specifically for people wishing to fund long-term care and preventative measures could extend access among low earners. A product with wider appeal would also be more likely to improve confidence in the product more generally and so stimulate demand.

This low-cost state-sponsored product would require underwriting from the Government, at least in the initial period. As with deferred payments, it could be designed in such a way as to become self-funding over time. A lifetime mortgage or a home reversion product can be envisaged, with the capital certainty of a reversion scheme likely to appeal to many homeowners, particularly at a time of falling house prices.

For example, an easy to understand home reversion plan could be made available only to individuals looking to purchase care services or protection against care needs. The following

---

<sup>68</sup> JRF, *Consultation response to HM Treasury: 'Regulating home reversion plans': Appendix 1*, September 2003:

<http://www.jrf.org.uk/knowledge/responses/docs/homereversion.asp>

<sup>69</sup> JRF, *Local government support for equity releases: A paper for the Local Government Association/Joseph Rowntree Foundation seminar June 2007*, pp11-17: <http://www.jrf.org.uk/bookshop/details.asp?pubID=907>

example uses indicative figures: much more detailed costing would be required to determine appropriate charging and loan levels.

For simplicity, it could differ from privately-offered products by basing the valuation of the property on the full market price rather than a discounted one. Risk could instead be mitigated by limiting the maximum LTV to 50 per cent. This approach would guarantee that the individual would retain a fixed proportion of the property and so might appeal to those wishing to leave a bequest. As with the US HECM model, attendance at an advice programme could be made a pre-requisite of accessing the loan.

Homeowners with no immediate care needs could sell up to 50 per cent equity or a maximum of £80,000 on the condition that they use the proceeds to purchase pre-funded long-term care insurance (LTCI). Homeowners who wished to fund domiciliary care/home modifications could sell between a minimum of 2 per cent equity and a maximum of 10 per cent equity or £15,000 each year they remain living in their home. At death or permanent entrance into residential care, the agency could sell the property and take their share plus any deferred (interest free) administration charge. Alternatively, they could market the property as a shared-ownership home for people unable to otherwise join the property ladder or purchase the remainder and add the house to the social housing stock.

In order to encourage and enable people to remain in their own home for as long as possible, those assessed as being eligible for domiciliary care and those assessed as eligible for home improvement grants would be able to access relatively small amounts of equity. In order to protect the state against high costs associated with a large number of repeat applications, a flat rate administration charge could be imposed for each drawdown. The charge would be deferred and interest-free. In the absence of any movement on benefit rules, this approach would internalise the debate, causing individuals to choose between a high number of relatively small advances which would result in a large level of total fees but would leave their benefit entitlement in place and a small number of larger advances which would incur lower total fees but would affect their benefit entitlement.

As set out above, the typical arrangement, valuation, legal and insurance costs associated with equity release total between £1,100 and £1,800. Costs could be reduced however if the FSA agreed to establish lighter regulation for arrangements made through the government agency and if IFAs agreed to accept reduced fees. In addition, the costs of subsequent advances would be lower than those associated with the initial application, both because there would not be the same requirement to receive advice and because new valuations could be made by applying average house price changes in the area to the original valuation.

Table 2 presents an example schedule of payments for an individual living in an un-mortgaged property with a current value of £150,000. In the example, the individual chooses to access 5 per cent equity in year one to pay for home improvements. They then release 2 per cent in year nine, 3 per cent in years 10-13 and 5 per cent in years 14 and 15 to pay for domiciliary care. Having entered residential care at the end of year 15, they sell the property and purchase an immediate needs annuity. The total price paid by the client, the value of the remaining estate and the net present value of the government subsidy all depend on the rate of house price growth.

If house prices were to grow at a steady rate of 3 per cent each year, then by year 15 the individual would have accessed £58,223 equity. Following the sale of the property, the individual would be required to repay £79,772 and would retain £153,924 equity, from which they could pay for their residential care needs. Based on a discount rate of 5 per cent, and assuming that the administration charges levied precisely equal the costs of each transaction the net present value (NPV) of the total government subsidy paid would be £5,652.

If house prices were to grow at a steady rate of 7 per cent each year, then the individual would access £86,799 in total, repaying £132,018 after the sale of the home and retaining £281,837. In this instance, the NPV of the state subsidy is negative, representing a profit for the agency. In general, the quicker house prices grow, the smaller the state subsidy required. In practice, if house prices were increasing at a rapid pace, the individual would be likely to sell a smaller proportion of their property in order to access the same level of required funds. As an alternative, individuals could access different 'principal limits' as used in the US HECM market, to ensure that a set NPV is not exceeded.

The same individual could instead sell a 30 per cent stake, worth £45,000, in year one to purchase a pre-funded LTCI policy.<sup>70</sup> An interest-free deferred administration charge of £1,500 and assumed 3 per cent annual growth in house prices would return £71,609 to the state and £162,087 to the estate if the individual again sold the house in year 15. Based on a discount rate of 5 per cent, the NPV would be £12,055. Again, a principal limit arrangement could instead be put in place.

---

<sup>70</sup> Partnership's Premium Cover pre-funded policy requires a single premium of £40,791 for a 75 year-old woman to receive a monthly benefit of £1,000 with a 3 per cent escalator and a six-month waiting period. See Table 3.

**Table 2: Example schedule of payments under state-sponsored home reversion scheme**

Year	Property value	In year benefits/charges			Cumulative benefits/charges			Home sold at year end		NPV of state subsidy <sup>1</sup>
		Equity released	Price paid	Admin charge	Equity release	Price paid	Admin charge	Returned to agency	Residual estate	
<b>1% pa growth in house prices</b>										
1	£150,000	5%	£7,500	£1,500	5%	£7,500	£1,500	£9,075	£142,425	£357
2	£151,500	0%	£0	£0	5%	£7,500	£1,500	£9,151	£143,864	£700
3	£153,015	0%	£0	£0	5%	£7,500	£1,500	£9,227	£145,318	£1,029
4	£154,545	0%	£0	£0	5%	£7,500	£1,500	£9,305	£146,786	£1,345
5	£156,091	0%	£0	£0	5%	£7,500	£1,500	£9,383	£148,269	£1,649
6	£157,652	0%	£0	£0	5%	£7,500	£1,500	£9,461	£149,767	£1,940
7	£159,228	0%	£0	£0	5%	£7,500	£1,500	£9,541	£151,279	£2,219
8	£160,820	0%	£0	£0	5%	£7,500	£1,500	£9,621	£152,807	£2,488
9	£162,429	2%	£3,249	£1,500	7%	£10,749	£3,000	£14,484	£149,569	£2,878
10	£164,053	3%	£4,922	£1,500	10%	£15,670	£4,500	£21,069	£144,624	£3,419
11	£165,693	3%	£4,971	£1,500	13%	£20,641	£6,000	£27,756	£139,595	£4,098
12	£167,350	3%	£5,021	£1,500	16%	£25,661	£7,500	£34,544	£134,480	£4,903
13	£169,024	3%	£5,071	£1,500	19%	£30,732	£9,000	£41,436	£129,278	£5,823
14	£170,714	5%	£8,536	£1,500	24%	£39,268	£10,500	£51,881	£120,540	£6,916
15	£172,421	5%	£8,621	£1,500	29%	£47,889	£12,000	£62,502	£111,643	£8,167
<b>3% pa growth in house prices</b>										
1	£150,000	5%	£7,500	£1,500	5%	£7,500	£1,500	£9,225	£145,275	£214
2	£154,500	0%	£0	£0	5%	£7,500	£1,500	£9,457	£149,678	£422
3	£159,135	0%	£0	£0	5%	£7,500	£1,500	£9,695	£154,214	£625
4	£163,909	0%	£0	£0	5%	£7,500	£1,500	£9,941	£158,885	£821
5	£168,826	0%	£0	£0	5%	£7,500	£1,500	£10,195	£163,697	£1,012
6	£173,891	0%	£0	£0	5%	£7,500	£1,500	£10,455	£168,652	£1,198
7	£179,108	0%	£0	£0	5%	£7,500	£1,500	£10,724	£173,757	£1,379
8	£184,481	0%	£0	£0	5%	£7,500	£1,500	£11,001	£179,015	£1,554
9	£190,016	2%	£3,800	£1,500	7%	£11,300	£3,000	£16,700	£179,016	£1,822
10	£195,716	3%	£5,871	£1,500	10%	£17,172	£4,500	£24,659	£176,929	£2,201
11	£201,587	3%	£6,048	£1,500	13%	£23,219	£6,000	£32,993	£174,643	£2,683
12	£207,635	3%	£6,229	£1,500	16%	£29,448	£7,500	£41,718	£172,146	£3,261
13	£213,864	3%	£6,416	£1,500	19%	£35,864	£9,000	£50,853	£169,427	£3,931
14	£220,280	5%	£11,014	£1,500	24%	£46,878	£10,500	£64,953	£161,935	£4,730
15	£226,888	5%	£11,344	£1,500	29%	£58,223	£12,000	£79,772	£153,924	£5,652
<b>5% pa growth in house prices</b>										
1	£150,000	5%	£7,500	£1,500	5%	£7,500	£1,500	£9,375	£148,125	£71
2	£157,500	0%	£0	£0	5%	£7,500	£1,500	£9,769	£155,606	£139
3	£165,375	0%	£0	£0	5%	£7,500	£1,500	£10,182	£163,462	£204
4	£173,644	0%	£0	£0	5%	£7,500	£1,500	£10,616	£171,710	£266
5	£182,326	0%	£0	£0	5%	£7,500	£1,500	£11,072	£180,370	£325
6	£191,442	0%	£0	£0	5%	£7,500	£1,500	£11,551	£189,464	£381
7	£201,014	0%	£0	£0	5%	£7,500	£1,500	£12,053	£199,012	£434
8	£211,065	0%	£0	£0	5%	£7,500	£1,500	£12,581	£209,037	£485
9	£221,618	2%	£4,432	£1,500	7%	£11,932	£3,000	£19,289	£213,410	£581
10	£232,699	3%	£6,981	£1,500	10%	£18,913	£4,500	£28,933	£215,401	£720
11	£244,334	3%	£7,330	£1,500	13%	£26,243	£6,000	£39,352	£217,199	£895
12	£256,551	3%	£7,697	£1,500	16%	£33,940	£7,500	£50,601	£218,778	£1,104
13	£269,378	3%	£8,081	£1,500	19%	£42,021	£9,000	£62,741	£220,106	£1,342
14	£282,847	5%	£14,142	£1,500	24%	£56,164	£10,500	£81,778	£215,212	£1,608
15	£296,990	5%	£14,849	£1,500	29%	£71,013	£12,000	£102,433	£209,406	£1,896
<b>7% pa growth in house prices</b>										
1	£150,000	5%	£7,500	£1,500	5%	£7,500	£1,500	£9,525	£150,975	-£71
2	£160,500	0%	£0	£0	5%	£7,500	£1,500	£10,087	£161,648	-£149
3	£171,735	0%	£0	£0	5%	£7,500	£1,500	£10,688	£173,069	-£233
4	£183,756	0%	£0	£0	5%	£7,500	£1,500	£11,331	£185,288	-£322
5	£196,619	0%	£0	£0	5%	£7,500	£1,500	£12,019	£198,364	-£417
6	£210,383	0%	£0	£0	5%	£7,500	£1,500	£12,755	£212,354	-£518
7	£225,110	0%	£0	£0	5%	£7,500	£1,500	£13,543	£227,324	-£625
8	£240,867	0%	£0	£0	5%	£7,500	£1,500	£14,386	£243,342	-£737
9	£257,728	2%	£5,155	£1,500	7%	£12,655	£3,000	£22,304	£253,465	-£873
10	£275,769	3%	£8,273	£1,500	10%	£20,928	£4,500	£34,007	£261,065	-£1,074
11	£295,073	3%	£8,852	£1,500	13%	£29,780	£6,000	£47,045	£268,683	-£1,347
12	£315,728	3%	£9,472	£1,500	16%	£39,252	£7,500	£61,553	£276,276	-£1,701
13	£337,829	3%	£10,135	£1,500	19%	£49,387	£9,000	£77,681	£283,796	-£2,143
14	£361,477	5%	£18,074	£1,500	24%	£67,460	£10,500	£103,327	£283,453	-£2,754
15	£386,780	5%	£19,339	£1,500	29%	£86,799	£12,000	£132,018	£281,837	-£3,544

Note: <sup>1</sup> Based on 5% discount rate.

The main risks faced by the state in this model would relate to mortality, interest rates and house prices. Lighter than expected mortality would lengthen the contract period and so make the NPV of the state subsidy higher in magnitude. The size of the sums repaid to the agency at the end of a longer than expected contract could attract negative publicity despite the fact that the state subsidy would actually be higher than if the individual had sold their property at an earlier stage.

The interaction of interest rates and house prices determine the level of subsidy or profit made by the state. Over the long-term, they should offset each other, with higher interest rates reflecting higher inflation which in turn reflects higher house prices. However, there is significant exposure to short term deviations in either market. House price risk can be further discounted depending on how the state views the properties it provides loans on. If they can be seen as potential low cost home ownership vehicles or social housing, then temporary fluctuations in house prices may not represent a serious problem.

The flexibility and low cost offered by the state-sponsored schemes set out above could potentially squeeze demand for private market offerings. However, this effect is likely to be limited because the state schemes would be limited to individuals using proceeds to fund long-term care and home adaptations, which represents a small proportion of the current market. Moreover, the state-sponsored schemes place a cap on what they will offer, meaning that some individuals will still prefer to access equity for long-term care needs via private providers. It is more likely that, by making the product more familiar, state-sponsorship would improve confidence in equity release more generally and so boost the private market.

### **Long-term care insurance**

The establishment of a sizeable LTCI market has significant potential welfare gains compared to an out-of-pocket system. In the absence of insurance, all individuals are subject to uncertainty and must therefore save or have access to sufficient funds to provide an acceptable level of care for the maximum possible duration of any care they might need. By pooling risk, insurance companies can use the law of large numbers to significantly reduce this uncertainty. Customers can therefore be charged a premium based on the average probability of their needing care and on the average duration of that care.

Potential welfare gains can be illustrated using indicative assumptions. Assuming that one in five people will require residential long-term care with an average duration of three years and a maximum duration of 20, at a cost of £28,000 each year, uninsured individuals must save an amount sufficient to provide care for the maximum duration: £560,000. In a sufficiently large insurance market, premiums take into account the probability of care and the average duration. Thus the typical customer is expected to need care for three-fifths of a year (1/5 probability of needing care for a duration of three years), meaning that their personal premium can be reduced to £16,800.

Pre-funded plans are offered to healthy individuals with no immediate need for care. They pay a pre-agreed annual benefit when the customer can no longer perform a number of activities of daily living (ADLs). Premiums are payable as regular or lump-sum payments and are reviewable by the insurer after an initial period of five or ten years. This lack of guarantee has made the product less attractive to potential customers, who know they could face significantly increased premiums as they age and became more likely to require care.



Very few insurance plan products are still available. Partnership's *Care Prepared Plan* is available to all people living in the UK aged 49 to 74. Premiums are payable as lump-sums or on a monthly or annual basis and are reviewable every five years. Premiums are reduced if customers opt to defer payment of the benefit by three, six, 12 or 24 months, but are increased if a benefit escalator is selected. Three levels of cover are provided: 'standard', 'deluxe' and 'premium'. Under all three types of cover the first failure of one ADL results in a lump-sum payment of up to three times the monthly premium: the 'independent living benefit'. Failure of two ADLs results in full monthly benefit payout under the Premium cover, and half of monthly benefit payout under the Deluxe cover. Failure of three ADLs results in full payout under all three types of cover. Payments made direct to care providers are tax free. Table 3 presents sample premiums associated with a monthly benefit of £1,000, by age and gender.

**Table 3: Sample premiums associated with £1,000 monthly benefit: pre-funded LTCI**

Age	Monthly premiums (£)			Single premiums (£)		
	Standard	Deluxe	Premium	Standard	Deluxe	Premium
<b>Females</b>						
<i>no escalator; three month waiting period</i>						
50	56.15	62.20	68.54	12,547	13,914	15,349
55	68.16	75.83	83.85	13,870	15,448	17,108
60	85.62	95.59	106.03	15,480	17,308	19,235
65	112.65	126.15	140.22	17,489	19,622	21,873
70	157.90	177.15	197.17	20,043	22,550	25,197
75	244.10	273.82	304.51	23,314	26,275	29,400
<i>3% escalator; six month waiting period</i>						
50	133.98	151.99	171.01	30,200	34,271	38,576
55	145.22	165.20	186.27	29,740	33,853	38,211
60	162.29	185.08	209.10	29,486	33,663	38,096
65	189.65	216.75	245.25	29,569	33,847	38,393
70	236.56	270.70	306.46	30,147	34,574	39,281
75	325.91	372.65	421.16	31,275	35,889	40,791
<b>Males</b>						
<i>no escalator; three month waiting period</i>						
50	38.06	38.68	39.30	8,075	8,211	8,346
55	45.97	46.73	47.49	8,797	8,949	9,101
60	57.88	58.86	59.85	9,724	9,897	10,070
65	76.68	77.97	79.26	10,910	11,102	11,294
70	107.59	109.21	110.84	12,356	12,554	12,753
75	164.93	166.85	168.78	14,124	14,301	14,478
<i>3% escalator; six month waiting period</i>						
50	78.62	80.38	82.14	16,872	17,255	17,641
55	86.05	88.01	89.99	16,613	17,001	17,393
60	97.68	99.96	102.25	16,528	16,924	17,325
65	116.44	119.16	121.89	16,669	17,072	17,478
70	147.38	150.63	153.88	17,021	17,411	17,804
75	203.99	207.83	211.66	17,590	17,938	18,288

Source: Partnership

### LTCI and low earners

The sample premiums detailed in Table 3 are largely beyond the reach of low earners: they do not have the spare funds to meet the monthly premiums and they do not have access to

sufficiently liquid wealth to meet the single premiums. As a result, pre-funded plans in the UK have been almost exclusively taken out by members of social grades A and B.<sup>71</sup>

Improved access to equity release products as discussed above could improve the ability of low earners to buy LTCI products, particularly if access to state-sponsored equity is conditional on taking out a policy.

### **LTCI market failings**

While the welfare benefits of insurance are clear, the LTCI market has so far not reached a significant size, prompting some discussion at our July financial services expert group as to whether long-term care represents an uninsurable risk.<sup>72</sup>

LTCI was first introduced in the UK at the same time as the Community Care Act 1990. It was not subject to FSA regulation until October 2004, but by then the main providers had withdrawn most of their products from the market due to low take-up. In total, around 40,000 LTCI policies were in place in 2006; 24,000 based on single premiums and 16,000 based on regular premiums. This represents 1.6 per cent of the 65+ age group currently in need of care and just 0.5 per cent of the entire 65+ group.<sup>73</sup> Low take-up has been attributed to a number of factors, on both the supply- and demand-sides.

With regards to supply, providers face difficult pricing decisions. The probability of a long term care claim is generally higher than for more traditional insurable products and rapid increases in longevity mean there is significant uncertainty about the expected duration and size of payouts. Actuarial insurance products are designed on the basis of measurable risk and probability. To counter the uncertainty inherent in longevity projections, providers have tended to produce premiums that err on the side of caution and annual payouts that are capped. In addition, premiums are generally reviewable every five years, meaning that customers face escalating costs as they age.

The market is also subject to some adverse selection, with the average age of people taking out pre-funded policies being 67.<sup>74</sup> A further problem is that insurers, concerned about the possibility of moral hazard, offer cover on the basis of tightly-specified criteria, such as failure of three ADLs, rather than a more general 'need for care'. This could potentially leave some people facing long-term care costs being unable to claim against an LTCI policy. As mentioned above, in the interests of fairness, locally designed eligibility criteria need to be replaced with a new nationally consistent measure. If LTCI is to become a viable product, it will be important for entitlement to be redesigned to more closely resemble this measure. In addition, the private insurance market provides no payout prior to a care need being established, and therefore fails to consider the benefits associated with preventative measures for older people such as home adaptations and the installation of telecare.

On the demand-side, many people underestimate the risk of needing to fund care, both because they choose not to consider the possibility and because, to the extent that they do consider it, they believe they will receive government support. As a result, the insurance products on offer appear unnecessary or overly expensive to many, as well as being long-term and complex.

---

<sup>71</sup> Conversation with Brian Fisher, LTC Marketing Manager AXA Lifetime Care.

<sup>72</sup> Resolution Foundation Financial Services Expert Group meeting, 21 July 2008

<sup>73</sup> Lang & Buisson, *Care of Elderly People Market Survey 2007*, p23

<sup>74</sup> JRF, Private funding mechanisms for long-term care, 2005, p5: <http://www.jrf.org.uk/bookshop/details.asp?pubID=692>

Left unchecked, the market appears destined to remain locked in a downwards spiral. Low demand means that insurance companies are unable to fully take advantage of the law of large numbers and must therefore maintain premiums at a higher level than would be possible if take-up was greater, thus further dampening demand. Faced with low demand, only two providers remain in the market. The absence of another competitor restricts demand still further because IFAs prefer to provide a choice of at least three products when advising clients on options, and therefore will often choose to overlook LTCI offerings.<sup>75</sup>

### **Scope for LTCI market innovation**

As with equity release, the introduction of more flexible products could help stimulate the LTCI market.

#### ***Dual pricing***

LTCI premiums are relatively large because of the high potential payouts faced by insurers. If the risks of needing home care and residential care were split, then premiums could be significantly reduced. For example, policies could be offered that covered the need for domiciliary care at a relatively low price with individuals continuing to take the risk of needing residential care in the knowledge that they could sell their property in that eventuality and purchase an immediate needs annuity.

Alternatively, policies covering residential care only could be sold at a price that reflected the reduced risk of payout compared to policies that cover any failure of ADLs.

#### ***Bundling products***

As mentioned, LTCI premiums are beyond the reach of many. Although equity release could provide the means of paying for insurance, very few have been used in this way in practice, partly because this would involve individuals using one product perceived as being poor value for money (equity release) to pay for another (LTCI). However, demand could be stimulated if more relevant products were designed.

For example, bundling of equity release and LTCI could allow for reduced prices due to economies of scale. There would also be scope for dual pricing. For reversion schemes, insurance for home care could be paid for at full cost, but insurance for residential care could be discounted to reflect the fact that the provider would receive a financial return at that point anyway following the sale of the property.

Using equity release to fund an insurance policy might also appear more attractive if the cover provided by the insurance was broader than simple LTCI. The use of equity release to pay for a bundled long-term care and private medical insurance would allow consumers with significant amounts of equity to remain living in their homes with no change in their disposable income but full cover against deteriorating health.

### **Scope for state support for LTCI**

Again, as with equity release, there are limits to how much commercial providers can reduce costs to encourage demand for LTCI. In order to make the product relevant for people with low and moderate incomes, the state needs to provide support to the market. This support includes facilitating growth in the private market and direct provision of a public product.

---

<sup>75</sup> Conversation with Philip Brown, Head of Retirement & Care Product Development, Partnership.

## ***State intervention***

### **Co-payment**

As part of a new funding settlement, the state could share insurance risks with financial providers. For example, the ABI has suggested a co-payment model for individuals taking out LTCI. Under its proposal, the state would agree to provide universal funding of a fixed proportion of the individual's care needs, based on an appropriate benchmark level of care subject to annual assessment, leaving the individual to insure against the remainder of their potential care costs. In all cases potential payouts would be reduced, meaning that premiums could also be reduced. Although premiums would probably be reviewable in most cases at first, an increase in the pool of clients could eventually allow for the introduction of guaranteed products. The implied endorsement, and possibly active encouragement, of LTCI products by the Government would help further stimulate the market.

### **Limited-liability**

Alternative means of sharing risks focus specifically on the uninsurable longevity-linked element of long-term care. For example, the state could remove longevity uncertainty from the private sphere by introducing the limited-liability model described in Wanless and agreeing to take responsibility for funding the care of an individual after an initial period. Private liability would therefore be capped and insurance providers would enjoy greater certainty about costs and so be able to reduce their premiums.

A reversal of this model, in which the state provides universal funding for a specified initial period before transferring the risk to the individual, would also reduce the payouts faced by insurance companies and so reduce premiums. However, the open-ended nature of this model would mean that insurance companies still faced considerable uncertainty about longevity, unless the state agreed to step in once again at a future point in the individual's care needs.<sup>76</sup>

As set out above, in the US the state provides insurance for providers of equity release products against the possibility of the total outstanding debt outstripping the value of the home when it is sold. In this model, the financial providers are able to calculate premiums based on measurable risk and the state funds the un-measurable longevity-based uncertainty element. A similar model can be envisaged in relation to LTCI. Providers, basing their calculations on Government Actuary Department projections for different cohorts, can calculate efficient risk-based insurance premiums in the knowledge that the Government will take responsibility for meeting any costs arising from longer than projected longevity. To fund this expenditure, the Government could issue longevity-linked bonds designed to hedge its risks.

Limited-liability LTCI products introduced in the US have been sold as asset-protecting. In return for taking out insurance which provides a payout for a specified period, individuals are offered preferential access to Medicaid in order to ensure that, should they survive beyond the protection of their insurance, they would not need to further drawdown their assets beyond an agreed level. A similar model could be envisaged in the UK, with people taking out appropriate policies receiving special consideration when they are means-tested.

---

<sup>76</sup> Wanless Social Care Review, *Securing Good Care for Older People: Taking a long-term view*, 2006, pp 239-250: [http://www.kingsfund.org.uk/publications/kings\\_fund\\_publications/securing\\_good.html](http://www.kingsfund.org.uk/publications/kings_fund_publications/securing_good.html)

In the UK, care cash plans already offer time-limited cover to those without existing care needs, providing more certainty for insurance companies about total payouts. In addition to paying out for failure of a specified number of ADLs, some products also provide benefits in the event of physical and mental illnesses more likely in older age, such as Alzheimer's, Motor-neurone disease and Parkinson's. For example, Lincoln's *Financial Foundations – Elderly Care Cover* is available to people aged 18 to 79 and pays out a pre-agreed cash sum on a one-off basis following failure of three ADLs or the diagnosis of the diseases set out above. Premiums are reviewable and the cash benefit can be index linked.

Each of these limited-liability models has income distribution implications. The PSSRU's 2006 analysis of the costs and distributional effects of a range of proposed funding options found that limited-liability provided above average gains for members of the highest income quintile only. Average benefits accruing to the lowest income quintile were just below average, but gains among the second and third income quintiles – low earners – were significantly lower.<sup>77</sup>

### **Direct state provision**

By lowering required premiums, the various risk-sharing proposals set out above could extend access to LTCI products. However, pre-funded options would be likely to remain the preserve of wealthier groups, with many low earners continuing to adopt a 'wait and see' policy.

Just as private providers could consider bundling LTCI with equity release in order to reduce costs and extend access, so the state could provide a product which links the payment of premiums to the purchase of an equity stake.

The International Longevity Centre has proposed an age-specific, income-based *National Care Fund* for the UK.<sup>78</sup> Contributions to the proposed Fund would be sought from people aged 65 and over, thus preventing one cohort of individuals 'paying twice'. 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. Assessment of need and the details of the entitlement could be designed to be much more flexible than those available from the private market: to include the option of funding preventative action for instance. Crucially, participants would be given flexibility over how and when to pay their contribution, including out of their estate, with the contributions of people choosing to pay at a later date subject to inflation. As such, low earners with low levels of liquid resources but access to housing wealth would still be able to contribute and gain cover.

The poorest individuals would have their contributions met by the state, while an upper cap would ensure the wealthiest individuals do not have to make excessive contributions. Those already in receipt of care when they reach the age threshold would be required to make a contribution based on an assessment of their means, but the state would contribute an extra amount equivalent to the difference in the cost of an immediate-needs annuity.

---

<sup>77</sup> PSSRU, *Paying for Long-Term Care for Older People in the UK: Modelling the Costs and Distributional Effects of a Range of Options*, August 2006, pp42-48: [http://www.pssru.ac.uk/pdf/dp2336\\_2.pdf](http://www.pssru.ac.uk/pdf/dp2336_2.pdf)

<sup>78</sup> ILC, *A National Care Fund for Long Term Care: A Policy Brief*, February 2008; ILC, *National Care Fund: Supplementary Paper One*, July 2008: <http://www.ilcuk.org.uk/view.jsp?view=browse&type=publication&order=date&by=desc&skip=0&pageID=55>

As with private insurance, the success of the scheme depends on high levels of participation and could be subject to adverse selection. While some form of auto-enrolment might be possible, another proposed option is to allow people to choose to join the *Fund* at a point after their 65<sup>th</sup> birthday, but at a higher cost than if they had joined straight away. Conversely, it is proposed that some could pay their contributions before they turn 65. Having joined the Fund, individuals would only be able to resign within the first year, in order to prevent withdrawal in the face of reduced risk of prolonged high care bills. Some refund would be payable if the individual were to die within the first 12 months of joining.

The ILC believes that the *Fund* would require an average contribution of £10,000, although there would be a trade-off in the complexity of the means assessment used to determine individual contributions between administration costs and perceived fairness. As with the ABI co-payment proposal detailed above, the benefits of the *Fund* could be supplemented by a contribution from the state. Alternatively, the state could agree to fund a fixed proportion of an individual's determined contribution.

The success of the *National Care Fund* would to some extent depend on the growth of the LTCI market, because wealthier households would want some means of topping-up their care coverage. Policies designed to promote both the social and private markets could be reinforcing: the creation of a government-sponsored scheme should improve trust in the private market, while the visibility of a private market might encourage people to join the social scheme. The Government could provide incentives for people to take out both forms of insurance by offering to match-fund some part of the private premium payments of people also opting into the *Fund*.

The *National Care Fund* is designed to be voluntary. Compulsion would result in the scheme becoming a hypothecated tax rather than an insurance fund. However, in the absence of compulsion the *Fund* is likely to face similar issues of take-up to private LTCI schemes, with many individuals opting out of paying a significant sum of money for an eventuality that may not happen. Given the good health enjoyed by most recent-retirees there may continue to be a tendency to underestimate the risk of needing care. Nevertheless, the option of delaying payment is likely to make the *Fund* a more attractive means of insuring against long-term care needs than most private policies for a large number of low-income high-wealth individuals.

### **Long-term savings mechanisms**

Equity release may continue to be a sensible means of accessing funds for purchasing long-term care and associated insurance products in decades to come, but it is not a solution for everyone and may not be a sustainable option over time. A significant minority of older households are projected to have no access to housing assets. The CML estimates that the number of tenant households aged 60 and over will increase from 2.6 million in 2006 to 3.0 million in 2026, representing one-quarter of all older households. Even among the three-quarters who do own property, there are likely to be a number with limited access to equity release products because of the low values of their houses.<sup>79</sup> While those without the means to pay for their own care should receive support from the state, the level of entitlement is likely to be basic, particularly if a form of universal entitlement is introduced. Moreover, some with care needs who might qualify for financial support might be denied access on the basis

---

<sup>79</sup> CML, *Prospects for UK housing wealth and inheritance*, July 2008:  
<http://www.cml.org.uk/cml/filegrab/ResearchReportProspectsforUKhousingwealthandinheritance.pdf?ref=5975>

of eligibility criteria. Others will want to supplement the care payments they make from equity release or LTCl by drawing down their savings.

Among the post-baby boomer generation, it is not clear what asset holding will look like at retirement. The average age of first-time buyers has increased in recent years, from 29 in 1974 to 34 in 2007.<sup>80</sup> In addition, increasing family breakdowns mean that a growing number of people are 'starting again' in the housing market in their 40s and 50s. Although the retirement age for future generations is set to increase, the ageing profile of housing advancement means that homeowners will reach ages at which it would be most beneficial to purchase LTCl holding properties that have had less time to appreciate in value than the ones owned by previous cohorts. Higher levels of personal debt among post-baby boomers also mean that a larger proportion may still have mortgaged property and outstanding debts when they reach retirement. Moreover, there is no guarantee that housing will continue to increase in value at the rates experienced since the middle of the twentieth century.

In order to guard against the possibility that housing assets will not provide individuals with the means to fund their long-term care 30 or 40 years from now, it is important to consider the encouragement of long-term saving among those of working age, particularly among low earners.

### **Low earners and saving**

Work undertaken for the Foundation by McKinsey & Company in 2006 concluded that just 22 per cent of low earners could be considered to be financially healthy. Of the 12 million people making up the low earners group, 12 per cent were described as being in an "acute" position, always running out of money before the end of the month. A further 26 per cent were considered "chronic", with virtually no savings for their age, and 39 per cent were described as being "mildly" financially unhealthy, with minimal savings for their age.

Among low earners, 42 per cent make savings from their incomes, compared with 55 per cent among higher earners. In addition, the amounts saved by low earners are lower than among the rest of the population. Saving among low earners is much more likely to be for specific short-term purposes than for the long-term. Saving for holidays significantly outstrips saving for retirement, even among those on the eve of retiring.

Retirement income is a principle concern among low earners: 48 per cent of those aged over 40 and below retirement say they worry about not having 'enough' income in retirement, compared with 33 per cent among a corresponding sample of the wider population. Just 53 per cent of low earners are members of an available employer's pension scheme, compared with 81 per cent of those with higher incomes. Similarly, just 17 per cent of low earners have personal pensions, compared with 27 per cent of people with higher incomes.

### **Long-term savings market failure**

In contrast to equity release and LTCl, the market for long-term savings products is a mature one with significant take-up. Employers' and private pensions, ISAs and other savings vehicles are highly visible and available to most members of society. Where the market fails is in relation to the amounts saved by many individuals, particularly low earners, and the failure to make any provision for potential long-term care costs.

---

<sup>80</sup> IFA Online, "Average first time buyer age reaches 34", 10 August 2007: <http://www.ifaonline.co.uk/public/showPage.html?page=462119>

It has been calculated that society as a whole is saving £27 billion less every year in pension funds than is needed for a comfortable retirement, with the shift from defined benefit schemes to defined contribution ones adding another £5-6 billion to the problem each year.<sup>81</sup>

### ***Attitudes to saving for long-term care***

Despite inadequate levels of savings, findings from the 2004 *British Social Attitudes* survey suggest that the British public broadly accepts that state provision for pensions should at least be partially means-tested and that individuals have a responsibility to save. Among respondents to the 2004 survey, 80 per cent agreed that the Government should encourage people to save for retirement and 72 per cent said that young people should start saving for retirement as soon as they can, even if that meant having to cut back on spending.<sup>82</sup>

The 2005 *Scottish Social Attitudes* survey included two questions designed to establish whether people believe that individuals have as much responsibility to save for personal care as they do for pensions. The two propositions resulted in quite different responses: while half agreed that individuals have some responsibility to save for a decent pension, just 16 per cent believed there to be a similar responsibility for people to save for care in old age. Two-thirds of the respondents thought that people do not have a responsibility to save for their care.<sup>83</sup> Note, however, that these questions were only asked as part of the Scottish survey and therefore may be somewhat biased by the experiences of free care north of the border.

In our December 2007 survey, 45 per cent of low earners stated that they had made no provision for their long-term care needs, compared with 39 per cent on average. Low earners were also less likely than average to expect to fund their care needs through their pensions or equity in their homes.

### **Scope for state support for long-term saving**

The key challenge in relation to long-term savings products is to increase saving provision. Indirect state intervention in the market could facilitate the introduction of more flexible and care-appropriate products as well as incentivising take-up.

### ***State intervention***

For example, the Government could ensure that under the new funding settlement individuals could take advantage of capital-protecting long-term savings policies, such as those used in the US which ring-fence the home from any care-related means test if the individual can show they have made adequate long-term care provision.

Lifetime savings accounts (LSAs), already in place in the US, represent an alternative tax-exempt long term savings vehicle. The Redwood Report for the Shadow Cabinet, published in 2007, proposed a UK version in which individuals would be permitted to invest in a fund with full income tax relief on contributions and no Capital Gains Tax on investments sold within the fund. Money could be withdrawn tax free to buy a pension annuity or make pension payments. In addition, individuals would be able to borrow from their account during their lifetime to fund specified items such as property, training courses, and children's university fees, subject to the money being repaid within an agreed period. Commercial

---

<sup>81</sup> The Actuarial Profession, *Equity Release Report 2005*, 13 January 2005, p8:

[http://www.actuaries.org.uk/data/assets/pdf\\_file/0006/19248/equityreleaserepian05V1.pdf](http://www.actuaries.org.uk/data/assets/pdf_file/0006/19248/equityreleaserepian05V1.pdf)

<sup>82</sup> NatCen, *British Social Attitudes*, 22<sup>nd</sup> Report, 2005/06, Table 7.5

<sup>83</sup> NatCen, *British Social Attitudes*, 23<sup>rd</sup> Report, 2006/07, Table 4.3



borrowing against the security of the fund would also be allowed to encourage people to invest in their own businesses.<sup>84</sup>

The Conservative document included wider proposals to provide individuals with greater freedom to fund their retirement by removing the compulsion to buy an annuity with the invested money in any pension fund and by removing the maximum age at which an individual can start drawing down their pension. However, a more prescriptive form of LSA drawdown could be used to increase private provision for long-term care. For example, it could be stipulated that the tax free status of LSAs is dependent on account holders using part of their funds to purchase LTCI at retirement.

Similar soft compulsion could be introduced in relation to existing pensions, with the level of tax relief associated with lump-sum pension payments conditional on a proportion of the fund being used to purchase some form of LTCI. The state could also promote the introduction of products that allow pensioners to take a reduced annuity at the start of retirement in return for an accelerated future income in the event of a need for care being established.<sup>85</sup>

The inadequate level of many people's pension pots means that it is difficult to envisage such action having a significant impact in the short-term, particularly for low earners. However, if the Government's emphasis on increasing pension provision among younger people and the introduction of auto-enrolment and personal accounts prove successful, post-baby boomer pensioners could be better placed to take advantage of such products.

---

<sup>84</sup> Economic Competitiveness Policy Group, *Freeing Britain to Compete: Equipping the UK for Globalisation Submission to the Shadow Cabinet*, August 2007: <http://www.conservatives.com/pdf/ECPGcomplete.pdf>

<sup>85</sup> Wanless Social Care Review, *Securing Good Care for Older People: Taking a long-term view*, 2006, p233: [http://www.kingsfund.org.uk/publications/kings\\_fund\\_publications/securing\\_good.html](http://www.kingsfund.org.uk/publications/kings_fund_publications/securing_good.html)

## **V – Low earners’ reaction to funding options**

In October 2008, Opinion Leader conducted two half-day workshops with low earners on our behalf. Each workshop involved 20 participants between the ages of 40 and 75, representing a mix of homeowners and non-homeowners and a mix of rural and urban residents. The workshops sought to gauge the reactions of low earners to a number of the potential funding options set out in this paper along with the Foundation’s vision for the future of long-term care and model for a new information, advice and guidance service.

### **General thoughts**

In general, there was low awareness among the participants of the realities people will face when they come to needing long-term care. This appeared to be partly due to people being unaware of facts and figures, but also partly due to misplaced assumptions. Many were unaware of local variations in eligibility criteria. Once made aware of it, they took a strong objection to it. Similarly, many were surprised at the high cost of formal care and the fact that the state does not automatically meet the costs, even for those with relatively modest means.

As mentioned above, surveys relating to long-term care funding have consistently returned a bias towards collective mechanisms such as a hypothecated national insurance or an increase in income tax. In our workshops, many of the low earner participants felt that they were entitled to be looked after in their old age having paid national insurance and tax all their lives. There was a clear emphasis on equity. Participants argued that everyone with care needs should have them met and that those without substantial assets should not suffer an inadequate level of care.

There was a rejection in both workshops of the concept of fully paying for their own long-term care. Participants assumed that care had been provided free at the point of use in the past and that calls for direct funding represented a reversal of policy. Despite support for the concept of equity, there was a belief that the current system penalises people for saving and rewards those who live in the here-and-now rather than building up savings. Homeowners argued that they had been prudent over the years paying off their mortgage and they resented the idea that others should get a free-ride from the Government at their expense. There was resistance to the argument that a large proportion of property equity is unearned and to the idea that the quality of care so-called ‘free-riders’ receive is often inadequate. Participants also highlighted conditions in Scotland, Wales and France, believing that long-term care in these countries is fully funded by the state:

*We’ve paid taxes all our lives, why should we have to pay more... to look after ourselves?*

*Why do people in Scotland get their prescriptions for free and I need to pay for it?*

On the whole, participants had made no financial plans for potential long-term care needs, partly due to an underestimation of the costs involved and partly because people prefer not to think about old age:

*You try to push it to the back of your mind most of the time... you could be dead tomorrow... everyone’s scared of ageing.*

Although asked to consider the merits of equity release and LTCI in particular, several participants volunteered their own suggestions for methods of increasing funding, including introducing a new National Lottery game and holding a regular national fundraising event for older people much like Children in Need or Live Aid.

### **Attitudes to equity release**

Participants were presented with examples of typical costs and benefits associated with both lifetime mortgages and home reversion products. Generally, views among homeowners were mixed. Those without dependents were not concerned about leaving an inheritance for their children and tended to see equity release as an attractive option. However, both they and others in the groups who reacted positively to the concept of equity release made it clear that the attraction was largely related to the opportunity to provide for a comfortable early retirement rather than funding long-term care. Indeed, some suggested that equity release offered a useful way of drawing down their wealth prior to needing long-term care in order to ensure they passed the means test.

Other participants were nervous about the concept of equity release. In particular, they expressed concern about taking on further debt at an advanced stage of life, suggesting that it would be “depressing”. Some were unworried by the prospect because they felt they wouldn’t miss the money when they were dead, but others wanted to make sure they left an inheritance for their children and grandchildren. For many, this desire was driven by the fear that their families would otherwise be unable to enter the housing market, perhaps reflecting the difficulties faced by accumulator low earners. Among those who reacted favourably to equity release, home reversions were favoured over lifetime mortgages because of the certainty of being able to retain some capital. Given the current contraction in the housing market, however, people were unable to definitively agree which form of equity release was better. Most participants were sceptical about the value for money offered by the schemes, with resistance to the idea of receiving anything other than a full market valuation of the property.

Although some group members accepted that equity release represented a sensible means of paying for long-term care in the absence of assistance from the Government, a number of participants argued that downsizing was a more acceptable option. They felt it would provide them with more control over their money, as well as offering the benefit of moving to a home more suitable for their age and situation. It was also considered a safer, more commonplace solution, with many commenting that it was “what people do nowadays”.

Group members were much more amenable to the idea of a state-run equity release scheme. The assumption was that such a product would operate without a profit element, thus providing better value for money. People argued that they had already provided banks with a profit by taking out a mortgage during their accumulation stage and that they didn’t want to further line their pockets as they decumulated. It was also felt that a Government scheme would be more trustworthy than a financial provider product, with less chance of collapse. One participant volunteered the idea of local authorities purchasing all or part of an individual’s property which they could then use to house social tenants when the individual entered care or died.

### **Attitudes to long-term care insurance**

Overall, there was little appetite for a standard form of private LTCI. Premiums were considered “frighteningly” high, both in absolute terms and in terms of the returns offered. It was viewed as an expensive gamble, with the prospect of paying out large sums of money and never seeing a penny of benefit. Moreover, to the extent that there might be some benefit, the goal of guaranteeing a place in a care home was not considered an attractive enough proposition to justify spending so much.

The prospect of using equity release to pay LTCI premiums was seen as more attractive, and was spontaneously suggested in both workshops. Freeing up bricks and mortar to fund a lump-sum premium was thought to be less visible and therefore less painful than using savings or a pension. Reduced premiums would also make LTCI more attractive, with group members suggesting government subsidies, starting payment at a younger age and encouraging more people to sign up.

As with equity release, participants favoured the prospect of a state-run scheme. Again trust and cost issues were raised. In addition, there was a sense that a state-run scheme would provide greater quality assurance in terms of the care provided. Even though participants were reminded that LTCI was simply a means of delivering financing rather than care itself, group members were still happier to have government involvement:

*It would be monitored better if it was government run.*

People also preferred a state-run scheme because it could address the gender imbalance in LTCI premiums. All group members agreed that it was unfair that women should be asked to pay more for insurance, particularly as they were likely to have fewer savings than men. Participants favoured an income-based premium along the lines of the ILC’s *National Care Fund* rather than a risk-based one, with people being charged on the basis of ability to pay. However, nobody in the workshops considered themselves to be part of the wealthy group, with homeowners baulking at the idea of subsidising other’s premiums. When asked if a state-run insurance scheme should be compulsory, nobody said that it *shouldn’t* be, but they did not see how it *could* be.

## **VI – Conclusions and recommendations**

Long-term care in England requires a new funding settlement. Both collective expenditure, administered by local authorities, and direct personal expenditure are inadequate, resulting in unmet need and an over-reliance on informal care provision. This inadequacy of funding produces a settlement which is unfair, inefficient, and poorly placed to meet the demands of an ageing population.

In order to allow individuals to factor potential long-term care costs into their retirement planning, the Government must make clear the level of entitlement people can expect to receive from the state. This entitlement should be designed to address the unfairness associated with current variations in approaches to eligibility across local authorities and with the current means test which provides no assistance to people with relatively modest means. This perceived unfairness cannot be entirely removed in any system other than one that is entirely collectively funded. We have proposed the introduction of a minimum universal entitlement which, while still requiring some form of means test to determine those requiring additional support, would at least ensure that no one is required to directly fund all of their own care needs.

However, the cost of providing universally adequate levels of care for all members of society is likely to be prohibitively high if collective funding sources alone are relied on. It is important, therefore, that a new funding settlement is accompanied by measures designed to facilitate individuals with the means to top-up their entitlement via direct expenditure. Among baby boomers and older generations, the majority of wealth is stored in housing. Therefore, products and mechanisms which allow this wealth to be drawn down are likely to be of most relevance. Younger generations have not yet accrued the same level of housing wealth and may be better served by long-term savings products. The use of LTCI to pool risks across society would produce welfare benefits for all generations.

The markets for equity release, LTCI and long-term savings products are all subject to market failures. In part these are supply-side issues, and there is scope within the industries for more flexible, cheaper and more relevant products. The state could support these efforts by intervening in these markets to help engender trust and reduce the costs faced by providers. In most instances, products can be envisaged that would represent sensible options for individuals either faced with immediate care needs or wishing to plan for the future. Where gaps remain, the state should consider directly providing or sponsoring products designed to widen access. Taken together, concerted industry and state action could provide a comprehensive range of product options that co-exist and complement each other and enable individuals with different care needs, resources, attitudes to risk and inclinations to plan to approach long-term care in a way that best suits them

Improved supply of equity release, LTCI and long-term savings products should help to stimulate demand. However, it is probable that the process would work more effectively the other way around, with heightened demand for such products encouraging industry and the state to design appropriate products. Existing demand-side failings in these markets are largely centred on individuals' ignorance or unwillingness to consider the need for long-term care financial planning. As a corrective measure, the state should act to communicate the reality of long-term care issues to the public via some form of 'national conversation' and

ensure that all members of society have access to appropriate advice. In addition to informing individuals about the availability and workings of a range of equity release, LTCI and savings products, improved access to money guidance could also reduce the costs of pre-sale advice associated with these products because a higher proportion of those approaching providers would already be 'product-ready'. While such measures should help to stimulate demand, it is likely that individuals will remain reluctant to think about long-term care. The Government may therefore need to use soft-compulsion and behavioural methods to ensure suitable options are taken up in significant numbers.

Our work with low earners suggests that, while older individuals resent the prospect of having to fund their own care needs, younger generations are prepared to take a more pragmatic view. When we explained the reality of the situation and the various products already available to low earners there was an acceptance that such options need to be considered and there was cautious support from some group members. The costs involved meant that equity release was seen as a more viable option than LTCI, but there was some interest in the idea of bundling the two products together, particularly if this were provided by the state.

While it is right that the Government is entering into a consultation process on the design of a new funding settlement, and while any potential state-sponsored equity release and LTCI products will take some time to develop, many of the actions set out above that seek to correct supply- and demand-side failings in the markets for long-term care financial products can and should be taken immediately.